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	03/26/2026

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** Based on clinical record review, interviews and document review, the facility failed to protect a resident's right to be free from neglect when licensed nurses failed to notify the physician of a diabetic resident's multiple episodes of hypoglycemia (low blood glucose) and when a Registered Nurse (RN) administered oral glucose gel, not in accordance with physician orders, to an unresponsive resident experiencing severe hypoglycemia for 1 of 14 sampled residents (Resident #8). This deficient practice had the potential to result in lack of necessary adjustments to the resident's medication orders and plan of care and for additional episodes of hypoglycemia to occur placing the resident at risk for organ damage, coma, and death.Findings include:Resident #8Resident #8 was admitted to the facility on [DATE], with diagnoses including type one diabetes mellitus with other circulatory complications and type one diabetes mellitus with diabetic autonomic (poly) neuropathy.A final Facility Reported Incident (FRI) report submitted by the facility on 01/23/2026, documented the report was related to an incident on 01/19/2026 involving Resident #8. The incident type was neglect and the allegation against the alleged perpetrator was verified. A Certified Nursing Assistant (CNA) found Resident #8 unresponsive and clammy at approximately 1:00 AM on 01/19/2026. An RN assessed the resident, checked the resident's blood glucose with a result of 31, and administered oral glucose gel outside of order guidelines. The RN did not administer the prescribed medication (Glucagon) per physician order. A finger stick blood glucose level was checked again and remained 31. Emergency Medical Services (EMS) arrived, administered 10% Dextrose (D10) to Resident #8, the resident briefly regained consciousness, then became unresponsive and Cardiopulmonary Resuscitation (CPR) was initiated by EMS. CPR was unsuccessful and Resident #8 expired.Resident #8's Order Summary Report documented the following physician orders:-Insulin Aspart subcutaneous solution pen-injector 100 units/ milliliter (ml), inject as per sliding scale: if 80-150 give 0 units, 151-200 give 6 units, 201-250 give 10 units, 251-300 give 15 units subcutaneously before meals and at bedtime of Diabetes Mellitus (DM), notify physician of Blood Glucose (BG) less than 80 or greater than 350. The order date was 12/24/2025. -Lantus SoloStar subcutaneous solution pen-injector 100 units/ ml (Insulin Glargine), inject 15 units subcutaneously one time a day for DM. The order date was 11/18/2025. -Lantus SoloStar subcutaneous solution pen-injector 100 units/ ml (Insulin Glargine), inject 50 units subcutaneously one time a day for DM. The order date was 11/18/2025. -Glucose gel: Give one tube of house stock oral glucose gel As Needed (PRN) for blood sugar less than 70 with signs and symptoms of hypoglycemia (if resident able to swallow). The order date was 11/18/2025.-Glucagon emergency kit 1 milligram (mg). Inject one kit Subcutaneously (SQ) PRN for hypoglycemia. Administer SQ or Intramuscularly (IM) for Capillary Blood Glucose (CBG) less than 70 and signs of hypoglycemia (inability to swallow or unresponsiveness). The order date was 11/18/2025.Resident #8's Care Plan documented the resident had a diagnosis of insulin-dependent diabetes mellitus type one, the date initiated was 06/10/2024. Interventions included:-Diabetes medication to include insulin as ordered by physician. Monitor/document for side effects and effectiveness.-Monitor/document/report PRN any signs/symptoms (s/sx) of hyperglycemia.-Monitor/document/report PRN any s/sx of hypoglycemia: (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait.A progress note dated 01/15/2026, documented Resident #8's Lantus was held due to a Blood Sugar (BS) of 46. Glucagon given. Will recheck.A progress note dated 01/17/2026, documented blood sugar reading low prior to breakfast, noted reading of 47 mg/ deciliter (dl) and able to offer patient juices and other fluids. Blood sugar reading up to 103 mg/ dl and reminded resident not to skip a meal. Able to discuss with resident concern of hypoglycemia and suggest to have staff reach out to provider to lower amount of Lantus given in the morning but resident stated resident did not want any changes and had been on the same amount of insulin for a long period of time. Will need to endorse to next shift to remind staff to offer midnight snacks.Resident #8's clinical record lacked documented evidence the physician was notified of the resident's BG less than 80 on 01/15/2026 and 01/17/2026.A Nurses Progress Note dated 01/19/2026, documented a CNA reported to the nurse Resident #8 was unresponsive and felt clammy. The nurse checked the resident's Fingerstick Blood Glucose (FSBG) which resulted in 31. The resident was not able to drink soda or eat, one tube of glucose gel was given. Repeat FSBG 20 minutes later was still 31. 911 emergency was called at 1:15 AM, on-call provider was called at 1:22 AM. When EMS arrived, repeat FSBG was 19. D10 was administered by EMS, repeat FSBG was 220. Resident became arousable, opening eyes and speaking with EMS, then resident coded and EMS started life-saving measures. After 34 minutes, time of death was pronounced by the acute care hospital physician at 2:21 AM.On 03/26/2026 at 2:12 PM, a Licensed Practical Nurse (LPN) verbalized staff were required to report to the physician when anything was out of normal for a resident. The LPN explained a blood pressure reading outside parameters, refusal of medications, falls and blood glucose readings outside parameters were all required to be reported to the physician. A nurse practitioner was usually available in the facility Monday-Friday from 7:30 AM to 4:30 PM and a provider was always on call when the nurse practitioner was not in the facility. The LPN verbalized parameters for when to call the physician to report blood glucose values were not the same for each resident and explained the parameters were included in the orders for insulin.On 03/26/2026 at 2:25 PM, the Director of Nursing (DON) verbalized a medication error included administering a medication at the wrong time, giving the wrong dose, via a wrong route, or to the wrong resident. A change in condition depended on what was happening with the resident and examples included a usually alert and oriented resident now being confused and a resident usually able to eat and drink now coughing or not able to swallow.If a resident had a change in condition, the DON's expectation of staff was to complete a nursing assessment and to contact the physician to notify the physician of the change and obtain orders if necessary or instruction to send the resident to the hospital. Communication with the physician when a resident had a change in condition was to be documented in a progress note. The DON verbalized staff's failure to notify the physician of a resident's change in condition could be considered neglect, depending on the situation, and confirmed all changes in condition should be reported to the physician.Parameters for when staff were expected to contact the physician regarding a resident's blood glucose were resident-specific and included in the orders for insulin. The DON confirmed if a blood glucose reading was outside of the parameters in the physician's order for insulin, it would be considered a change in condition.The DON confirmed the DON was familiar with Resident #8 and the resident had a diagnosis of diabetes. The DON recalled the resident's blood glucose was checked before meals, at bedtime, and as needed. The parameters for when staff were supposed to contact the physician were for blood glucose readings less than 80 mg/ dl and greater than 350 mg/ dl. The DON and the Chief Nursing Officer (CNO) reviewed Resident #8's record and confirmed the resident had blood glucose readings below 80 on 01/15/2026 and 01/17/2026. The DON and CNO denied having documented evidence the physician was notified of the blood glucose readings outside parameters and verbalized the CNO would contact the physician to verify if the physician was notified. The DON verbalized following Resident #8's death, facility leadership discovered the RN administered Glucose gel to Resident #8 for hypoglycemia. The DON explained Glucose gel would be (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used for residents who were able to speak and due to Resident #8 being found unresponsive, with low blood glucose, Glucagon should have been administered as ordered by the physician.On 03/26/2026 at 3:00 PM, the Administrator confirmed the Administrator was the facility's Abuse Coordinator and verbalized neglect occurred when the facility deprived a resident of basic needs, food, shelter, water, or care. The Administrator/Abuse Coordinator denied having documentation of the facility's investigation of Resident #8's death in the facility and verbalized the Administrator/Abuse Coordinator was not clinical however, recalled staff found Resident #8 unresponsive and the RN was supposed to have administered a different type of medication.On 03/26/2026 at 4:05 PM, the CNO verbalized the CNO contacted the facility's medical director and nurse practitioner, and neither were able to find documentation a physician was notified on 01/15/2026 and 01/17/2026 of Resident #8's blood glucose being outside the parameters in the physician's orders.The facility's Licensed Practical Nurse/Registered Nurse Job Description, undated, documented the primary purpose of the position was to identify and meet the medical, physical and psychosocial needs of reach resident in accordance with physician orders and the plan of care. A summary of principal accountabilities included administering all medications and treatments in accordance with the physician order for each resident, monitoring and evaluating each resident's response to current medications and treatments, notifying the provider as indicated with any new or concerning observations/findings, and communicating changes in condition to the DON, the resident's provider and resident's representative as indicated.The American Diabetes Association's Standards of Care in Diabetes - 2026, dated 01/2026, 6. Glycemic Goals, Hypoglycemia and Hyperglycemic Crises, documented level 1 hypoglycemia was defined as glucose less than 70 mg/ dl and greater than or equal to 54 mg/ dl. Level 2 hypoglycemia was defined as glucose less than 54 mg/ dl. Level 3 hypoglycemia was a severe event characterized by altered mental and/or physical status requiring assistance for treatment of hypoglycemia, irrespective of glucose level. Hypoglycemia had a broad range of negative health consequences and level 3 hypoglycemia could progress to loss of consciousness, seizure, coma, or death. Recurrent level 2 and/or level 3 hypoglycemia was an urgent medical issue and required intervention with treatment plan adjustment, behavioral intervention, delivery of diabetes self-management education and use of technology to assist with hypoglycemia prevention and identification.The facility policy titled Blood Glucose Monitoring, dated 04/11/2025, documented the facility would perform blood glucose monitoring per physician's orders. The procedure included but was not limited to the following steps: verifying the physician's order, collecting the blood sample from the fingertip, reading the digital display to receive the blood glucose result, reporting critical test results to the physician timely, and documenting the procedure.The facility policy titled Abuse, Neglect, and Exploitation, dated 04/11/2025, documented neglect was the failure of the facility, its employees, or service providers to provide goods and services to a resident which were necessary to avoid physical harm, mental anguish, or emotional distress.Cross reference tag F610FRI 2723311

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review, the facility failed to provide documented evidence the facility conducted a thorough investigation of an incident suspicious for neglect of 1 of __ sampled residents (Resident #8). This deficient practice had the potential for ongoing physical and/or psychosocial harm to residents due to allegations of neglect not being thoroughly investigated and documented to ensure appropriate protections were put in place to prevent future neglect. Findings include:Resident #8Resident #8 was admitted to the facility on [DATE], with diagnoses including type one diabetes mellitus with other circulatory complications and type one diabetes mellitus with diabetic autonomic (poly) neuropathy.A final Facility Reported Incident (FRI) report submitted by the facility on [DATE], documented the report was related to an incident on [DATE] involving Resident #8. The incident type was neglect and the allegation against the alleged perpetrator was verified. A Certified Nursing Assistant (CNA) found Resident #8 unresponsive and clammy at approximately 1:00 AM on [DATE]. A Registered Nurse (RN) assessed the resident, checked the resident's blood glucose with a result of 31, and administered oral glucose gel outside of order guidelines. The RN did not administer the prescribed medication (Glucagon) per physician order. A finger stick blood glucose level was checked again and remained 31. Emergency Medical Services (EMS) arrived, administered 10% Dextrose to Resident #8, the resident briefly regained consciousness, then became unresponsive and Cardiopulmonary Resuscitation (CPR) was initiated by EMS. CPR was unsuccessful and Resident #8 expired.On [DATE] at 3:00 PM, the Administrator/Abuse Coordinator denied the Administrator/Abuse Coordinator had documentation of the facility's investigation of the incident on [DATE], involving Resident #8. The Administrator/Abuse Coordinator explained the facility's former Director of Nursing (DON) had the documentation and the Administrator/Abuse Coordinator was unable to locate the information in the former DON's office. Additionally, the Administrator/Abuse Coordinator verbalized being unable to access many electronic files following the facility's change of ownership in February 2026.The facility policy titled Abuse, Neglect, and Exploitation, dated [DATE], documented an immediate investigation was warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occurred. Written procedures for investigation included but were not limited to: identifying staff responsible for the investigation, identifying and interviewing all involved persons (including the alleged victim, alleged perpetrator, witnesses, and others who may have knowledge of the allegations) and providing complete and thorough documentation of the investigation.Cross reference tag F600FRI 2723311