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	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on interview, clinical record review, and document review the facility failed to obtain informed consent for a psychoactive medication prior to the administration of the medication for 3 of 19 sampled residents (Resident #23, #28 and #66). Findings include: Resident #23 Resident #23 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease with acute exacerbation, major depressive disorder, single episode, unspecified and anxiety disorder, unspecified. Resident #23's Order Summary Report, with active orders as of 05/21/2024, documented the following: -Hydroxyzine Hydrochloride (HCl) oral tablet 25 milligrams (mg), give 25 mg by mouth two times a day for anxiety. -Duloxetine HCl oral capsule delayed release particles 60 mg, give 60 mg by mouth one time a day for depression. -Melatonin oral tablet 3 mg, give 9 mg by mouth one time a day for circadian rhythm regulation. Resident #23's Medication Administration Record (MAR) for April 2024, documented the following: -Alprazolam oral tablet 0.25 mg, give 0.25 mg by mouth every eight hours as needed for anxiety. The start date was 04/26/2024, the discontinue date was 04/29/2024. The medication was administered to Resident #23 on 04/27/2024. -Duloxetine HCl oral capsule delayed release particles 60 mg, give 60 mg by mouth one time a day for depression. The start date was 04/26/2024. The medication was administered to Resident #23 from 04/26/2024 through 04/30/2024. -Melatonin oral tablet 3 mg, give three mg by mouth one time a day for circadian rhythm regulation. The start date was 04/25/2024, the discontinue date was 05/13/2024. The medication was administered to Resident #23 from 04/25/2024 through 04/30/2024. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
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F 0552

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Resident #23's MAR for May 2024, documented the following:

-Duloxetine HCl oral capsule delayed release particles 60 mg, give 60 mg by mouth one time a day for depression. The start date was 04/26/2024. The medication was administered to Resident #23 from 05/01/2024 through 05/20/2024.

-Hydroxyzine HCl oral tablet 25 mg, give 25 mg by mouth two times a day for anxiety. The start date was 05/03/2024. The medication was administered to Resident #23 from 05/03/2024 through 05/20/2024.

-Melatonin oral tablet 3 mg, give 3 mg by mouth one time a day for circadian rhythm regulation. The start date was 04/25/2024, the discontinue date was 05/13/2024. The medication was administered to Resident #23 from 05/01/2024 through 05/12/2024.

-Melatonin oral tablet 3 mg, give 9 mg by mouth one time a day for circadian rhythm regulation. The start date was 05/13/2024. The medication was administered to Resident #23 on 05/13/2024, 05/14/2024, 05/16/2024, 05/17/2024, 05/18/2024, 05/19/2024 and 05/20/2024.

Resident #23's clinical record contained a signed Psychotropic Drug Disclosure and Consent for Duloxetine and Xanax. The forms were signed and dated 04/30/2024.

Resident #23's clinical record contained a signed Psychotropic Drug Disclosure and Consent for Hydroxyzine. The form was signed and dated 05/22/2024.

Resident #23's clinical record lacked documented evidence of informed consent prior to the initial administration of Duloxetine, Hydroxyzine, Melatonin and Alprazolam (Xanax).

On 05/28/2024 at 12:33 PM, during an interview with the Director of Nursing Services (DNS) and the Divisional Director of Clinical Operations (DDCO), the DNS confirmed psychotropic medications required informed consent prior to administration. The DNS explained a psychotropic was any medication having an effect on the brain. The DDCO and the DNS confirmed Melatonin was a psychotropic medication. The DNS reviewed Resident #23's clinical record and confirmed an informed consent was not obtained prior to the administration of Duloxetine, Hydroxyzine, Melatonin, and Alprazolam (Xanax).

31739

Resident #28

Resident #28 was admitted to the facility on [DATE], with diagnoses including bi-polar disorder and anxiety disorder.

A physician's order dated 04/24/2024, documented Clonazepam oral tablet 1 mg, give by mouth three times a day for anxiety.

Resident #28's MARs dated April 2024 and May 2024, documented Clonazepam oral tablet 1 mg, was administered three times a day per the physician order.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #28's clinical record lacked documented evidence of a signed Psychotropic Drug Disclosure and Consent prior to the administration of Clonazepam oral tablet. A physician's order dated 05/01/2024, documented Vraylar oral capsule 3 mg, give three mg by mouth one time a day for borderline personality disorder. Resident #28's MAR dated May 2024, documented Vraylar oral capsule 3 mg, was administered one time a day per the physician order. Resident #28's clinical record lacked documented evidence of a signed Psychotropic Drug Disclosure and Consent prior to the administration of Vraylar oral capsule. On 05/23/2024 at 11:28 AM, the DNS confirmed no informed consent had been obtained prior to the administration of Clonazepam oral tablet or Vraylar oral capsule to Resident #28. The DNS confirmed an informed consent was required prior to the administration of an antianxiety or antipsychotic medication. Resident #66 Resident #66 was admitted to the facility on [DATE], with a diagnosis of anxiety. A physician's order dated 03/02/2024, documented Hydroxyzine HCl tablet, 25 mg, give 25 mg by mouth every six hours as needed for anxiety. Resident #66's MAR dated March 2024, documented Hydroxyzine HCl tablet, 25 mg, was administered on the following dates: -03/03/2024 -03/20/2024 -03/27/2024 -03/29/2024 Resident #66's MAR dated April 2024, documented Hydroxyzine HCl tablet, 25 mg, was administered on the following dates: -04/04/2024 -04/10/2024 -04/11/2024 -04/13/2024 -04/15/2024 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-04/18/2024 -04/20/2024 -04/21/2024 Resident #66's record documented a consent for Hydroxyzine HCl tablet, 25 mg, was signed on 04/23/2024. On 05/23/2024 at 11:54 AM, the DNS confirmed Resident #66 had been administered Hydroxyzine HCl tablet, 25 mg, in March 2024 and April 2024 prior to the informed consent having been completed and signed. The DNS verbalized a consent for the use of an antianxiety medication was required prior to administration of the medication. The facility policy titled Psychotropic Drugs, updated January 2019, documented psychotropic drugs were any drugs which affected brain activities associated with mental processes and behavior. Psychotropics included but were not limited to anti-psychotics, anti-depressants, anti-anxiety, hypnotics, and anticonvulsants (when used as a mood stabilizer). The facility policy titled Notice of Resident Rights Under Federal Law, updated November 2016, documented residents had the right to be informed, in advance, of the care furnished to the resident. Residents had the right to be informed, in advance, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option the resident preferred. The facility policy titled, Informed Consent for Psychotropic Drugs, updated September 2017, documented an informed consent was to have been obtained prior to the administration of an anti-psychotic, anti-depressant, anti-anxiety, and/or hypnotic medication.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 49557 Based on observation and interview, the facility failed to ensure the current menu was posted, allowing residents to review and request an alternative if preferred. Findings include: On 05/19/2024 at 10:27 AM, the menu for breakfast, lunch and dinner posted in the dining room near the Brookside Unit was dated for Friday 05/17/2024. 43310 On 05/19/2024 at 10:57 AM, the breakfast, lunch, and dinner menus posted on the menu board near the Classics Unit entry way was dated for Friday 05/17/2024. 31739 On 05/19/2024 at 10:02 AM, the menu for breakfast, lunch and dinner posted in the Advantage Unit was dated for 05/17/2024. On 05/20/2024 at 10:53 AM, the Nutritional Services Supervisor confirmed the menu posted on 05/19/2024 in the Advantage Unit was for 05/17/2024. The Nutritional Services Supervisor verbalized the current days menu should have been posted before breakfast was served. The Nutritional Services Supervisor verbalized having provided verbal instructions to have the menu changed but was not. The Nutritional Services Supervisor verbalized not having a policy on menu postings and had been proving instructions verbally.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a potential incidence of misappropriation of a resident's prescribed narcotic pain medication was reported for misappropriation of property for 1 of 2 residents reviewed for potential narcotic diversion (Resident #44). This deficient practice could lead to undetected narcotic diversion from residents causing increased pain and diminished quality of life. Findings include: Resident #44 Resident #44 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, cognitive communication deficit, and aphasia. On 05/22/2024 at 2:25 PM, a Registered Nurse (RN) from a contracted hospice agency verbalized the hospice had to replace a bottle of liquid Morphine for Resident #44 on 05/21/2024. The RN explained the bottle appeared to have been tampered with, the medication was discolored, and there was a paper like substance visible in the bottle. An Order Summary Report for Resident #44, documented Morphine Sulfate (concentrate) solution 20 milligrams (mg)/milliliter (ml), give 5 mg by mouth every four hours as needed for pain. The order start date was 01/31/2024. The narcotic count sheet for Resident #44's Morphine Sulfate documented a bottle containing 13.25 ml was discarded on 05/21/2024, due to discoloration. On 05/22/2024 at 3:23 PM, the Resident Care Manager (RCM) verbalized the RCM was not aware of any concerns regarding Morphine needing to be discarded for Resident #44. On 05/22/2024 at 3:30 PM, the Director of Nursing Services (DNS) verbalized the DNS was not aware of any issues with a resident's Morphine being discarded due to discoloration. The DNS verbalized if the DNS was made aware of any such issue, the DNS would immediately start an investigation, including interviewing all involved and reviewing narcotic counts. On 05/22/2024 at 3:37 PM, the RN for Resident #44 verbalized the RN had discarded the Morphine with the hospice RN on 05/21/2024. The RN explained the hospice RN wanted to discard because the Morphine appeared watered down, there was a substance floating in the liquid, and the self-sealing bottle adapter had been removed. The RN verbalized the RN, and the hospice RN notified the DNS the medication needed to be discarded. On 05/22/2024 at 4:02 PM, the DNS confirmed the incident had not been reported or investigated as potential misappropriation of resident property. The DNS verbalized the facility would begin investigating the concern. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated 10/2022, documented the facility would immediately report all suspected and/or allegations of misappropriation of resident property in accordance with state and federal law. Cross reference with tag F610

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a potential incidence of misappropriation of a resident's prescribed narcotic pain medication was investigated for misappropriation of property for 1 of 2 residents reviewed for potential narcotic diversion (Resident #44). This deficient practice could lead to undetected narcotic diversion from residents causing increased pain and diminished quality of life. Additionally, the facility failed to thoroughly investigate a resident's allegation of abuse and ensure a suspended employee did not continue to work in the facility until an investigation was completed for 1 of 19 sampled residents (Resident #19). Resident #19 alleged a male staff member touched the resident inappropriately while checking the resident's brief. One of the male staff members working at the time the allegation occurred was scheduled and continued to work in the facility from the time the facility was made aware of the allegation on 05/16/2024, until 05/23/2024. The lack of a thorough investigation and failure to prevent the staff member from working in the facility allowed an alleged perpetrator continued access, with the potential for further abuse, to the alleged victim and all other residents in the facility. On 05/23/2024 at 3:05 PM, the Administrator was notified of Immediate Jeopardy (IJ) related to the failure to thoroughly investigate an allegation of abuse and failure to protect Resident #19 and all other residents in the facility from an alleged perpetrator during the facility's investigation. The IJ began on 05/16/2024, when the facility was made aware of the allegations of abuse by Resident #19 of being touched inappropriately by a male staff member. The lack of a thorough investigation into the allegation and protection of residents by failing to ensure a suspended employee did not continue to work in the facility had the potential to result in sexual abuse and cause harm to all residents in the facility. On 05/23/2024 at 4:23 PM, the plan to remove the immediacy for F610 was accepted by the State Agency (SA) and included the following summarized actions: -The alleged perpetrator was suspended to ensure completion of the investigation regarding care provided to the resident of concern on the date of the incident. -All residents were interviewed related to sexual abuse, and non-interviewable residents were assessed for sexual trauma. -All facility staff would be educated on Abuse Prevention and Investigation. On 05/29/2024, while onsite and after confirming the facility's implementation of the immediate corrective action completed on 05/24/2024 at 5:00 PM, the IJ was removed in the presence of the Administrator. The deficient practice remained at a scope of D and the severity lowered to potential for minimal harm following the removal of the IJ. The facility's implementation of the plan to remove the immediacy of the IJ was verified as follows: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews were conducted with two Registered Nurses (RN), one Licensed Practical Nurse (LPN), three Certified Nursing Assistants (CNA), seven residents, the Director of Nursing Services (DNS), the Administrator, the Divisional Director of Clinical Operations (DDCO), and the Staff Development RN. Review of the Empress Caring Representative (ECR) Checklists completed with all residents on 05/23/2024, documented all residents were interviewed and screened for the following: -Ability to make choices about daily life which were important to the resident. -Did staff treat the resident with dignity and respect. -Did residents get the help and care needed without waiting a long time. -Confrontations with staff and/or other residents -Sexual abuse -Observation or personal experience of the following: being treated with humiliation, mean things said, hurt (treated roughly, slapped, hit, shoved), or a situation which made the resident feel uncomfortable. Review of the Inservice Education Summary, dated 05/23/2024, documented the Divisional Director of Clinical Operations (DDCO), the Administrator, the Director of Nursing Services (DNS), and the Resident Care Manager (RCM) received education via lecture and handouts on the following topics: -Abuse investigation policy -Abuse investigation pathway -Investigation of alleged sexual abuse -Abuse policy Review of training certificates documented all staff received training related to abuse identification and reporting and the facility's policy titled Abuse Investigation. The training was completed as of 05/24/2024. Findings include: Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including spondylosis without myelopathy or radiculopathy, lumbar region, anxiety disorder, unspecified and depression, unspecified. An initial Facility Reported Incident (FRI) dated 05/16/2024, documented Resident #19 alleged the resident was sexually abused by a male staff member. The resident alleged the male staff member inserted the staff member's finger into the resident's rectum and vagina. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/20/2024 at 10:54 AM, Resident #19 recalled a male staff member touched Resident #19 inappropriately. The incident was reported to staff. On 05/20/2024 at approximately 12:20 PM, a female staff member entered Resident #19's room. The female staff member verbalized the female staff member was looking for a Certified Nursing Assistant (CNA). The female staff member described the CNA as a tall man. Upon mention of a tall man, Resident #19 appeared frightened, pulled a blanket over the resident's body, and began to cry. A progress note dated 05/16/2024, documented Resident #19 reported the incident to a Licensed Practical Nurse (LPN). A skin assessment was completed and the Advanced Practice Registered Nurse (APRN) was notified. An Investigator's Interview Statement of Event dated 05/17/2024, documented Resident #19 reported to an LPN a male employee put the employee's fingers inside the resident's vagina and anus every time the employee had to change the resident's brief. The date of event was documented as 05/16/2024. A timeline of events provided by the facility, related to the incident on 05/16/2024, documented the following: -On 05/16/2024, a facility investigation was initiated. Possible alleged persons, a CNA and a Nurse-Aid in Training (NAT), were suspended pending an investigation. -On 05/17/2024 at 10:00 AM and 3:45 PM, phone calls were placed to the NAT to obtain an interview statement. -On 05/18/2024 at 2:00 PM, the facility had not received a return phone call from the NAT. An additional phone call was placed to the NAT and the facility was awaiting a return call. -On 05/20/2024 at 12:36 PM, a phone call was placed to the NAT to reiterate the removal of the NAT from the schedule until an interview statement could be obtained, the facility was awaiting a return call. A Disciplinary Action Form documented the DNS interviewed the NAT on 05/20/2024. The allegations were not substantiated, and the NAT returned to work on 05/20/2024. An Investigator's Interview Statement of Event dated 05/20/2024, documented the NAT was interviewed regarding the alleged incident on 05/16/2024. The interview was conducted by the DNS and the Administrator. The NAT confirmed the NAT worked the night (NOC) shift on 05/15/2024. The NAT denied going to the side of the building where Resident #19 resided. The NAT denied having worked with Resident #19 or entering Resident #19's room during the shift. On 05/20/2024 at 8:47 AM, a CNA explained the CNA knew what tasks or care were required for each resident by checking the electronic medical record. Tasks were documented as soon as care was provided. Resident #19's clinical record indicated the NAT completed the following tasks for Resident #19 on 05/15/2024 at 9:56 PM: bladder monitor, bowel monitor, hour of sleep snack, meal monitor, fluids, and turn and reposition frequently with shift care rounds as tolerated/as allowed by resident. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/23/2024 at 12:15 PM, the DNS confirmed the DNS was aware of the allegation of sexual abuse reported by Resident #19. The DNS recalled actions taken to protect Resident #19 during the facility's investigation included removing any male caregivers from the resident's care and a social worker met with the resident. The DNS verbalized interviews were conducted with the male staff who were potential suspects, a CNA and an NAT. The CNA and NAT denied going into Resident #19's room during the shift when the alleged sexual abuse occurred. The DNS verbalized the investigation was complete and the CNA and the NAT were cleared to return to work on 05/20/2024. The DNS denied the DNS completed a review of Resident #19's clinical record as part of the investigation into the allegation of sexual abuse. The DNS verbalized the DNS could have reviewed the clinical record to verify if either the CNA or the NAT provided care to Resident #19. During the interview, the DNS reviewed Resident #19's clinical record and confirmed the clinical record indicated the NAT provided care to Resident #19 during the NOC shift on 05/15/2024. The DNS denied it would be common for staff to document in a resident's clinical record if the staff member was not providing care to the resident. The DNS confirmed investigation into an allegation of abuse would typically include a review of the resident's clinical record. On 05/23/2024 at 12:44 PM, a copy of the NAT's timecard was provided by Human Resources (HR) Staff. The NAT's timecard documented the following: -The NAT worked from 5:59 PM on 05/15/2024, until 6:02 AM on 05/16/2024. -The NAT worked from 5:45 PM on 05/16/2024, until 6:01 AM on 05/17/2024. -The NAT worked from 6:11 PM on 05/17/2024, until 6:02 AM on 05/18/2024. -The NAT worked from 5:55 PM on 05/18/2024, until 6:02 AM on 05/19/2024. -The NAT worked from 5:53 PM on 05/20/2024, until 5:56 AM on 05/21/2024. -The NAT worked from 5:51 PM on 05/22/2024, until 6:03 AM on 05/23/2024. On 05/23/2024 at 1:01 PM, during an interview with the DNS and the Divisional Director of Clinical Operations (DDCO), the DNS explained when an allegation of abuse was made, the DNS would suspend the alleged perpetrator(s) until the investigation had been completed. If the investigation found the employee(s) was not responsible or involved, the employee(s) would be allowed to return to work. The DNS explained it would have been appropriate to suspend any male employee working at the time the alleged sexual abuse of Resident #19 occurred. The DNS verbalized the CNA was initially suspended when the facility began the investigation. During the investigation, the DNS learned the NAT was also working the NOC shift on 05/15/2024. The DNS verbalized the DNS made several calls to the NAT to inform the NAT of the suspension until the completion of the investigation however, the DNS was not able to contact the NAT until 05/20/2024. The DNS verbalized the NAT did not work between 05/16/2024 and 05/20/2024. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/23/2024 at 1:07 PM, the DNS and the DDCO reviewed the NAT's timecard and confirmed the timecard documented the NAT worked the NOC shifts beginning on 05/15/2024, 05/16/2024, 05/17/2024, 05/18/2024, 05/20/2024 and 05/22/2024. When asked, if due to the DNS's failure to reach the NAT by phone, anyone remained in the facility to notify the NAT the NAT was suspended and could not work until the completion of the investigation, the DNS verbalized the DNS could not confirm anyone stayed to notify the NAT. The DNS reviewed the facility's schedule for 05/23/2024, and confirmed the NAT was scheduled to work the NOC shift. The DNS verbalized there was a potential for further abuse to all residents when a suspended employee was allowed to continue to work unsupervised in the facility while an investigation was ongoing. The facility policy titled Notice of Resident Rights Under Federal Law, updated 11/2016, documented residents had the right to be free from verbal, sexual, physical, or mental abuse. The facility policy titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated 10/2022, documented each resident had the right to be free from abuse including verbal, mental, sexual or physical abuse. The facility implemented policies and processes so residents were not subjected to abuse by staff. The policies addressed screening, training, prevention, identification, investigation, protection, and reporting/response. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Sexual abuse was defined as non-consensual sexual contact of any type. The facility was to conduct a thorough investigation of allegations of abuse in accordance with state and federal regulations and referred to the abuse investigation policy. The facility was to protect residents from harm during and after the investigation and referred to the abuse protection policy. The facility policy titled Abuse Protection, updated 10/2022, documented the facility was to protect residents from physical and psychosocial harm during and after an investigation. The facility was to suspends and/or removes the alleged perpetrator from patient care areas immediately. The facility policy titled Abuse Investigation, updated 10/2022, documented the facility was to conduct a thorough investigation of allegations of abuse. The facility was to protect the alleged victim during and after the course of the investigation according to the abuse protection policy. Cross reference with F835 FRI #NV00071208 41848 Resident #44 Resident #44 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, cognitive communication deficit, and aphasia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER: Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3050 N Ormsby Carson City, NV 89703	

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/22/2024 at 2:25 PM, a Registered Nurse (RN) from a contracted hospice agency verbalized the hospice had to replace a bottle of liquid Morphine for Resident #44 on 05/21/2024. The RN explained the bottle appeared to have been tampered with, the medication was discolored, and there was a paper like substance visible in the bottle. An Order Summary Report for Resident #44, documented Morphine Sulfate (concentrate) solution 20 milligrams (mg)/milliliter (ml), give 5 mg by mouth every four hours as needed for pain. The order start date was 01/31/2024. The narcotic count sheet for Resident #44's Morphine Sulfate documented a bottle containing 13.25 ml was discarded on 05/21/2024, due to discoloration. On 05/22/2024 at 3:23 PM, the Resident Care Manager (RCM) verbalized the RCM was not aware of any concerns regarding Morphine needing to be discarded for Resident #44. On 05/22/2024 at 3:30 PM, the Director of Nursing Services (DNS) verbalized the DNS was not aware of any issues with a resident's Morphine being discarded due to discoloration. The DNS verbalized if the DNS was made aware of any such issue, the DNS would immediately start an investigation, including interviewing all involved and reviewing narcotic counts. On 05/22/2024 at 3:37 PM, the RN for Resident #44 verbalized the RN had discarded the Morphine with the hospice RN on 05/21/2024. The RN explained the hospice RN wanted to discard because the Morphine appeared watered down, there was a substance floating in the liquid, and the self-sealing bottle adapter had been removed. The RN verbalized the RN, and the hospice RN notified the DNS the medication needed to be discarded. On 05/22/2024 at 4:02 PM, the DNS confirmed the incident had not been reported or investigated as potential misappropriation of resident property. The DNS verbalized the facility would begin investigating the concern. The facility policy titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated 10/2022, documented the facility would conduct a thorough investigation of potential, suspected, and/or allegations of misappropriation of resident property in accordance with state and federal regulations. Cross reference with tag F609

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739 Based on clinical record review, interview, and document review, the facility failed to develop a person-centered Comprehensive Care Plan for 1) the use of insulin, and include the correct diagnosis for 1 of 19 sampled residents (Resident #50), and 2) for infection control related to indwelling devices and a history of Multi-drug Resistent Organisms (MDRO), including the use of Enhanced Barrier Precautions (EBP) for 1 of 9 residents reviewed for Facility Reported Incidents and Complaint investigations (Resident #77). Findings include: Resident #50 Resident #50 was admitted to the facility on [DATE], with a diagnosis of type I diabetes mellitus. A physician's order dated 04/30/2024, documented NovoLOG Injection Solution 100 UNIT/milliliters (ml), inject as per sliding scale. Resident #50's Medication Administration Record (MAR) dated May 2024, documented the administration of NovoLOG Injection Solution as per the physician order. Resident #50's Care Plan lacked documented evidence of the use of insulin and of the diagnosis of type I diabetes mellitus. On 05/23/2024 at 12:04 PM, the Director of Nursing Services (DNS), confirmed Resident #50's Care Plan lacked documented evidence of the use of insulin and the diagnosis of type I diabetes mellitus. The DNS verbalized the correct diagnosis and insulin use should have been documented in the resident's record to ensure the resident's treatment was appropriately provided. 43310 Resident #77 Resident #77 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and acute and chronic respiratory failure with hypoxia. A diagnosis of personal history of methicillin resistant staphylococcus aureus (MRSA) infection was added on 05/01/2024. A Discharge Summary dated 04/25/2024, from the sending facility documented Resident #77 had extended-spectrum beta-lactamase (ESBL) in the resident's urine and MRSA in the resident's sputum resulted on 02/23/2024, a course of antibiotics was completed. A physician's order dated 04/26/2024, documented trach stoma: cleanse with normal saline (NS) or wound cleanser, pat dry. Apply gauze over stoma; and secure with tape. Change twice daily until healed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 04/26/2024, documented enteral feed: water flush 15-30 cubic centimeters (cc) water through tube before and after medication pass administration. A Daily Skilled Nursing Note dated 04/27/2024, documented Resident #77 had a percutaneous endoscopic gastrostomy (PEG) tube in place. A Daily Skilled Nursing Note dated 05/05/2024, documented Resident #77 had a stoma from a previous tracheostomy which required cleansing and redressing. There was minimal brown drainage from stoma dried to the resident's skin. Resident #77's Comprehensive Care Plan lacked documented evidence of a care plan related to infection control, including EBP related to the resident's PEG tube, tracheal stoma, and a personal history of MRSA. Resident #77's clinical record lacked documented evidence of an order for EBPs. On 05/22/2024 at 7:46 AM, the Assistant Director of Nursing (ADON) verbalized the facility did not have a Comprehensive Care Plan policy and confirmed the facility used the Resident Assessment Instrument (RAI) to direct the development of care plans. On 05/28/2024 at 11:58 AM, the DNS confirmed the expectation was a care plan would be developed and implemented for all types of transmission based precautions (TBP), including EBP. The DNS confirmed Resident #77's Comprehensive Care Plan lacked documented evidence of a care plan related to MRSA or EBP/TBP and did not include an order for EBP/TBP. The Resident Assessment Instrument (RAI) 3.0 manual, Chapter 2, The Care Area Assessment (CAA) Process and Care Plan Completion dated 10/2023, documented the residents plan of care would be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. The resident's care plan would be revised based on changing goals, preferences, and needs of the resident and in response to current interventions. The RAI 3.0 manual, Chapter 4, CAA Process and Care Planning, dated 10/2023, documented the care plan should be revised on an ongoing basis to reflect changes in the resident and the care the resident was receiving.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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 the care plan for a resident with a history of falls was updated following an unwitnessed fall for 1 of 19 sampled residents (Resident #5). This deficient practice could prevent the implementation of new interventions to prevent the resident from further falls with the potential for the resident to become injured from a preventable fall. Findings include: Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including repeated falls, difficulty in walking, not elsewhere classified, and other abnormalities of gait and mobility. On 05/20/2024 at 8:57 AM, Resident #5 verbalized the resident had been experiencing more difficulty with walking and fell on [DATE]. The resident explained the resident was attempting to transfer themselves to the wheelchair and fell on the floor. The resident verbalized the resident's roommate had found the resident on the floor and then notified staff. The resident explained the nurse and an aide picked the resident up off the floor and put the resident back in bed. On 05/21/2024 at 9:25 AM, the Registered Nurse (RN) for Resident #5 confirmed the resident had an unwitnessed fall on 05/18/2024 at 7:00 PM. A Progress Note for Resident #5, dated 05/18/2024, documented the resident had a fall with no visual injuries. The clinical record for Resident #5 lacked an update to the resident's fall risk care plan. The fall risk care plan had last been updated on 02/18/2024. On 05/21/2024 at 2:59 PM, the Director of Nursing Services verbalized after a resident had an unwitnessed fall the resident's care plan would be updated to address any new concerns or new interventions to prevent further falls. The facility policy titled Fall Evaluation (Morse Scale) and Management, updated 03/2018, documented a licensed nurse would review and update the care plan with newly identified interventions after a resident fell .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, clinical record review, and document review, the facility failed to ensure resident's medications were not left, unsecured, at a resident's bedside for 2 of 19 sampled residents (Residents #5 and #339), medicated powders were not applied by unlicensed staff for 1 of 19 sampled residents (Residents #5) and medications were not left unsecured on a medication cart while a Certified Nursing Assistant (CNA) was watching the cart. This deficient practice had the potential for a resident to administer medication at a dose not prescribed creating increased potential for adverse medication reactions and for a resident to not receive necessary monitoring and assessment for the application of medicated powders. Findings include: Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including repeated falls, difficulty in walking, not elsewhere classified, and other abnormalities of gait and mobility. On 05/20/2024 at 9:05 AM, the following medications were located on the windowsill and table next to Resident #5's bed: - Nystop 100,000 units/gram (gm) powder. The label documented to apply the powder topically to areas every 24 hours as needed. - Phytoplex treatment antifungal powder containing 2 percent (%) Miconazole Nitrate. - Fluticasone Propionate nasal spray, 50 micrograms (mcg)/spray. The Order Summary Report for Resident #5 included an order for Fluticasone Propionate suspension 50 mcg/actuation, one spray in each nostril one time a day for nasal congestion and allergic rhinitis. The Order Summary Report did not include orders for the Nystop or Phytoplex powder. On 05/21/2024 at 9:16 AM, a Certified Nursing Assistant 1 (CNA) verbalized the CNA1 was familiar with the care of Resident #5. The CNA1 explained the powders at the bedside were applied by the CNA to the skin under the resident's breasts and pannus after bathing the resident. On 05/21/2024 at 9:25 AM, the Registered Nurse1 (RN) for Resident #5 confirmed the medicated powders and nasal spray were at the bedside in the resident's room. The RN1 verbalized the nasal spray should have been locked in the medication cart to ensure the medication was administered by the nurse and not by the resident. The RN1 verbalized the powders could be left in the resident's room and the powders were applied by the CNAs. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/21/2024 at 9:46 AM, the Director of Nursing Services (DNS) verbalized a CNA could not apply a medicated powder because a CNA had not received the education or training necessary to administer medications and medications, including powders, would not be left at the bedside. The DNS explained medications would be stored in the medication cart for safety and to prevent residents from taking a medication without a physician order. The Nevada Nurse Practice Act documents the following: Nevada Administrative Code (NAC) 632.220 Medication and treatment of patients; response to orders; adjustment of dosage or frequency of medication. 1. A registered nurse shall perform or supervise: (a) The verification of an order given for the care of a patient to ensure that it is appropriate and properly authorized and that there are no documented contraindications in carrying out the order; (b) Any act necessary to understand the purpose and effect of medications and treatments and to ensure the competence of the person to whom the administration of medications is delegated. Cross reference with F726 49557 Resident #339 Resident #339 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and chronic respiratory failure with hypoxia. On 05/20/2024 at 1:56 PM, the following medications were in Resident #339's beside table: -Albuterol hfa 90 micrograms (mcg) per actuation (act) -Spiriva Respimat 2.5 mcg/act -Symbicort Budesonide 80 mcg/Fumarate Dihydrate 4.5 mcg Resident #339 verbalized the Spiriva Respimat and the Symbicort inhalers were brought in to the facility by the resident's family member due to the facility not having the medication available when the resident arrived. A CNA2 entered Resident #339's room to retrieve the resident's lunch tray. The albuterol inhaler was on the resident's lunch tray. The CNA2 verbalized the CNA2 would return the inhaler to the resident's nurse. Resident #339 expressed to the CNA2 the resident needed to keep the inhaler. The CNA2 handed the inhaler back to the resident and verbalized the CNA2 would inform the resident's nurse the inhaler was in the resident's room. The Order Summary Report for Resident #339 included the following physician orders: (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ventolin inhalation aerosol solution 108 (90 base) mcg/act (albuterol sulfate), two puffs inhale orally every four hours as needed for shortness of breath (SOB). -Spiriva Respimat inhalation aerosol solution 2.5 mcg/act, two inhalations orally every four hours as needed for SOB. -Budesonide-Formoterol Fumarate inhalation aerosol 80-4.5 mcg/act, two puffs inhale orally two times per day for chronic obstructive pulmonary disease. On 05/22/2024 at 12:52 PM, the LPN assigned to Resident #339 denied the CNA2 informed the LPN of an inhaler being in Resident #339's room. The LPN recalled the resident's family member brought the resident's inhalers from home and the LPN instructed the family member to take them back home as the facility had the inhalers available from the pharmacy. The LPN verbalized the LPN was unaware the inhalers remained in the resident's room. The LPN explained medications were not allowed in resident rooms, unsupervised by staff, as staff could not keep track of when the resident took the medications and other people could access the medications. On 05/22/2024 at 12:59 PM, the LPN entered Resident #339's room and located the Albuterol, Spiriva, and Symbicort inhalers. The resident allowed the LPN to remove the inhalers and the LPN placed the inhalers in the medication cart. On 05/23/2024 at 10:25 AM, during an interview with the DNS, the Assistant Director of Nursing (ADON), the Resident Care Manager (RCM), and the Divisional Director of Clinical Operations (DDCO) the DNS explained medications were not allowed to be left in resident rooms due to safety concerns. The DDCO recalled having a conversation with Resident #339 on 05/22/2024, related to safety and explained why the resident could not keep medications in the resident's room. The DDCO verbalized the resident was educated on the danger of the resident taking albuterol without being monitored by staff due to the resident's history of atrial fibrillation and Albuterol's potential to increase the resident's heart rate to an unsafe level. 46301 On 05/19/2024 at 10:07 AM, upon entry into the Brookside nursing station, the medication cart parked on the outside of the nursing station was seen with greater than 20 over the counter plastic bottles each containing pills in the bottles sitting on top of the medication cart. CNA3 was at the nursing station watching the medications. CNA3 left as soon as RN2 came out of the restroom. On 05/19/2024 at 10:21 AM, CNA3 verbalized watching the medications on top of the medication cart while the nurse used the restroom. CNA3 explained having been asked by the nurse to watch the medication cart and confirmed it was not in the CNA's scope of practice to watch the medications. On 05/19/2024 at 10:53 AM, RN2 explained the plastic bottles seen on top of the medication cart were vitamins, and RN2 confirmed vitamins were considered to be medications. RN2 verbalized having asked CNA3 to watch the medication cart in order to use the restroom. The facility policy titled Medication Storage, dated 01/2023, documented medications supply shall be accessible only to licensed nursing personnel or staff members lawfully authorized to administer medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 N Ormsby Carson City, NV 89703	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Nevada Nurse Practice Act documents the following: Nevada Administrative Code (NAC) 632.222 Delegation and supervision of nursing care. 1. A registered nurse may delegate nursing care to other personnel and supervise other personnel in the provision of care if those person were qualified to provide the care. NAC 632.244 Assignment of unauthorized acts prohibited. A registered nurse or a licensed practical nurse shall not assign to a person the performance of an act the person was not otherwise authorized by law to perform.

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

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46301

Based on interview, clinical record review and document review the facility failed to provide showers to a dependent resident for 1 of 19 sampled residents (Resident #3).

Findings include:

Resident #3

Resident #3 was admitted to the facility originally admitted [DATE], readmitted on [DATE]. Resident #3 discharged on [DATE] and readmitted on [DATE], with diagnoses including rheumatoid arthritis, unspecified, other specified functional intestinal disorders and chronic kidney disease, stage 3.

On 05/20/2024 at 1:06 PM, Resident #3 explained the resident had not been receiving a shower twice a week as scheduled over the last several months. Resident #3 verbalized the Resident felt bad not being able to take a shower when showers were scheduled twice a week. Resident #3 explained to take a shower the resident required assistance and the use of a Hoyer lift.

Resident #3's care plan dated 05/12/24, documented the resident's bathing schedule was to be scheduled for Wednesday and Saturday, during the evening and the resident was a two person assist.

On 05/22/2024 at 10:51 AM, a Certified Nursing Assistant (CNA) verbalized residents had showers scheduled twice a week during the day or night shift depending on the assignments. The CNA explained Resident #3 normally gets a bed bath and knew the resident's hair needed to be washed. The CNA verbalized the resident should be offered a shower at different times prior to documenting the shower as refused on the Resident Plan of Care (POC).

The POC Response History related to bathing dated 02/21/2024 - 05/23/2024, documented the resident had no documentation if a shower or bed bath had been offered or refused for the resident on the resident's scheduled shower dates.

-02/24/2024, six days between offered showers/bed bath.

-03/23/2024, six days between offered showers/bed bath.

-03/30/2024, five days between offered showers/bed bath.

-04/06/2024, six days between offered showers/bed bath.

-04/13/2024, six days between offered showers/bed bath.

-04/24/2024, six days between offered showers/bed bath.

-05/18/2024, six days between offered showers/bed bath.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 N Ormsby Carson City, NV 89703	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/2024 at 10:05 AM, the Assistant Director of Nursing (ADON) confirmed Resident #3 was in the facility and should have been offered a shower/bed bath for the dates above. On 05/23/2024 at 10:08 AM, the Director of Nursing Services (DNS) confirmed the POC Response History related to bathing for Resident #3 lacked documentation Resident #3 had received a shower twice per week over the last 90 days. The DNS verbalized Resident #3's shower schedule was twice a week on Wednesday and Saturday, on the evening shift and the resident required staff assistance due to the resident's limited mobility. The DNS was not aware the resident had not been receiving scheduled showers twice per week. The DNS explained the resident could choose any day or time to receive a shower, and showers were an important part of the resident's care. The importance of regular showers was to ensure residents received proper hygiene and to decrease residents' susceptibility to infections. The DNS explained there was not a facility policy followed related to showering and/or bathing and there was nothing documented in the facility's standard of practice followed related to showering and/or bathing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024

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

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46301 Based on personnel record review, document review, and interview, the facility failed to ensure nursing staff were trained and certified to perform Cardio-Pulmonary Resuscitation (CPR) in the event of a resident cardiac arrest for 1 of 5 sampled licensed nurses (Employee #2). The deficient practice could result in a negative outcome for a resident in cardiac arrest while awaiting the arrival of emergency medical personnel. Findings include: Employee #2 Employee #2 was hired as the Director of Nursing (DNS) with a start date of [DATE]. The DNS's personnel record documented CPR training and certification expired on ,d+[DATE]. On [DATE] at 10:37 AM, the Human Resources staff verbalized CPR was required to be taken by all licensed nurses and confirmed Employee #2 did not have a current CPR certification. The facility policy titled Cardiopulmonary Resuscitation (CPR), updated ,d+[DATE], documented licensed nurses employed by the facility were required to have current CPR certification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER: Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3050 N Ormsby Carson City, NV 89703	

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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** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure 1) wound care was provided as ordered and a resident's plan of care, including medications for pain and symptom management, was coordinated with a contracted hospice provider for 1 of 19 sampled residents (Resident #9), 2) a resident was evaluated after a fall per facility policy for 1 of 19 sampled residents (Resident #5), 3) an order was in place prior to administering medication to a resident for 1 of 6 residents observed during medication administration (Resident #5), 4) the pharmacy, the physician and an on-call manager were notified when ordered medications were not available in the facility for 1 of 19 sampled residents (Resident #23) and 5) the physician was notified when a resident's blood sugar was over a certain level for 1 of 19 sampled residents (Resident #50). This deficient practice could result in additional pain and discomfort and poor palliative wound care outcomes for a resident on hospice services, the potential for an adverse outcomes due to lack of assessments after a resident fell and the lack of physician notification for a resident with high blood sugar. Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including local infection of the skin and subcutaneous tissue, unspecified, methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, and cellulitis of right lower limb. Wound Care and Hospice Coordination On 05/20/2024 at 9:47 AM, Resident #9 was curled up in a fetal position at the end of the bed and had a bandage partially covering a wound to the top of the resident's right foot. The bandage appeared wet with a yellowish fluid. The resident's right lower extremity appeared red, swollen, and moist with skin sloughing. The resident had large black, scabbed areas on the front of the right lower extremity. On 05/22/2024 at 11:24 AM, the Licensed Practical Nurse1 (LPN) for Resident #9 verbalized the resident's wound care was completed by the contracted hospice agency. The LPN1 verbalized the LPN1 would rewrap the wound when needed by applying honey and then wrapping in gauze. The LPN1 explained hospice updates and communication were in a binder at the nurse's station. On 05/22/2024 at 2:25 PM, the Registered Nurse (RN) from the contracted hospice agency verbalized the hospice nurses provided palliative wound care three days a week for Resident #9. The hospice RN explained the hospice RN was not aware of any wound care being provided by the facility, but the hospice staff provided the facility with updated wound care orders with the hospice plan of care and a new medication list weekly to ensure the facility plan of care matched the hospice plan of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Hospice Plan of Care Update Report for Resident #9, dated 05/09/2024, documented the hospice RN would cleanse the wound with wound cleanser or normal saline, inspect for signs of infection, dry with gauze, pack wound with alginate, cover with abdominal dressing, and then wrap with kerlix. The Order Summary Report for Resident #9 documented surgical wound care: right lateral ankle and right medial knee every one hour as needed to cleanse and rewrap dressing. The order start date was 04/10/2024. A facility-initiated care plan for Resident #9, dated 04/14/2024, documented wound care would be completed by hospice or a staff RN on Monday, Wednesday, and Friday. The wound would be cleansed with wound cleansers, covered with xeroform and an abdominal pad, and then covered with rolled gauze. The facility policy titled Skin Integrity, updated 10/2022, documented the facility had a systematic approach and monitoring process for evaluating and documenting skin integrity. Care would be provided to treat, heal, and prevent, if possible, further development of skin ulcers/pressure ulcers/wounds. The following discrepancies were present between the Hospice Plan of Care Update Report (POC) medication orders and the facility's Order Summary Report (facility order): - the POC documented Calcium Carbonate 1000 milligrams (mg) chewable tablet, give orally every two hours as needed for acid reflux with a start date of 03/27/2024. - the facility order documented Calcium Carbonate oral tablet, give two tablets by mouth every four hours as needed per hospice orders with a start date of 04/02/2024. - the POC documented Lorazepam 0.5 mg tablet, take one tablet every four hours as needed for nausea, insomnia, anxiety, restlessness with a start date of 03/27/2024. - the facility order documented Lorazepam oral tablet 0.5 mg, give 0.5 mg by mouth every two hours as needed for insomnia, anxiety, nausea, and restlessness and Lorazepam oral tablet 0.5 mg, give 0.5 mg by mouth every six hours for anxiety. Both orders had a start date of 05/13/2024. - the POC documented Morphine concentrate 100 mg/5 milliliter (ml) oral solution, give 0.25 ml every four hours as needed for pain or shortness of breath with a start date of 03/27/2024. - the facility order documented Morphine Sulfate oral solution 100 mg/ 5 ml, give 0.5 ml by mouth every two hours as needed for pain with a start date of 05/13/2024, and Morphine Sulfate oral solution 20 mg/ml, give 0. 25 ml by mouth every two hours as needed for pain with a start date of 04/03/2024. - the POC documented Morphine extended release (ER) 15 mg tablet, give one tablet two times daily for pain with a start date of 05/07/2024. - the facility order documented Morphine Sulfate ER tablet 30 mg, give 30 mg by mouth three times a day for pain with a start date of 05/13/2024. The facility order included the following additional orders not included on the hospice POC: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER: Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3050 N Ormsby Carson City, NV 89703	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ascorbic Acid tablet 500 mg, give 1000 mg by mouth one time a day for supplement. The start date was 03/29/2024. - Aspirin oral capsule 81 mg, give 81 mg by mouth one time a day. The start date was 03/29/2024. - Bisacodyl suppository 10 mg, insert one suppository rectally as needed for constipation if no results from Milk of Magnesia (MOM). The start date was 03/28/2024. - Docusate Sodium capsule 100 mg, give 200 mg by mouth one time a day. The start date was 03/29/2024. - Ferrous Sulfate oral tablet 325 mg, give 325 mg by mouth two times a day. The start date was 03/29/2024. - Fleet Enema 118 milliliters (ml), insert 118 ml rectally as needed for constipation if no results from suppository. The start date was 03/28/2024. - MOM suspension 400 mg/5 ml, give 30 ml by mouth as needed for constipation. The start date was 03/28/2024. The hospice binder contained two documents titled Medicine List containing all current hospice ordered medications. One was dated on 05/08/2024, and one was dated 05/20/2024. On 05/22/2024 at 2:25 PM, the Assistant Director of Nursing (ADON) verbalized the facility did not have a designated hospice coordinator, but the hospice coordinator responsibilities were shared by the interdisciplinary team. On 05/23/2024 at 9:03 AM, the Director of Nursing Services (DNS) verbalized hospice had taken over the wound care for Resident #9 and the hospice wound care orders should have matched the facility wound care orders. The DNS verbalized it would not be appropriate for an LPN to apply anything to the wound if it was not in the orders. The DNS verbalized hospice medication orders should have matched the facility medication orders to ensure both the facility and the hospice provider were providing consistent care. The facility policy titled Hospice - Provision of Care by Outside Providers, updated 09/2017, documented the facility would collaborate with outside providers to coordinate the provision of hospice care. The hospice and the facility would communicate, establish, and agree upon a coordinated Plan of Care (POC). The facility would maintain a POC consistent with the hospice POC. Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including repeated falls, difficulty in walking, not elsewhere classified, and type two diabetes mellitus with diabetic neuropathy, unspecified. Post-Fall Assessment (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/2024 at 8:57 AM, Resident #5 verbalized the resident had been experiencing more difficulty with walking and fell on [DATE]. The resident explained the resident was attempting to transfer themselves to the wheelchair and fell on the floor. The resident verbalized the resident's roommate had found the resident on the floor and then notified staff. The resident explained the nurse and an aide picked the resident up off the floor and put the resident back in bed. The resident verbalized staff had not assessed the resident after the fall. On 05/21/2024 at 9:25 AM, the Registered Nurse1 (RN) for Resident #5 confirmed the resident had an unwitnessed fall on 05/18/2024 at 7:00 PM. A Progress Note for Resident #5, dated 05/18/2024, documented the resident had a fall with no visual injuries. An RN had come and assessed the resident. The Progress Note was documented by a LPN. The clinical record for Resident #5 lacked a documented assessment from an RN post-fall, orthostatic vital signs, and a post-fall blood sugar check. On 05/21/2024 at 2:59 PM, the DNS verbalized the DNS had not been notified of the resident's fall until 05/21/2024. The DNS verbalized after a resident had an unwitnessed fall the resident would be assessed to rule out injury, blood sugar would be checked if the resident was a diabetic, and orthostatic vital signs would be obtained and documented under the vital signs in the electronic health record. The facility policy titled Fall Evaluation (Morse Scale) and Management, updated 03/2018, documented a licensed nurse would complete an interdisciplinary progress note, the nursing evaluation, orthostatic vital signs, and a blood glucose reading at the time of the fall. Cross reference with tag F657 49557 Administration of Medication Without an Order On 05/23/2024 at 7:47 AM, Resident #5 requested medication for the resident's right knee pain. The RN retrieved a tube of Diclofenac Sodium 1 percent (%) gel, donned gloves, and applied the gel to Resident #5's right knee. The nurse did not review Resident #5's MAR prior to administering the medication. A physician order dated 04/24/2024, documented Voltaren external gel 1 % (Diclofenac sodium topical), apply to right knee topically two times a day for pain for ten days. The order status was completed. The order was no longer active on the resident's MAR. On 05/23/2024 at 10:03 AM, the RN confirmed Resident #5 did not have a current order for Diclofenac Sodium 1 % gel. The RN explained the process when a resident requested a medication for which the resident did not have a current order was for the nurse to contact the physician. The RN confirmed the RN did not contact the physician prior to applying the Diclofenac Sodium gel to Resident #5's right knee. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/2024 at 10:43 AM, during an interview with the DNS, the Resident Care Manager (RCM), and the Divisional Director of Clinical Operations (DDCO) the DNS explained it was the DNS's expectation of nursing staff to follow the medication administration policy during medication administration which included the five rights. The DNS confirmed all medications administered to residents required an active physician's order. The DNS explained medication orders were discontinued either by manually discontinuing the order in the electronic medical record or by the physician placing a stop date on the order. The stop date would automatically discontinue the order on the specified date. The DNS confirmed administering a medication after a stop date would be administering a medication without an order. The facility policy titled Medication Administration : General Guidelines, dated 01/2021, documented medications were administered as prescribed. Medications were administered in accordance with written orders of the prescriber. The nurse was to verify the medication was correct three times before administering the medication. The facility policy titled Medication Administration : Quick Reference Guide, updated 06/2017, documented the nurse was to review the resident's MAR for ordered medications. The nurse was to administer the medication/s per physician order. The nurse was to follow the five rights of medication administration: right person, right medication, right dose, right time, and right route. The nurse was to validate the medication via the MAR and to triple checked the medication ordered during the medication administration process. Physician Ordered Treatment Not Available in Facility Resident #23 Resident #23 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease with acute exacerbation, type two diabetes mellitus with diabetic polyneuropathy, and chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity. On 05/20/2024 at 8:24 AM, during an interview with Resident #23, the resident had diffuse, dry and flaky skin with multiple yellow areas on the resident's lower legs. The resident explained the resident had been treated for cellulitis. The resident recalled the open areas on the resident's legs were treated with iodine and another treatment the resident could not remember. A physician order dated 05/17/2024, documented Ammonium Lactate Solution 70 percent (%), apply to bilateral legs topically two times per day for dry skin. Resident #23's Medication Administration Record (MAR) documented the physician ordered Ammonium Lactate 70% was not administered from 05/17/2024 through 05/20/2024. On 05/22/2024 at 10:59 AM, a LPN2 explained Resident #23 had old cellulitis spots the facility was treating with Betadine and Ammonium Lactate. The LPN2 verbalized the Ammonium Lactate was on order from the pharmacy, the LPN2 had called the pharmacy on 05/22/2024, and was awaiting a call back. The LPN2 confirmed the order for Resident #23's Ammonium Lactate Solution 70% had a start date of 05/17/2024, and the medication had not been administered. (continued on next page)

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

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 05/23/2024 at 10:27 AM, during an interview with the DNS, the Assistant Director of Nursing (ADON), the Divisional Director of Clinical Operations (DDCO), and a Resident Care Manager (RCM) the DNS explained the facility received deliveries from the pharmacy twice a day, every day except Sundays. If an ordered medication was not available in the facility, it was the DNS's expectation of staff to contact the pharmacy and notify the provider. The provider could give approval to administer the medication late or provide an order for a substitute medication. The DNS confirmed Resident #23's physician ordered ammonium lactate solution had not been administered as ordered since the order was placed on 05/17/2024, and was documented as on order from the pharmacy.

The DNS verbalized a progress note in Resident #23's clinical record documented a nurse contacted the pharmacy and the physician on 05/22/2024, regarding the Ammonium Lactate solution. The DNS explained the DNS's expectation would have been for the nurse to contact the on-call manager for help to get the medication from the pharmacy or to get an order from the physician to change the medication. The DNS confirmed Resident #23's clinical record lacked documented evidence the pharmacy, the provider, or the on-call manager were contacted prior to 05/22/2024, regarding the missing Ammonium Lactate solution.

The facility policy titled Medication Administration : Quick Reference Guide, updated 06/2017, documented if a medication/treatment was not available to be administered, the nurse documented the reason for the non-administration and notified the physician. The nurse was to check with the pharmacy to see how soon the medication was going to be available at the facility and was to document the conversation.

Cross reference with F755 and 759

31739

Resident Blood Sugar

Resident #50

Resident #50 was admitted to the facility on [DATE], with a diagnosis of type I diabetes mellitus.

A physician's order dated 04/30/2024, documented NovoLOG Injection Solution 100 UNIT/ml, inject as per sliding scale:

if 200 - 250 = 2 Units;

251 - 300 = 4 Units;

301 - 350 = 6 Units;

351 - 400 = 8 Units;

401 - 450 = 10 Units;

451+ = 13 Units call provider (physician),

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	subcutaneously before meals and at bedtime for diabetes mellitus. Resident #50's MAR dated 05/10/2024 at 4:00 PM, documented the resident's blood sugar level was 505. Resident #50's record lacked documented evidence the physician was notified of the resident's blood sugar level of 505. On 05/23/2024 at 12:02 PM, the DNS confirmed the physician's order for Resident #50's insulin documented the physician was to be notified if the resident's blood sugar level was over 451. The DNS verbalized the importance of notifying the physician so the physician could make adjustments to the resident's treatment and care to ensure the resident's blood sugar stayed within normal levels. The facility policy titled, Medication Administration Subcutaneous Insulin, dated 01/2023, documented insulin was to be administered as order by the physician.

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43310

Based on observation, clinical record review, interview, and document review, the facility failed to ensure 1 of 19 sampled residents (Resident #62) did not develop a new wound and failed to ensure the new wound was reported timely to the wound care team, physician orders for treatment were obtained prior to providing wound care, and nutritional support for wound healing was assessed resulting in the wound developing into a stage II pressure injury (PI).

Findings include:

Resident #62 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified dementia, moderate, with psychotic disturbance, and cognitive communication deficit, muscle weakness (generalized), cognitive communication deficit, age related physical debility, and chronic combined systolic (congestive) and diastolic (congestive) heart failure.

Resident #62's Minimum Data Set 3.0 (MDS) assessment dated [DATE], Section M, documented the resident was at risk of pressure injury but did not have any unhealed pressure injuries.

Resident #62's MDS assessment dated [DATE], Section M, documented the resident was at risk of pressure injury but did not have any unhealed pressure injuries.

A Nurse Progress note dated 05/11/2024, documented Resident #62 had a very reddened coccyx and a few opened areas were noted. The wound was cleansed, an ointment was applied, and a foam pad was used to dress the wound. Resident #62's peri area was very reddened and an ointment was applied. The resident was yelling out many times during the night.

A Weekly Skilled Interdisciplinary Team (IDT) Meeting note dated 05/13/2024, documented Resident #62 frequently had pain rated at a 4 to 6/10 on a numeric pain scale of 1-10. The pain was related to worsening moisture-associated skin damage (MASD) on the resident's bilateral buttocks. The diagnoses listed for Resident #62 in the IDT note did not include MASD or PI. The IDT note lacked any additional documentation related to the resident's skin or wounds.

A Daily Skilled Evaluation for Behavior/Dementia/Depression note, dated 05/14/2024, completed by a Registered Nurse (RN) Resident #62 was agitated, uncomfortable, and had been scratching at the resident's buttocks. Upon assessment Resident #62 had developed an open area on the upper buttock near the buttocks crease. The open area had started to tunnel and was about 0.5 centimeters (cm) deep. The wound was cleansed and redressed using a non-stick pad and op-site dressings. The resident's provider was notified by entering a note into a communication log. Resident #62 was administered tramadol for pain and trazadone for sleep.

(continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Skin Wound note dated 05/16/2024, documented a Certified Nursing Assistant (CNA) asked the documenting RN to look at Resident #62's sacral wound and change the dressing. The RN documented Resident #62 had a wound which had to have started as a pinpoint wound to the sacrum. The drainage from the wound was described as pink/brown and looked like the end of a Q-tip could cover the wound. A one by one inch dressing was removed and replaced with a larger dressing, after cleansing the wound with wound cleanser. Resident #62 was medicated after the dressing change but was screaming even louder than before the dressing change, therefore tolerated fair. A Nutrition note dated 05/19/2024, written by a Registered Dietician (RD) did not include documented evidence of a plan for nutritional support related to skin or wounds. An Alert Charting: Skin Issue note, dated 05/20/2024, entered by the Director of Nursing Services (DNS) documented a nurse reported Resident #62 had a PI to the coccyx. A stage II PI measuring 2.5 cm by 1.6 cm by 0.5 cm, was noted and had red, granulation tissue (new connective tissue) present. The wound edges were macerated and moderated serosanguinous (clear or light yellow mixed with small amounts of blood) drainage was present. The resident's provider was notified, and treatment orders were requested. A Nutrition note dated 05/20/2024, written by an RD documented per the DNS, Resident #62 had a new skin issue to the coccyx. Health shakes were added, and additional protein was added at lunch and dinner to help promote wound healing. A Physician's order dated 05/20/2024 documented to cleanse the area to the coccyx with wound cleanser and pat dry, apply Medi-honey to wound bed and fluff with alginate, one time a day for PI and as needed for soiling or dislodgement. Cover with Opti-foam every three days and as needed for soiling or dislodgement. On 05/21/2024, an RN verbalized when a new wound was identified a progress note was entered into the resident's clinical record. The wound team included the DNS, the Assistant Director of Nursing (ADON), and the Resident Case Manager (RCM). The RN explained it was unclear when the wound team rounded, and the RN was not sure what the wound team's process was. On 05/21/2014, the DNS verbalized the expectation was when a new wound was found, the wound team would be notified by phone. The DNS explained each resident's progress and alert notes were read out loud daily during the Daily Clinical Meeting. A wound care certified nurse or other nurse, was assigned to assess any new observation of a resident's skin not being intact. The nurse was to document the assessment in a progress note or weekly skin assessment evaluation form in the resident's clinical record. On 05/21/2024, the DNS confirmed a member of the wound care team, including the DNS, was not informed Resident #62 had a new stage II PI until 05/20/2024. The DNS confirmed the wound was first noted and documented on 05/11/2024, and the DNS/wound care team was not notified as expected. The DNS confirmed when the wound was first identified and noted to be an open wound on 05/11/2024, wound care orders should have been obtained and wound care initiated. On 05/21/2024, the DNS verbalized ensuring nurses were provided education regarding the expectations related to reporting new wounds to the DON or ADON when they were discovered could have ensured timely treatment and prevented the wound from progressing to a stage II PI. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Skin Integrity, updated 10/2022, documented when skin impairment was noted after admission, the licensed nurse initiated an alert charting note. Notifications were made to the physician and documented. The Food and Nutrition Services Manager and/or the RD were notified of new PI and worsening wound conditions for nutritional needs evaluation. The DNS was notified of skin impairments which indicated a potential for significant change in condition, including stage II PI. A physician's order was obtained if treatment was needed.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46301 Based on observation, interview, clinical record review, and document review the facility failed to ensure a resident's urostomy drainage bag was kept off the floor while the resident was laying in bed for 1 of 19 sampled residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including rheumatoid arthritis, unspecified, other specified functional intestinal disorders and chronic kidney disease, stage 3. A physician's order dated 05/10/2024, documented to maintain urostomy care every shift. Resident #3's care plan included an intervention to provide urostomy care at least once each shift, start date 05/10/2024. On 05/22/2024 at 9:58 AM, Resident #3 was laying in bed and the resident's urostomy drainage bag was on the floor. On 05/22/2024 at 10:01 AM, a Registered Nurse (RN) explained catheter drainage bags should never be on the floor due to the potential for drainage issues and the increased risk of infections. The RN confirmed the Resident #3's urostomy drainage bag was on the floor due to constant kinks developed when the drainage bag was hung on the side of the bed. On 05/22/2024 at 10:49 AM, a Certified Nursing Assistant (CNA) confirmed the Resident #3's urostomy drainage bag was on the floor due to the resident's urostomy backing up if the bag was not on the floor. The CNA verbalized the urostomy drainage bag should not be on the floor as it could increase the resident's risk of infection. On 05/22/2024 at 2:01 PM, the Director of Nursing Services confirmed a resident with a urostomy would be at higher risk of infection if the drainage bag was on the floor. The DON explained there was not a facility policy followed related to catheter or urostomy care and there was nothing documented in the facility's standard of practice followed related to catheter care/urostomy care. Cross reference with tag F880

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 N Ormsby Carson City, NV 89703	

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure oxygen was administered as ordered for 1 of 19 sampled residents (Resident #339). Findings include: Resident #339 Resident #339 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and chronic respiratory failure with hypoxia. On 05/20/2024 at 1:30 PM, Resident #339 verbalized Resident #339's nose and mouth got dry because the resident's oxygen did not have a humidifier on it. A physician's order dated 05/18/2024, documented oxygen three liters per minute (LPM), continuous delivery via nasal cannula (NC), humidified. Resident #339's Care Plan documented a problem of Establish Baseline Plan of Care. Interventions included oxygen, three LPM, continuous deliver via NC humidified. Date initiated was 05/18/2024. On 05/22/2024 at 12:55 PM, a Licensed Practical Nurse (LPN) confirmed Resident #339 had a current order for oxygen administration. The LPN verbalized the order was for three LPM via NC. The LPN confirmed the order included the oxygen to be humidified. On 05/22/2024 at 12:58 PM, the LPN entered Resident #339's room and confirmed oxygen was being administered without humidification. On 05/23/2024 at 10:16 AM, during an interview with the Director of Nursing Services (DNS), the Resident Care Manager (RCM) and the Divisional Director of Clinical Operations (DDCO), the DNS explained the process when oxygen was ordered was the nurse would verify the order and administer the appropriate LPM according to the order. The DNS verbalized a humidifier was not required if the LPM was less than four, unless the physician's order stated to include it. The DNS explained the purpose of humidification with oxygen administration was to add moisture and to prevent drying or sores in the resident's nose. The DNS confirmed Resident #339's physician order for oxygen documented to administer three LPM via NC, continuous delivery, humidified. The DNS confirmed administering oxygen to Resident #339 without humidification was not following the physician's order. The facility policy titled Respiratory Care; Oxygen Administration, dated 12/2017, documented oxygen was administered per physician order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Medication Administration : Quick Reference Guide, updated 06/2017, documented nurses reviewed each resident's Medication Administration Record (MAR) or Treatment Administration Record (TAR) for ordered medications. The nurse followed the five rights of medication administration. Right medication included triple checking the medication ordered during the medication administration process.

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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** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure Dialysis Transfer forms were completed and maintained for 2 of 19 sampled residents (Resident #80 and #57). Findings include: Resident #80 Resident #80 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus with other diabetic kidney complications, end stage renal disease (ESRD), and dependence on renal dialysis. A physician's order dated 04/18/2024 documented dialysis on Monday, Wednesday, and Friday (M, W, F), pick up time at 10:00 AM. On 05/21/2024 at 12:15 PM, Resident #80's dialysis binder, located at the nurse's station, contained only blank copies of the Dialysis Transfer forms and did not include documentation related to dialysis or pre and post dialysis assessments. On 05/21/2024 at 2:16 PM, a Registered Nurse (RN) explained Resident #80 was transported by the facility to dialysis the morning of 05/21/2024. The dialysis binder, used to communicate with the dialysis center, was sent with the resident. The resident returned to the facility following dialysis and did not have the dialysis binder. The RN verbalized the expectation was the information in the resident's dialysis binder would be entered into the resident's clinical record. On 05/21/2024 at 4:13 PM, the Director of Nursing Services (DNS) verbalized the Dialysis Transfer forms were initiated by the facility prior to sending a resident to dialysis. Post dialysis, the Dialysis Transfer form was filled out by the Dialysis Nurse and returned with the patient to the facility. The Dialysis Transfer forms were scanned into the residents' electronic health record (EHR). The DNS confirmed Resident #80's clinical record did not include scanned copies of the Dialysis Transfer form and the information documented on the forms was not included in the resident's clinical record. Cross reference with F842 46301 Resident #57 Resident #57 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including end stage renal disease and dependence on renal dialysis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 04/07/2024, documented Resident #57 was to receive dialysis treatment at a dialysis center, every Monday, Wednesday, and Friday. Ensure vitals and dialysis communication sheets were completed and sent in dialysis binder. Resident #57's clinical record lacked documented evidence of a completed dialysis communication transfer form for the following dates: -04/01/2024 -04/03/2024 -04/05/2024 -04/08/2024 -04/10/2024 -04/12/2024 -04/17/2024 -04/19/2024 -04/24/2024 -05/01/2024 -05/03/2024 -05/06/2024 -05/08/2024 -05/15/2024 -05/17/2024 -05/20/2024 On 05/23/2024 at 9:44 AM, the DNS confirmed Resident #57's clinical record lacked the completed dialysis communication transfer forms for the above dates. The DNS verbalized the nursing staff should have been checking for the form once the resident returned from dialysis. The facility policy titled, Dialysis, updated 03/2015, documented the facility required the dialysis center to provide the following information upon the resident's return from dialysis; post-dialysis weights, labs done at dialysis, medications given at dialysis center, and follow-up care or procedures needing to be done at the facility. If the dialysis center does not provide the information the facility was to notify the Director of Nursing.

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

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **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 physician visits were completed timely for 1 of 19 sampled residents (Resident #9). This deficient practice could result in a resident not receiving assessments a physician can perform. Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including local infection of the skin and subcutaneous tissue, unspecified, methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, and cellulitis of right lower limb. The clinical record for Resident #9 included documentation of the resident's last physician visit on 04/07/2024. On 05/28/2024 at 2:52 PM, the Director of Nursing Services confirmed the resident had not been seen by a physician or nurse practitioner since 04/07/2024 and verbalized the resident should have had a visit from a provider since the last documented visit. The facility policy titled Physician Visits, updated 02/2008, documented residents would be seen by a physician at least once every 30 days for the first 90 days after admission.

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46301 Based on observation, interview, and document review, the facility failed to ensure a sufficient number of licensed nurses were scheduled to perform resident care according to the Facility Assessment for 1 of 2 shifts during the weekends in December of 2023. Findings include: The Centers for Medicare and Medicaid Services, Payroll-Based Journal (PBJ) Staffing Data Report, dated 10/01/2023 through 12/31/2023, documented the facility had excessively low weekend staffing. The Facility Assessment Tool documented the facility capacity and staffing projections. The licensed nursing schedule was maintained over two separate shifts; 6:00 AM-6:00 PM (first shift) projected three to four licensed nurses and 6:00 PM-6:00 AM (second shift) projected three to four licensed nurses. On 05/28/2024 at 1:01 PM, the Director of Nursing Services (DNS) explained the Facility Assessment Tool staffing projections were based on an average daily census of 72. The Schedule Staffing sheet for 12/17/2023, documented the second shift had two licensed nurses working the shift. The facility census on 12/17/2023, was 89, 17 residents over the average daily census, based on the Facility Assessment Tool. On 05/28/2024 at 1:05 PM, the DNS verbalized the facility expectation for licensed nurses per shift was three to four nurses per weekend shift and confirmed the Facility Assessment staffing was not being followed creating a shortage of nurses for 12/17/2023 weekend shift.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41848

Based on observation, interview, clinical record review, and document review, the facility failed to ensure 1) the Infection Preventionist (IP) had the skills necessary to review lab results to determine the appropriateness of implementing transmission-based precautions (TBP) 2) a nurse administering medications had completed a competency for medication administration. This deficient practice could lead to residents not being placed on transmission-based precautions when necessary, causing other residents to be exposed to communicable diseases and residents not receiving medications as prescribed, creating increased potential for adverse medication reactions 3) the Infection Preventionist (IP) had the knowledge necessary to ensure the appropriate selection and administration of pneumococcal vaccines resulting in residents not being offered the pneumococcal vaccines recommended for the resident by the Centers for Disease Control and prevention (CDC), and 4) the IP had the knowledge needed to correctly complete the Antibiotic Stewardship Program (ASP) tools and documentation including antibiotic time outs. This failure had the potential for residents to be treated with ineffective antibiotics resulting in prolonged infections and/or the development of infections with multi-drug resistant organisms (MDRO). This failure had the potential to affect the facility's entire resident population of 89.

Findings include:

Infection Preventionist

On [DATE] at 10:00 AM, the IP verbalized a resident had to be symptomatic and have signs of redness, swelling, fever, heat, and excessive drainage to be placed in TBP. The IP verbalized the IP could not use lab results to determine presence of infection or the need for isolation.

On [DATE] at 8:53 AM, the IP explained the IP would not review wound cultures obtained by a hospital because the cultures were obtained prior to the resident's admission to the facility.

On [DATE] at 8:58 AM, the Director of Nursing Services (DNS) explained the facility would be able to reference wound cultures from a resident's hospital stay prior to admission to the facility.

The facility job description titled Infection Preventionist, signed by the IP on [DATE], documented the IP would review and analyze infectious disease laboratory reports.

Medication Competency

On [DATE] at 9:25 AM, a Registered Nurse (RN) verbalized medicated powders could be left in a resident's room and the powders could be applied by the CNAs.

On [DATE] at 2:33 PM, the DNS verbalized the facility did not complete a competency checklist with nurses but did utilize a pharmacy audit tool to validate the nurse's knowledge regarding medication administration.

(continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 2:34 PM, the medication audit tool was requested from the DNS and the Divisional Director of Clinical Operations for an RN observed administering medications in the facility. The facility was unable to provide the requested medication audit tool. Cross reference with F880 and F658 43310 Pneumococcal vaccines On [DATE] at 11:11 AM, the IP explained the process for determining if a resident needed a pneumococcal vaccine was to determine if the resident's last vaccination was out of date. The resident would be offered the pneumococcal polysaccharide vaccine (PPSV) 23. The IP explained out of date meant the vaccine was recommended to be given every five years and would be offered if it had been over five years since the resident's last pneumococcal vaccine. The IP confirmed pneumococcal vaccines expired after five years and needed to be repeated. On [DATE] at 11:14 AM, the IP verbalized the PPSV-23 vaccine was offered due to the facility did not carry the pneumococcal conjugate vaccine (PCV) 13 or 20. The IP explained the first step in the IP's process was to have the resident sign a consent for pneumococcal vaccine and then the provider would determine which vaccine was to be administered. After discussing the process for determination of need for additional pneumococcal vaccines the IP confirmed a resident would not be able to consent to a vaccine until the type of vaccine needed was determined. On [DATE] at 11:18 AM, the IP verbalized pneumococcal vaccines were supposed to be offered by the admitting nurse. The admitting nurse was then responsible for ensuring the vaccine was administered or a declination was obtained. On [DATE] at 11:20 AM, the IP verbalized, regarding the IP's understanding of pneumococcal vaccines, the IP did not know the vaccines by heart because the guidance changed all the time. The IP explained the floor nurses should be able to determine when a resident needed additional vaccines and which vaccine was needed. The IP confirmed floor nurses were not provided with a flow sheet such as an algorithm or decision tree to assist with determining which pneumococcal vaccine was needed. On [DATE] at 12:44 PM, the IP confirmed the facility did not offer PCV15 or PCV20 vaccines and confirmed vaccines were to be offered per the CDC guidance depending on the medications a resident was taking. The IP confirmed the facility did not have an official form for screening resident needs for pneumococcal vaccines. The IP confirmed, a resident's need for pneumococcal vaccine was determined by reviewing the resident's medical history, list of medications, and notifying the provider. The provider would determine the vaccine requirements and write an order for the vaccine. (continued on next page)

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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

On [DATE] at 3:44 PM, the DNS verbalized on [DATE], the DNS and IP located and printed a copy of the CDC guidance related to choosing the correct pneumococcal vaccine needed for an individual. The DNS confirmed the facility had not been using CDC guidance including the CDC pneumococcal decision flow sheet or other format/process to assist in determining the CDC's recommendation for pneumococcal vaccines for the facility's residents.

A facility policy titled, Pneumococcal Vaccination of Residents, updated ,d+[DATE], documented the facility followed the CDC recommendations for vaccination.

The CDC document titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate, dated [DATE], documented an instructional flow sheet to guide the determination of eligibility for a pneumococcal vaccine and the vaccine needed by an individual based on age, comorbidities, and previous administration of pneumococcal vaccines. Comorbidities for adults between the ages of 19 and 64 included diabetes mellitus and chronic renal failure. The recommendations for adults over [AGE] years of age varied depending on age at time of previous vaccination, the type of vaccine previously administered, and the presence of immunocompromising conditions, cochlear implant, or cerebrospinal fluid leak. An application (app) and a web-based version, were available to assist with determining which vaccines were recommended.

Cross reference with F883 and F835

Antibiotic Stewardship

A facility document titled Line Listing for Infections by Resident Report, (Line Listing for Infections) for January through [DATE], completed by the IP, did not include all residents listed on the Orders Listing Report, which documented each resident in the facility with a physician's order for antibiotics.

Line Listing for Infections Form:

The facility form titled Line Listings for Infections by Resident, included the following areas for documentation:

-Resident name and age,

-Resident room number, unit, and date of admission,

-Date of infection (onset)

-Site of infection,

-Symptoms present at admission

-Pathogen/organism

-Community or Healthcare associated (CAI/HAI)

(continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Transmission Based Precautions (TBP) initiated (the word none was pre-populated into each line of this section every month) -Date resolved/comments The Line Listing Report did not include an area to document the prescribed antibiotic, ordered lab work, or results of lab work. On [DATE] at 11:45 AM, the IP verbalized the process for tracking infections and antibiotic use included daily review of a facility document titled Orders Listing Report, (Order Report). The Order Report was a list of physician orders including antibiotics and other antimicrobial medications. Upon review the IP entered data for each resident with new orders for antibiotics/antimicrobials on to the Line Listing Report, the IP explained the IP used the Line Listing Report to see what antibiotic each resident was receiving, how long they were to receive the prescribed antibiotic, and to see what the stop dates were for an antibiotic. The data was reviewed and compared with McGeer's Criteria. The IP explained the IP entered the stop date of an antibiotic into the Line Listing Report's column labeled date resolved/comments. The IP explained the date an infection was resolved was the same date an antibiotic was completed. The IP confirmed the end date of the antibiotic was entered into the forms resolved/comments column and the date an infection was clinically resolved was not entered onto the form. On [DATE] at 11:55 AM, the IP explained the Line Listing Report did not include a place to document the type of infection (such as urinary tract infection (UTI), or cellulitis). Therefore, the IP documented the type of infection in the column labeled Pathogen/Organism. On [DATE] at 12:18 PM, the IP confirmed the Line Listing Report did not include a place to document the following: - The antibiotic being used. - Antibiotic start and stop dates. - Ordered lab work, such as cultures. - Lab results including cultures. The IP explained the column labeled site of infection was used to document anatomically where an infection was located and did not have enough room for the IP to include the type of infection such as urinary tract infection or cellulitis. The IP verbalized the column labeled pathogen/organism was used to document the type of infection, such as fungal, chronic obstructive pulmonary disease, and pneumonia due to the lack of a column to document the infection type. The IP confirmed the IP did not document the pathogen/organism. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The IP confirmed an antibiotic time out was not documented and explained an antibiotic time out form was not utilized due to no antibiotic had reached the time level to meet a time out and it had not been an issue. The IP confirmed the form did not include a space to document if and when a culture was collected, therefore the information was not included on the line listing and the pathogen was not documented. On [DATE] at 12:28 PM, the IP explained the Order Listing Report was reviewed daily and compared to laboratory reports to ensure the correct antibiotic was being used. On [DATE] at 12:39 PM, the IP verbalized the column for documenting TPB pre-populated the precautions as none and had to be manually changed to enter the type of TPB used. The IP confirmed down box did not include Enhanced Barrier Precautions (EBP). A document titled Infection Preventionist Job Description, signed by the IP on [DATE], documented the IP planned, developed, organized, implemented, evaluated, coordinated, and directed the infection control program. The IP was responsible for providing staff and residents with information regarding the facility's policies related to pneumococcal vaccines. The IP ensured the facility was in compliance with current CDC guidance related to infection control and interpreted infection control policies and procedures. The IP directed antibiotic stewardship activities within the facility to improve antibiotic use by tracking antibiotic starts, adherence to evidence-based published criteria, and reviewing antibiotic resistance patterns in the facility. A Centers for Disease Control and Prevention (CDC) document titled Core Elements of Antibiotic Stewardship for Nursing Homes, retrieved from CDC.gov on [DATE], standardized practices should be applied during the care of any resident suspected of an infection or started on an antibiotic. Practices included improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing and antibiotic review process known and an antibiotic time out for all antibiotics prescribed in the facility. The antibiotic time-out review provided clinicians with an opportunity to reassess the ongoing need for, and choice of an antibiotic when the clinical picture is clearer, and more information is available. The facility policy titled Antimicrobial Stewardship Program (ASP), dated ,d+[DATE], documented the IP monitored and supported ASP activities through audits, review of physician/provider orders, documentation, and clinical reports. Evaluation and decision making processes for antibiotic use were the IP's primary role. The IP communicated with providers regarding residents' current clinical status in a timely manner. Cultures were obtained before treatment was started and monitored to determine if the results indicated a change in treatment was needed. Tracking and monitoring included monitoring outcomes of antibiotic use, MDROs, adverse drug events due to antibiotics, and rates of clostridium difficile (C-diff) via line listings. Cross reference with F881 and F835

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure ordered medications were available and administered for 2 of 6 residents observed for medication administration (Resident #88 and #5) and 1 of 19 sampled residents (Resident #23). Findings include: Resident #88 Resident #88 was admitted to the facility on [DATE], with diagnoses including aftercare following joint replacement surgery and essential (primary) hypertension. On 05/22/2024 at 8:08 AM, a Licensed Practical Nurse (LPN) was preparing medications for Resident #88. The LPN verbalized the ordered medication, Amlodipine-Olmesartan 10-20 milligrams (mg), was not available in the facility. A physician's order dated 05/19/2024, with a start date of 05/20/2024, documented Amlodipine-Olmesartan oral tablet 10-20 mg, give one tablet by mouth one time a day for hypertension. Resident #88's Medication Administration Record (MAR) documented Amlodipine-Olmesartan 10-20 mg was not administered to Resident #88 during the 9:00 AM medication pass on 05/20/2024, 05/21/2024, and 05/22/2024, and was documented as OO. The legend on the MAR indicated a response of OO equated to On Order from Pharmacy. On 05/22/2024 at 10:53 AM, a Registered Nurse (RN) explained the facility received deliveries from the pharmacy every day. If the facility got a new admission, the nurse would immediately put the medication orders in the computer so the pharmacy was aware of the orders. Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of postlaminectomy syndrome, not elsewhere classified. On 05/23/2024 at 7:36 AM, an RN began preparing medications for Resident #5. The RN verbalized the physician ordered Cholecalciferol 1000 units was not available in the medication cart. A physician order dated 09/13/2023, with a start date of 09/14/2023, documented Cholecalciferol tablet 1000 units, give 1000 units by mouth one time a day for supplement. On 05/23/2024 at 10:06 AM, the RN verbalized the RN was not able to locate the physician ordered Cholecalciferol for Resident #5 and confirmed the medication had not been administered. The medication was ordered to be administered at 8:00 AM. (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	05/29/2024

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5's MAR documented the physician ordered Cholecalciferol 1000 units as not given during the 8:00 AM medication pass on 05/23/2024 and was documented as On Order from Pharmacy. Resident #23 Resident #23 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease with acute exacerbation, type two diabetes mellitus with diabetic polyneuropathy, and chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity. A physician order dated 05/17/2024, documented Ammonium Lactate solution 70 percent (%), apply to bilateral legs topically two times per day for dry skin. Resident #23's MAR documented the physician ordered Ammonium Lactate 70% was not administered from 05/17/2024 through 05/20/2024. On 05/22/2024 at 10:59 AM, an LPN explained the facility received deliveries from the pharmacy twice a day and the facility could have items delivered immediately (STAT). STAT would be used when a medication was needed urgently and did not arrive with the usual twice daily deliveries. On 05/23/2024 at 10:27 AM, during an interview with the Director of Nursing Services (DNS), a Resident Care Manager who was also the Assistant Director of Nursing (RCM1/ADON), the Divisional Director of Clinical Operations (DDCO), and a Resident Care Manager (RCM2), the DNS explained the facility received deliveries from the pharmacy twice a day, every day except Sundays. If an ordered medication was not available in the facility, it was the DNS's expectation of staff to contact the pharmacy and notify the provider. The provider could give approval to administer the medication late or provide an order for a substitute medication. The DNS confirmed Resident #23's physician ordered ammonium lactate solution 70% had not been administered as ordered since the order was placed on 05/17/2024 and was documented as on order from the pharmacy. On 05/23/2024 at 10:43 AM, during an interview with DNS, the RCM2, and the DDCO, the RCM2 confirmed the facility did not have Resident #88's physician ordered Amlodipine-Olmesartan since 05/19/2024. The DNS explained it was the DNS's expectation of nursing staff to follow the medication administration policy during medication administration. The facility policy titled Medication Administration: Quick Reference Guide, updated 06/2017, documented if a medication/treatment was not available to be administered, the nurse documented the reason for the non-administration and notified the physician. The nurse checks with the pharmacy to see how soon the medication was going to be available at the facility and documents the conversation. The nurse would then notify the physician. Cross reference with F759 and F684

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024

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F 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49557

Based on observation, interview, clinical record review, and document review the facility failed to ensure medications were administered with an error rate of less than 5 percent (%). There were 47 opportunities and four medication errors. The medication error rate was 8.51%.

Findings include:

Resident #88

Resident #88 was admitted to the facility on [DATE], with diagnoses including aftercare following joint replacement surgery and essential (primary) hypertension.

On 05/22/2024 at 8:08 AM, a Licensed Practical Nurse (LPN) was preparing medications for Resident #88. The LPN verbalized the physician ordered Amlodipine-Olmesartan 10-20 milligrams (mg) was not available in the facility. The LPN explained the process when a physician ordered medication was not available in the facility was staff would contact the pharmacy and notify the physician. The LPN verbalized it was concerning due to the resident's elevated blood pressure and the resident had already missed two doses of the medication on previous days.

A physician's order dated 05/19/2024, with a start date of 05/20/2024, documented Amlodipine-Olmesartan oral tablet 10-20 mg, give one tablet by mouth one time a day for hypertension.

Resident #88's Medication Administration Record (MAR) documented the Amlodipine-Olmesartan 10-20 mg was not given on 05/20/2024, 05/21/2024, and 05/22/2024 and was documented as OO. The legend on the MAR indicated a response of OO equated to On Order from Pharmacy.

Resident #55

Resident #55 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including cerebral infarction, unspecified and thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction.

On 05/23/2024 at 7:24 AM, a Registered Nurse (RN) began preparing medications for Resident #55. One of the prepared medications included Aspirin 81 mg, chewable tablets.

On 05/23/2024 at 7:34 AM, the RN administered one tab of chewable Aspirin 81mg to Resident #55.

A physician's order dated 03/08/2023, with a start date of 03/09/2023, documented Aspirin enteric coated (EC) tablet delayed release 81mg, give 81mg by mouth one time a day for prophylaxis.

On 05/23/2024 at 9:53 AM, the RN confirmed the Aspirin administered to Resident #55 during the morning medication pass was not enteric coated and did not match the physician's order.

Resident #5

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 N Ormsby Carson City, NV 89703	

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of postlaminectomy syndrome, not elsewhere classified. On 05/23/2024 at 7:36 AM, the RN began preparing medications for Resident #5. The RN verbalized the physician ordered Cholecalciferol 1000 units was not available in the medication cart. On 05/23/2024 at 7:47 AM, Resident #5 requested medication for the resident's right knee pain. The RN retrieved a tube of Diclofenac Sodium 1% gel, donned gloves, and applied the gel to Resident #5's right knee. A physician order dated 09/13/2023, with a start date of 09/14/2023. Documented Cholecalciferol tablet 1000 units, give 1000 units by mouth one time a day for supplement. A physician order dated 04/24/2024, documented Voltaren external gel 1% (Diclofenac Sodium topical), apply to right knee topically two times a day for pain for ten days. The order status was completed. The order was no longer active on the resident's MAR. On 05/23/2024 at 10:03 AM, the RN confirmed Resident #5 did not have a current order for Diclofenac Sodium 1% gel. The RN explained the process when a resident requested a medication for which the resident did not have a current order, was the RN would contact the physician. The RN verbalized the RN should have contacted the physician prior to applying the medication to the resident's right knee. On 05/23/2024 at 10:06 AM, the RN verbalized the RN was not able to locate the physician ordered Cholecalciferol for Resident #5 and confirmed the medication had not been administered. The medication was ordered to be administered at 8:00 AM. Resident #5's MAR documented the Cholecalciferol 1000 units as not given during the 8:00 AM medication pass on 05/23/2024, and was documented as OO. The legend on the MAR indicated a response of OO equated to On Order from Pharmacy. On 05/23/2024 at 10:43 AM, during an interview with the Director of Nursing Services (DNS), the Resident Care Manager (RCM), and the Divisional Director of Clinical Operations (DDCO), the DNS explained it was the DNS's expectation of nursing staff to follow the medication administration policy during medication administration which included the five rights. The DNS confirmed all medications administered to residents required an active physician's order. The DNS explained medication orders were discontinued either by manually discontinuing the order in the electronic medical record or by the physician placing a stop date on the order. The stop date would automatically discontinue the order on the specified date. The DNS confirmed administering a medication after a stop date would be administering a medication without an order. The facility policy titled Medication Administration: General Guidelines, dated 01/2021, documented medications were to be administered as prescribed. Medications were to be administered in accordance with written orders of the prescriber. The nurse was to verify the medication was correct three times before administering the medication. Medications were to be administered within 60 minutes of the scheduled time. (continued on next page)

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Medication Administration: Quick Reference Guide, updated 06/2017, documented the nurse was to review the resident's MAR for ordered medications. The nurse would follow the five rights of medication administration: right person, right medication, right dose, right time, and right route. The nurse was to validate the medication via the MAR and would triple checked the medication ordered during the medication administration process. The nurse would validate the right timing of the medication via the MAR, one hour prior to and up to one hour after the listed administration time. The nurse would administer the medication/s per physician order and if an order was unclear or the medication did not match the MAR/Treatment Administration Record (TAR), the nurse was to call the physician for clarification. Cross reference with F658 and F755

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46301

Based on observation, interview, clinical record review, and document review the facility failed to ensure 1) medications were not left unsecured on a medication cart while a Certified Nursing Assistant (CNA) was to watch the medication cart, 2) medications were stored according to manufacturer guidelines, 3) discontinued medications were removed from a medication cart, and 4) medications were labeled.

Unsecured Medication

On [DATE] at 10:07 AM, upon entry into the Brookside nursing station, the medication cart parked on the outside of the nursing station was seen with greater than 20 over the counter plastic bottles with pills in the bottles sitting on top of medication cart. A CNA was at the nursing station watching the medications. The CNA left as soon as the nurse came out of the restroom.

On [DATE] at 10:21 AM, the CNA verbalized watching the medications on top of the medication cart while the nurse used the restroom. The CNA explained having been asked by the nurse to watch the medication cart and confirmed it was not in the CNA's scope of practice to watch the medications.

On [DATE] at 10:53 AM, the Registered Nurse (RN) explained the plastic bottles seen on top of the medication cart were vitamins, and the RN confirmed vitamins were considered to be medications. The RN verbalized having asked the CNA to watch the medication cart while using the restroom.

The facility policy titled Medication Storage, dated ,d+[DATE], documented medications supply shall be accessible only to licensed nursing personnel or staff members lawfully authorized to administer medications.

The Nevada Nurse Practice Act documents the following:

Nevada Administrative Code (NAC) 632.222 Delegation and supervision of nursing care.

1. A registered nurse may delegate nursing care to other personnel and supervise other personnel in the provision of care if those persons were qualified to provide the care.

NAC 632.244 Assignment of unauthorized acts prohibited.

A registered nurse or a licensed practical nurse shall not assign to a person the performance of an act the person was not otherwise authorized by law to perform.

49557

Medication storage per manufacturer guidelines and discontinued medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:23 PM, during a review of the medication cart for the 400, 500, and 600 halls, in the presence of a Licensed Practical Nurse (LPN), a bottle of Lactulose solution 10 grams (GM)/15 milliliters (ml) was located in the cart. The bottle belonged to Resident #17. The LPN removed the bottle of Lactulose solution from the cart and verbalized the medication should not be in the cart as Resident #17 had expired the week prior. A physician's order for Resident #17, dated [DATE], documented Lactulose oral solution, 10 GM/15 ml, give 30 ml by mouth one time a day to treat constipation. The order status was discontinued with a discontinued date was [DATE]. A bottle of Lorazepam oral concentrate, 2 milligrams (mg)/ml, containing approximately 17 ml of medication was located inside the controlled medication drawer of the medication cart. The bottle belonged to Resident #19. The medication box indicated the medication should be kept between 36 and 46 degrees Fahrenheit. The manufacturer medication guide, attached to the bottle, documented Lorazepam should be stored at a cold temperature. Refrigerate at 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit) and protect from light. The LPN confirmed the box containing the Lorazepam oral concentrate and the manufacturer medication guide documented the medication should be stored between 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). The LPN confirmed the medication should not be stored in the medication cart. On [DATE] at 10:28 AM, when asked what the facility process was for medications belonging to residents who had discharged or expired, the Assistant Director of Nursing (ADON) verbalized the ADON would have to review the facility policy. The ADON explained the medications would typically be removed from the medication cart and placed in the medication room to be set up for destruction. On [DATE] at 12:27 PM, the Director of Nursing Services (DNS) verbalized medications should be stored in locked medication carts or rooms and according to manufacturer guidelines. The DNS confirmed if a medication package indicated a medication should be stored in the refrigerator, it was expected the medication would be stored in the refrigerator. The facility policy titled Medication Storage, dated ,d+[DATE], documented medications were stored following manufacturer's recommendations to maintain the medication's integrity and to support safe and effective drug administration. Medications requiring refrigeration or temperatures between two to eight degrees Celsius (36 to 46 degrees Fahrenheit) were kept in a refrigerator with a thermometer to allow temperature monitoring. Discontinued medications were immediately removed from stock and disposed of according to procedures for medication disposal. Medication Labeling On [DATE] at 3:18 PM, during a review of the medication cart for the 300 hall, in the presence of a RN2 and the RCM, an unopened bottle of Morphine Sulfate oral solution, 100 mg/5 ml was located in the cart. The medication box and bottle lacked a resident label. Additionally, a bottle of Lorazepam 2mg/ml containing approximately 24 ml was located in the cart. The label on the bottle was not legible. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RN2 confirmed the bottle of Morphine Sulfate oral solution lacked a resident label and the label on the bottle of Lorazepam was not legible. The RCM explained a label should include the resident's name, the prescription, directions, dosage, and strength. The RCM verbalized the facility could not use a medication if it lacked a complete label. The RN2 explained the process when a medication lacked a complete or legible label was to not use the medication and notify the DNS. The Pharmacy Services Agreement, effective from [DATE] through [DATE], documented the pharmacy would label all dispensed medications in accordance with applicable law and currently accepted professional standards. The facility policy titled Medication Administration: Quick Reference Guide, updated ,d+[DATE], documented the nurse would triple check the medication ordered, compared the medication bottle to the Medication Administration Record (MAR) and verify the dose via the prescription label and strength on the medication container.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER: Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3050 N Ormsby, Carson City, NV 89703	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35601 Based on observation, interview and document review, the facility failed to ensure food preparation counters were kept clear of personal items with the potential to cross contaminate food for the facility census; and failed to ensure staff performed hand hygiene while serving meal trays to residents. Findings include: Personal Items On 05/19/2024 at 10:09 AM, a personal beverage from a fast food restaurant and personal bag was located on a counter with plate holders stacked next to the items. The Dietary Aide verbalized it was not a food prep counter and it was okay to have personal items there. The Dietary Aide confirmed the stacked plate holders were clean. The Dietary Aide pointed at a second counter against the wall and verbalized it was the food prep counter. On 05/19/2024 at 10:10 AM, the second food prep counter had one charging cord on the counter and one charging cord hanging from the wall with the cord laying on the counter. The Dietary Aide confirmed the cords were present and were not supposed to be there. On 05/19/2024 at 10:36 AM, the Nutritional Services Supervisor confirmed the first counter was a food prep area and personal items were not okay to be present, such as a personal beverage and a personal bag. A Dietary Aide was prepping food on the first counter. The second counter had a Dietary Aide prepping sandwiches with charging cords still present. The Nutritional Services Supervisor verbalized the charging cords should not have been present on the counter during food preparation. On the morning 05/20/2024, the Nutritional Services Supervisor was unable to provide a facility policy related to personal items in the kitchen. 49557 Hand Hygiene On 05/19/2024 at 12:13 PM, a Certified Nursing Assistant (CNA1) entered resident room [ROOM NUMBER] with a lunch meal tray. The CNA1 exited the resident's room with another tray and placed the tray on top of the meal tray cart. The tray had remains of a previous meal left on it. The CNA1 then delivered a lunch meal tray to room [ROOM NUMBER]. The CNA1 did not perform hand hygiene after removing the tray from room [ROOM NUMBER], prior to delivering the tray to room [ROOM NUMBER]. (continued on next page)

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/19/2024 at 12:16 PM, the CNA1 explained hand hygiene was required to be performed after handling soiled trays. The CNA1 verbalized the meal tray removed from room [ROOM NUMBER] and placed on top of the meal tray cart was a soiled tray from breakfast. The CNA1 confirmed the CNA1 did not perform hand hygiene after handling the soiled tray. 31739 On 05/19/2024 at 12:34 PM, a Nursing Aid in Training (NAT) in the Advantage Unit removed a lunch meal tray from the meal cart and entered resident room [ROOM NUMBER] with the meal tray. The NAT did not perform hand hygiene prior to delivering the tray to room [ROOM NUMBER]. On 05/19/2024 at 12:38 PM, CNA2 in the Advantage Unit removed a lunch meal tray from the meal cart and entered resident room [ROOM NUMBER] with the meal tray. CNA2 did not perform hand hygiene prior to delivering the tray to room [ROOM NUMBER]. On 05/19/2024 at 12:45 PM, both the NAT and CNA2 confirmed knowing to perform hand hygiene prior to delivering meal trays to residents in resident rooms but denied not having performed hand hygiene prior to doing so. On 05/20/2024 at 8:37 AM, the Nutritional Services Supervisor verbalized having not been aware of the lack of proper hand hygiene during the lunch meal tray service on the previous day. The Nutritional Services Supervisor confirmed the use of alcohol-based hand rub should have been used before and after serving a meal or assisting a resident with a meal. The facility policy titled Handwashing/Hand Hygiene, updated 03/2018, documented staff were to use an alcohol-based hand rub or soap and water after contact with objects in the immediate vicinity of the resident, and before and after handling food and/or assisting residents with meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER: Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3050 N Ormsby Carson City, NV 89703	

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on interview and document review the facility failed to demonstrate effective and knowledgeable administration by not ensuring an allegation of sexual abuse was thoroughly investigated and an alleged perpetrator of sexual abuse was not allowed to continue to work in the facility until an investigation was completed (see tag F610), 2) the Infection Preventionist (IP) had the skills and knowledge necessary to accurately monitor and track infections and antibiotic use. The IP's failure to consistently track infections and antibiotic use from the onset of the infection through to the resolution of the infection had the potential to result in residents developing infections with Multi Drug Resistant Organisms (MDRO). Further potential to spread infections with MDROs througout the facility's entire resident census of 89; and 3) and the IP had the skills and knowledge necessary to correctly identifiy the pneumococcal vaccines residents were eligble to receive. The IP's lack of understanding related to screening residents for eligiblity to receive a pneumococcal vaccine and the selection of the correct pneumococcal vaccine for each eligible resident resulted in the facility's failure to identifiy residents in need of additional pneumoccal vaccines. Findings include: Investigation of allegation of abuse Resident #19 was admitted to the facility on [DATE], with diagnoses including spondylosis without myelopathy or radiculopathy, lumbar region, anxiety disorder, unspecified and depression, unspecified. On [DATE] at 12:15 PM, the Director of Nursing Services (DNS) confirmed the DNS was aware of the allegation of sexual abuse reported by Resident #19 on [DATE]. The DNS verbalized interviews were conducted with the male staff who were potential suspects, a Certified Nursing Assistant (CNA) and a Nurse-Aid in Training (NAT). The DNS verbalized the investigation was complete and the CNA and the NAT were cleared to return to work on [DATE]. The DNS denied the DNS completed a review of Resident #19's clinical record as part of the investigation into the allegation of sexual abuse. The DNS verbalized the DNS could have reviewed the clinical record to verify if either the CNA or the NAT had provided care to Resident #19. The DNS confirmed an investigation into an allegation of abuse would typically include a review of the resident's clinical record. On [DATE] at 1:01 PM, during a joint interview with the DNS and the Divisional Director of Clinical Operations (DDCO), the DNS verbalized the facility's abuse coordinator was the Administrator. The DNS confirmed the Administrator and the DNS were involved in the investigation of Resident #19's allegations of sexual abuse. The DNS explained when an allegation of abuse was made, the DNS would suspend the employee/s until the investigation was completed. If the investigation found the employee was not responsible or involved, the employee/s would be allowed to return to work. The DNS explained it would have been appropriate to suspend any male employee working at the time the alleged sexual abuse of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #19 occurred. The DNS verbalized the DNS made several calls to the NAT to inform the NAT of the suspension until the completion of the investigation however, the DNS was not able to contact the NAT until [DATE]. The DNS verbalized the NAT did not work between [DATE], and [DATE]. On [DATE] at 1:07 PM, the DNS and the DDCO reviewed the NAT's timecard and confirmed the timecard documented the NAT worked the night (NOC) shifts beginning on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. When asked, if due to the DNS's failure to reach the NAT by phone, anyone remained in the facility to notify the NAT the NAT was suspended and could not work until the completion of the investigation, the DNS verbalized the DNScould not confirm anyone stayed to notify the NAT. The DNS verbalized there was a potential for further abuse to all residents when a suspended employee was allowed to continue to work unsupervised in the facility while an investigation was ongoing. The facility policy titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated ,d+[DATE], documented the facility implemented policies and processes so residents were not subjected to abuse by staff. The policies addressed screening, training, prevention, identification, investigation, protection, and reporting/response. The facility conducted a thorough investigation of allegations of abuse in accordance with state and federal regulations and referred to the abuse investigation policy. The facility protected residents from harm during and after the investigation and referred to the abuse protection policy. The facility policy titled Abuse Investigation, updated ,d+[DATE], documented the facility conducted a thorough investigation of allegations of abuse. The facility protected the alleged victim during and after the course of the investigation according to the abuse protection policy. The facility policy titled Abuse Protection, updated ,d+[DATE], documented the facility protected residents from physical and psychosocial harm during and after an investigation. The facility suspends and/or removes the alleged perpetrator from resident care areas immediately. Cross reference with F610 43310 Antibiotic Stewardship Program A facility document titled Line Listing for Infections by Resident Report, (Line Listing for Infections) for January through [DATE], completed by the IP, did not include all residents listed on the Orders Listing Report, which documented each resident in the facility with a physician's order for antibiotics. Line Listing for Infections Form: The facility form titled Line Listings for Infections by Resident, included the following areas for documentation: -Resident name and age, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024

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

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Resident room number, unit, and date of admission, -Date of infection (onset) -Site of infection, -Symptoms present at admission -Pathogen/organism -Community or Healthcare associated (CAI/HAI) -Transmission Based Precautions (TBP) initiated (the word none was pre-populated into each line of this section every month) -Date resolved/comments The Line Listing Report did not include an area to document the prescribed antibiotic, ordered lab work, or results of lab work. On [DATE] at 11:45 AM, the IP verbalized the process for tracking infections and antibiotic use included daily review of a facility document titled Orders Listing Report, (Order Report). The Order Report was a list of physician orders including antibiotics and other antimicrobial medications. Upon review the IP entered data for each resident with new orders for antibiotics/antimicrobial's on to the Line Listing Report. The IP explained the IP used the Line Listing Report to see what antibiotic each resident was receiving, how long they were to receive the prescribed antibiotic, and to see what the stop dates were for an antibiotic. The data was reviewed and compared with McGeer's Criteria. The IP explained the IP entered the stop date of an antibiotic into the Line Listing Report's column labeled date resolved/comments. The IP explained the date an infection was resolved was the same date an antibiotic was completed. The IP confirmed the end date of the antibiotic was entered into the forms resolved/comments column and the date an infection was clinically resolved was not entered onto the form. On [DATE] at 11:55 AM, the IP explained the Line Listing Report did not include a place to document the type of infection (such as urinary tract infection (UTI), or cellulitis). Therefore, the IP documented the type of infection in the column labeled Pathogen/Organism. On [DATE] at 12:18 PM, the IP confirmed the Line Listing Report did not include a place to document the following: - The antibiotic being used. - Antibiotic start and stop dates. - Ordered lab work, such as cultures. - Lab results including cultures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER: Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3050 N Ormsby Carson City, NV 89703	

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The IP explained the column labeled site of infection was used to document anatomically where an infection was located and did not have enough room for the IP to include the type of infection such as urinary tract infection or cellulitis. The IP verbalized the column labeled pathogen/organism was used to document the type of infection, such as fungal, chronic obstructive pulmonary disease, and pneumonia due to the lack of a column to document the infection type. The IP confirmed the IP did not document the pathogen/organism. The IP confirmed an antibiotic time out was not documented and explained an antibiotic time out form was not utilized due to no antibiotic had reached the time level to meet a time out and it had not been an issue. The IP confirmed the form did not include a space to document if and when a culture was collected, therefore the information was not included on the line listing and the pathogen was not documented. On [DATE] at 12:28 PM, the IP explained the Order Listing Report was reviewed daily and compared to laboratory reports to ensure the correct antibiotic was being used. On [DATE] at 12:39 PM, the IP verbalized the column for documenting TPB pre-populated the precautions as none and had to be manually changed to enter the type of TPB used. The IP confirmed down box did not include Enhanced Barrier Precautions (EBP). A facility form titled Order Listing Report, documented physician's orders for each resident prescribed an antibiotic during each month. The Order Listing Reports from [DATE] through [DATE], documented a total of 31 residents were prescribed one or more antibiotics and/or antimicrobials between these dates. The Order Listing Reports and Line Listing for Infections form were compared and documented from [DATE] through [DATE], the IP failed to include 10 of the 31 residents documented as having been prescribed an antibiotic/antimicrobial on the Line Listing for Infections report intended to be used by the IP for tracking infections and antibiotic use throughout the facility. A document titled Infection Preventionist Job Description, signed by the IP on [DATE], documented the IP planned, developed, organized, implemented, evaluated, coordinated, and directed the infection control program. The IP was responsible for providing staff and residents with information regarding the facility's policies related to pneumococcal vaccines. The IP ensured the facility was in compliance with current CDC guidance related to infection control and interpreted infection control policies and procedures. The IP directed antibiotic stewardship activities within the facility to improve antibiotic use by tracking antibiotic starts, adherence to evidence-based published criteria, and reviewing antibiotic resistance patterns in the facility. A Centers for Disease Control and Prevention (CDC) document titled Core Elements of Antibiotic Stewardship for Nursing Homes, retrieved from CDC.gov on [DATE], standardized practices should be applied during the care of any resident suspected of an infection or started on an antibiotic. Practices included improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing and antibiotic review process known and an antibiotic time out for all antibiotics prescribed in the facility. The antibiotic time-out review provided clinicians with an opportunity to reassess the ongoing need for, and choice of an antibiotic when the clinical picture is clearer, and more information is available. (continued on next page)

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	295067	A. Building B. Wing	05/29/2024

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Antimicrobial Stewardship Program (ASP), dated ,d+[DATE], documented the IP monitored and supported ASP activities through audits, review of physician/provider orders, documentation, and clinical reports. Evaluation and decision making processes for antibiotic use were the IP's primary role. The IP communicated with providers regarding residents' current clinical status in a timely manner. Cultures were obtained before treatment was started and monitored to determine if the results indicated a change in treatment was needed. Tracking and monitoring included monitoring outcomes of antibiotic use, MDROs, adverse drug events due to antibiotics, and rates of clostridium difficile (C-diff) via line listings. Pneumococcal Vaccines On [DATE] at 11:11 AM, the IP explained the process for determining if a resident needed a pneumococcal vaccine was to determine if the resident's last vaccination was out of date. The resident would be offered the pneumococcal polysaccharide vaccine (PPSV) 23. The IP explained out of date meant the vaccine was recommended to be given every five years and would be offered if it had been over five years since the resident's last pneumococcal vaccine. The IP confirmed pneumococcal vaccines expired after five years and needed to be repeated. On [DATE] at 11:20 AM, the IP verbalized, regarding the IP's understanding of pneumococcal vaccines, the IP did not know the vaccines by heart because the guidance changed all the time. The IP explained the floor nurses should be able to determine when a resident needed additional vaccines and which vaccine was needed. The IP confirmed floor nurses were not provided with a flow sheet such as an algorithm or decision tree to assist with determining which pneumococcal vaccine was needed. On [DATE] at 12:44 PM, the IP confirmed the facility did not have an official form for screening resident needs for pneumococcal vaccines. The IP confirmed, a resident's need for pneumococcal vaccine was determined by reviewing the resident's medical history, list of medications, and notifying the provider. The provider would determine the vaccine requirements and write an order for the vaccine. On [DATE] at 3:44 PM, the DNS verbalized on [DATE], the DNS and IP located and printed a copy of the CDC guidance related to choosing the correct pneumococcal vaccine needed for an individual. The DNS confirmed the facility had not been using CDC guidance including the CDC pneumococcal decision flow sheet or other format/process to assist in determining the CDC's recommendation for pneumococcal vaccines for the facility's residents. On [DATE] at 4:48 PM, the DNS confirmed the DNS had not been aware of a concern related to the IP's pneumococcal vaccine process. A facility policy titled, Pneumococcal Vaccination of Residents, updated ,d+[DATE], documented the facility followed the CDC recommendations for vaccination. (continued on next page)

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

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The CDC document titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate, dated [DATE], documented an instructional flow sheet to guide the determination of eligibility for a pneumococcal vaccine and the vaccine needed by an individual based on age, comorbidities, and previous administration of pneumococcal vaccines. Comorbidities for adults between the ages of 19 and 64 included diabetes mellitus and chronic renal failure. The recommendations for adults over [AGE] years of age varied depending on age at time of previous vaccination, the type of vaccine previously administered, and the presence of immunocompromising conditions, cochlear implant, or cerebrospinal fluid leak. An application (app) and a web-based version, were available to assist with determining which vaccines were recommended. A facility policy titled, Pneumococcal Vaccination of Residents, updated ,d+[DATE], documented the facility followed the CDC recommendations for vaccination. The electronic health record (EHR) of each resident was updated to include when a resident received a vaccine, refused a vaccine, or did not get vaccinated. When a resident was administered a vaccine, it was documented in the resident's immunization record. Education was provided regarding the risk and benefits and the applicable Vaccination Information Sheet was provided.

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	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0839 Level of Harm - Potential for minimal harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. 31739 Based on clinical record review, document review and interview, the facility failed to ensure a health provider's clinical documentation was representative of the provider's accurate licensure. Findings include: Review of Provider visits of 74 of 89 resident records starting on 02/07/2024, documented the Provider as a Doctor of Medicine (MD). A search of the Provider in the National Provider Identifier Registry resulted in the Provider having been licensed as an Advanced Practice Registered Nurse (APRN), not an MD. On 05/28/2024 at 9:57 AM, the Provider confirmed the Provider was licensed as an APRN. The Provider verbalized the Provider had not been aware the documentation into resident records was documented as an MD. The Provider verbalized the Provider should have been reviewing the documentation for accuracy, and there had not been a separate review of the Provider's documentation by the Medical Director prior to the document being placed into a resident's record. On 05/28/2024 at 10:04 AM, the Director of Nursing Services (DNS), confirmed the Provider was an APRN and provided services to residents on a rotating basis. The DNS verbalized it was not the facility's practice to review the Providers documentation for accuracy prior to placement into resident records. On 05/28/2024 at 10:19 AM, the Medical Director confirmed the Provider was an APRN and the Medical Director was responsible for reviewing the Provider's documentation, and the oversight of the Provider and the residents in the facility. The Medical Director verbalized reviewing the Providers documentation at each scheduled visit the Medical Director had with each resident. The Medical Director had not been aware the Provider's documentation into resident records was documented as an MD. The Medical Director Independent Contractor Agreement with the facility, dated 04/16/2020, documented the provider agreed to provide services in accordance with all applicable requirements of federal, state and local laws, rules, and/or regulations, and prepare and maintain complete and detailed clinical records concerning residents in accordance with prudent record-keeping procedures. Cross reference F841 and F842

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 N Ormsby Carson City, NV 89703	

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F 0841 Level of Harm - Potential for minimal harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 31739 Based on clinical record review, document review and interview, the Medical Director of the facility failed to ensure a health provider's clinical documentation was representative of the provider's accurate licensure. Findings include: Review of Provider visits of 74 of 89 resident records starting on 02/07/24, documented the Provider as a Doctor of Medicine (MD). A search of the Provider in the National Provider Identifier Registry resulted in the Provider having been licensed as an Advanced Practice Registered Nurse (APRN), not an MD. On 05/28/2024 at 9:57 AM, the Provider confirmed the Provider was licensed as an APRN. The Provider verbalized the Provider had not been aware the documentation into resident records was documented as an MD. The Provider verbalized the Provider should have been reviewing the documentation for accuracy, and there had not been a separate review of the Provider's documentation by the Medical Director prior to the document being placed into a resident's record. On 05/28/2024 at 10:04 AM, the Director of Nursing Services (DNS), confirmed the Provider was an APRN and provided services to residents on a rotating basis. The DNS verbalized it was not the facility's practice to review the Providers documentation for accuracy prior to placement into resident records. On 05/28/2024 at 10:19 AM, the Medical Director confirmed the Provider was an APRN and the Medical Director was responsible for reviewing the Provider's documentation, and the oversight of the Provider and the residents in the facility. The Medical Director verbalized reviewing the Providers documentation at each scheduled visit the Medical Director had with each resident. The Medical Director had not been aware the Provider's documentation into resident records was documented as an MD. The Medical Director Independent Contractor Agreement with the facility, dated 04/16/2020, documented the provider agreed to provide services in accordance with all applicable requirements of federal, state and local laws, rules, and/or regulations, and prepare and maintain complete and detailed clinical records concerning residents in accordance with prudent record-keeping procedures. Cross reference F839 and F842

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	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739 Based on clinical record review, document review and interview, the facility failed to complete Medication Administration Records (MAR) for the administration of an anti-coagulant for 1 of 19 sampled residents (Resident #66), and to ensure documentation in resident records accurately represented the licensure of a Provider for 74 of 89 residents (Residents #2, #3, #4, #5, #8, #9, #10, 12, #14, #15, #16, #19, #20, #21, #23, #24, #25, #26, #27, #28, #29, #30, #31, #33, #34, #36, #37, #38, #39, #40, #41, #42, #44, #45, #46, #49, #50, #53, #54, #55, #56, #59, #60, #61, #62, #63, #64, #65, #66, #68, #69, #70, #71, #72, #73, #74, #75, #76, #78, #79, #80, #83, #85, #238, #239, #240, #241, #242, #243, #244, #245, #246, #338, and #339), and failed to ensure complete resident clinical records were maintained for 2 of 19 sampled residents (Resident #80 and #68). Findings include: Medication Administration Record Resident #66 Resident #66 was admitted to the facility on [DATE], with a diagnosis of pulmonary embolism. A physician's order dated 03/01/2024, documented Apixaban oral tablet 5 milligrams (mg), give 5 mg by mouth two times a day for pulmonary embolism. Resident #66's MAR dated 03/07/2024 and 04/03/2024, lacked documented evidence Apixaban oral tablet 5 mg had been administered at either of the scheduled times on those dates. On 05/23/2024 at 11:42 AM, the Director of Nursing Services (DNS), confirmed Resident #66 was in the facility on 03/07/2024 and 04/03/2024, and there had been no progress note documenting the reason for the lack of documentation of the administration of Apixaban oral tablet to the resident on those dates. The DNS confirmed the nurse should have documented the administration of the medication or the refusal of the medication by the resident into the resident's record. Health Provider Documentation A search of the Provider in the National Provider Identifier Registry resulted in the Provider having been licensed as an Advanced Practice Registered Nurse (APRN), not a Doctor of Medicine (MD). Resident #2 Resident #2 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #3 (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 was admitted to the facility on [DATE], with a diagnosis of chronic kidney disease, stage three. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #4 Resident #4 was admitted to the facility on [DATE], with a diagnosis of dementia. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #5 Resident #5 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #8 Resident #8 was admitted to the facility on [DATE], with a diagnosis of dementia. A Provider Progress Note dated 03/11/2024 documented the Provider as an MD. Resident #9 Resident #9 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 04/05/2024 documented the Provider as an MD. Resident #10 Resident #10 was admitted to the facility on [DATE], with a diagnosis of type I diabetes mellitus. A Provider Progress Note dated 05/01/2024 documented the Provider as an MD. Resident #12 Resident #12 was admitted to the facility on [DATE], with a diagnosis of bi-polar disorder. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #14 Resident #14 was admitted to the facility on [DATE], with a diagnosis of major depressive disorder. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 N Ormsby Carson City, NV 89703	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15 Resident #15 was admitted to the facility on [DATE], with a diagnosis of anxiety. A Provider Progress Note dated 02/09/2024 documented the Provider as an MD. Resident #16 Resident #16 was admitted to the facility on [DATE], with a diagnosis of epilepsy. A Provider Progress Note dated 04/03/2024 documented the Provider as an MD. Resident #19 Resident #19 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 05/01/2024 documented the Provider as an MD. Resident #20 Resident #20 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus. A Provider Progress Note dated 05/13/2024 documented the Provider as an MD. Resident #21 Resident #21 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 02/23/2024 documented the Provider as an MD. Resident #23 Resident #23 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #24 Resident #24 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #25 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 N Ormsby Carson City, NV 89703	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 04/19/2024 documented the Provider as an MD. Resident #26 Resident #26 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #27 Resident #27 was admitted to the facility on [DATE], with a diagnosis of Parkinson's Disease. A Provider Progress Note dated 03/11/2024 documented the Provider as an MD. Resident #28 Resident #28 was admitted to the facility on [DATE], with a diagnosis of bi-polar disorder. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #29 Resident #29 was admitted to the facility on [DATE], with a diagnosis of cognitive communication deficit. A Provider Progress Note dated 05/01/2024 documented the Provider as an MD. Resident #30 Resident #30 was admitted to the facility on [DATE], with a diagnosis of multiple sclerosis. A Provider Progress Note dated 02/09/2024 documented the Provider as an MD. Resident #31 Resident #31 was admitted to the facility on [DATE], with a diagnosis of dementia. A Provider Progress Note dated 04/19/2024 documented the Provider as an MD. Resident #33 Resident #33 was admitted to the facility on [DATE], with a diagnosis of bi-polar disorder. A Provider Progress Note dated 04/19/2024 documented the Provider as an MD. (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #34 Resident #34 was admitted to the facility on [DATE], with a diagnosis of dementia. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #36 Resident #36 was admitted to the facility on [DATE], with a diagnosis of chronic kidney disease, stage three. A Provider Progress Note dated 05/01/2024 documented the Provider as an MD. Resident #37 Resident #37 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus. A Provider Progress Note dated 05/01/2024 documented the Provider as an MD. Resident #38 Resident #38 was admitted to the facility on [DATE], with a diagnosis of Wernicke's encephalopathy. A Provider Progress Note dated 04/19/2024 documented the Provider as an MD. Resident #39 Resident #39 was admitted to the facility on [DATE], with a diagnosis of multiple sclerosis. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #40 Resident #40 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 04/01/2024 documented the Provider as an MD. Resident #41 Resident #41 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #42 Resident #42 was admitted to the facility on [DATE], with a diagnosis of cerebral palsy. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Provider Progress Note dated 05/01/2024 documented the Provider as an MD. Resident #44 Resident #44 was admitted to the facility on [DATE], with a diagnosis of muscle weakness. A Provider Progress Note dated 02/07/2024 documented the Provider as an MD. Resident #45 Resident #45 was admitted to the facility on [DATE], with a diagnosis of chronic atrial fibrillation. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #46 Resident #46 was admitted to the facility on [DATE], with a diagnosis of Parkinson's Disease. A Provider Progress Note dated 05/13/2024 documented the Provider as an MD. Resident #49 Resident #49 was admitted to the facility on [DATE], with a diagnosis of Wernicke's encephalopathy. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #50 Resident #50 was admitted to the facility on [DATE], with a diagnosis of type I diabetes mellitus. A Provider Progress Note dated 04/22/2024 documented the Provider as an MD. Resident #53 Resident #53 was admitted to the facility on [DATE], with a diagnosis of chronic kidney disease, stage three. A Provider Progress Note dated 04/01/2024 documented the Provider as an MD. Resident #54 Resident #54 was admitted to the facility on [DATE], with a diagnosis of dementia. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #55 (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	05/29/2024

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #55 was admitted to the facility on [DATE], with a diagnosis of chronic kidney disease, stage three. A Provider Progress Note dated 04/22/2024 documented the Provider as an MD. Resident #56 Resident #56 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 04/22/2024 documented the Provider as an MD. Resident #59 Resident #59 was admitted to the facility on [DATE], with a diagnosis of dementia. A Provider Progress Note dated 03/22/2024 documented the Provider as an MD. Resident #60 Resident #60 was admitted to the facility on [DATE], with a diagnosis of Parkinson's Disease. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #61 Resident #61 was admitted to the facility on [DATE], with a diagnosis of Parkinson's Disease. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #62 Resident #62 was admitted to the facility on [DATE], with a diagnosis of dementia. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #63 Resident #63 was admitted to the facility on [DATE], with a diagnosis of congestive heart failure. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #64 Resident #64 was admitted to the facility on [DATE], with a diagnosis of intervertebral disc degeneration, lumbar region. A Provider Progress Note dated 03/06/2024 documented the Provider as an MD. (continued on next page)

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	295067	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #65 Resident #65 was admitted to the facility on [DATE], with a diagnosis of dementia. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #66 Resident #66 was admitted to the facility on [DATE], with a diagnosis of pulmonary embolism. A Provider Progress Note dated 05/15/2024 documented the Provider as an MD. Resident #68 Resident #68 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 05/15/2024 documented the Provider as an MD. Resident #69 Resident #69 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #70 Resident #70 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus. A Provider Progress Note dated 04/01/2024 documented the Provider as an MD. Resident #71 Resident #71 was admitted to the facility on [DATE], with a diagnosis of intracranial hemorrhage affecting the right dominant side. A Provider Progress Note dated 04/03/2024 documented the Provider as an MD. Resident #72 Resident #72 was admitted to the facility on [DATE], with a diagnosis of methicillin-resistant staphylococcus aureus. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #73 (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #73 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus. A Provider Progress Note dated 05/01/2024 documented the Provider as an MD. Resident #74 Resident #74 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #75 Resident #75 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #76 Resident #76 was admitted to the facility on [DATE], with a diagnosis of type I diabetes mellitus. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #78 Resident #78 was admitted to the facility on [DATE], with a diagnosis of muscle weakness. A Provider Progress Note dated 03/22/2024 documented the Provider as an MD. Resident #79 Resident #79 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus. A Provider Progress Note dated 05/13/2024 documented the Provider as an MD. Resident #80 Resident #80 was admitted to the facility on [DATE], with a diagnosis of end stage renal disease. A Provider Progress Note dated 05/15/2024 documented the Provider as an MD. Resident #83 Resident #83 was admitted to the facility on [DATE], with a diagnosis of epilepsy. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #85 Resident #85 was admitted to the facility on [DATE], with a diagnosis of congestive heart failure. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #238 Resident #238 was admitted to the facility on [DATE], with a diagnosis of fracture of unspecified parts of lumbosacral spine and pelvis. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #239 Resident #239 was admitted to the facility on [DATE], with a diagnosis of chronic kidney disease, stage three. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #240 Resident #240 was admitted to the facility on [DATE], with a diagnosis of anxiety. A Provider Progress Note dated 05/15/2024 documented the Provider as an MD. Resident #241 Resident #241 was admitted to the facility on [DATE], with a diagnosis of anxiety. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #242 Resident #242 was admitted to the facility on [DATE], with a diagnosis of chronic kidney disease, stage three. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #243 Resident #243 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #244 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #244 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #245 Resident #245 was admitted to the facility on [DATE], with a diagnosis of chronic kidney disease, stage three. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. Resident #246 Resident #246 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease. A Provider Progress Note dated 05/17/2024 documented the Provider as an MD. Resident #338 Resident #338 was admitted to the facility on [DATE], with a diagnosis of ataxic cerebral palsy. A Provider Progress Note dated 05/01/2024 documented the Provider as an MD. Resident #339 Resident #339 was admitted to the facility on [DATE], with a diagnosis of chronic kidney disease, stage three. A Provider Progress Note dated 05/20/2024 documented the Provider as an MD. On 05/28/2024 at 9:57 AM, the Provider confirmed the Provider was licensed as an APRN. The Provider verbalized the Provider had not been aware the documentation into resident records was documented as an MD. The Provider verbalized the Provider should have been reviewing the documentation for accuracy, and there had not been a separate review of the Provider's documentation by the Medical Director prior to the document being placed into a resident's record. On 05/28/2024 at 10:04 AM, the Director of Nursing Services (DNS), confirmed the Provider was an APRN and provided services to residents on a rotating basis. The DNS verbalized it was not the facility's practice to review the Providers documentation for accuracy prior to placement into resident records. On 05/28/2024 at 10:19 AM, the Medical Director confirmed the Provider was an APRN and the Medical Director was responsible for reviewing the Provider's documentation, and the oversight of the Provider and the residents in the facility. The Medical Director verbalized reviewing the Providers documentation at each scheduled visit the Medical Director had with each resident. The Medical Director had not been aware the Provider's documentation into resident records was documented as an MD. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medical Director Independent Contractor Agreement with the facility, dated 04/16/20, documented the provider agreed to provide services in accordance with all applicable requirements of federal, state, and local laws, rules, and/or regulations, and prepare and maintain complete and detailed clinical records concerning residents in accordance with prudent record-keeping procedures. Cross reference F839 and F841 Incomplete Resident Records 43310 Resident #80 Resident #80 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus with other diabetic kidney complications, end stage renal disease (ESRD), and dependence on renal dialysis. A physician's order dated 04/18/2024, documented dialysis on Monday, Wednesday, and Friday (M, W, F), pick up time at 10:00 AM. A physician's order dated 04/18/2024, documented to check Resident #80's blood sugar after meals and at bedtime for diabetes, for five days. Notify the physician if blood sugars were less than 80 or greater than 300. The order was discontinued on 04/21/2024. A physician's order dated 04/20/2024, documented to check Resident #80's blood sugar twice daily and call the physician if over 250. The order was discontinued on 04/22/2024. A physician's order dated 04/18/2024, documented following dialysis, evaluate blood flow for fistula or grafts (dialysis access site) on either side of dressing to ensure the dressing was not too tight. Palpate (feel) the side of fistula or graft for thrill (vibration) presence or absence every shift (yes or no). If unable to palpate thrill auscultate (listen to with a stethoscope) fistula or graft for bruit (rushing sound), presence or absence every shift (yes or no), one time a day, every M, W, F. If unable to palpate thrill or auscultate bruit, remove dressing, reevaluate fistula or graft, notify MD and document in the progress notes. A physician's order dated 04/18/2024, documented to palpate the fistula or graft for thrill presence or absence every shift. Document any changes in the progress notes and notify physician. A physician's order dated 04/18/2024, documented to auscultate fistula or graft for bruit (rushing sound) presence or absence every shift (yes or no) document any changes in progress notes and notify physician. A physician's order dated 04/18/2024, documented to monitor extremity or area of fistula or graft for changes in circulation, movement, and sensation (yes or no) every shift. Document any changes in progress notes and notify physician. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #80's Treatment Administration Record (TAR) for April 2024 lacked documented evidence the resident's fistula or graft was assessed for circulation/blood flow to ensure the dressing was not too tight following dialysis on 04/26/2024. Resident #80's TAR for April 2024 lacked documented evidence Resident #80's fistula or graft was palpated for presence or absence of thrill and/or auscultated for presence or absence of bruit each shift on the following dates: -04/18/2024 -04/20/2024 -04/22/2024 -04/26/2024 -04/27/2024 -04/28/2024. Resident #80's TAR for April 2024 lacked documented evidence Resident #80's fistula or graft was monitored for changes in circulation, movement, and sensation each shift on the following dates: -04/18/2024 -04/20/2024 -04/22/2024 -04/26/2024 -04/27/2024 -04/28/2024. Resident #80's clinical record did not include an order for monitoring the resident's blood sugars, including before and after dialysis, and lacked documented evidence the residents blood sugar was checked each day before and after dialysis. On 05/21/2024 at 3:02 PM, a Registered Nurse (RN) explained orders to check Resident #80's blood sugars had been discontinued and new orders were not received. The RN confirmed Resident #80's clinical record lacked documented evidence the resident's pre and post dialysis blood sugars were assessed and documented. On 05/21/2024 at 4:13 PM, the DNS confirmed diabetic residents receiving dialysis were to have blood sugars checked pre and post dialysis per the facility's dialysis policy. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/2024 at 4:18 PM, the DNS explained the physician's orders to check Resident #80's blood sugars had been discontinued and new orders were not provided. The DNS confirmed Resident #80's clinical record lacked an order to check the residents blood sugars and blood sugars were not being assessed pre and post dialysis and should have been completed and documented in the clinical record and on the Dialysis Transfer form in the dialysis binder. On 05/21/2024 at 4:27 PM, the DNS verbalized a review of the facility's policy related to dialysis, and educating providers and nurses, could have ensured the critical elements of dialysis were completed, such as pre and post blood sugars, vital signs, and weights were assessed and documented in the resident's Electronic Health Record (EHR). The facility policy titled, Dialysis, updated 03/2015, documented the facility provided ongoing monitoring of the dialysis access site, completed dressing changes, and provided care of the access site per physician orders. The facility completed a blood glucose check before and after dialysis for resident's with diabetes. Cross reference with F698 49557 Resident #68 Resident #68 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, schizoaffective disorder, unspecified, and diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequelae. A progress note dated 05/04/2024, documented Resident #68 was observed touching the leg of a female resident in the facility dining area. The residents were immediately separated. Resident #68 was reminded by nursing it was inappropriate to touch other residents' private parts. Resident #68's care plan documented a problem of bold behaviors in the facility, touching female residents' private parts. The date initiated was 05/06/2024. On 05/21/2024 at 2:37 PM, a Certified Nursing Assistant (CNA) recalled Resident #68 was in the facility dining area on 05/04/2024. The CNA verbalized the CNA observed Resident #68 reach out and touch a female resident on the knee. The CNA verbalized the residents were immediately separated and the incident was reported to the nurse. On 05/22/2024 at 10:40 AM, RN2 recalled approximately two weeks prior, Resident #68 was observed touching the leg of a female resident. The RN verbalized the RN did not observe Resident #68 touching a female resident, the touching was reported to the RN by a CNA. The RN demonstrated the touching by placing the RN's hands on the inner part of the surveyor's knee. The RN confirmed Resident #68 did not touch a female resident's private parts. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/2024 at 2:12 PM, the Assistant Director of Nursing (ADON) recalled an incident occurred on 05/04/2024, involving Resident #68 touching a female resident's legs, near the knees. The ADON confirmed Resident #68's care plan documented Resident #68 touched female residents' private parts. The ADON confirmed Resident #68 had not touched resident's private parts and the care plan did not accurately reflect the resident's behavior. The Principals for Nursing Documentation, Standards of Practice, dated 2010, documented an essential component of nursing practice included accurate, clear, concise, and complete documentation into a resident's record.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46301 Based on interview and document review, the facility failed to accurately report weekend staffing coverage documented on the payroll-based staffing (PBJ) requirements submitted to the Center for Medicare and Medicaid Services (CMS). Findings include: The Centers for Medicare and Medicaid Services, Payroll-Based Journal (PBJ) Staffing Data Report, dated 10/01/2023 through 12/31/2023, documented the facility had excessively low weekend staffing. Facility nursing schedules and timesheets indicated sufficient staffing coverage for weekends for 10/01/2023 through 12/31/2023, excluding the weekend of 12/17/2024. The PBJ reports submitted to CMS lacked sufficient staffing coverage for weekend for 10/01/2023 through 12/31/2023. On 05/28/2024 at 1:05 PM, the Director of Nursing Services (DNS) indicated the facility had been submitting PBJ data. The DNS confirmed the PBJ reports submitted to CMS were inaccurate and the facility did have sufficient staffing coverage for weekends for 10/01/2023 through 12/31/2023, excluding the weekend of 12/17/2024.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 43310 Based on interview and document review the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify 1) concerns related to the identification for the need of Enhanced Barrier Precautions (EBP) and Transmission Based Precautions (TBP), 2) an Advanced Practice Registered Nurse (APRN) signed documentation with the credentials of Medical Doctor, 3) a lack of thorough investigation related to resident abuse, 4) the lack of an effective process for tracking and reconciling narcotic medications, including hospice medications, 5) the facility lacked a designated Hospice Coordinator, and 6) concerns related to screening and offering pneumococcal vaccines. Findings include: Transmission Based Precautions On 05/28/24 at 4:31 PM, the Director of Nursing Services (DNS) confirmed the QAPI committee had not identified concerns related to TBP, including EBP. The DNS explained the QAPI committee could have identified the concern by conducting an audit for EBP as a new requirement which would have led to the identification of the need for a Performance Improvement Project (PIP). Education could have been provided to staff to ensure precautions were implemented and maintained appropriately. Cross reference with F880 Credentials On 05/28/24 at 4:37 PM, the Administrator confirmed the QAPI committee had not identified an APRNs signature included the credentials of MD. The Administrator verbalized Medical Records could have identified the concern during daily audits and brought the concern to the attention of the QAPI committee. Cross reference with F839 Abuse Investigations On 05/28/2024 at 4:39 PM, the Administrator confirmed the QAPI committee had not identified a lack of thorough investigation in resident abuse allegations. The Administrator verbalized the concern with a recent investigation could have been identified by verifying employees contact information upon hire. The Administrator was not aware of additional concerns related to abuse investigations. Cross reference with F610 Narcotic Medications On 05/28/2024 at 4:44 PM, the DNS confirmed the QAPI committee had not identified a concern related to tracking and reconciling narcotic medications, including hospice medications. The DNS was not able to identify how the QAPI committee could have been aware and verbalized a plan would need to be developed. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross reference with F609 and F610 Hospice Coordinator On 05/28/2024 at 4:46 PM, the DNS confirmed the QAPI committee had not identified a concern related to the lack of facility Hospice Coordinator. The DNS explained the facility was not aware a Hospice Coordinator was needed. The DNS verbalized having a designated Hospice Coordinator could have helped to ensure communication related to medications occurred between hospice, floor staff, and the DNS. Cross reference with F684 Pneumococcal Vaccines On 05/28/2024 at 4:48 PM, the DNS confirmed the QAPI committee had not identified a concern related to the selection of pneumococcal vaccines and resident screening and education related to the vaccines. The QAPI committee could have identified the concern by reviewing immunization information and performing audits. Identifying the concern could have ensured residents determined to be eligible to receive a pneumococcal vaccine were offered the vaccine and had an opportunity to receive or decline the vaccine. Cross Reference with F883 The facility policy titled QAPI, updated 10/2018, documented the Executive Director was responsible and accountable to ensure QAPI was effectively implemented and integrated throughout the facility. The facility developed a QAPI plan to identify and correct quality deficiencies when they occur throughout the facility as well as to identify opportunities for improvement. QAPI was integrated across all the care and service areas, systems, and management practices of the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure 1) a resident with a multi-drug resistant organism (MDRO) infection (an infection with a germ resistant to an antibiotic, for which certain treatments would not work or would be less effective) was not provided care with the use of transmission based precautions (TBP) to prevent the spread of the MDRO to other residents in the facility for 1 of 19 sampled residents (Resident #9). This deficient practice could cause the spread of an MDRO to other residents in the facility with the potential to result in serious adverse effects to resident's health, 2) a bin for the disposal of used Personal Protective Equipment (PPE) was placed inside a room for a resident requiring TBP for 1 of 19 sampled residents (Resident #9) and 3) a resident's urostomy drainage bag was kept off the floor while the resident was lying in bed for 1 of 19 sampled residents (Resident #3). Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including local infection of the skin and subcutaneous tissue, unspecified, methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, and cellulitis of right lower limb. TBP On 05/20/2024 at 9:47 AM, the door to Resident #9's room did not have signage indicating the resident was on enhanced barrier precautions (EBP) or TBP and there was not a cart for personal protective equipment (PPE) near the outside of the resident's room. The resident was curled up in a fetal position at the end of the bed and had a bandage partially covering a wound to the top of the resident's right foot. The bandage appeared wet with a yellowish fluid. The resident's right lower extremity appeared red, swollen, and moist with skin sloughing. The resident had large black, scabbed areas on the front of the right lower extremity. On 05/20/2024 at 10:18 AM, the Licensed Practical Nurse (LPN) for Resident #9 verbalized the resident had wounds and should have had a sign on the outside of the door to indicate the resident was on EBP for the resident's wound. The LPN confirmed the resident did not have a sign on the resident's door and there was not a PPE cart outside of the resident's room. On 05/20/2024 at 12:22 PM, a sign was on the outside of Resident #9's door. The sign documented the resident was on EBP. A hospital Discharge Summary for Resident #9, dated 03/27/2024, documented the resident had a discharge diagnosis of unstageable right non healing ankle wound with cellulitis with cultures of methicillin resistant staphylococcus aureus (MRSA) and Alcaligenes Faecalis (A. Faecalis). The Wound Culture results documented the wound was cultured on 03/20/2024 and had moderate growth of MRSA and light growth of A. Faecalis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER: Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3050 N Ormsby Carson City, NV 89703	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Minimum Data Set 3.0 Assessment, dated 04/03/2024, documented the resident had an MDRO and wound infection. The Order Summary Report for Resident #9 documented an order for EBP with a start date of 04/04/2024. On 05/22/2024 at 8:51 AM, the LPN for Resident #9 verbalized the resident did not have an infection in the resident's wound. On 05/22/2024 at 9:11 AM, the Infection Preventionist (IP) verbalized a resident with a wound requiring dressing changes would be on EBP. The IP confirmed Resident #9's door had not had an EBP sign and there was not a PPE cart outside of the room on the morning of 05/20/2024. The IP verbalized Resident #9 would not require TBP as the resident was colonized with MRSA and did not have an active infection. The IP explained the IP did not know about the A. Faecalis culture. The IP verbalized the IP would provide documentation to show Resident #9 was colonized with MRSA and did not have an active infection. On 05/22/2024 at 10:00 AM, the IP explained the IP did not yet have an answer to explain how the determination was made regarding the status of the MRSA infection in Resident #9. The IP verbalized a resident had to be symptomatic and have signs of redness, swelling, fever, heat, and excessive drainage to be placed in TBP. The IP verbalized the IP could not use lab results to determine presence of infection or the need for isolation. On 05/22/2024 at 2:25 PM, the contracted hospice Registered Nurse (RN) for Resident #9 verbalized the hospice agency provided palliative wound care for Resident #9 three days a week and utilized TBP when providing care because the resident had an MRSA infection in the wound. On 05/23/2024 at 8:53 AM, the IP verbalized the IP had determined the resident was colonized based on the McGreer's criteria worksheet the IP completed on new admissions with potential infections and a note from the physician. The IP explained the IP did not use the cultures obtained by the hospital because the cultures were obtained prior to the resident's admission to the facility. The Provider Progress Note provided and referenced by the IP, dated 04/05/2024, documented the resident had a local infection of the skin and subcutaneous tissue, unspecified. On 05/23/2024 at 8:58 AM, the Director of Nursing Services (DNS) confirmed the facility did not have a McGreer's criteria worksheet for Resident #9. The DNS explained the facility would be able to reference wound cultures from a resident's hospital stay prior to admission to the facility. The facility policy titled Transmission-Based Precautions (Isolation), dated 05/2015, documented TBP was used whenever measures more stringent than Standard Precautions were needed to prevent or control the spread of infection. Examples of infections requiring Contact Precautions included infections with MDROs. Cross reference with F726 43310 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PPE Disposal Bin On 05/23/2024 at 9:30 AM, the IP and the DNS were in Resident #9's room (room [ROOM NUMBER]). Two signs were posted on the door of room [ROOM NUMBER]. One sign was for EBP and the other sign was for Contact Precautions. The DNS opened the door to the room and was wearing a gown, but was not wearing gloves. On 05/23/2024 at 9:32 AM, the DNS explained the DNS had been wearing gloves but upon doffing the gloves discovered there was not a designated bin available in room [ROOM NUMBER] to properly dispose of the contaminated gloves. The DNS had opened the door to attempt to get someone to bring a bin to the room. The DNS confirmed TBP rooms, including EBP and contact precautions, required a bin to be placed inside the room to allow for the disposal of used Personal Protective Equipment (PPE) prior to exiting the room. On 05/23/2024 at 9:40 AM, the IP was standing in the doorway of room [ROOM NUMBER] holding a clear bag. The IP verbalized the bag contained contaminated dressings removed from the resident's wound during a dressing change. The IP was waiting for someone to bring a red bag so the IP could properly dispose of the contaminated materials. The IP confirmed a dedicated bin should have already been placed in the room. The IP explained Resident #9 had been placed on EBP earlier in the week and was now being placed on contact precautions. The IP confirmed a dedicated bin had not been placed in room [ROOM NUMBER] when EBP was initiated. The IP confirmed the expectation was when any form of TBP was implemented, a dedicated bin would be placed inside the room to allow for the appropriate disposal of waste materials and PPE after each use. The facility policy titled Enhanced Barrier Precautions, dated 03/26/2024, documented the facility ensured an appropriate linen barrel/hamper and waste container, with the appropriate liner, were placed in or near the resident's room. The facility policy titled Transmission -Based Precautions (Isolation), dated 05/2015, did not include instructions for the disposal of PPE prior to leaving a room under TBP. The facility policy titled Infection Control Policies and Practices, dated 05/30/2023, documented the facility followed the Centers for Disease Control and Prevention (CDC) guidelines. The CDC document titled Implementation of Personal Protective Equipment, updated 07/12/2022, documented when implementing contact precautions or EBP to position a trash can inside the resident room, near the exit, for discarding PPE after removal and prior to exiting the room. 46301 Urostomy Care Resident #3 Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including rheumatoid arthritis, unspecified, other specified functional intestinal disorders and chronic kidney disease, stage 3. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 05/10/2024, documented to maintain urostomy care every shift. Resident #3's care plan included an intervention to provide urostomy care at least once each shift, start date 05/10/2024. On 05/22/2024 at 9:58 AM, Resident #3 was laying in bed and the resident's urostomy drainage bag was on the floor. On 05/22/2024 at 10:01 AM, an RN explained catheter drainage bags should never be on the floor due to the potential for drainage issues and the increased risk of infections. The RN confirmed the resident's urostomy drainage bag was on the floor due to constant kinks developed when the drainage bag was hung on the side of the bed. On 05/22/2024 at 10:49 AM, a Certified Nursing Assistant (CNA) confirmed the resident's urostomy drainage bag was on the floor due to the resident's urostomy backing up if the bag was not on the floor. The CNA verbalized the urostomy drainage bag should not be on the floor as it could increase the resident's risk of infection. On 05/22/2024 at 2:01 PM, the DNS confirmed a resident with a urostomy would be at higher risk of infection if the drainage bag was on the floor. The DNS explained there was not a facility policy followed related to catheter or urostomy care and there was nothing documented in the facility's standard of practice followed related to catheter care/urostomy care. Cross reference with tag F691.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on document review and interview, the facility failed to ensure 1) the facility's form titled Line Listing for Infections by Resident, (Line Listing Report) completed by the Infection Preventionist (IP) included the necessary elements the IP needed for tracking infections and antibiotic use, 2) the IP accurately documented on the Line Listing for Infections form each month and included 10 of 31 residents prescribed antibiotics for infections from 01/01/2024 - 05/23/2024, on the form (Resident #5, #24, #71, #62, #54, #60, #9, #69, #72, and #66) with the potential to affect the facility's entire resident census of 89, and 3) staff and residents received education related to antibiotic use and the Antibiotic Stewardship Program (ASP). Findings include: Line Listing for Infections Form: The facility form titled Line Listings for Infections by Resident, included the following areas for documentation: -Resident name and age, -Resident room number, unit, and date of admission, -Date of infection (onset) -Site of infection, -Symptoms present at admission -Pathogen/organism -Community or Healthcare associated (CAI/HAI) -Transmission Based Precautions (TBP) initiated (the word none was pre-populated into each line of this section every month) -Date resolved/comments The Line Listing Report did not include an area to document the prescribed antibiotic, ordered lab work, or results of lab work. (continued on next page)

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F 0881

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

On 05/23/2024 at 11:45 AM, the IP verbalized the process for tracking infections and antibiotic use included daily review of a facility document titled Orders Listing Report, (Order Report). The Order Report was a list of physician orders including antibiotics and other antimicrobial medications. Upon review, the IP entered data for each resident with new orders for antibiotics/antimicrobials on the Line Listing Report. The IP explained the IP used the Line Listing Report to see what antibiotic each resident was receiving, how long they were to receive the prescribed antibiotic, and to see what the stop dates were for an antibiotic. The data was reviewed and compared with McGeer's Criteria.

The IP explained the IP entered the stop date of an antibiotic into the Line Listing Report's column labeled date resolved/comments. The IP explained the date an infection was resolved was the same date an antibiotic was completed. The IP confirmed the end date of the antibiotic was entered into the forms resolved/comments column and the date an infection was clinically resolved was not entered onto the form.

On 05/23/2024 at 11:55 AM, the IP explained the Line Listing Report did not include a place to document the type of infection, such as urinary tract infection (UTI), or cellulitis. Therefore, the IP documented the type of infection in the column labeled Pathogen/Organism.

On 05/23/2024 at 12:18 PM, the IP confirmed the Line Listing Report did not include a place to document the following:

- The antibiotic being used.

- Antibiotic start and stop dates.

- Ordered lab work, such as cultures.

- Lab results including cultures.

The IP explained the column labeled site of infection was used to document anatomically where an infection was located and did not have enough room for the IP to include the type of infection such as urinary tract infection or cellulitis.

The IP verbalized the column labeled pathogen/organism was used to document the type of infection, such as fungal, chronic obstructive pulmonary disease, and pneumonia due to the lack of a column to document the infection type. The IP confirmed the IP did not document the pathogen/organism.

The IP explained the IP used the column labeled date resolved/comments to document the stop date of prescribed antibiotics and confirmed the date entered did not document the date an infection was resolved.

The IP confirmed an antibiotic time out was not documented and explained an antibiotic time out form was not utilized due to the time level to meet a time out had not been reach for any antibiotics being used in the facility, and had not been an issue. The IP confirmed the form did not include a space to document if and when a culture was collected, therefore the information was not included on the line listing and the pathogen was not documented.

(continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/23/2024 at 12:39 PM, the IP verbalized the column for documenting TBP pre-populated the precautions as none and had to be manually changed to enter the type of TBP used. The IP confirmed the drop down box did not include Enhanced Barrier Precautions (EBP). Infection Preventionist Documentation (January 2024 - May 2024) Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type II diabetes mellitus with other circulatory complications, acute and chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease (COPD). Resident #24 Resident #24 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including COPD, chronic respiratory failure with hypoxia, and chronic kidney disease, stage II (mild). Resident #71 Resident #71 was admitted to the facility on [DATE], with diagnoses including intracranial hemorrhage affecting right dominant side, acute kidney failure with tubular necrosis, and elevated white blood cell count, unspecified. Resident #62 Resident #62 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic combined systolic (congestive) and diastolic (congestive) heart failure, and age related physical debility. Resident #54 Resident #54 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type II diabetes mellitus with other circulatory complications and chronic respiratory failure with hypoxia. Resident #60 Resident #60 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease with dyskinesia with fluctuations, COPD, and urinary tract infection, site not specified. Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, and chronic diastolic (congestive) heart failure. Resident #69 (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #69 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus with diabetic polyneuropathy, COPD, idiopathic gout, multiple sites, and gastroparesis. Resident #72 Resident #72 was admitted to the facility on [DATE], with a diagnosis of methicillin-resistant staphylococcus aureus. Resident #66 Resident #66 was admitted to the facility on [DATE], with a diagnosis of pulmonary embolism. January 2024 A facility document titled Order Listing Report, dated 01/01/2024 - 01/31/2024, documented the following: -Resident #5 had a physician's order dated, 01/31/2024 for Amoxicillin 875/125 milligrams (mg) for sinusitis. -Resident #24 had a physician's order dated 01/10/2024 for cephalexin 500 mg, for cellulitis. A facility document titled Line Listing for Infections by Resident, completed by the IP for the month of January 2024 documented Resident #5 had a UTI with an onset date of 01/31/2024, and did not document the resident had sinusitis. Resident #24 was not included on the report. February 2024 A facility document titled Order Listing Report, dated 02/01/2024 - 02/29/2024, documented Resident #71 had a physician's order for cephalexin 500 mg, for a UTI. A facility document titled Line Listing for Infections by Resident, completed by the IP for the month of February 2024, did not include Resident #71. March 2024 A facility document titled Order Listing Report, dated 03/01/2024 - 03/31/2024, documented Resident #62 had a physician's order for Cefdinir 300 mg, for a UTI. A facility document titled Line Listing for Infections by Resident, completed by the IP for the month of March 2024, did not include Resident #62. April 2024 A facility document titled Order Listing Report, dated 04/01/2024 - 04/30/2024, documented the following: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Resident #54 had a physician's order dated 04/21/2024, for penicillin 500 mg, for a tooth infection. -Resident #60 had a physician's order dated 04/13/2024, for Cefdinir 300 mg, for a UTI. -Resident #9 had a physician's order dated 04/20/2024, for Augmentin 600-42.9 mg/5 milliliters (ml). -Resident #69 had a physician's order dated 04/15/2024, for Macrobid 100 mg, for UTI. -Resident #72 had a physician's order dated 04/07/2024, for ciprofloxacin 500 mg, for cellulitis/wounds. -Resident #66 had a physician's order dated 04/28/2024, for doxycycline 100 mg, for bronchitis. -Resident #24 had a physician's order dated 04/27/2024, for nystatin powder 100,000 units/gram (gm) for candidiasis. A facility document titled Line Listing for Infections by Resident, completed by the IP for the month of April 2024, did not include Resident #54, #60, #9, #69, #72, #66 and #24. May 2024 A facility document titled Order Listing Report, dated 05/01/2024 - 05/31/2024, documented the following: -Resident #9 had a physician's order for amoxicillin potassium clavulanate, 875-125 mg, for infection and a physician's order for linezolid 600 mg, for wound infection. -Resident #68 had a physician's order for doxycycline 100 mg, for prevention related to device implantation. A facility document titled Line Listing for Infections by Resident, completed by the IP for the month of May 2024, did not include Resident #9, and #68. On 05/23/2024 at 12:28 PM, the IP explained the Order Listing Report was reviewed daily and compared to laboratory reports to ensure the correct antibiotic was being used. On 05/23/2024 at 12:50 PM, the IP explained when a resident was on the Order Listing Report with a prescribed antibiotic, they were added to the Line Listing for Infections by Resident. On 05/23/2024 at 1:07 PM, the IP confirmed the Order Listing Report was reviewed daily and residents with orders for antibiotics were added to the Line Listing for Infections by Resident Report daily. The IP confirmed when a resident with antibiotic orders was not added to the Line Listing for Infections by Resident Report, the documentation was not complete or current. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A Centers for Disease Control and Prevention (CDC) document titled Core Elements of Antibiotic Stewardship for Nursing Homes, retrieved from CDC.gov on 05/28/2024, standardized practices should be applied during the care of any resident suspected of an infection or started on an antibiotic. Practices included improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing and antibiotic review process known and an antibiotic time out for all antibiotics prescribed in the facility. The antibiotic time-out review provided clinicians with an opportunity to reassess the ongoing need for, and choice of an antibiotic when the clinical picture is clearer, and more information is available. The facility policy titled Antimicrobial Stewardship Program (ASP), dated 09/2017, documented the IP monitored and supported ASP activities through audits, review of physician/provider orders, documentation, and clinical reports. Evaluation and decision making processes for antibiotic use were the IP's primary role. The IP communicated with providers regarding residents' current clinical status in a timely manner. Cultures were obtained before treatment was started and monitored to determine if the results indicated a change in treatment was needed. Tracking and monitoring included monitoring outcomes of antibiotic use, MDROs, adverse drug events due to antibiotics, and rates of clostridium difficile (C-diff) via line listings. The facility policy titled Infection Control and Antibiotic Stewardship Committee, updated 09/2017, documented the Infection Control Committee (Committee) oversaw the surveillance, investigation, reporting, control, and prevention of infection. The Committee monitored for proper implementation of and adherence to infection control policies and procedures, adherence to established ASP policies and standards of practice. A facility document titled The Five D's of Antimicrobial Stewardship, undated, documented De-escalation included an antibiotic time out. An antibiotic time out was done to re-evaluate antibiotic use once microbiology results were available. Staff Education On 05/28/24 at 10:26 AM, the facility was not able to provide documented evidence of the provision of education related to the ASP and/or antibiotic use to nursing staff and residents. On 05/28/24 at 10:48 AM, the DON confirmed the facility did not provide education to residents related to antibiotic use and did not provide education to staff related to the ASP. The facility policy titled Antimicrobial Stewardship Program (ASP), dated 09/2017, documented education was provided to both nursing staff and providers on the goals of the ASP. Educational materials were available to assist in educating residents, resident representatives, nursing staff and other interdisciplinary team members regarding antibiotic resistance, the opportunity for improving antibiotic use and the ASP.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on interview, clinical record review, and document review the facility failed to ensure 1) 2 of 5 residents sampled for influenza vaccinations (Residents #62 and #9) were screened for eligibility to receive an influenza vaccine, education regarding the vaccine was provided to the resident and/or the resident representative, and the vaccine was offered and either administered or declined, and 2) 7 of 16 residents eligible to receive a pneumococcal vaccine (Residents #9, #80, #85, #77, #23, and #242) were screened for eligibility to receive a pneumococcal vaccine, education regarding the vaccine was provided to the resident and/or the resident representative, and the indicated pneumococcal vaccine was offered and either administered or declined. Findings include: Influenza Vaccines Resident #62 Resident #62 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified dementia, moderate, with psychotic disturbance, chronic combined systolic (congestive) and diastolic (congestive) heart failure, and age related physical debility. Resident #62's State Immunization Record documented the resident was last administered an influenza vaccine on 09/20/2022. Resident #62's clinical record lacked documented evidence the resident was screened for eligibility to receive an influenza vaccine, education regarding the vaccine was provided to the resident and/or the resident representative, and the vaccine was offered and either administered or declined. On 05/23/2024 at 11:02 AM, the Infection Preventionist (IP) verbalized Resident #64 was not offered an influenza vaccine due to being admitted to the facility after 04/01/2024, as this was the end of flu season. Upon review of the residents original admitted [DATE], the IP confirmed Resident #64's clinical record lacked documented evidence the resident was screened for eligibility to receive an influenza vaccine, education regarding current vaccines was provided to the resident and/or the resident's representative, and the vaccine was offered and either administered or declined. On 05/23/2024 at 11:04 AM, the IP verbalized the concern regarding missing vaccinations could have been prevented if identified by the admitting nurse. The IP explained the admissions form required the admitting nurse to document information related to immunizations. Audits were usually conducted weekly, but were not completed during the week in question. The IP verbalized the IP attempted to catch them, but could not always catch them all. Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, and chronic diastolic (congestive) heart failure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER: Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3050 N Ormsby Carson City, NV 89703	

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #9's State Immunization Record documented the resident was last administered an influenza vaccine on 11/23/2021. Resident #9's clinical record lacked documented evidence the resident was screened for eligibility to receive an influenza vaccine, education regarding the vaccine was provided to the resident and/or the resident representative, and the vaccine was offered and either administered or declined. On 05/23/2024 at 11:29 AM, the IP confirmed Resident #9's clinical record lacked documented evidence the resident was screened for eligibility to receive an influenza vaccine, education regarding the current vaccines was provided to the resident and/or the resident's representative, and the vaccine was offered and either administered or declined. The IP explained the admitting nurse may have been confused due to the resident was admitted on hospice. The IP confirmed hospice residents still received care including offering immunizations. Pneumococcal Vaccine Resident #9's State Immunization Record documented the resident received one dose of pneumococcal conjugate vaccine (PCV) 13, on 07/17/2019. Resident #9 was [AGE] years of age. On 05/23/2024 at 11:32 AM, the IP confirmed Resident #9 was eligible to receive immunization with either PCV-20 or pneumococcal polysaccharide vaccine (PPSV) 23. The IP confirmed Resident #9's clinical record lacked documented evidence the resident was screened for eligibility to receive a pneumococcal vaccine, education regarding the Centers for Disease Control and Prevention's (CDC) recommended vaccines, PCV-20 or PPSV-23, were provided to the resident and/or the resident's representative, and a vaccine was offered and either administered or declined. Resident #80 Resident #80 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus with other diabetic kidney complications, end stage renal disease (ESRD), and dependence on renal dialysis. Resident #80 was [AGE] years of age. Resident #80's State Immunization Record documented the resident received one does of a pneumococcal vaccine on 09/07/2018, and one dose of PCV-13 on 08/14/2021. On 05/23/2024 at 11:17 AM, the IP confirmed Resident #80's clinical record lacked documented evidence the resident was screened for eligibility to receive a pneumococcal vaccine, education regarding the CDC's recommended vaccines, PCV-20, or PPSV-23, was provided to the resident and/or the resident's representative, and a vaccine was offered and either administered or declined. On 05/23/2024 at 11:28 AM, the IP confirmed Resident #80's comorbidities, including diabetes mellitus, ESRD, and dependence on dialysis increased the resident's need for the vaccination risk due to increased risk for developing pneumonia. On 05/23/2024 at 11:38 AM, the IP confirmed the facility followed CDC guidance. Resident #77 (continued on next page)

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #77 was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, and other pulmonary embolism without acute cor pulmonale. Resident #77 was [AGE] years of age. Resident #77's State Immunization Record documented the resident received one dose of PPSV-23 on 08/27/2020. On 05/28/2024 at 12:59 PM, the IP confirmed Resident #77's clinical record lacked documented evidence the resident was screened for eligibility to receive a pneumococcal vaccine, education regarding the CDC's recommended vaccines, PCV-15, or PCV-20, was provided to the resident and/or the resident's representative, and a vaccine was offered and either administered or declined. Resident #85 Resident #85 was admitted to the facility on [DATE], with diagnoses including pneumonia, unspecified organism, chronic systolic (congestive) heart failure, acute kidney failure, unspecified, and typical atrial flutter. Resident #85 was [AGE] years of age. Resident #23 Resident #23 was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, type II diabetes mellitus, pneumonia, unspecified organism, pulmonary hypertension, unspecified, and acute diastolic (congestive) heart failure. Resident #23 was [AGE] years of age. Resident #242 Resident #242 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified, acute pulmonary edema, acute and chronic respiratory failure with hypoxia, acute on chronic diastolic (congestive) heart failure, and hypertensive heart and chronic kidney disease with heart failure and stage I through stage IV chronic kidney disease, or unspecified chronic kidney disease. Resident #242 was [AGE] years of age. Resident #85, #23, and #242's clinical records lacked documented evidence the residents were screened for eligibility to receive a pneumococcal vaccine, education regarding the CDC's recommended vaccines was provided to the residents and/or the resident's representative, and a vaccine was offered and either administered or declined. On 05/28/2024 at 12:44 PM, the IP confirmed the facility followed CDC guidance. On 05/28/2024 at 3:36 PM, the Director of Nursing Services (DNS) confirmed Resident #85, #23, and #242's clinical records lacked documented evidence the residents were screened for eligibility to receive a pneumococcal vaccine, education regarding the CDC's recommended vaccines were provided to the residents and/or the residents' representatives, and a vaccine was offered and either administered or declined. (continued on next page)

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/28/2024 at 3:44 PM, the DNS confirmed the facility had not been using CDC guidance including the CDC pneumococcal decision flow sheet or other format/process to assist in determining the CDC's recommendation for pneumococcal vaccines for the facility's residents. A CDC document titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate, dated 09/22/2023, included an instructional flow sheet to guide the determination of eligibility for a pneumococcal vaccine and the vaccine needed by an individual based on age, comorbidities, and previous administration of pneumococcal vaccines. Comorbidities for adults between the ages of 19 and 64 included diabetes mellitus and chronic renal failure. The recommendations for adults over [AGE] years of age varied depending on age at time of previous vaccination, the type of vaccine previously administered, and the presence of immunocompromising conditions, cochlear implant, or cerebrospinal fluid leak. An application (app) and a web-based version, were available to assist with determining which vaccines were recommended. A facility policy titled, Pneumococcal Vaccination of Residents, updated 03/2022, documented the facility followed the CDC recommendations for vaccination. The electronic health record (EHR) of each resident was updated to include when a resident received a vaccine, refused a vaccine, or did not get vaccinated. When a resident was administered a vaccine, it was documented in the resident's immunization record. Education was provided regarding the risk and benefits and the applicable Vaccination Information Sheet was provided. Cross reference with F726

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024

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

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on clinical record review, interview, and document review the facility failed to ensure a Registered Nurse (RN) was screened for eligibility to receive a COVID-19 (COVID) booster vaccine, education regarding the vaccine was provided, and the vaccine was offered and either administered or declined. Findings include: Employee #1 was hired as an RN on 07/10/2023. Employee #1's COVID-19 Vaccination Record Card documented Employee #1 was administered a COVID vaccine on 02/01/2021 and 02/22/2021. Employee #1's State Immunization Record documented the RN received one dose of [NAME] COVID vaccine on 09/17/2021. The facility was not able to provide documented evidence Employee #1 was screened for eligibility to receive a COVID booster vaccine, provided education regarding COVID booster vaccines, and if a booster vaccine was offered and administered or declined. On 05/23/2024 at 11:41 AM, the Infection Preventionist (IP) verbalized the facility held a COVID vaccination clinic twice per year with a third party administering COVID booster vaccines. The IP verbalized when an employee received a COVID booster vaccine, a copy of the immunization record was kept in the employee's Human Resources (HR) file. The IP explained when an employee declined a COVID booster vaccine, the facility did not collect or retain a signed declination from the employee. The IP confirmed Employee #1's HR file did not include a record of administration or a signed declination for a COVID booster vaccine. The facility policy titled COVID-19 Vaccine, revised 04/18/2022, documented the facility's primary source for information regarding the prevention and management of COVID was the Centers for Disease Control and Prevention (CDC). COVID vaccinations and recommended boosters were offered to all employees per CDC guidelines. Education regarding the COVID vaccine being offered was provided, including risk and benefits. The facility maintained documentation regarding COVID vaccination and recommend boosters for all employees. A copy of a vaccine declination form was maintained for employees who declined a vaccine. A CDC document titled Stay Up to Date with COVID-19 Vaccines, last updated on 05/14/2024, documented the CDC recommended the 2023-2024 updated COVID-19 vaccines to protect against serious illness from COVID-19. Everyone five years of age and older should get one dose of an updated COVID vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 N Ormsby Carson City, NV 89703	

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 46301 Based on personnel record review, interview and document review, the facility failed to ensure communications training was completed by staff for 4 of 20 sampled employees (Employee #11, #14, #16, and #20). Findings include: Employee #11 Employee #11 was hired as a Certified Occupational Therapist on 10/01/2023. Employee #11's personnel record lacked documented evidence of communication training. Employee #14 Employee #14 was hired as a Licensed Practical Nurse (LPN) on 09/01/2023. Employee #14's personnel record lacked documented evidence of communication training. Employee #16 Employee #16 was hired as a CNA on 09/07/2023. Employee #16's personnel record lacked documented evidence of communication training. Employee #20 Employee #20 was hired as a Housekeeper on 03/28/2024. Employee #20's personnel record lacked documented evidence of communication training. The Facility Assessment, last reviewed on 05/08/23, lacked documented evidence of staff completing communication training nor a plan for communication training. On 05/28/2024 at 2:17 PM, the Human Resources staff verbalized being unsure when or how often the training for communication was required to be taken. The Human Resources staff confirmed Employees #11, #14, #16, and #20, did not receive timely communications training. The facility policy titled Communication Training, published November 2017, documented communication training was important to be able to exchange an idea or ideas between individuals properly and easily understood. Communication training would cover areas such as how a message was received, body language perception, not making assumptions, how communicating appropriately could result in a non-hostile situation, importance of how to communicate with a resident with cognitive deficits, and how to approach a resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024

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Ormsby Post Acute Rehabilitation	3050 N Ormsby Carson City, NV 89703

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 46301 Based on personnel record review, interview and document review, the facility failed to ensure resident rights training was completed by staff for 9 of 20 sampled employees (Employee #1, #6, #9, #11, #14, #16, #18, #19 and #20). Findings include: Employee #1 Employee #1 was hired as the Administrator on 03/30/2024. Employee #1's personnel record documented resident rights training completed on 05/17/2024, 48 days after hire. Employee #6 Employee #6 was hired as the Food and Nutrition Services Manager on 06/15/2021. Employee #6's personnel record documented resident rights training completed 05/02/2024, however lacked documented evidence resident rights was completed in 2023. Employee #9 Employee #9 was hired as a Certified Nursing Assistant (CNA) on 04/04/2018. Employee #9's personnel record documented resident rights training completed 05/01/2024, however lacked documented evidence resident rights training was completed in 2023. Employee #11 Employee #11 was hired as a Certified Occupational Therapist on 10/01/2023. Employee #11's personnel record lacked documented evidence of resident rights training. Employee #14 Employee #14 was hired as a Licensed Practical Nurse (LPN) on 09/01/2023. Employee #14's personnel record documented resident rights training completed 05/03/2024, however lacked documented evidence resident rights training was completed in 2023. Employee #16 Employee #16 was hired as a CNA on 09/07/2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024

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

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee #16's personnel record lacked documented evidence of resident rights training. Employee #18 Employee #18 was hired as a [NAME] on 07/10/2023. Employee #18's personnel record documented resident rights training completed 05/03/2024, however lacked documented evidence resident rights training was completed in 2023. Employee #19 Employee #19 was hired as a Hospitality Aide on 04/30/2024. Employee #19's personnel record documented resident rights training completed on 05/24/2024, 24 days after hire. Employee #20 Employee #20 was hired as a Housekeeper on 03/28/2024. Employee #20's personnel record documented resident rights training completed on 05/13/2024, 46 days after hire. On 05/28/2024 at 2:17 PM, the Human Resources staff verbalized being unsure when or how often the training for resident rights was required to be taken. The Human Resources staff confirmed Employee #1, #6, #9, #11, #14, #16, #18, #19 and #20, did not receive timely resident rights training. The facility policy titled Staff Training on Resident Rights, last updated July 2015, documented all staff were required to train for resident rights upon hire and at least annually thereafter. Participants in the resident rights training would complete evaluations of each training to improve the QAPI process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER: Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3050 N Ormsby Carson City, NV 89703	

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 46301 Based on personnel record review, interview and document review, the facility failed to ensure elder abuse training was completed timely for 5 of 20 sampled employees (Employee #1, #4, #14, #19 and #20). Findings include: Employee #1 Employee #1 was hired as the Administrator on 03/30/2024. Employee #1's personnel record documented elder abuse training completed on 04/26/2024, 27 days after hire. Employee #4 Employee #4 was hired as the Registered Dietician on 11/07/2018. Employee #4's personnel record documented elder abuse training completed 04/16/2024, however lacked documented evidence elder abuse training was completed in 2023. Employee #14 Employee #14 was hired as a Licensed Practical Nurse (LPN) on 09/01/2023. Employee #14's personnel record lacked initial elder abuse training completed prior to starting work on the floor. Employee #19 Employee #19 was hired as a Hospitality Aide on 04/30/2024. Employee #19's personnel record lacked initial elder abuse training completed prior to starting work on the floor. Employee #20 Employee #20 was hired as a Housekeeper on 03/28/2024. Employee #20's personnel record lacked initial elder abuse training completed prior to starting work on the floor. (continued on next page)

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

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/2023 at 10:36 AM, the Human Resources staff verbalized all staff were required to complete elder abuse training prior to starting work on the floor with residents and every year thereafter. The Human Resources staff confirmed Employees #1, #4, #14, #19 and #20 lacked timely elder abuse training. The facility policy titled Abuse Training, updated 10/2022, documented all employees, contract staff and routine volunteers were trained on abuse prevention, reporting, and intervention upon hire and annually thereafter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 N Ormsby Carson City, NV 89703	

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 46301 Based on interview and document review, the facility failed to ensure Quality Assurance Performance Improvement (QAPI) training had been completed to include objectives of resident care needs for 15 of 20 sampled employees (Employee #1, #2, #4, #5, #6, #7, #9, #10, #11, #12, #14, #16, #18, #19 and #20). Findings include: Employee #1 Employee #1 was hired as the Administrator on 03/30/2024. Employee #1's personnel record documented QAPI training completed on 05/24/2024, 55 days after hire. Employee #2 Employee #2 was hired as the Director of Nursing Services on 11/01/2021. Employee #2's personnel record documented the last QAPI training was completed on 05/24/2024. The employee's record lacked documented evidence QAPI training had been completed for 2023. Employee #4 Employee #4 was hired as the Dietary Manager on 06/15/21. Employee #4's personnel record documented QAPI training last completed on 05/24/2024. The employee's personnel record lacked documented evidence QAPI training was completed for 2023. Employee #5 Employee #5 was hired as the Social Services Director on 05/01/2024. Employee #5's personnel record documented QAPI training completed on 05/27/2024, 26 days after hire. Employee #6 Employee #6 was hired as the Food and Nutrition Services Manager on 06/15/2021. Employee #6's personnel record documented QAPI training completed 05/25/2024, however lacked documented evidence QAPI training was completed in 2023. Employee #7 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024

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

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee #7 was hired as a Certified Nursing Assistant (CNA) on 01/10/2023. Employee #7's personnel record documented QAPI training completed 05/27/2024, however lacked documented evidence QAPI training was completed in 2023. Employee #9 Employee #9 was hired as a CNA on 04/04/2018. Employee #9's personnel record documented QAPI training completed 05/24/2024, however lacked documented evidence QAPI training was completed in 2023. Employee #10 Employee #10 was hired as a housekeeper on 10/13/2020. Employee #10's personnel record documented QAPI training completed 05/24/2024, however lacked documented evidence QAPI training was completed in 2023. Employee #11 Employee #11 was hired as a Certified Occupational Therapist on 10/01/2023. Employee #11's personnel record lacked documented evidence of QAPI training. Employee #12 Employee #12 was hired as the Infection Preventionist on 08/30/2021. Employee #12's personnel record documented QAPI training completed 05/24/2024, however lacked documented evidence QAPI training was completed in 2023. Employee #14 Employee #14 was hired as a Licensed Practical Nurse (LPN) on 09/01/2023. Employee #14's personnel record lacked documented evidence QAPI training had been completed. Employee #16 Employee #16 was hired as a CNA on 09/07/2023. Employee #16's personnel record lacked documented evidence QAPI training had been completed. Employee #18 Employee #18 was hired as a cook on 07/10/2023. (continued on next page)

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

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee #18's personnel record documented QAPI training completed 05/24/2024, however lacked documented evidence QAPI training was completed in 2023. Employee #19 Employee #19 was hired as a Hospitality Aide on 04/30/2024. Employee #19's personnel record documented QAPI training completed on 05/28/2024, 28 days after hire. Employee #20 Employee #20 was hired as a Housekeeper on 03/28/2024. Employee #20's personnel record lacked documented evidence of QAPI training. On 05/28/2024 at 2:17 PM, the Human Resources staff verbalized being unsure when or how often the training for resident rights was required to be taken. The Human Resources staff confirmed Employee #1, #2, #4, #5, #6, #7, #9, #10, #11, #12, #14, #16, #18, #19 and #20 did not receive timely QAPI training. The facility policy titled QAPI Plan, last updated October 2018, documented QAPI identified areas for improvement to drive quality of care and services provided to residents. The Committee would collect data, develop and implement corrective action plans for the areas of concern and monitor the areas to determine if the changes made to care areas were effective. All staff input was valuable to maintain the highest level of care provided to residents. The facility policy titled Nursing Personnel Education and Training, published November 2016, documented all staff were required to complete QAPI training upon hire and at least annually thereafter.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 46301 Based on interview and document review, the facility failed to provide timely infection control training to all staff to ensure proper procedures and standards of the program for 7 of 20 sampled employees (#1, #9, #11, #14, #16, #18 and #19). Findings include: Employee #1 Employee #1 was hired as the Administrator on 03/30/2024. Employee #1's personnel record documented infection control training completed on 05/17/2024, 48 days after hire. Employee #9 Employee #9 was hired as a Certified Nursing Assistant (CNA) on 04/04/2018. Employee #9's personnel record documented infection control training completed 05/01/2024, however lacked documented evidence infection control training was completed in 2023. Employee #11 Employee #11 was hired as a Certified Occupational Therapist on 10/01/2023. Employee #11's personnel record documented infection control training completed 04/07/2024, however lacked documented evidence infection control training was completed in 2023. Employee #14 Employee #14 was hired as a Licensed Practical Nurse (LPN) on 09/01/2023. Employee #14's personnel record documented infection control training completed 05/24/2024, however lacked documented evidence infection control training was completed in 2023. Employee #16 Employee #16 was hired as a CNA on 09/07/2023. Employee #16's personnel record lacked documented evidence infection control training had been completed. Employee #18 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER: Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3050 N Ormsby, Carson City, NV 89703	

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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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee #18 was hired as a cook on 07/10/2023. Employee #18's personnel record documented infection control training completed 05/03/2024, however lacked documented evidence infection control training was completed in 2023. Employee #19 Employee #19 was hired as a Hospitality Aide on 04/30/2024. Employee #19's personnel record documented infection control training completed on 05/24/2024, 28 days after hire. On 05/28/2024 at 2:17 PM, the Human Resources staff verbalized being unsure when or how often the training for infection control was required to be taken. The Human Resources staff confirmed Employees #1, #9, #11, #14, #16, #18 and #19, did not receive timely infection control training. The facility policy titled Nursing Personnel Education and Training, published November 2016, documented all staff were required to complete infection control training upon hire and at least annually thereafter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024

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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. 46301 Based on interview and document review, the facility failed to ensure compliance and ethics training was completed timely for 15 of 20 sampled employees (#1, #2, #3, #4, #5, #6, #7, #9, #10, #11, #14, #16, #18, #19 and #20). Employee #1 Employee #1 was hired as the Administrator on 03/30/2024. Employee #1's personnel record documented compliance and ethics training completed on 04/26/2024, 27 days after hire. Employee #2 Employee #2 was hired as the Director of Nursing (DON) on 11/01/2021. Employee #2's personnel record documented the last compliance and ethics training was completed on 04/24/2024. The employee's record lacked documented evidence compliance and ethics training had been completed for 2023. Employee #3 Employee #3 was hired as the Activities Director on 03/06/2023. Employee #3's personnel record documented the last compliance and ethics training was completed on 04/09/2024. The employee's record lacked documented evidence compliance and ethics training had been completed for 2023. Employee #4 Employee #4 was hired as the Dietary Manager on 06/15/21. Employee #4's personnel record documented the last compliance and ethics training was completed on 04/16/2024. The employee's record lacked documented evidence compliance and ethics training had been completed for 2023. Employee #5 Employee #5 was hired as the Social Services Director on 05/01/2024. Employee #5's personnel record documented compliance and ethics training completed on 05/27/2024, 26 days after hire. Employee #6 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Ormsby Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 N Ormsby Carson City, NV 89703	

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employee #6 was hired as the Food and Nutrition Services Manager on 06/15/2021. Employee #6's personnel record documented the last compliance and ethics training was completed on 04/23/2024. The employee's record lacked documented evidence compliance and ethics training had been completed for 2023. Employee #7 Employee #7 was hired as a Certified Nursing Assistant (CNA) on 01/10/2023. Employee #7's personnel record documented the last compliance and ethics training was completed on 04/03/2024. The employee's record lacked documented evidence compliance and ethics training had been completed for 2023. Employee #9 Employee #9 was hired as a CNA on 04/04/2018. Employee #9's personnel record documented the last compliance and ethics training was completed on 04/16/2024. The employee's record lacked documented evidence compliance and ethics training had been completed for 2023. Employee #10 Employee #10 was hired as a housekeeper on 10/13/2020. Employee #10's personnel record documented the last compliance and ethics training was completed on 05/01/2024. The employee's record lacked documented evidence compliance and ethics training had been completed for 2023. Employee #11 Employee #11 was hired as a Certified Occupational Therapist on 10/01/2023. Employee #11's personnel record lacked documented evidence of compliance and ethics training. Employee #14 Employee #14 was hired as a Licensed Practical Nurse (LPN) on 09/01/2023. Employee #14's personnel record documented the last compliance and ethics training was completed on 05/24/2024. The employee's record lacked documented evidence compliance and ethics training had been completed for 2023. Employee #16 Employee #16 was hired as a CNA on 09/07/2023. (continued on next page)

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	295067	A. Building B. Wing	05/29/2024

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Ormsby Post Acute Rehabilitation	3050 N Ormsby Carson City, NV 89703

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employee #16's personnel record lacked documented evidence compliance and ethics training had been completed. Employee #18 Employee #18 was hired as a cook on 07/10/2023. Employee #18's personnel record documented the last compliance and ethics training was completed on 05/03/2024. The employee's record lacked documented evidence compliance and ethics training had been completed for 2023. Employee #19 Employee #19 was hired as a Hospitality Aide on 04/30/2024. Employee #19's personnel record documented compliance and ethics training completed on 05/28/2024, 28 days after hire. Employee #20 Employee #20 was hired as a Housekeeper on 03/28/2024. Employee #20's personnel record lacked documented evidence of compliance and ethics training. On 05/28/2024 at 2:17 PM, the Human Resources staff verbalized being unsure when or how often the training for compliance and ethics was required to be taken. The Human Resources staff confirmed Employees #1, #2, #3, #4, #5, #6, #7, #9, #10, #11, #14, #16, #18, #19 and #20, did not receive timely compliance and ethics training. The facility policy titled Compliance and Ethics Program, published November 2019, documented all staff were required to complete compliance and ethics training upon hire and annually thereafter. The purpose of the training was to prevent and detect criminal, civil and administrative violations to promote quality of care.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 46301 Based on interview and document review, the facility failed to ensure behavioral health training was completed timely for 10 of 20 sampled employees (Employee #1, #4, #5, #9, #10, #11, #14, #16, #19 and #20). Employee #1 Employee #1 was hired as the Administrator on 03/30/2024. Employee #1's personnel record documented behavioral health training completed on 05/24/2024, 55 days after hire. Employee #4 Employee #4 was hired as the Dietary Manager on 06/15/21. Employee #4's personnel record documented the last behavioral health training was completed on 05/24/2024. The employee's record lacked documented evidence behavioral health training had been completed for 2023. Employee #5 Employee #5 was hired as the Social Services Director on 05/01/2024. Employee #5's personnel record documented behavioral health training completed on 05/27/2024, 26 days after hire. Employee #6 Employee #6 was hired as the Food and Nutrition Services Manager on 06/15/2021. Employee #6's personnel record documented the last behavioral health training was completed on 05/25/2024. The employee's record lacked documented evidence behavioral health training had been completed for 2023. Employee #9 Employee #9 was hired as a CNA on 04/04/2018. Employee #9's personnel record documented the last behavioral health training was completed on 05/25/2024. The employee's record lacked documented evidence behavioral health training had been completed for 2023. Employee #10 (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee #10 was hired as a housekeeper on 10/13/2020. Employee #10's personnel record lacked documented evidence of behavioral health training. Employee #11 Employee #11 was hired as a Certified Occupational Therapist on 10/01/2023. Employee #11's personnel record lacked documented evidence of behavioral health training. Employee #14 Employee #14 was hired as a Licensed Practical Nurse (LPN) on 09/01/2023. Employee #14's personnel record lacked documented evidence of behavioral health training. Employee #16 Employee #16 was hired as a CNA on 09/07/2023. Employee #16's personnel record lacked documented evidence of behavioral health training. Employee #19 Employee #19 was hired as a Hospitality Aide on 04/30/2024. Employee #19's personnel record documented behavioral health training completed on 05/28/2024, 28 days after hire. Employee #20 Employee #20 was hired as a Housekeeper on 03/28/2024. Employee #20's personnel record lacked documented evidence of behavioral health training. On 05/28/2024 at 2:17 PM, the Human Resources staff verbalized being unsure when or how often the training for behavioral health was required to be taken. The Human Resources staff confirmed Employees #1, #4, #5, #9, #10, #11, #14, #16, #19 and #20, did not receive timely behavioral health training. The facility policy titled Nursing Personnel Education and Training, published November 2016, documented behavioral health was required to be completed by employees upon hire and annually thereafter.