STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on interview, clinical record review, and document review the facility failed to ensure 1) a resident was free from neglect when a Certified Nursing Assistant (CNA) refused to get the resident out of bed per the resident's request and closed the resident's door while the resident called out for help and when the resident's brief was not changed for a period of eight hours for 1 of 12 sampled residents (Resident #12), 2) a resident was not verbally abused by a Licensed Practical Nurse (LPN1) when the LPN yelled at the resident for 1 of 12 sampled residents (Resident #3), 3) a resident was not physically abused by the facility Physician when the resident asked the Physician to stop a breast examination and the Physician continued for 1 of 12 sampled residents (Resident #4), and 4) a resident was protected from resident-to-resident sexual abuse when the resident was kissed by another resident for 1 of 12 sampled residents (Resident #5). Findings include: Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including vertebrogenic low back pain and anxiety disorder, unspecified. Failure to assist resident out of bed A Facility Reported Incident (FRI) submitted 07/23/2024, documented Resident #12 alleged the resident requested to get out of bed at approximately 2:30 AM on 07/18/2024. A CNA1 declined to get the resident up. The resident then began to yell for help and the CNA1 closed the resident's door. The resident reported the resident was anxious about having the door shut. The facility was able to verify the incident occurred as the CNA1 stated the CNA1 did refuse to help the resident and closed the resident's door to prevent the resident from calling out for help. The employee was terminated. Resident #12's Care Plan documented Resident #12 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to the resident being unable to get out of bed. The resident had increased anxiety at night. The date initiated was 05/20/2024, and the revision date was 06/04/2024. Interventions included the following: -Resident has increased anxiety at night, get resident up in chair if resident wishes. The date initiated was 06/04/2024. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/2024 at 11:21 AM, a CNA2 verbalized the CNA2 was familiar with Resident #12. The CNA2 explained Resident #12 required either a Hoyer lift or assistance of two people to transfer between the bed and the resident's wheelchair. On 09/18/2024 at 12:14 PM, Resident #12 recalled utilizing the call light to request assistance to get out of bed. The resident recalled the staff member who answered the call light would not help the resident out of bed and the resident reported the incident to the Administrator. A Grievance Form dated 07/18/2024, documented Resident #12 reported the CNA1 of concern refused to get the resident up when the resident asked and the CNA1 closed the resident's door. Another CNA then checked on the resident and the resident was assisted out of bed by the day shift staff. The CNA1 of concern was immediately suspended. A Disciplinary Action Form dated 07/18/2024, documented the CNA1 of concern was suspended due to the CNA1 being connected with an allegation of abuse. A review of the facility's records related to the investigation of the allegation of neglect included an undated statement from the CNA1 of concern. The statement documented the CNA1 of concern answered Resident #12's call light at 3:30 AM, the resident informed the CNA1 the resident wanted to get up from bed. The CNA1 told the resident no and closed the door. On 09/18/2024 at 3:00 PM, the Director of Nursing (DON) explained types of abuse included physical, neglect, verbal, sexual, misappropriation of property, and involuntary seclusion. The DON verbalized the DON was familiar with the allegation reported by Resident #12 regarding CNA1 refusing to assist the resident out of bed and closing the resident's door when the resident yelled out for help. The DON explained the facility's previous Administrator conducted the interview with the CNA1 of concern, the CNA1 admitted to the incident and the CNA1's employment was terminated as a result. The DON reviewed the statement from the CNA1 of concern and confirmed the incident would be considered neglect. Failure to change resident's brief A FRI submitted 07/26/2024, documented Resident #12 alleged on 07/22/2024, the resident's brief had not been changed all day shift. The resident was going to bed at 8:00 PM, when staff discovered the resident was wet and had bowel movement all over the resident. Resident #12's Care Plan documented the following: Problem: Bowel incontinence related to chronic constipation, pelvic floor weakness, chronic debility, chronic bowel leakage, and laxative use. The date initiated was 05/20/2024, and the revision date was 08/15/2024. Interventions included the following: -Check resident every two hours and assist resident with toileting as needed, offer each occasion to attempt preservation of continence. The date initiated was 05/20/2024. -Offer resident to toilet at the same time each day. Resident usually had a bowel movement after breakfast and after lunch. Attempt toileting and offer alternative: bedpan/bedside commode. The date initiated was 05/20/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide resident with pericare after each bowel incontinent episode. The date initiated was 05/20/2024. Problem: Urinary incontinence. Resident with mixed bladder incontinence related to chronic constipation, pelvic floor weakness, post-menopausal hormonal changes, overactive bladder, and polyneuropathy. The date initiated was 05/20/2024, and the revision date was 08/15/2024. Interventions included: -Brief use: Change every two hours, with soiling or when wetness was detected. The date initiated was 05/20/2024. -Incontinent: Check and change resident every two hours, frequently with shift care rounds, and as required for incontinence. Wash, rinse, and dry perineum. The date initiated was 05/20/2024. On 09/18/2024 at 11:21 AM, a CNA2 explained residents were rounded on at least every two hours. While rounding on residents, CNAs would check to make sure residents were clean and dry. The CNA2 explained Resident #12 was incontinent of bowel and bladder. Resident #12 required assistance from staff for brief changes and was transferred from the wheelchair to the resident's bed with a Hoyer lift or two-person assistance when the resident's brief needed to be changed. On 09/18/2024 at 12:14 PM, Resident #12 verbalized the amount of time it took staff to respond to the resident's call light varied. The resident recalled a time the resident waited more than two hours for staff to respond to the resident's call light after the resident had a bowel movement. The resident described the bowel movement as loose and leaking out of the resident's brief. The resident verbalized it made the resident feel very bad to wait so long while sitting in feces. A review of the facility's records related to the investigation of the allegation of neglect included an interview with the CNA3 assigned to provide care to Resident #12 on 07/22/2024. The interview statement was dated 07/23/2024. The statement documented the CNA3 of concern changed Resident #12's brief at 10:00 AM. The CNA3 stated the CNA3 did not check the resident every two hours as required. A Disciplinary Action Form dated 07/22/2024, documented the CNA3 of concern's employment was terminated due to not checking an incontinent resident for a period of eight hours, resulting in potential for harm to the resident. On 09/18/2024 at 3:00 PM, the DON explained it was the DON's expectation residents would be rounded on every two hours. Briefs were expected to be changed every two to three hours and as needed. CNAs were responsible for rounding and brief changes. The DON recalled Resident #12's allegation of not having the resident's brief changed all day shift. The DON explained the resident complained the resident was wet. When the resident was checked it was found the resident also had a bowel movement. The CNA3 of concern was interviewed and admitted to not checking the resident's brief. The DON confirmed failure to check an incontinent resident's brief for a period of eight hours was considered neglect. The facility policy titled Abuse, Neglect, or Exploitation, updated November 2016, defined neglect as conduct resulting in a deprivation of care necessary to maintain an individual's minimum physical and mental health. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility document titled Pride Education Module, updated October 2022, documented residents had the right to be free from abuse and neglect. Abuse was defined as the deprivation of goods or services necessary to attain or maintain physical, mental, and psychosocial well-being. Neglect was defined as the failure to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect included cases when the staff's indifference or disregard for resident care, comfort, or safety, resulted in or could result in adverse outcomes. Examples of neglect included failure to answer call lights, failure to provide adequate care, failure to change soiled bed linens and clothes, and failure to provide adequate assistance with personal hygiene. The facility document titled Notice of Resident Rights Under Federal Law, updated November 2016, documented residents had the right to be free from abuse and neglect. The facility policy titled Perineal Care, updated November 2016, documented perineal care (peri care) prevented skin breakdown of the perineal area, iteching, burning, odor, and infections. Peri care was very important in maintaining the resident's comfort. More frequent care was required for residents who were incontinent. The facility's CNA job description, updated March 2012, documented essential functions of the CNA included answering call lights, providing assistance with bathing, dressing, toileting and oral hygiene. CNAs worked under general supervision and performed duties in caring for residents in compliance with state and federal regulations. 50210 Verbal abuse A FRI submitted 06/23/2024, documented LPN1 was responding to a call light by Resident #3, and while providing care, LPN1 began yelling at the resident. Yelling was heard by other staff in the facility. Resident #3 Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of acute reversible ischemia of large intestine, extent unspecified. On 09/18/2024 at 12:19 PM, Resident #3 explained on the date of the incident, Resident #3 turned on the call light after having had a bowel movement. Resident #3 explained the LPN came to answer the call light, but the LPN had an ear plug in and was talking with someone on the phone. The LPN undid the resident's briefs and turned the resident on the left side. The LPN left the room and after 20 minutes, Resident #3 began calling out for help. Resident #3 explained when LPN1 returned, LPN1 told the resident LPN1 went to get a CNA because LPN1 was too busy to help the resident. Resident #3 told LPN1 if LPN1 wasn't on their phone, they might not be so busy. The LPN then yelled, do you see me on my phone now? and I said, do you see me on my phone now? poking the resident in the chest with every word. Resident #3 told LPN1 to leave the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 explained the resident was so upset, and the resident cried the whole next day. Resident #3 verbalized feeling unsafe in the facility. A working schedule dated 06/30/2024, documented LPN1 was working night shift on Resident #3's hallway. A witness statement from LPN1 received by phone, undated, documented on the date of the event, LPN1 observed Resident #3's call light and requested a CNA to answer the light. After 20 minutes, the call light was on again. In the course of assisting the resident, the resident verbalized feeling LPN1 yelled at the resident and LPN1 apologized for raising LPN1's voice. The resident was upset and LPN1 requested assistance from another nurse. A witness statement from a CNA dated 06/23/2024, documented the event occurred on night shift. Resident #3 was extremely upset and crying because LPN1 was rude to Resident #3, yelling at the resident and treating the resident like a five-year-old child. The CNA documented witnessing the LPN, who was on a cell phone, refusing to help Resident #3. A witness statement from LPN2 dated 06/23/2024, documented on the date of the event, LPN1 asked for help with a resident. When LPN2 entered Resident #3's room, Resident #3 began explaining the altercation. LPN2 observed LPN1 raising LPN1s voice and yelling back and forth with the resident. The Resident began crying and requested to file a verbal abuse report. On 09/18/2024 at 12:42 PM, LPN3 explained LPN3 was presently the only nurse on the hallway to include Resident #3. Abuse included financial, physical and verbal abuse, or anything making a resident feel uncomfortable or unsafe. Verbal abuse included calling names, yelling, and saying mean things. The nurse verbalized the nurse did not receive any trainings from the facility related to abuse prevention but was aware of abuse through other nursing positions. A Social Services Note dated 06/24/2024, documented the previous social worker and previous Executive Director spoke with the resident about the incident to have occurred over the weekend. Resident #1 expressed the resident was satisfied the LPN was no longer working at the facility. The Social Services Note was electronically signed with the name of the Licensed Social Worker (LSW). On 09/18/2024 at 2:00 PM, the LSW explained when instructed by the Director of Social Services, the LSW's involvement in incident reports included asking residents about their feelings, investigating the emotional impacts of an event, observing changes in resident behavior, documenting the follow up in a Progress Note, and even referring the resident to Behavioral Health Services as necessary. The LSW verbalized the Social Services note was completed by the previous LSW of the facility. On 09/18/2024 at 4:39 PM, the DON explained verbal abuse included yelling, swearing, and condescending words. The facility verified the allegation of verbal abuse, terminated the LPN in question, and submitted a complaint to the Nevada State Board of Nursing. Physical Abuse (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A FRI submitted 06/29/2024, documented the facility Physician was performing a breast exam on Resident #4. The resident felt the physician was getting off on it, which made the resident uncomfortable, and caused the resident to ask the physician to stop. The physician continued the examination to complete the measurement. Once the resident made it clear the resident was uncomfortable, the Physician stopped. Resident #4 Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of primary osteoarthritis of the left wrist. On 09/18/2024 at 2:49 PM, Resident #4 explained the physician was doing a breast exam on the resident's right breast. The resident explained the Physician was squeezing the breast, almost like fondling it. The resident felt uncomfortable and asked the Physician to stop, but the Physician continued the exam. Resident #4 asked the Physician to stop three times before pushing the Physician's hand away. The Physician then moved to the left breast and the resident asked the Physician to stop three more times before forcibly pushing the Physician's hand away again. Resident #4's most recent Brief Interview for Mental Status (BIMS) dated 08/24/2024, documented a score of 14 (intact cognitive abilities). A witness statement from a CNA, dated 07/02/2024, documented the CNA was present during the physical examination. The Physician informed Resident #4 the Physician would check the breast and the Physician did not wait for consent or to hear if the resident was comfortable. The resident looked uncomfortable and the Physician looked at the resident weird, and would not stop touching the resident. The resident asked the Physician three or four times to stop touching the resident's breast and doctor kept going, disregarding the resident's request. The Physician's hand went under Resident #4's gown after the resident told the Physician to stop. After Resident #4 told the Physician to quit it, the Physician stopped. The resident moved the Physician's hand once, pushing it away softly. On 09/18/2024 at 3:14 PM, the CNA explained on the day of the examination, the Physician seemed to be in a rush. The Physician told Resident #4 the physician would check the breast and would check the breast. Resident #4 told the Physician to stop multiple times. The physician would stop, tell the resident the Physician would check again, and check the breast. Resident #4 pushed the Physician's hand away and the Physician stopped. The Physician could have waited for consent from the resident. A Social Services Progress Note dated 06/29/2024, documented Social Services met with Resident #4 who explained on 06/27/2024, the Physician came into the resident's room to follow up with the resident on an ultrasound that was ordered to check on a lump on Resident #4's breast. The resident explained the resident informed the Physician the ultrasound found nothing, but the Physician insisted on doing a breast exam again. The resident reported the Physician grabbed the resident's breast and was squeezing it. The resident reported the resident told the Physician to stop and the Physician did not. The resident reported the Physician then checked Resident #4's other breast, and the resident again told the Physician to stop three times before the resident slapped the Physician's hand away and said, I said stop! (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/2024 at 3:36 PM, the LSW explained being aware of the event between the Physician and Resident #4. The LSW verbalized Resident #4 did not want the Physician to continue to work with Resident #4. On 09/18/2024 at 4:42 PM, the DON, verbalized abuse could include unwanted touching and breasts were inherently sexual in nature. If a patient did not want to be touched, it could be considered abuse and would be worth an investigation. The DON verbalized if a resident did not want to be touched, it could be considered inappropriate touching. The DON described the situation occurrence between Resident #4 and the Physician as a gray area and the DON was unsure whether it was a concern of abuse or resident rights. The DON explained it was important to consider the perspective of the resident as that could determine abuse. A statement from the Physician dated 07/01/2024, documented the Physician found a lump in the resident's breast and was attempting to measure the size of the lump. The Physician examined the resident's legs, arms, lungs and breasts last. Resident #4 asked the Physician why the Physician was doing the exam. When the resident asked the Physician to stop, the Physician stopped. The Physician did not remember the Resident pushing the Physician's hand away. On 09/18/2024 at 5:09 PM, the Physician explained the Physician found a lump in Resident #4's right breast, ordered an ultrasound, and returned for a follow-up examination to ensure no malignancy was missed. The Physician explained the Physician only examined the breast of concern. During the exam, the resident asked why the physician was examining the resident's breast three times and three times the physician explained the reason for the breast examination. When the resident asked the Physician to stop, the Physician stopped. Sexual Abuse A FRI submitted 09/10/2024, documented Resident #6 was seen kissing Resident #5 on the lips. The two were immediately separated and Resident #6 was put under one-to-one supervision. Resident #6 continued to make comments the resident would pursue Resident #5 and there was nothing the facility could do to stop it. Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including multiple sclerosis and cognitive communication deficit. Resident #5's care plan included a problem initiated 04/24/2024, documenting Resident #5 had impaired cognitive function, impaired thought processes and extended effects of multiple sclerosis white matter disease. An intervention initiated 04/24/2024, documented Resident #5 had difficulty understanding healthcare information in written format and to reinforce with verbal explanation with Resident #5's responsible party. A problem initiated 9/16/2024, documented on 09/11/2024, Resident #5 was kissed on the lips by another resident. Resident #5's Progress Notes documented the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 05/27/2024, Resident #5 was seen kissing another resident in the dining room. -On 06/24/2024, a resident was seen kissing Resident #5's hand in the main dining area. -On 08/05/2024, staff noticed Resident #5's impulsivity and inappropriate touching and kissing with male residents. -On 09/06/2024, Resident #5 was not oriented. -On 09/09/2024, Resident #5's mother was recently given power of attorney (POA) and was Resident #5's legal guardian. Resident #5 was oriented to person and situation, not to time or place. -On 09/11/2024, Resident #5 was being wheeled by Hospitality Aide (HA 1). Another resident began talking with Resident #5 when the resident bent over and kissed Resident #5 on the lips. The other resident walked away laughing. -On 09/06/2024, Resident #5 was assessed on 09/06/2024 and was not oriented. Resident #5 did not remember current happenings, family and friends and was unable to converse, read, or write. Resident #6 Resident #6 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including schizoaffective disorder unspecified and major depressive disorder single episode unspecified. Resident #6's care plan included a problem initiated 06/11/2024, documenting Resident #6 demonstrated disinhibited sexual behavior with other residents related to an incident on 05/06/2024, and 06/11/2024. Resident #6 exhibited bold behaviors in the facility including touching residents' legs, following residents into rooms, fondling nonconsenting residents, and kissing residents on the hand. On 09/10/2024, Resident #6 kissed another resident on the lips who was sitting in their wheelchair in the hall. Interventions documented to praise Resident #6's positive actions when maintaining boundaries with residents and to redirect the resident when asked not to kiss or touch other residents. Resident #6's Progress Notes documented the following: -On 05/06/2024, Resident #6 continued to be noncompliant with distancing from other residents Resident #6 attempted to follow other residents into their room and shouted Resident #6 wanted the other resident and would have the other resident. -On 05/13/2024, Social Services met with Resident #6 about the resident having inappropriate contact with a resident approximately one week prior. -On 05/17/2024, Resident #6 developed a romantic attachment with a resident who was unable to show capacity to enter into a romantic relationship -On 06/10/2024, staff noted intermittent inappropriate behavior with other residents (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 09/10/2024, Resident #6 walked down the hall and stopped to talk with another resident on one-to one supervision. The resident was in their wheelchair next to HA1. HA1 told Resident #6 not to touch another resident. Resident #6 leaned over and kissed the resident on the lips A statement from HA1 undated, documented Resident #6 was talking to Resident #5 when Resident #6 leaned over and kissed Resident #5. A statement from a CNA undated, documented on 09/10/2024, the CNA observed Resident #6 lean down and kiss Resident #5 on the lips. HA1 put their hand out to move Resident #6 away. The CNA informed Resident #6 their actions were not okay and the resident walked away laughing. A statement from the Activities Director undated, documented HA1 reported Resident #6 kissed Resident #5. Resident #5 was brought to the Activities Director's office and Resident #5 was visibly upset. Resident #6 repeatedly stated Resident #6 would come after Resident #5 and there was nothing the facility could do about it. Resident #6 was put on one-to-one supervision and the police were called. On 09/15/2024 at 11:15 AM, HA2 was seated outside Resident #6's room. HA2 verbalized being told verbally about the event on 09/11/2024 and of Resident #6's sexually aggressive behaviors. HA2 described a time when a nurse walked past Resident #6 with a female resident. Resident #6 got distracted by the resident, but HA2 redirected the resident and encouraged the nurse to continue walking. On 09/18/2024 at 11:19 AM, Resident #6 verbalized approximately one week prior, Resident #6 gave Resident #5 a hug and a kiss on the top of the head. Resident #6 explained Resident #6 did not realize kissing Resident #5 was the wrong thing to do and would like to see Resident #5 again. Around the same time of the incident, HA2 began sitting outside Resident #6's room. On 09/18/2024 at 11:41 AM, a Registered Nurse (RN) verbalized Resident #6 had a history of sexual behaviors and was on one-to-one supervision before but was not on one-to-one supervision when the event occurred. The RN explained the RN did not see Resident #6 kiss Resident #5. The RN was in a resident's room when the RN heard HA1 tell Resident #6 no sir, no thank you. The RN went to see what happened and saw HA1 with their hand out to stop Resident #6. HA1 informed the RN Resident #6 kissed Resident #5 on the lips. Resident #6 was verbally aggressive, telling the RN the RN could not keep Resident #6 away from Resident #5, and the RN called the police. Since then, Resident #6 was on one-to-one supervision again. The RN verbalized it was inappropriate for Resident #6 to kiss Resident #5 because of Resident #5's impaired mental status and cognitive condition. On 09/18/2024 at 12:50 PM, an LPN verbalized a resident would need to be able to consent to sexual advances by another resident, and the ability to consent would be determined by their guardianship status and whether the resident was alert and oriented. The LPN explained Resident #5 had trouble communicating needs and was unsure whether Resident #5 was alert and oriented. On 09/18/2024 at 3:36 PM, the LSW verbalized Resident #5's mother recently became Resident #5's legal guardian in August of 2024. The LSW explained Resident #6 had a history of behaviors related to touching other residents prior to 09/11/2024, and Resident #5 had a history of impulsive behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/2024 at 4:51 PM, the DON explained sexual abuse could include inappropriate unwanted touching and could apply to a resident without the ability to consent. The DON confirmed Resident #5 was not their own representative and was unable to consent to medical treatment. The facility policy titled, Notice of Resident Rights Under Federal Law, dated 04/2016, documented residents had the right to refuse or discontinue treatment, the right to be treated with respect and dignity, the right to a dignified existence and self-determination, and the right to be free from sexual, verbal, and physical abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, clinical record review, and document review, the facility failed to ensure a resident's insulin was not self-administered by a staff member for 1 of 12 sampled residents (Resident #2). This deficient practice had the potential to result in a resident not having an adequate amount of insulin available to treat the diagnosed condition for which the medication was prescribed. Findings include: Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type I diabetes mellitus with diabetic polyneuropathy, type I diabetes mellitus with unspecified diabetic retinopathy without macular edema, and type I diabetes mellitus with hypoglycemia without coma. A Facility Reported Incident (FRI), documented on 08/05/2024 a Licensed Practical Nurse (LPN) had witnessed another nurse administering Resident #2's insulin for the nurse's personal use. An Order Review Report for Resident #2, documented the resident had an order for Humalog injection solution 100 units/milliliter, inject as per sliding scale. The order start date was 03/01/2024. A statement, signed by the nurse and dated 08/09/2024, documented the nurse had self-administered Resident #2's insulin. On 09/18/2024 at 1:00 PM, the Director of Nursing (DON) verbalized the DON would have expected for the nurse to have contacted management for support or for the nurse to seek emergency medical care. The DON verbalized the nurse should not have taken the resident's medications. On 09/18/2024 at 2:11 PM, Resident #2 verbalized the resident had been speaking with the nurse when the nurse checked the nurse's blood sugar while standing by the medication cart. The nurse had informed the resident the nurse's blood sugar was very high and the nurse had forgotten the nurse's own insulin pen at home. The resident verbalized the resident could hear the noise of the nurse drawing up insulin, but the resident was blind and had not realized the nurse had self-administered the resident's insulin until the resident had been told what happened by another resident and staff. The resident verbalized the resident had felt upset because the nurse did not ask the resident's permission and it was wrong for staff to take resident's medications. The facility document titled PRIDE Education Module, updated 10/2022, documented misappropriation of resident property meant the deliberate use of a resident's belongings without the resident's consent. Diversion of resident's medication for staff use was an example of misappropriation of resident property. FRI #NV00071907

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, clinical record review, and document review, the facility failed to ensure professional standards for prescribing medications were followed by a practitioner for 1 of 12 sampled residents (Resident #1). This deficient practice had the potential to result in a resident suffering an adverse health outcome from receiving medications for diagnoses the resident did not have. Findings include: Resident #1 Resident #1 was admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including metabolic encephalopathy, acquired absence of right leg above knee, and sequelae of protein-calorie malnutrition. A Facility Reported Incident (FRI), dated 06/10/2024, documented Resident #1 was readmitted from the hospital on 06/07/2024. The admitting nurse input medication orders for Resident #1 from another resident's hospital discharge summary. The resident received the incorrect medications for three days before the error was discovered and reported. The resident was sent to the Emergency Department (ED) on 06/10/2024 and was hospitalized for four days. An Order Review Report for Resident #1, documented the following medication orders dated 06/07/2024 and had been electronically signed by the Physician: - acetaminophen oral tablet 325 milligrams (mg), give 975 mg by mouth one time a day for pain. - amantadine hydrochloride (HCl) oral tablet 100 mg, give one tablet by mouth two times a day for hypertension. - asenapine maleate sublingual tablet, give one tablet sublingually one time a day for schizophrenia as evidenced by delusional statements. - benztropine mesylate oral tablet 1 mg, give one tablet by mouth one time a day for Parkinson's. - carbamazepine oral tablet 200 mg, give 200 mg by mouth two times a day for hypertension. - carbidopa-levodopa oral tablet 25-100 mg, give one tablet by mouth four times a day for Parkinson's. - clonazepam oral tablet 1 mg, give one tablet by mouth two times a day for feeling anxious. - cyclobenzaprine HCl oral tablet 5 mg, give one tablet by mouth three times a day for muscle spasms for 10 days. - finasteride oral tablet 5 mg, give one tablet by mouth one time a day for benign prostatic hyperplasia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- lisinopril oral tablet 5 mg, give one tablet by mouth one time a day for hypertension. - potassium chloride oral packet 20 milliequivalents (mEq), give 20 mEq by mouth one time a day for supplement. - Seroquel oral tablet 400 mg, give 200 mg by mouth one time a day for schizophrenia as evidenced by auditory hallucinations. - sertraline HCl oral tablet 25 mg, give 50 mg by mouth one time a day for depression as evidenced by self-isolation. - simvastatin oral tablet 20 mg, give one tablet by mouth one time a day for hyperlipidemia. - tamsulosin HCl oral capsule 0.4 mg, give one capsule by mouth one time a day for benign prostatic hyperplasia. - trazodone HCL oral tablet 50 mg, give one tablet by mouth one time a day for depression as evidenced by inability to sleep. The resident's diagnoses did not include hypertension, Parkinson's disease, or hyperlipidemia. The June 2024 Medication Administration Record for Resident #1 documented the following: - acetaminophen had been administered four times between 06/07/2024 and 06/10/2024. - asenapine, benztropine, finasteride, lisinopril, and trazodone were each administered three times between 06/07/2024 and 06/09/2024. - potassium, Seroquel, sertraline, simvastatin, and tamsulosin were each administered three times between 06/08/2024 and 06/10/2024. - amantadine, carbamazepine, and clonazepam were each administered five times between 06/08/2024 and 06/10/2024. A Nursing Progress Note, dated 06/10/2024, documented the resident's vital signs were assessed twice and the resident's systolic blood pressure was 89 each time. The resident was unable to stay awake or alert to eat or drink fluids. The provider was notified, and orders were received to send the resident to the ED. A Hospitalist History and Physical Note, dated 06/10/2024, documented Resident #1 presented to the ED on 06/10/2024, after accidental medications were given at the facility. The resident had been discharged from the Hospital on 06/06/2024, to the facility for further rehabilitation. The resident was inappropriately receiving Tylenol, asenapine, benztropine, finasteride, lisinopril, potassium, Seroquel, sertraline, simvastatin, tamsulosin, trazodone, amantadine, carbamazepine, clonazepam, cyclobenzaprine, and carbidopa-levodopa. The resident was noted to be hypotensive in the ED. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/19/2024 at 10:38 AM, the Physician verbalized the nurse had entered the medications for the wrong resident and Resident #1 had received the wrong medications from the time of admission on 06/07/2024 until the mistake was discovered on 06/10/2024. The Physician verbalized the Physician did not adjust psychotropic medications and would have relied on the behavioral health team to review the psychotropic medication orders. The Physician confirmed the resident had received medications to treat diagnoses the resident did not have. The Physician explained the Physician had skimmed through the orders and signed them because the Physician's expectation was for the admitting nurse to contact the Physician with any questions when inputting medications for a new admission. On 09/19/2024 at 1:05 PM, the Director of Nursing (DON) verbalized the DON would expect the provider to question the order for a medication to treat a diagnosis the resident did not have prior to electronically signing the order. The facility document titled Medical Director Independent Contractor Agreement, with a commencement date of 05/01/2020, documented the Provider agreed to be responsible for the coordination of medical care at the facility and the Provider shared responsibility with the facility for assuring the facility was providing the care required. This responsibility included providing oversight and supervision of the medical care of residents and helping the facility identify, evaluate, and address/resolve medical and clinical issues affecting resident care, medical care, or quality of life, or are related to the provision of services by physicians and other health care practitioners. FRI #NV00071439

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, clinical record review, and document review, the facility failed to ensure a resident was not administered medications without a diagnosis related to the indication for the use of the medications for 1 of 12 sampled residents (Resident #1). This deficient practice resulted in a resident requiring hospitalization to monitor for adverse side effects of the unnecessary medications. Findings include: Resident #1 Resident #1 was admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including metabolic encephalopathy, acquired absence of right leg above knee, and sequelae of protein-calorie malnutrition. A Facility Reported Incident (FRI), dated 06/10/2024, documented Resident #1 was readmitted from the hospital on 06/07/2024. The admitting nurse input medication orders for Resident #1 from another resident's hospital discharge summary. The resident received the incorrect medications for three days before the error was discovered and reported. The resident was sent to the Emergency Department (ED) on 06/10/2024 and was hospitalized for four days. An Order Review Report for Resident #1, documented the following medication orders dated 06/07/2024 and had been electronically signed by the Physician: - acetaminophen oral tablet 325 milligrams (mg), give 975 mg by mouth one time a day for pain. - amantadine hydrochloride (HCl) oral tablet 100 mg, give one tablet by mouth two times a day for hypertension. - asenapine maleate sublingual tablet, give one tablet sublingually one time a day for schizophrenia as evidenced by delusional statements. - benztropine mesylate oral tablet 1 mg, give one tablet by mouth one time a day for Parkinson's. - carbamazepine oral tablet 200 mg, give 200 mg by mouth two times a day for hypertension. - carbidopa-levodopa oral tablet 25-100 mg, give one tablet by mouth four times a day for Parkinson's. - clonazepam oral tablet 1 mg, give one tablet by mouth two times a day for feeling anxious. - cyclobenzaprine HCl oral tablet 5 mg, give one tablet by mouth three times a day for muscle spasms for 10 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- finasteride oral tablet 5 mg, give one tablet by mouth one time a day for benign prostatic hyperplasia. - lisinopril oral tablet 5 mg, give one tablet by mouth one time a day for hypertension. - potassium chloride oral packet 20 milliequivalents (mEq), give 20 mEq by mouth one time a day for supplement. - Seroquel oral tablet 400 mg, give 200 mg by mouth one time a day for schizophrenia as evidenced by auditory hallucinations. - sertraline HCl oral tablet 25 mg, give 50 mg by mouth one time a day for depression as evidenced by self-isolation. - simvastatin oral tablet 20 mg, give one tablet by mouth one time a day for hyperlipidemia. - tamsulosin HCl oral capsule 0.4 mg, give one capsule by mouth one time a day for benign prostatic hyperplasia. - trazodone HCL oral tablet 50 mg, give one tablet by mouth one time a day for depression as evidenced by inability to sleep. The resident's diagnoses did not include hypertension, Parkinson's disease, or hyperlipidemia. The June 2024 Medication Administration Record for Resident #1 documented the following: - acetaminophen had been administered four times between 06/07/2024 and 06/10/2024. - asenapine, benztropine, finasteride, lisinopril, and trazodone were each administered three times between 06/07/2024 and 06/09/2024. - potassium, Seroquel, sertraline, simvastatin, and tamsulosin were each administered three times between 06/08/2024 and 06/10/2024. - amantadine, carbamazepine, and clonazepam were each administered five times between 06/08/2024 and 06/10/2024. A Nursing Progress Note, dated 06/10/2024, documented the resident's vital signs were assessed twice and the resident's systolic blood pressure was 89 each time. The resident was unable to stay awake or alert to eat or drink fluids. The provider was notified, and orders were received to send the resident to the ED. A Hospitalist History and Physical Note, dated 06/10/2024, documented Resident #1 presented to the ED on 06/10/2024, after accidental medications were given at the facility. The resident had been discharged from the Hospital on 06/06/2024, to the facility for further rehabilitation. The resident was inappropriately receiving Tylenol, asenapine, benztropine, finasteride, lisinopril, potassium, Seroquel, sertraline, simvastatin, tamsulosin, trazodone, amantadine, carbamazepine, clonazepam, cyclobenzaprine, and carbidopa levodopa. The resident was noted to be hypotensive in the ED. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/19/2024 at 10:38 AM, the Physician verbalized the nurse had entered the medications for the wrong resident and Resident #1 had received the wrong medications from the time of admission on 06/07/2024 until the mistake was discovered on 06/10/2024. The Physician confirmed the resident had received medications to treat diagnoses the resident did not have. On 09/19/2024 at 1:05 PM, the Director of Nursing (DON) confirmed the resident had received medications to treat conditions for which the resident did not have a diagnosis. The facility policy titled Medication Administration, dated 01/2023, documented medication would be administered in accordance with written orders of the prescriber. If a dose seemed excessive considering the resident's age and condition, or a medication order seemed to be unrelated to the resident's current diagnosis or condition the nurse would call the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse would contact the prescriber for clarification. FRI #NV00071439