STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295075	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pahrump Health and Rehabilitation Center	4501 N Blagg Road Pahrump, NV 89060

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review the facility failed to ensure the physician ordered dressing changes for a midline catheter (a small flexible tube inserted into a vein of the upper arm) for 1 of 33 sampled residents (Resident 84). The deficient practice had the potential for the midline catheter to become infected due to the dressing not being changed.Findings include:Resident 84 (R84) was admitted to the facility on [DATE] with diagnoses including osteomyelitis of vertebra, sacral and sacrococcygeal region, urinary tract infection, and acute kidney failure. On 12/16/2025 at 11:22 AM, R84 was lying in bed with a midline catheter in the upper left arm. The midline dressing was not dated.A Physician Order dated 11/27/2025 documented may insert midline for intravenous (IV) antibiotics. R84's medical record lacked a physician order for midline dressing changes. On 12/17/2025 at 12:18 PM, a Licensed Practical Nurse (LPN) explained residents with IV lines would have the dressing changed within the first 24 hours of admission and then every seven days after. The LPN explained R84 was scheduled to have midline dressing changes on Sundays. The LPN confirmed R84's midline dressing was not dated and reviewed R84's medical record and confirmed no documentation the dressing was changed. The LPN explained was unable to determine when the midline dressing was last changed. On 12/17/2025 at 3:07 PM, the Director of Nursing (DON) explained midline dressing changes would be completed within 24 hours of admission and every seven days following. The DON reviewed R84's medical record and confirmed there was no order for midline dressing changes. The facility policy titled Vascular Access Devices and Infusion Therapy Procedures, dated 2011, documented transparent membrane dressings for midlines were changed at a minimum frequency of every seven days and as necessary (PRN).

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure 1) a smoking safety evaluation was completed to determine whether a resident was safe to smoke independently or required supervision for 1 of 33 sampled residents (Resident 39); and 2) and prevent residents or staff from smoking in the facility enclosed courtyard. The deficient practice had the potential to place residents, staff, and visitors at risk of injury related to smoking.Findings include:1) Resident 39 (R39) was admitted [DATE], readmitted [DATE], with diagnosis including paraplegia, anxiety disorder, and schizoaffective disorder. R39 was listed on the facility's smokers list.A Care Plan dated 11/30/2025, documented resident was a smoker.On 12/16/2025 at 11:22 AM, R39 reported going outside the facility grounds to smoke independently.On 12/18/2025 at 7:10 AM, R39 was observed outside, across the street from the facility, seated in a wheelchair and smoking alone without staff supervision.A Smoking Safety Evaluation dated 09/14/2025, lacked documented evidence of an interdisciplinary team (IDT) determination regarding whether the resident was safe to smoke independently or required supervision, as Section E was left blank.On 12/17/2025 at 12:54 PM, the Director of Nursing (DON), explained the facility was a non-smoking facility and residents that chose to leave the facility grounds to smoke were to have a smoking assessment and a smoking safety evaluation completed.On 12/18/2025 at 4:10 PM, the Executive Director (ED), explained the purpose of the smoking safety evaluation was to determine if R39 was safe to smoke independently. The ED acknowledged R39's smoking safety evaluation dated 09/14/2025, lacked documentation of the IDT determination regarding whether the resident was safe to smoke independently or required supervision, as the designated section was not completed.2) On 12/17/2025 at 2:20 PM, during an inspection of the facility's enclosed courtyard, the area under the patio roof which contained one table and nine chairs was observed. Fifteen cigarette butts were found on the ground, two of which were within six inches of the facility walls. Multiple burn marks were present on the cement floor next to the table, consistent with cigarettes being extinguished against the cement surface. Cigarette ashes were observed on the floor, and one empty packet of cigarettes was found in the trash bin.On 12/17/2025 at 2:38 PM, a Licensed Practical Nurse (LPN), reported that the enclosed courtyard was used by residents as well as staff during the nightshift.On 12/17/2025 in the afternoon, the Environmental Service (EVS) Director acknowledged evidence of smoking activity had previously been found in the courtyard, including smoking materials, by the staff member responsible for emptying the trash bin in the courtyard. The EVS Director explained the findings were reported to management.On 12/17/2025 at 2:48 PM, the Executive Director (ED), explained the enclosed courtyard was used by both residents and staff. The ED confirmed the cigarette butts on the ground, two of which were within 6 inches of the facility walls, the extinguished cigarette burns on the cement, and the ashes on the floor. The ED explained staff had not been observed smoking in the courtyard during the day, was aware staff used the courtyard at night, and staff may have smoked at night. The ED reported violations of the facility non-smoking policy were a continuous concern for the facility. The ED stated had received reports in the past of evidence of smoking in the courtyard by staff and residents and acknowledged the use of the courtyard for smoking posed a fire risk for the facility.A facility policy titled Resident Smoking Safety Independent and Unsupervised updated January 2025, documented it was the policy of the center to provide a safe environment for residents, staff, and visitors by limiting the use of smoking materials on its grounds. Residents who wished to smoke were evaluated for their ability to smoke safely. A Notice of Smoke-Free Center Policy Brochure, updated March 2025, documented Smoking was Prohibited in all Buildings and on Exterior Grounds. A facility policy titled Smoke-Free Center, updated February 2025, documented if a resident wanted to smoke independently off grounds and the center has knowledge of the resident's desire, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Center validates they have been evaluated to do so safely. Oxygen was not allowed in smoking areas at any time. Smokers remained at least 20 feet away from oxygen in use. Smoking including the use of e-cigarettes was prohibited for everyone on the property owned and operated by the Center, including residents, employees, visitors, volunteers, consultants, contractors, and government representatives. The policy applied to buildings, vehicles, parking lots and common outdoor areas within the boundaries of the ground.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review the facility failed to communicate to the dialysis center, the need for contact precautions related to infectious dermatitis for 1 of 33 sampled residents (Resident 11). The deficient practice had the potential to place others at risk for transmission of infection. Findings include:Resident 11 (R11) was admitted to the facility on [DATE] with diagnoses including spinal stenosis of lumbar region, polyneuropathy, and end stage renal disease dependance on renal dialysis. On 12/16/2025 at 1:18 PM, R11 had rash that staff treated with medication and isolation and the resident goes to dialysis. A Physician Order, undated, documented dialysis Monday, Wednesday and Friday.A Nursing Progress note dated 11/26/2025 documented the Director of Nursing (DON) was notified of a new rash with small pustule like areas. A Physician Order dated 12/08/2025, documented contact precautions as recommended for residents known or suspected to be infected with infectious agents transmitted person to person via the direct/indirect contact route every shift for infectious dermatitis. On 12/18/2025 at 9:36 AM, a Registered Nurse (RN) explained to communicate care with the dialysis center the staff would utilize pre- dialysis assessments. The pre-dialysis assessment was printed out and sent with the resident to dialysis. The pre-dialysis assessment documented any changes in condition and if new isolation orders were received. The information would either be typed or handwritten, if there was no designated space to provide the information, on the pre-dialysis assessment.R11's pre-dialysis assessment dated [DATE] lacked documentation regarding contact isolation. On 12/18/2025 at 12:14 PM, the Director of Nursing (DON) and Infection Preventionist confirmed the dialysis center was not contacted regarding the need for contact isolation related to infectious dermatitis for R11.The facility policy titled Dialysis, updated 03/2015, documented the facility communicates with the dialysis center by completing the dialysis transfer form. The dialysis transfer form included changes in medical or mental status since last dialysis appointment. Complaint 2286702

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and document review the facility failed to ensure medication was not left unattended on top of a medication cart. The deficient practice had the potential for placing residents at risk for improper use of medication.Findings include: On 12/18/2025 at 8:12 AM, a medication bottle of fluticasone propionate nasal spray 50 micrograms (a medication used for nasal symptoms such as congestion, sneezing, runny nose, and nasal itching), was observed on top of a mediation cart in the hallway, unattended and accessible to any person walking by. The nurse was observed inside a nearby resident's room. On 12/18/2025 at 8:15 AM, a Registered Nurse (RN), confirmed had left the medication unattended on top of the medication cart and walked away to enter a resident's room. The RN acknowledged should not have left the medication unattended and accessible to all due to resident safety risks if ingested or used by a resident. On 12/18/2025 at 11:29 AM, the Director of Nursing (DON), stated medication should not have been left out unattended. The DON explained if a medication was not being used, it should have been returned to the medication cart and locked. The DON acknowledged medication left unattended posed a risk to residents if they were to access the medication.A facility policy titled Medication Storage, dated 01/2025, documented medications and biological were to be stored in a controlled environment. This may include medication carts, medication rooms, medication cabinets or other suitable containers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and document review, the facility failed to ensure 1) the use of protective personal equipment (PPE) for 1 of 33 sampled residents (Resident 18) and 2 unsampled residents (Resident 16 and 115) on contact precautions and enhanced barrier precautions and 2) report an outbreak of infectious dermatitis to the state health authority. The deficient practice had the potential for the spread of infectious organisms.Findings include:1) On 12/17/2025 at 11:45 AM, a Certified Nursing Assistant (CNA) explained if a resident was on contact precautions, staff were to apply personal protective equipment (PPE) as listed on the signage prior to entering the resident room and remove prior to exiting the resident room. For residents that require Enhanced Barrier Precautions (EBP) the PPE would be applied when staff were providing direct care tasks for the residents. A. On 12/18/2025 at 9:28 AM, R115 had a sign posted to the left of the door which documented the following: -Contact Precautions everyone must clean hands, including before entering and when leaving the room. Providers and Staff must: put on gloves and gown before room entry and discard gloves and gown before room exit. The Director of Nursing (DON) was in R115's room wearing gloves providing resident care. The DON exited R115's room with gloves on, walked to the medication cart parked approximately 25 feet adjacent to R115's room, removed the gloves and obtained a new pair of gloves from a glove box on the side of the medication cart and returned to R115's room. On 12/19/2025 at 11:09 AM, the DON acknowledged did not follow proper use of PPE and hygiene for R115. B. On 12/18/2025 at 10:02 AM, R16 had a sign posted upon entry of room which documented the resident was on Contact Precautions. A CNA was at R16's bedside wearing no PPE. C. On 12/18/2025 at 11:22 AM, R18 had a sign posted upon entry of room which documented the following: Enhanced Barrier Precautions providers and staff must wear gloves and a gown for the following high-contact resident care activities dressing, bathing or showering, transferring, changing linens, providing personal hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, or wound care: any skin opening requiring a dressing. R18's room door was closed, upon knocking a response to enter was received. Upon opening R18's door, R18 was lying in bed and a staff member wearing gloves was noted at the side of the bed holding linens and explained was providing resident care. On 12/18/2025 at 11:29 AM, the DON and Infection Preventionist explained expectations for Enhanced Barrier Precautions was for staff to use gowns and gloves when providing direct care. For Contact Precautions the expectation was for staff to apply gloves, a gown, and a mask prior to entering the resident room. All PPE was to be removed prior to exiting the room, staff were expected to wash or sanitize immediately upon exiting the room prior to beginning another task. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Enhanced Barrier Precautions (EBP), revised 03/26/2025, documented EBP was employed when performing high-contact resident care activities such as a) dressing b) bathing/showering c) transferring d) providing hygiene e) changing linens f) changing briefs or assisting with toileting A facility policy titled Transmission-Based Precautions (Isolation), updated 03/2025, documented contact isolation precautions: personnel having contact with infected resident should wear gloves and a gown, prior to leaving the resident's room, gown and gloves are removed and hand hygiene performed. A facility policy titled Handwashing/Hand Hygiene updated August 2025, documented personnel were to follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene was to be after removing gloves. 2) Multiple residents reported itchy skin and expressed concerns about a possible skin condition affecting multiple residents at the facility. A review of the facility's infection control surveillance process revealed a document titled Line Listings for Infections by Resident. Between the dates of 12/09/2025 and 12/13/2025 a total of 18 residents was identified with skin infections, rash and deemed health care associated infection (HAI). The identified pathogen/organism was infectious dermatitis. Eight additional residents were identified as infectious dermatitis exposure. For a total of 26 residents affected. The document identified the 26 residents were placed in contact isolation and provided treatment including antibiotics. A color-coded map of the facility dated December 2025, revealed hallways 100, 200, 300, 500, 600, and 700 were affected with either residents with infectious dermatitis color coded in blue, or infectious dermatitis exposure color coded in green. On 12/18/2025 at 11:29 AM, during a joint interview, the Infection Preventionist (IP) and the Director of Nursing (DON), stated a skin condition was identified on 12/09/2025 which consisted of a red rash, itchiness on different areas of the body including the abdomen, arms, and peri area. Some rashes were lightly raised; some were flushed to the skin. Shingles were ruled out. The Medical Director, the Physician's Assistant, and the Wound Doctor rounded on the residents. The Medical Director diagnosed it as infectious dermatitis. Residents were placed on contact precautions and physicians treated the exposed residents as preventative measures. The IP and DON reported one staff member was affected and displayed the same symptoms. The staff member was sent to a local urgent care clinic and was treated for symptoms of scabies. The IP and DON clarified that the staff member was not diagnosed with scabies, instead was treated for the symptoms of scabies. The IP and DON (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported all but four resident's skin condition had resolved. The four remaining residents were improving and would be off isolation in the next few days, and no new cases had been identified since 12/13/2025. The IP and DON explained difficulties of obtaining a diagnosis of scabies including having to take residents to a dermatologist. Although scabies were not officially diagnosed, measures were taken and residents were treated as suspicion of scabies to protect residents. The IP was familiar with outbreak reporting requirements and was aware of the process to report a facility outbreak. The IP acknowledged the skin condition and more than 1 case constituted a reportable outbreak. The IP reported the Medical Director said to report it as infectious dermatitis. The facility reached out to the state infection prevention contact via email to request guidance, no response was received, no follow-up attempt to contact the state IP was made, and the facility did not report the outbreak. On 12/18/2025 at 2:03 PM, the Medical Director (MD), reported initially two new cases of itchy skin were reported to the MD, then a roommate in the same area. The MD explained scabies were difficult to diagnose, skin scraping would have needed to be done to diagnose. The MD diagnosed residents with infectious dermatitis, and all affected residents were treated as if it was suspicion of scabies for resident safety. The MD reported facility was to report outbreaks and once there was suspicion of cases a report to the state should have been made. The Medical Director stated the facility did not have a confirmed infection of scabies, but it was treated as the same, which was reportable to the state. A facility policy titled Outbreak of Communicable Diseases, updated 04/22/2023, documented the facility identified and managed infectious outbreaks in accordance with standards of practice as established by federal, state, and local guidance. An outbreak of most communicable diseases was defined as one the following, one case of an infection that was highly communicable, trends that are ten percent or more above the historical rate of infection for the Center, or occurrence of three or more cases of the same infection over a specified period of time and in a defined area. The executive Director/Designee was responsible for telephoning a report to the health department.