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	05/14/2026

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 interview, clinical record review and document review, the facility failed to ensure 1 of 19 sampled residents (Resident #97) was protected from resident-to-resident physical abuse. This deficient practice had the potential to result in pain, physical injury and mental anguish to residents.Findings include:Resident #97Resident #97 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including pleural effusion, not elsewhere classified and chronic respiratory failure with hypoxia.Resident #81Resident #81 was admitted to the facility on [DATE], with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris and chronic obstructive pulmonary disease, unspecified.On 05/11/2026 at 8:58 AM, Resident #97 recalled having trouble with a prior roommate. The roommate would not allow Resident #97 to turn the light on long enough to use the urinal and kept turning the light off. Resident #97 verbalized the roommate hit Resident #97 in the face with a closed fist. Afterward, Resident #97 grabbed the roommate by the shirt and hit the roommate back. Resident #97 denied any resulting injuries from the altercation; however, verbalized the resident no longer trusted the roommate and didn't want to go to sleep as Resident #97 was afraid the roommate would stick a knife in the resident's chest. The incident occurred less than one month prior, and Resident #97 had not seen the roommate following the incident.A final Facility Reported Incident (FRI) report submitted by the facility on 05/03/2026, documented Resident #97 and Resident #81, roommates at the time of the incident, punched each other. On 04/30/2026 at approximately 9:30 PM, Resident #97 was repeatedly screaming when Resident #81 got up and struck Resident #97 in the head. Resident #97 then struck Resident #81 in the head/face region. Both residents were interviewed and admitted to hitting one another.A progress note dated 05/03/2026, documented Resident #97 got into a physical altercation with the resident's roommate on 04/30/2026. Resident #97 utilized the call light to ask for assistance with the urinal. The Certified Nursing Assistant (CNA) turned on the light on Resident #97's side of the room. Resident #97 wanted all the lights to be turned on. The CNA explained the CNA could only turn on the light on the resident's side of the room as the roommate was sleeping. Resident #97 became upset and started yelling. The CNA explained staff and the resident needed to be respectful and quiet as the resident's roommate was sleeping. Resident #97 stopped yelling and finished using the urinal. The CNA was in another resident room when the CNA heard Resident #97 yelling out again. As the CNA approached the room the CNA heard Resident #97 say the roommate hit Resident #97. Upon entering the room, the CNA observed the roommate standing over Resident #97's bed with a clenched fist and the light was turned off. Both residents were engaging in verbal aggression toward each other.On 05/13/2026 at 3:14 PM, the DON verbalized abuse could be mental, sexual, physical, or verbal and caused a negative reaction by the resident, caused the resident to feel upset or affected the resident's emotions in a negative way. Physical abuse would include moving a resident and leaving a bruise, striking a resident and kicking a resident.On 05/14/2026 at 8:23 AM, the DON recalled Resident #97 had a confrontation with the resident's former roommate, Resident #81. The DON explained Resident #97 often refused to use the call light and had behaviors of yelling out to get what (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	the resident wanted. At the time of the incident, Resident #97 needed to use the urinal and the CNA turned on the light on Resident #97's side of the room. The CNA explained Resident #81 was sleeping so the CNA could not turn on all the lights in the room, Resident #97 agreed and used the urinal. While assisting with other residents the CNA heard Resident #97 yelling out. As the CNA approached the room, the CNA heard Resident #97 say Resident #81 hit Resident #97. The CNA saw Resident #81 standing over Resident #97's bed with a closed fist. The DON confirmed the DON helped to complete the investigation of the incident and recalled Resident #81 admitted to hitting Resident #97. Resident #81 claimed the resident reacted to being hit by Resident #97 first.The facility policy titled Abuse, Neglect and Exploitation, dated 04/11/2025, documented abuse was the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish which could include staff to resident abuse and certain resident to resident altercations. It included verbal abuse, sexual abuse, physical abuse, and mental abuse. Physical abuse included but was not limited to hitting, slapping, punching, biting and kicking.FRI 3000830

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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 interview, clinical record review and document review, the facility failed to ensure 1 of 19 sampled residents (Resident #62) was protected from potential misappropriation of property when an allegation a nurse stole the resident's medication was not reported to the Abuse Coordinator timely. This deficient practice placed all residents in the facility at risk for misappropriation of property due to delayed suspension of the alleged perpetrator and delayed investigation of the allegation.Findings include:Resident #62Resident #62 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure, unspecified whether with hypoxia or hypercapnia and other chronic pain.On 05/11/2026 at 11:54 AM, Resident #62 verbalized the resident had pain in both arms and took Lyrica to help manage the pain. The resident verbalized the resident would be in bad shape if the resident did not receive the medication and explained if one day's worth of medication was missed, the resident experienced a lot of pain. Resident #62 recalled there were two or three times the resident did not receive an ordered dose of Lyrica and was told the facility had run out of the medication. The resident verbalized the missed doses occurred when two specific staff members were working however, the two staff members no longer worked in the facility and the resident had not missed any more doses of pain medication.A final Facility Reported Incident (FRI) report submitted by the facility on 04/17/2026, documented two residents voiced concerns about pain management only when a specific nurse worked the unit. The date of the incident was 04/13/2026. The alleged perpetrator was a Registered Nurse (RN1) and the exact allegation against RN1 was RN1 may have been diverting medications.A Nurse's Note dated 03/06/2026, documented the nurse spoke to Resident #62's family member who informed the nurse Resident #62 mentioned problems regarding medications. The resident claimed medications were not being administered, nurses were not giving the resident Pregabalin (Lyrica) and may have been stealing the medication. Management would be made aware.A Nurse's Note dated 03/09/2026, documented by the Director of Nursing (DON), indicated the DON followed up with Resident #62 regarding the resident's Lyrica medication. The DON spoke with the Assistant DON (ADON) who was present on Friday and spoke with the primary nurse. The ADON stated Resident #62 was upset regarding the Lyrica being given. The ADON stated when removing the Lyrica from the packet, the medication broke in half. When the resident was shown this, the resident became upset. The DON spoke with Resident #62 on 03/09/2026 and the resident stated the resident did not know how a medication could break. The DON explained sometimes capsules break when pushing them out of the packet. The resident verbalized agreement but stated the resident was still suspicious.On 05/13/2026 at 3:14 PM, the DON verbalized misappropriation of resident property was when someone utilized a resident's property in a way not tolerated or wanted by the resident and included stealing money or using one resident's medication for another resident. The DON confirmed stealing a resident's medication would be considered misappropriation of resident property. If an allegation of abuse, neglect or misappropriation of property was reported to facility staff, the DON verbalized the expectation was the staff member would report the allegation immediately to the Administrator and/or DON. The Administrator was the facility's Abuse Coordinator (AC).The DON confirmed the DON was familiar with the allegations described in the FRI submitted 04/17/2026. The DON recalled a resident came to the DON and reported the resident felt like a certain nurse was not giving the resident their pain medication and the issue had been occurring for months. A few days later, Resident #62 reported to the DON the resident did not feel like the resident was getting their prescribed pain medication. The two residents were complaining about the same shifts the nurse of concern, RN1, worked in the facility. The DON recalled during the investigation into the allegations, the DON reviewed the Medication Administration Records (MARs) and narcotic logbook for the shifts RN1 worked. The DON denied any additional clinical record review was completed as part of the investigation.On 05/13/2026 at 3:42 PM, the DON reviewed the nurse's note dated 03/06/2026 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicating the resident's family member reported an allegation Pregabalin was not being administered to Resident #62 and nurses may have been stealing the medication. The DON confirmed the note documented an allegation of misappropriation of resident property and should have been reported immediately. The DON denied the allegation was reported to facility leadership.The DON confirmed the DON entered the nurse's note dated 03/09/2026 and explained the former ADON informed the DON Resident #26 had a concern about a Lyrica capsule being broken. The DON denied neither the nurse who documented the 03/06/2026 nurse's note nor the former ADON reported the allegation of misappropriation of property. The DON confirmed RN1 continued to work in the facility from 03/06/2026, when the allegation was made, until 03/27/2026.On 05/13/2026 at 3:59 PM, the Administrator confirmed the Administrator was the facility's AC and verbalized the Administrator/AC was usually responsible to conduct investigations when an allegation of abuse, neglect, or misappropriation of resident property was made. All allegations and/or suspicion of abuse, neglect, and misappropriation were to be reported to Administrator/AC immediately.The Administrator/AC confirmed the Administrator/AC was aware of the allegations documented in the FRI regarding Resident #62 and the resident's pain medications. The Administrator/AC recalled reporting the incident; however, explained the matter was mostly clinical and the DON conducted most of the investigation. The Administrator/AC reviewed the nurse's note dated 03/06/2026, confirmed the note documented an allegation of misappropriation of resident property and confirmed the allegation should have been reported immediately. The Administrator/AC denied the allegation was reported timely, denied an investigation was initiated immediately and denied any protections were put in place on or around 03/06/2026 to protect residents from misappropriation of property.The facility policy titled Pain Management, dated 04/11/2025, documented if a resident reported or there were signs of increased pain, the facility should evaluate whether there was a time or day pattern to ensure the problem was not due to drug diversion. The facility policy titled Abuse, Neglect and Exploitation, dated 04/11/2025, documented the facility would provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures to prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. Possible indicators of abuse included but were not limited to: resident, staff or family report of abuse and resident reports of theft of property or missing property. An immediate investigation was warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occurred and the facility would make efforts to ensure all residents were protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples of protection included responding immediately to protect the alleged victim and integrity of the investigation and room/staffing changes to protect the resident from the alleged perpetrator.FRI 2982885