STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	05/14/2026

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

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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. Based on observation, interview, and document review, the facility failed to ensure 1) proper hand hygiene was performed by dietary staff, 2) refrigerated food was stored properly, 3) food was discarded by the expiration date, and 4) the outside propane gas grill (Barbecue) was cleaned appropriately. This deficient practice had the potential to affect all residents in the facility by increasing the risk of infection and foodborne illnesses. Findings include: Hand Washing On 05/11/2026 at 8:31 AM, a Dietary [NAME] was holding a baking pan containing potatoes. The Dietary [NAME] was not wearing gloves. The Dietary [NAME] place the baking pan onto the food preparation surface and donned gloves without performing hand hygiene. On 05/13/2026 at 11:40 AM, the Dietary [NAME] was holding a baking pan containing chicken. The Dietary [NAME] was not wearing gloves. The Dietary [NAME] place the baking pan onto the food preparation surface and donned gloves without performing hand hygiene. On 05/14/2026 at 9:24 AM, Dietary [NAME] was holding a baking pan containing carrots. The Dietary [NAME] was not wearing gloves. The Dietary [NAME] place the baking pan onto the food preparation surface and donned gloves without performing hand hygiene. The Dietary [NAME] picked up a ladle and continued to stir soup on the adjacent stove. On 05/11/2026 at 9:00, the Dietary Supervisor confirmed staff were required to perform hand hygiene when donning gloves and changing gloves. The Dietary Supervisor explained staff were required to wear gloves to prevent transmitting illness to residents Food Storage On 05/11/2026 at 8:45 AM, in the walk-in refrigerator, a shrink-wrapped cooked ham was stored in a bin on the bottom shelf. Raw pork chops were stored in a plastic bag placed atop the ham. The ham shrink wrap was in contact with the pork chop bag. On 05/11/2026 at 8:50 AM, the Dietary Supervisor confirmed the ham and pork chops should be stored separately in different bins and stated improper storage could result in resident illness. Expired Food On 05/11/2026 at 9:02 AM, in the walk-in refrigerator, a metal hotel pan of caramel sauce was sealed with plastic wrap. Exp. 05/08/2026 was written on the plastic wrap. On 05/11/2026 at 9:08 AM, the Dietary Supervisor confirmed the caramel sauce should have been discarded and stated the refrigerator was checked daily. Barbecue Grill On 05/11/2026 at 9:17 AM, a barbecue grill located at the back of the facility was open, revealing the interior grate covered in layers of char and grease. On 05/11/2026 at 9:18 AM, the Dietary Supervisor confirmed the barbecue grill should have been cleaned after use. A facility policy titled Food Safety Requirements, implemented 04/11/2025, staff shall not touch food with bare hands and exhibit appropriate use of gloves, tongs, deli paper, and spatulas. Food should be stored in a manner to prevent the deterioration or contamination of the food, including the growth of microorganisms. Refrigerated food should be used, frozen, or discarded as applicable by the use-by-date. All equipment used in the handling of food shall be cleaned, sanitized and handled in a manner to prevent contamination.

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and document review, the facility failed to ensure the data collected for infection surveillance was used to identify the potential cause of facility acquired infections and prevent further facility acquired infections for 5 of 5 months reviewed for 2026. This deficient practice had the potential to result in residents contracting preventable infections and poor infection control practices continuing due to a lack of targeted education provided to facility staff.Findings include: The 2026 Infection Surveillance spreadsheets documented the following facility acquired infections: January 2026 had two corona virus (Covid) infections, two eye infections, 13 urinary tract infections, eight cases of pneumonia, seven fungal/yeast infections, one case of cellulitis, one respiratory illness, one ear infection, and one wound infection. February 2026 had six urinary tract infections, two cases of pneumonia, one case of shingles, seven yeast infections, two cases of cellulitis, and one case of a clostridium difficile (C. diff) infection. March 2026 had five skin rashes, two cases of cellulitis, two wound infections, five yeast infections, two eye infections, one urinary tract infection, one case of dermatitis, and one case of pneumonia. April 2026 had four respiratory infections, four yeast infections, two oral abscesses, four cases of pneumonia, two cases of cellulitis, three skin rashes, four cases of C. diff, one wound infection, three urinary tract infections, and one skin infection. May 2026 for the period of May 1, 2026, through May 14, 2026, had two wound infections, five urinary tract infections, two yeast infections, and one case of rheumatic fever. On 05/14/2026 at 1:09 PM, the Infection Preventionist verbalized the facility had not provided education to staff specific to the data collected from the infection surveillance and the facility had not analyzed the data to determine the cause of the facility acquired infections. The facility policy titled Infection Prevention and Control Program, dated 04/11/2025, documented a system of surveillance would be utilized for prevention, identification, investigating, and controlling infections and communicable diseases for all residents and staff. The Infection Preventionist would maintain documentation of incidents, findings, and any corrective actions made by the facility and report surveillance findings to the facility's Quality Assessment and Assurance Committee.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to: 1) ensure a resident had the right to wear personal clothing, 2) provide a shower to a paraplegic resident who wished to take a shower, and 3) treat a resident with respect and dignity when a certified nursing assistant addressed the resident in a degrading manner, for 2 of 19 sampled residents (Resident #3 and #81). The deficient practice had to potential to cause psychosocial harm and mental anguish resulting from not being treated with dignity and respect.Findings include:Resident #3 Resident #3 was admitted to the facility on [DATE], with diagnoses including paraplegia, unspecified, adult failure to thrive, and atherosclerotic heart disease of native coronary artery without angina pectoris. Personal Items On 05/11/2026 at 12:29 PM, Resident #3 was lying in bed wearing a hospital gown and no personal items could be observed in the resident's room. The resident explained being admitted to the facility without any personal belongings. The resident had attempted on several occasions to have the facility assist the resident with obtaining the personal items left in the resident's apartment. The resident verbalized not feeling a need to talk with staff any longer because nothing would be done to accommodate the resident's request. The resident was wearing a hospital gown on 05/11/2026, 05/12/2026, 05/13/2026, and 05/14/2026. Resident #3's Personal Belongings Inventory sheet dated 04/06/2026, documented the resident was admitted with the following items: -black padded boots -one grey and blue hat -one grey wallet -one blue shirt. On 05/12/2026 at 2:18 PM, a Registered Nurse verbalized Resident #3 was dressed in a hospital gown everyday since admitting to the facility, as a result of not having any personal clothes. There was a surplus of clothes to provide to residents with no personal clothing and nothing has been offered to the resident. On 05/13/2026 at 10:25 AM, the Social Worker explained completing resident assessments and asking all residents if the residents were missing anything, if the resident needing anything, and went through a list of things with residents to see how the Social Worker can support the resident with the residents needs. In addition, the Social Worker would enter resident rooms on a daily basis to ask if all resident needs were being met. The Social Worker explained having not met Resident #3 to date and had not completed an assessment on the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/2026 at 11:27 AM, Resident #3 was lying in bed in the resident's room, wearing a green hospital gown. Resident #3 explained having not met the Social Worker to date and was not holding the resident's breath waiting. On 05/14/2026 at 10:05 AM, the Director of Nursing (DON) confirmed Resident #3 only came in with four personal items and had not been accommodated, offered, or provided personal clothing in lieu of a hospital gown. The DON explained the resident should have been offered assistance with gathering the resident's personal clothing and offered clothing from the facility clothing surplus. The DON verbalized not having put eyes on the resident until 05/13/2026, and confirmed the resident was wearing a hospital gown. The DON explained the facility was supposed to be a homelike environment and clothes were to be provided and the resident assisted into clothing to feel at home. The facility policy titled Safe and Homelike Environment, last revised on 09/02/2025, documented the facility would create and maintain, to the extent possible, a homelike environment that de-emphasized the institutional setting. The facility would allow residents to use personal belongings, including clothing, to assist in creating and maintaining a homelike environment. The social service designee would encourage the resident to bring in personal belongings. Showers On 05/11/2026 at 12:29 PM, Resident #3 explained being admitted to the facility under the care of a hospice agency. The hospice agency would provide the resident with bed baths once every week or two; however, the resident wished to receive a shower. The resident verbalized aside from hospice, the facility had provided the resident one shower since admitting to the facility and offered no further showers. On 05/12/2026 at12:25 PM, Resident #3 was lying in bed in a green hospital gown. The resident reached into the hospital gown and pulled the resident's hand back out of the gown. On the resident's hands were pieces of skin. The resident explained the dying skin peeled from the resident's chest was from not receiving a shower and the resident's expressed the resident's head was also itching as a result. On 05/12/2026 at 2:18 PM, an RN verbalized the hospice agency was in charge of providing Resident #3 showers and the facility did not provide showers for that reason. The RN explained the facility had provided one shower to the resident and hospice provided only bed baths to the resident. On 05/12/2026 at 3:54 PM, the Hospice Licensed Practical Nurse (LPN) explained the resident was receiving bed baths once a week from hospice. The Hospice LPN was unaware of any other baths or showers offered to the resident. A Shower Schedule documented the resident received a bed bath on 05/07/2026 and 05/11/2026. On 05/14/2026 at 9:41 AM, a Certified Nursing Assistant (CNA1) verbalized all residents were to receive two showers per week; however, Resident #3 was only receiving bed baths from the hospice agency and the facility had not provided Resident #3 a shower. On 05/14/2026 at 9:53 AM, the DON explained the facility should be providing showers to Resident #3 and presented the resident's shower schedule. The shower schedule documented the resident had received a shower on May 7, May 11, and May 14, 2026. The DON was able to produce documented (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evidence within the shower schedules, hospice had provided bed baths for the resident and the facility had not provided showers to the resident. The DON confirmed the facility had not provided showers to the resident and verbalized if hospice was providing bed baths to the resident, the expectation would be for the staff to not be providing showers to the resident. A Follow-Up Question Report related to showering and bathing documented Resident #3 had only received three bed baths since admission to the facility and the bed baths were provided by the hospice agency. The Hospice Plan of Care dated 04/23/2026, lacked documented evidence hospice would provide bathing for the resident as a part of the terminal prognosis. The Hospice Plan of Care dated 05/05/2026, lacked documented evidence hospice would provide bathing for the resident as a part of the terminal prognosis. The facility policy titled Coordination of Hospice Services, implemented on 04/11/2025, documented when a resident was receiving hospice care and services, the facility would coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being. The facility would coordinate care with the hospice provider and coordinate a plan of care and services that each entity would provide in order to meet the needs of the resident. The facility retained primary responsibility for implementing those aspects of care that were not related to the duties of the hospice agency. Residents receiving hospice would continue to receive the same facility services as residents who were not on hospice care. The facility policy titled Residents' Rights, undated, documented residents had the right to make their own choices and the facility must treat the resident with respect, dignity, and must care for the resident to promote quality of life. The resident must not be abused, neglected, or exploited by anyone. Cross reference tag F600 Resident #81 Resident #81 was admitted on [DATE] with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris, chronic obstructive pulmonary disease unspecified, and non-st elevation (nstemi) myocardial infarction. On 05/11/2026 at 10:22 AM, CNA #2 entered Resident #81 room without knocking and stated, I was told it smelled like poop and to come change you. On 05/11/2026 at 10:32 AM, Resident #81 stated the comment about the poop was embarrassing and reported the CNA rarely knocked on the door before entering. On 05/11/2026 at 10:45 AM, the CNA #2 confirmed the statement may have embarrassed Resident #81 and should have knocked before entering the room. A facility policy titled, Residents' Rights, undated, documented facility must treat residents with dignity and respect and must care for residents in a manner that promotes residents' quality of life.

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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** Based on interview, record review, and document review, the facility failed to ensure a resident was provided with education related to the common side effects and treatment purpose of a psychotropic medication prior to the resident receiving the medication for 2 of 19 sampled residents (Residents #5 and #64). This deficient practice had the potential for a resident to receive medication without the resident having had the opportunity to make an informed decision regarding the medication prior to receiving the medication. Findings include: Resident #5 Resident #5 was admitted to the facility on [DATE], with diagnoses including bipolar disorder, current episode manic severe with psychotic features and anxiety disorder, unspecified. The Order Summary Report for Resident #5 documented an order for quetiapine fumarate oral tablet 300 milligrams (mg). Give one tablet by mouth one time a day for manic depression. The order start date for the medication was 03/12/2026. A Psychotropic Medication Consent for quetiapine 300 mg every day, documented consent was provided by the resident's representative on 04/21/2026. A Medication Administration Record (MAR), dated March 2026, documented the resident received a quetiapine 300 mg oral tablet once a day starting on 03/12/2026. On 05/13/2026 at 11:38 AM, the Chief Nursing Officer (CNO) verbalized the psychotropic medication consent was not completed before the psychotropic medication was started. The CNO verbalized the resident's representative should have been given the opportunity to consent or refuse the medication before the medication was administered to the resident. Resident #64 Resident #64 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including schizoaffective disorder, bipolar type, personality disorder, unspecified, dissociative and conversion disorder, unspecified, and major depressive disorder, recurrent, unspecified. A Physician's Order dated 01/21/2026, documented olanzapine oral tablet 5 mg. Give one tablet by mouth one time a day for schizoaffective disorder related to schizoaffective disorder, bipolar type, schizoaffective disorder, unspecified, personality disorder, unspecified, dissociative and conversion disorder, unspecified and major depressive disorder, recurrent, unspecified. Resident #64's January, February and March 2026 MARs documented the olanzapine was administered once daily from 01/21/2026 through 03/30/2026, with the exception of one dose not administered on 02/01/2026. Resident #64's clinical record lacked documented evidence a Psychotropic Medication Consent was completed. On 05/12/2026 at 1:32 PM, the Director of Nursing (DON) verbalized staff were required to obtain (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consent prior to administration of psychotropic and opiate medications. The consent was used to inform the resident about the risks and benefits of the medication and to explain the medication to the resident. The DON verbalized Resident #64 had several consents in the resident's record due to several psychotropic medications being ordered and the DON would have to look for the consent related to olanzapine. On 05/12/2026 at 3:00 PM, the Assistant DON (ADON) reviewed Resident #64's January 2026 MAR and acknowledged the medication was administered to the resident. The ADON verbalized the ADON was attempting to locate the consent for the medication. On 05/13/2026 at 12:37 PM, the CNO verbalized facility staff had reviewed all records and the facility did not have an informed consent for Resident #64 prior to administration of olanzapine. The CNO confirmed a consent should have been obtained prior to administration of the medication. The facility policy titled Use of Psychotropic Medication(s), last reviewed/revised 04/28/2025, documented a psychotropic drug was any drug which affected brain activities associated with mental processes and behavior. Psychotropic drugs included but were not limited to antipsychotics, antidepressants, anti-anxiety and hypnotics. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative was to be informed of the benefits, risks and alternatives for the medication including any black box warnings. The resident had the right to accept or decline the initiation or increase of the medication. The facility would document the resident or representative was informed in advance of the risks and benefits of the proposed care, treatment alternatives or other options, and the preferred option to accept or decline in a format the facility deemed to use (e.g., written consent form, narrative note, etc.). The facility document titled Resident Rights, undated, documented residents had the right to make their own choices, the right to request, refuse, and/or discontinue any treatment, and the right to complete information about their medical condition and treatment. If the resident refused treatment, the facility was required to tell the resident what could happen because of the refusal and tell the resident about other possible treatments.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to provide reasonable accommodation by not ensuring a resident's electric wheelchair was repaired and made available for use for 1 of 19 sampled residents (Resident #8). This deficient practice had the potential to cause the resident emotional distress. Findings include:Resident #8Resident #8 was admitted to the facility on [DATE], with diagnoses including major depressive disorder, recurrent, in partial remission, anxiety disorder, unspecified, and other sequalae of cerebral infarction.On 05/11/2026 at 2:15 PM, Resident #8 verbalized the resident had an electric wheelchair and had not been able to use the wheelchair since admitting to the facility. The resident had no idea where the wheelchair had gone and verbalized the resident had not gotten out of bed and gone out into the facility's common areas. The resident explained the resident's right leg was non-operational and could not be moved and because the resident had remained in bed, both the left and right heels had begun to hurt.Resident #8's Personal Belonging Inventory, dated 11/12/2025, documented the resident was admitted to the facility with one electric chair with a charger.On 05/12/2026 at 2:07 PM, the Activities Director verbalized Resident #8 rarely came out of the resident's room due to difficulty sitting and was unaware the resident had an electric wheelchair.On 05/12/2026 at 2:20 PM, a Registered Nurse (RN) verbalized Resident #8 used to have an electric wheelchair and had arrived at the facility with a personal electric wheelchair. The RN explained being under the impression the electric wheelchair did not have a footrest; however, the electric wheelchair was operational. Maintenance would not touch the resident's wheelchair because the wheelchair was a safety liability for the Maintenance Director.On 05/12/2026 at 2:52 PM, the Maintenance Supervisor confirmed Resident #8 had an electric wheelchair; however, the wheelchair had been sitting in the dining room for about two weeks. The Maintenance Supervisor verbalized the electric wheelchair was missing a footrest but was not able to repair the footrest due to not being certified to work on the wheelchair. The Maintenance Supervisor verbalized the manufacturing company should have been contacted to fix the resident's wheelchair but had not been notified.On 05/12/2026 at 2:55 PM, an electric wheelchair was observed in the corner of the dining room.On 05/14/2026 at 9:47 AM, the Director of Nursing (DON) verbalized Resident #8 was admitted to the facility in October 2025 with an electric wheelchair, which was documented on the inventory sheet. The DON confirmed the wheelchair was sitting in the dining room and the DON did not know how long it had been there. The DON admitted the DON learned during the survey week that the wheelchair belonged to Resident #8. The DON explained the DON did not know what was wrong with the wheelchair and had heard that Resident #8 wanted a seatbelt attached. The DON verbalized that maintenance would be expected to address the issue, or physical therapy would order the needed accessory. The DON did not know why the issue had not been addressed and confirmed Resident #8 had not been accommodated, as the facility had not repaired the electric wheelchair.On 05/14/2026 at 11:42 AM, the DON explained the family of Resident #8 had been contacted and the family had ordered a new seatbelt and footrest for the electric wheelchair. The DON verbalized the DON would provide the email correspondence with the family.On 05/14/2026 at approximately 3:00 PM, the DON verbalized the DON was unable to locate an email chain with the resident's family confirming discussion of, and the ordering of, parts for the electric wheelchair. The DON confirmed the resident had been without the resident's wheelchair for quite some time with no accommodation provided by the facility to repair the electric wheelchair.The facility policy titled Promoting/Maintaining Resident Self-Determination, last revised 05/06/2026, documented the facility was in the practice of promoting and protecting resident rights by facilitating resident self-determination through support and resident choice. The facility would ensure each resident had the opportunity to exercise autonomy related to the things that were important to the resident's life such as interests and preferences.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's right to make choices about aspects of life in the facility that were significant to the resident, by not providing an appropriate wheelchair that would allow the resident to get out of bed, for 1 of 19 sampled residents (Resident #3). This deficient practice had the potential to cause psychosocial distress to the resident. Findings include:Resident #3Resident #3 was admitted to the facility on [DATE], with diagnoses including paraplegia, unspecified, adult failure to thrive, and atherosclerotic heart disease of native coronary artery without angina pectoris.On 05/11/2026 at 12:29 PM, Resident #3 was lying in bed. Next to the bed was a manual wheelchair with plastic wrap around each one of the wheels. The wheels did not have any markings indicating the wheelchair had been used.The resident verbalized the facility provided the wheelchair and has never used the wheelchair. The resident explained the resident did not have enough core strength, as a result of paraplegia, and could not sit in the wheelchair safely. The resident wished to be able to leave the resident's room daily and go outside to enjoy the sunshine. The resident verbalized staff had not gotten the resident out of bed, nor offered to get the resident out of bed, since admitting to the facility. The resident verbalized feeling like it was an act of congress for the facility to acknowledge the resident's requests.Activities care plan, initiated on 04/09/2026, documented the resident had independent hobbies and interest and would need assistance to and from activities. The goals for the resident were for the resident to attend one physical activity to decrease the resident's depression, increase the resident's energy, and maintain the resident's health. The activities would be monitored for the resident's satisfaction with the resident's leisure choices and encourages for the resident to participate in an activity of interest.On 05/12/2026 at 2:07 PM, the Activities Director explained each resident would be asked what types of activities they would like to participate in upon admission to the facility. Residents would be able to go outside and sit on the patio if the resident preferred. If a resident needed assistance to go outside, staff would help the resident out of bed and outside per the resident's preference.The Activities Director verbalized Resident #3 had a wheelchair in the resident's room and believed the resident had never used the wheelchair to the Activity Director's knowledge and confirmed the resident had not left the resident's room since admission.On 05/12/2026 at 2:18 PM, a Registered Nurse (RN) verbalized not seeing Resident #3 come out of the resident's room since being in the facility and was not aware the resident could not use the wheelchair provided.On 05/13/2026 at 10:25 AM, the Social Worker verbalized not having any conversations with Resident #3 and admitted to not initiating any assessments nor providing support for the resident. The Social Worker explained not having met the resident to date and did not know if the resident had any requests, preferences needing to be honored, nor knew what the resident wished to do while in the facility.On 05/14/2026 at 10:27 AM, Resident #3 verbalized not having met the Social Worker and was not holding the resident's breath waiting either.On 05/14/2026 at 9:53 AM, the Director of Nursing (DON) explained Resident #3 was on hospice care and needed assistance with all Activities of Daily Living (ADLs). Staff would need to use a Hoyer lift to get the resident out of bed and place the resident in a wheelchair. The DON verbalized the resident had a wheelchair and was unaware why the resident had not used the wheelchair to date. The DON explained the resident had paraplegia and the resident would not be able to safely use the manual wheelchair provided and would need to be provided a wheelchair with reclining capabilities so the resident would not fall.The DON confirmed the resident's wheelchair was not safe for the resident and the facility had not provided the resident with a safe wheelchair to allow the resident to leave their room. The DON confirmed the resident had not left their room since admission. The DON explained the facility was a homelike environment and all residents' requests and preferences for residents needed to be honored.The (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policy titled Safe and Homelike Environment, last revised 09/02/2025, documented residents had the right to a safe, clean, comfortable, and homelike environment, and to receive services maximizing residents' independence.The facility policy titled Residents' Rights, undated, documented residents had the right to make their own choices, and the facility must treat the resident with respect, dignity, and must care for the resident to promote quality of life. The resident must not be abused, neglected, or exploited by anyone.Cross reference with Tag F600.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and document review, the facility failed to ensure 1 of 19 sampled residents (Resident #97) was protected from resident-to-resident physical abuse. This deficient practice had the potential to result in pain, physical injury and mental anguish to residents.Findings include:Resident #97Resident #97 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including pleural effusion, not elsewhere classified and chronic respiratory failure with hypoxia.Resident #81Resident #81 was admitted to the facility on [DATE], with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris and chronic obstructive pulmonary disease, unspecified.On 05/11/2026 at 8:58 AM, Resident #97 recalled having trouble with a prior roommate. The roommate would not allow Resident #97 to turn the light on long enough to use the urinal and kept turning the light off. Resident #97 verbalized the roommate hit Resident #97 in the face with a closed fist. Afterward, Resident #97 grabbed the roommate by the shirt and hit the roommate back. Resident #97 denied any resulting injuries from the altercation; however, verbalized the resident no longer trusted the roommate and didn't want to go to sleep as Resident #97 was afraid the roommate would stick a knife in the resident's chest. The incident occurred less than one month prior, and Resident #97 had not seen the roommate following the incident.A final Facility Reported Incident (FRI) report submitted by the facility on 05/03/2026, documented Resident #97 and Resident #81, roommates at the time of the incident, punched each other. On 04/30/2026 at approximately 9:30 PM, Resident #97 was repeatedly screaming when Resident #81 got up and struck Resident #97 in the head. Resident #97 then struck Resident #81 in the head/face region. Both residents were interviewed and admitted to hitting one another.A progress note dated 05/03/2026, documented Resident #97 got into a physical altercation with the resident's roommate on 04/30/2026. Resident #97 utilized the call light to ask for assistance with the urinal. The Certified Nursing Assistant (CNA) turned on the light on Resident #97's side of the room. Resident #97 wanted all the lights to be turned on. The CNA explained the CNA could only turn on the light on the resident's side of the room as the roommate was sleeping. Resident #97 became upset and started yelling. The CNA explained staff and the resident needed to be respectful and quiet as the resident's roommate was sleeping. Resident #97 stopped yelling and finished using the urinal. The CNA was in another resident room when the CNA heard Resident #97 yelling out again. As the CNA approached the room the CNA heard Resident #97 say the roommate hit Resident #97. Upon entering the room, the CNA observed the roommate standing over Resident #97's bed with a clenched fist and the light was turned off. Both residents were engaging in verbal aggression toward each other.On 05/13/2026 at 3:14 PM, the DON verbalized abuse could be mental, sexual, physical, or verbal and caused a negative reaction by the resident, caused the resident to feel upset or affected the resident's emotions in a negative way. Physical abuse would include moving a resident and leaving a bruise, striking a resident and kicking a resident.On 05/14/2026 at 8:23 AM, the DON recalled Resident #97 had a confrontation with the resident's former roommate, Resident #81. The DON explained Resident #97 often refused to use the call light and had behaviors of yelling out to get what the resident wanted. At the time of the incident, Resident #97 needed to use the urinal and the CNA turned on the light on Resident #97's side of the room. The CNA explained Resident #81 was sleeping so the CNA could not turn on all the lights in the room, Resident #97 agreed and used the urinal. While assisting with other residents the CNA heard Resident #97 yelling out. As the CNA approached the room, the CNA heard Resident #97 say Resident #81 hit Resident #97. The CNA saw Resident #81 standing over Resident #97's bed with a closed fist. The DON confirmed the DON helped to complete the investigation of the incident and recalled Resident #81 admitted to hitting Resident #97. Resident #81 claimed the resident reacted to being hit by Resident #97 first.The facility policy titled Abuse, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Neglect and Exploitation, dated 04/11/2025, documented abuse was the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish which could include staff to resident abuse and certain resident to resident altercations. It included verbal abuse, sexual abuse, physical abuse, and mental abuse. Physical abuse included but was not limited to hitting, slapping, punching, biting and kicking.FRI 3000830

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and document review, the facility failed to ensure 1 of 19 sampled residents (Resident #62) was protected from potential misappropriation of property when an allegation a nurse stole the resident's medication was not reported to the Abuse Coordinator timely. This deficient practice placed all residents in the facility at risk for misappropriation of property due to delayed suspension of the alleged perpetrator and delayed investigation of the allegation.Findings include:Resident #62Resident #62 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure, unspecified whether with hypoxia or hypercapnia and other chronic pain.On 05/11/2026 at 11:54 AM, Resident #62 verbalized the resident had pain in both arms and took Lyrica to help manage the pain. The resident verbalized the resident would be in bad shape if the resident did not receive the medication and explained if one day's worth of medication was missed, the resident experienced a lot of pain. Resident #62 recalled there were two or three times the resident did not receive an ordered dose of Lyrica and was told the facility had run out of the medication. The resident verbalized the missed doses occurred when two specific staff members were working however, the two staff members no longer worked in the facility and the resident had not missed any more doses of pain medication.A final Facility Reported Incident (FRI) report submitted by the facility on 04/17/2026, documented two residents voiced concerns about pain management only when a specific nurse worked the unit. The date of the incident was 04/13/2026. The alleged perpetrator was a Registered Nurse (RN1) and the exact allegation against RN1 was RN1 may have been diverting medications.A Nurse's Note dated 03/06/2026, documented the nurse spoke to Resident #62's family member who informed the nurse Resident #62 mentioned problems regarding medications. The resident claimed medications were not being administered, nurses were not giving the resident Pregabalin (Lyrica) and may have been stealing the medication. Management would be made aware.A Nurse's Note dated 03/09/2026, documented by the Director of Nursing (DON), indicated the DON followed up with Resident #62 regarding the resident's Lyrica medication. The DON spoke with the Assistant DON (ADON) who was present on Friday and spoke with the primary nurse. The ADON stated Resident #62 was upset regarding the Lyrica being given. The ADON stated when removing the Lyrica from the packet, the medication broke in half. When the resident was shown this, the resident became upset. The DON spoke with Resident #62 on 03/09/2026 and the resident stated the resident did not know how a medication could break. The DON explained sometimes capsules break when pushing them out of the packet. The resident verbalized agreement but stated the resident was still suspicious.On 05/13/2026 at 3:14 PM, the DON verbalized misappropriation of resident property was when someone utilized a resident's property in a way not tolerated or wanted by the resident and included stealing money or using one resident's medication for another resident. The DON confirmed stealing a resident's medication would be considered misappropriation of resident property. If an allegation of abuse, neglect or misappropriation of property was reported to facility staff, the DON verbalized the expectation was the staff member would report the allegation immediately to the Administrator and/or DON. The Administrator was the facility's Abuse Coordinator (AC).The DON confirmed the DON was familiar with the allegations described in the FRI submitted 04/17/2026. The DON recalled a resident came to the DON and reported the resident felt like a certain nurse was not giving the resident their pain medication and the issue had been occurring for months. A few days later, Resident #62 reported to the DON the resident did not feel like the resident was getting their prescribed pain medication. The two residents were complaining about the same shifts the nurse of concern, RN1, worked in the facility. The DON recalled during the investigation into the allegations, the DON reviewed the Medication Administration Records (MARs) and narcotic logbook for the shifts RN1 worked. The DON denied any additional clinical record review was completed as part of the investigation.On 05/13/2026 at 3:42 PM, the DON reviewed the nurse's note dated 03/06/2026 (continued on next page)

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

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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** Based on observation, interview, record review, and document review, the facility failed 1) to ensure a resident's chronic pain care plan included non-pharmacological interventions to manage the resident's pain for 1 of 19 sampled residents (Resident #2). This deficient practice had the potential to result in a resident's pain not being managed effectively. 2) to ensure a resident's dialysis care plan included interventions staff could implement to get the resident to agree to go to dialysis and education staff were to provide to the resident when the resident refused dialysis treatments for 1 of 19 sampled residents (Resident #97). This deficient practice had the potential to result in the resident experiencing life-threatening complications related to missing dialysis treatments without adequate knowledge of the possible outcomes of refusal. 3) to identify and document trauma-specific interventions for a resident with a known trauma diagnosis for 1 of 19 sampled residents (Resident #12). This deficient practice had the potential to result in re-traumatization due to the lack of individualized trauma-specific interventions in the care plan, and 4) to document respiratory care and interventions in the care plan for a resident with a diagnosis of respiratory failure who was receiving oxygen therapy for 1 of 19 sampled residents (Resident #71). This deficient practice had the potential to result in unrecognized changes in condition and inadequate monitoring for complications related to oxygen use due to the lack of respiratory-specific care plan interventions. 5) to ensure a resident's care plan included the physicianˆordered behavioral interventions, including psychotherapy, for a resident diagnosed with adjustment disorder with depressed mood for 1 of 19 sampled residents (Resident #88). This deficient practice had the potential to result in the resident not receiving the necessary behavioral health interventions to address their identified psychosocial needs. Findings include: Resident #2 Resident #2 admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified fracture of upper end of right humerus, sequela and unspecified fracture of lower end of right femur, subsequent encounter for closed fracture with routine healing. On 05/11/2026 at 10:05 AM, Resident #2 verbalized the resident had pain in the resident's right leg. The resident verbalized the resident had a new pill but was unsure if it was working as the resident had continued pain causing the resident to spend more time in bed. The Medication Administration Record for Resident #2, dated May 2026, documented the resident's pain level on 05/12/2026 at 4:53 AM was six out of 10. The resident was administered a 2 milligram (mg) hydromorphone tablet for pain. The Pain Level Summary for Resident #2 documented the resident's pain was at a seven on 05/12/2026 at 8:02 AM. The resident's record lacked documented interventions implemented to address the resident's pain level. A chronic pain care plan for Resident #2 lacked non-pharmacological interventions to address the resident's pain. On 05/12/2026 at 12:17 PM, the Registered Nurse (RN) for Resident #2 confirmed the resident's pain level at 8:02 AM had been a seven and no interventions had been implemented to address the pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RN verbalized the RN was waiting to see if the hydromorphone the resident had received at 4:53 AM would help alleviate the resident's pain at 8:02 AM. On 05/12/2026 at 12:31 PM, the Director of Nursing (DON) verbalized the resident should have been evaluated to determine if a non-pharmacological intervention was needed when the resident's pain level was a seven at 8:02 AM and the resident's care plan should have included non-pharmacological interventions to address pain to ensure those interventions were provided. The facility policy titled Pain Management, dated 04/11/2025, documented interventions for pain management would be incorporated into the components of the comprehensive care plan. Non-pharmacological interventions would include environmental comfort measures, elevating or supporting limbs, physical modalities, exercises, and cognitive/behavioral interventions. The facility policy titled Comprehensive Care Plans, dated 04/11/2025, documented the care plan would include resident specific interventions reflecting the resident's needs and preferences. Cross reference with tag F697 Resident #97 Resident #97 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including end stage renal disease and dependence on renal dialysis. On 05/11/2026 at 8:54 AM, Resident #97 verbalized the resident usually went to dialysis on Mondays, Wednesdays, and Fridays; however, the resident had missed the last two scheduled dialysis treatments due to constipation and abdominal pain. On 05/11/2026 in the afternoon, a Registered Nurse (RN) verbalized Resident #97 refused to go to the resident's scheduled dialysis treatment in the morning. Progress notes in Resident #97's clinical record documented the resident refused to go to dialysis on 04/17/2026, 04/27/2026, 05/08/2026, and 05/11/2026. Resident #97's Care Plan documented the resident needed dialysis services and was at risk for complications related to refusals to go to dialysis. The Care Plan lacked interventions to address reasons for the refusal, education staff were to provide to the resident at the time of refusal, and any interventions used to get the resident to agree to go to dialysis. On 05/14/2026 at 8:45 AM, the DON verbalized potential complications of missing physician ordered dialysis treatments included physical decline of the resident, laboratory tests being outside normal limits, malaise, nausea, vomiting, and the resident feeling terrible. The DON explained the DON's expectation of staff if a resident refused to go to dialysis was the nurse would educate the resident about why it was important to go to treatment sessions, potential negative side effects of refusing the treatment, and how the body could not survive without it. If the nurse's education did not convince the resident to go to dialysis, the nurse was expected to get the physician involved and the physician was to educate the resident regarding potential outcomes. Education was to be provided each time the resident refused a scheduled dialysis treatment. The DON verbalized education was typically provided verbally. The nurse and the physician would (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	later enter a progress note to document the education and what interventions were attempted to get the resident to agree to go to dialysis. If a resident had a history of refusals, the DON verbalized the DON would expect the resident's care plan to include tips and tricks on what worked to get the resident to agree to go to dialysis, education to provide to the resident at the time of refusal, and staff follow up with the resident. The DON confirmed the DON was familiar with Resident #97 and verbalized the resident was hit and miss with refusing dialysis treatments depending on how the resident was feeling. On 05/14/2026 at 1:10 PM, the DON confirmed Resident #97 refused to go to multiple dialysis treatments and denied the resident's care plan included tips and tricks which got the resident to agree to go and education to provide to the resident at the time of refusal. The facility policy titled Hemodialysis, reviewed 05/05/2026, documented the facility would assure each resident received care and services for the provision of hemodialysis consistent with professional standards of practice. The facility would communicate with the attending physician, dialysis facility and/or nephrologist for any canceled or postponed treatments and document any responses to the changes in treatment in the medical record. Dialysis could be stopped, postponed or delayed due to a resident's declination of the treatment or presence of an acute illness or complication to the resident before, during, after and in between dialysis sessions. The facility policy titled Comprehensive Care Plans, dated 04/11/2025, documented the care plan would include resident specific interventions reflecting the resident's needs and preferences. Resident #12 Resident #12 was admitted to the facility on [DATE], with a diagnosis of post-traumatic stress disorder (PTSD), unspecified. Resident #12's Health and Physical dated 04/10/2026, documented a diagnosis of PTSD. The facility Physician Diagnoses Verification Summary signed on 04/27/2026, documented Resident #12 had a diagnosis of PTSD. Resident #12's Minimum Data Set (MDS) 3.0 admission summary dated [DATE], Section I - Active Diagnoses, documented the resident had a diagnosis of PTSD. Resident #12's Care Plan lacked documentation of the resident's diagnosis of PTSD, the resident's history of trauma, the triggers and stressors to the resident, and any interventions to decrease the potential of re-traumatizing the resident. On 05/14/2026 at 11:31 AM, DON confirmed Resident #12's PTSD diagnosis and the resident's trauma indicators and interventions had not been documented in the resident's care plan. The DON verbalized the care plan should have included the resident's PTSD diagnosis and interventions so floor staff would know the resident's trauma indicators and the proper interventions. The facility policy titled, Trauma Informed Care, dated 06/15/2025, documented the facility would identify a resident's trauma-based triggers and interventions to decrease the re-traumatization of the resident, and those triggers and interventions would be documented in the resident's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #71 Resident #71 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease, unspecified. On 05/11/2026 at 8:46 AM, Resident #71 was sitting in a wheelchair in the resident's room. The wheelchair had an oxygen tank attached to the back of the wheelchair and the resident was wearing a nasal cannula connected to the tank. The oxygen tank's reading was at 2 liters per minute (LPM). The resident's room included an oxygen concentrator by the head of the resident's bed, and was not on. On 05/11/2026 at 8:47 AM, Resident #71 confirmed needing oxygen 24 hours a day and received oxygen either by the oxygen concentrator in the resident's room or the oxygen tank attached to the resident's wheelchair. A physician order dated 03/12/2026, documented oxygen 2 LPM via nasal cannula, continuous, every shift, related to chronic respiratory failure with hypoxia. Resident #71's MDS 3.0 quarterly assessment dated [DATE], Section O - Special Treatments, Procedures, and Programs, documented the resident was receiving oxygen therapy, and Section I - Active Diagnoses, documented the resident had a pulmonary diagnosis of respiratory failure. Resident #71's Care Plan lacked documentation of the resident's respiratory diagnoses, the administration of oxygen, the oxygen flow rates, and the monitoring of changes in condition and complications with the use of oxygen. On 05/14/2026 at 11:22 AM, the DON confirmed Resident #71's respiratory diagnosis and use of oxygen was not documented in the resident's care plan. The DON verbalized floor staff utilized the care plan to check for a residents care and interventions and confirmed Resident #71's respiratory diagnosis and oxygen use should have been documented in the resident's care plan. The DON verbalized having been responsible for completing audits to verify the accuracy and updates of resident care plans. The facility policy titled, Oxygen Administration, dated 04/11/2025, documented a resident's care plan shall identify the use and interventions for oxygen therapy, such as, the type of oxygen delivery system, when to administer or discontinue oxygen, the equipment setting for the prescribed flow rates, and the monitoring for complications associated with the use of oxygen. Resident # 88 Resident # 88 was admitted to the facility on [DATE] with diagnoses congestive heart failure, cardiomegaly, chronic kidney disease, stage four, generalized anxiety and psychoactive substance dependence. On 05/13/2026 at 8:02 AM, during an interview, Resident # 88 got teary and began speaking about the resident's grandson who was recently shot and killed in Reno, stating I'm experiencing a lot more anxiety and depression due to the recent situation. A physician's order dated 04/20/2026, documented for Behavioral Interventions for adjustment disorder with depressed mood, including psychotherapy, to talk and process the situational (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depression related to the recent violent death of Residents grandson and adjustment to long-term care placement. Encourage to participate in psychotherapy. Resident # 88 Care Plan lacked documented evidence to include psychotherapy. The Care Plan was initiated on 02/27/2026 and reviewed and updated on 03/10/2026 by the Assistant Director of Nursing (ADON). On 05/13/2026 at 10:23 AM the ADON confirmed that the updated interventions were not in the care plan and verbalized the staff would not have known how to care for the resident by only looking at the Care Plan. The ADON confirmed the Care Plan should have been updated. On 05/13/2026 at 3:38 PM, the Director of Social Work, verbalized the Care Plan was not updated and staff would not know how to care for the resident by only looking at the Care Plan dated 02/27/2026. A facility policy titled Comprehensive Care Plans, date implemented 04/11/2025, documented Comprehensive care plan included resident rights and meet the resident's medical, nursing and mental and psychosocial needs and to maintain the resident's highest practicable well-being. The Care Plan will be reviewed and revised after each comprehensive and quarterly MDS assessment, and alternative interventions will be documented, as needed. A facility policy titled Trauma Informed Care, date implemented 06/15/2025, documented, the facility will identify triggers and develop care plan interventions which minimize the effect of the trigger on residents.

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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** Based on personnel record review, document review, and interview, the facility failed to ensure 2 of 20 sampled employees (Employee #4 and #17) had current cardiopulmonary resuscitation (CPR) training. This deficient practice placed residents at risk from an employee not having completed all employment eligibility requirements.Findings include:Employee #4Employee #4 was hired at the facility on [DATE], as an Assistant Director of Nursing.Employee #17Employee #17 was hired at the facility on [DATE], as a Registered Nurse.Employee #4 and #17 lacked documented evidence of a current CPR and first aid certification.On [DATE] at 2:46 PM, the Human Resources Coordinator (HRC) explained all licensed nurses were required to have a current CPR and first aid certification upon hire and expiration of the current certification. The HRC confirmed Employee #4 and #17 were licensed nurses and did not have a CPR and first aid certification.The facility policy titled Cardiopulmonary Resuscitation (CPR), implemented on [DATE], documented staff would maintain current CPR certification for healthcare providers through a CPR provider whose training included a hands-on session either in a physical or virtual instructor led setting in accordance with acceptable national standards.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure a resident's care related to a gastrointestinal (GI) infection was coordinated between the facility and the resident's established GI physician for 1 of 19 sampled residents (Resident #44) and interventions were implemented, including administration of physician ordered medications, to address a resident's constipation for 1 of 19 sampled residents (Resident #97). This deficient practice had the potential to result in a resident not receiving timely treatment and suffering from complications of a prolonged parasitic infection in the resident's GI tract or fecal impaction. Findings include: Resident #44 Resident #44 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including gastrointestinal hemorrhage, unspecified and enterocolitis due to clostridium difficile, not specified as recurrent. A GI specialist consultation note, dated 12/15/2025, documented the resident would continue to follow up with the specialist. A GI Panel laboratory result, dated 04/27/2026, documented the resident was negative for Clostridium difficile (C. diff) and positive for the parasite Entamoeba histolytica (a protozoan parasite infecting the GI tract with the ability to spread to other organs, most commonly the liver). The Care Plan for Resident #44, revised on 04/23/2026, documented the resident had a history of C.diff. The Care Plan lacked documentation of the resident's parasite infection. A Nursing Progress Note, dated 05/13/2026, documented the resident was receiving treatment for C.diff. The clinical record for Resident #44 lacked documentation the resident's established GI specialist was notified of the laboratory result from 04/27/2026 indicating the resident had an intestinal parasite infection. On 05/14/2026 at 1:10 PM, the Infection Preventionist (IP)/Assistant Director of Nursing (ADON) verbalized the resident's record should have included a charting alert documenting the resident had a parasitic infection, so staff were aware of the correct infection. The IP/ADON confirmed the IP/ADON was unable to provide documentation or evidence of the facility notifying the resident's GI specialist of the GI panel result documenting the resident had a parasite infecting the resident's GI tract. The IP/ADON verbalized the facility should have coordinated care with the resident's GI provider. Resident #97 Resident #97 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including pleural effusion, not elsewhere classified and chronic respiratory failure with hypoxia. On 05/11/2026 at 8:54 AM, Resident #97 exhibited facial grimacing, belching, and was heard saying (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ow repeatedly prior to initiating the interview. The resident verbalized the resident had issues with constipation and had not had a bowel movement (BM) in a couple of days. The resident was nauseated and had pain in the resident's lower abdomen and rectum. The resident explained the lack of BM for multiple days, abdominal pain and nausea were previously reported to a nurse, and the resident took a medication for nausea; however, the medication was not effective. The Task: Bowel and Bladder Elimination record for May 2026 documented Resident #97 did not have a BM on the following dates: 05/01/2026, 05/03/2026-05/07/2026, 05/09/2026 and 05/10/2026. Resident #97's Care Plan documented the resident had a potential for constipation related to debility and End Stage Renal Disease (ESRD). Interventions initiated 02/07/2026 included: -Follow facility protocol for bowel management. -Monitor medications for side effects of constipation. Keep physician informed of any problems. -Monitor/document/report as needed for any signs/symptoms (s/sx) of complications related to constipation: agitation, abdominal distention, vomiting, small loose stools, fecal smearing, bowel sounds, abdominal tenderness, guarding, rigidity, and fecal impaction. Resident #97's Medication Administration Record (MAR) documented the following physician orders and administrations: -Fleet enema 7-19 grams/ 118 milliliters (ml) (sodium phosphates). Insert 118 ml rectally as needed (PRN) for constipation if no results from suppository, give next shift during waking hours only. Notify Medical Doctor (MD) if no results. The order date was 04/25/2026 and there were no administrations documented in the MAR. -Milk of Magnesia suspension 400 milligrams (mg)/ 5 ml (magnesium hydroxide). Give 30 ml by mouth every 24 hours PRN for constipation if resident does not have a BM for three days. Administer milk of magnesia per physician order on day four. The order date was 04/25/2026 and the discontinue date was 05/08/2026. There were no administrations documented in the MAR. -Ondansetron hydrochloride tablet 4 mg. Give one tablet by mouth every eight hours PRN for nausea and vomiting. The order date was 04/27/2026. The medication was administered on 05/07/2026, 05/09/2026, and 05/11/2026. Resident #97's clinical record lacked documented evidence staff implemented any interventions to address the resident's lack of BM from 05/03/2026-05/07/2026. On 05/14/2026 at 8:51 AM, the Director of Nursing (DON) verbalized when a resident had a BM, staff would document in the tasks section of the electronic medical record. Interventions the facility could implement to address constipation included asking the resident about the resident's normal frequency of BMs and administering PRN stool softeners, milk of magnesia, and lactulose. The physician's orders for PRN medications included instructions for when the medication was to be given based on how many days the resident had gone without a BM. The DON reviewed Resident #97's record, confirmed the record indicated Resident #97 did not have a BM from 05/03/2026-05/07/2026 (a five-day period), and confirmed the DON would have expected (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff to have addressed the constipation. The DON verbalized the DON would have to verify if any interventions were implemented. On 05/14/2026 at 9:45 AM, the DON verbalized the DON had reviewed Resident #97's clinical record and confirmed there were no interventions implemented to address the resident's lack of BM for five days. On 05/14/2026 at 2:01 PM, the Administrator verbalized the facility did not have a policy related to bowel management or constipation and explained the facility would follow protocol/physician orders. The facility policy titled Medication Administration, last reviewed/revised 05/06/2026, documented medications were administered by licensed nurses, or other staff who were legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice. The facility document titled Residents' Rights, undated, documented residents should receive the services and/or items included in the plan of care.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure a resident's report of pain was addressed with an intervention to reduce the pain level to the resident's acceptable level of pain for 1 of 19 sampled residents (Resident #2). This deficient practice had the potential to result in a resident experiencing prolonged pain at a level unacceptable to the resident causing the resident to experience diminished quality of life and emotional well-being.Findings include: Resident #2 Resident #2 admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified fracture of upper end of right humerus, sequela and unspecified fracture of lower end of right femur, subsequent encounter for closed fracture with routine healing. On 05/11/2026 at 10:05 AM, Resident #2 verbalized the resident had pain in the resident's right leg. The resident verbalized the resident had a new pill but was unsure if it was working as the resident had continued pain causing the resident to spend more time in bed. A Pain Evaluation Assessment, dated 04/30/2026, documented the resident's acceptable pain level was four out of 10. The Medication Administration Record for Resident #2, dated May 2026, documented the resident's pain level on 05/12/2026 at 4:53 AM was six out of 10. The resident was administered a 2 milligram (mg) hydromorphone tablet for pain. The Pain Level Summary for Resident #2 documented the resident's pain was at a seven on 05/12/2026 at 8:02 AM. The resident's record lacked documented interventions implemented to address the resident's pain level. A chronic pain care plan for Resident #2 lacked non-pharmacological interventions to address the resident's pain. On 05/12/2026 at 12:17 PM, the Registered Nurse (RN) for Resident #2 confirmed the resident's pain level at 8:02 AM had been a seven and no interventions had been implemented to address the pain. The RN verbalized the RN was waiting to see if the hydromorphone the resident had received at 4:53 AM would help alleviate the resident's pain at 8:02 AM. The RN confirmed the RN had not implemented any interventions to address the resident's pain level of seven even though the resident's acceptable pain level was four. On 05/12/2026 at 12:31 PM, the Director of Nursing (DON) verbalized the resident should have been evaluated to determine if a non-pharmacological intervention was needed when the resident's pain level was a seven at 8:02 AM and the resident's care plan should have included non-pharmacological interventions to address pain to ensure those interventions were provided. The DON verbalized the DON would expect a pain medication to have been offered or for the RN to have paged the provider to ask for pain medication to alleviate the resident's pain. The DON verbalized if the resident had requested to not receive any interventions to alleviate the resident's pain, the RN would still be expected to reassess the resident's pain after an hour to determine if the resident's pain had improved or determine if the resident wanted an intervention to alleviate the resident's pain or if the resident continued to refuse. The facility policy titled Pain Management, dated 04/11/2025, documented interventions for pain management would be incorporated into the components of the comprehensive care plan. Non-pharmacological interventions would include environmental comfort measures, elevating or supporting limbs, physical modalities, exercises, and cognitive/behavioral interventions. If re-assessment findings indicated pain was not adequately controlled, the pain management regimen and plan of care would be revised as indicated. Cross reference with tag F656

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review and interview, the facility failed to ensure residents with trauma diagnoses were assessed by the facility to recognize and respond to the effects of the trauma and implementation of interventions for 2 of 19 sampled residents (Resident #12 and #88). This deficient practice had the potential to result in a resident experiencing re-traumatization due to the lack of assessments to recognize trauma-specific interventions.Findings include: Resident #12 Resident #12 was admitted to the facility on [DATE], with a diagnosis of post-traumatic stress disorder (PTSD), unspecified. Resident #12's Health and Physical dated 04/10/2026, documented a diagnosis of PTSD. The facility Physician Diagnoses Verification Summary signed on 04/27/2026, documented Resident #12 had a diagnosis of PTSD. Resident #12's Minimum Data Set (MDS) 3.0 admission summary dated [DATE], Section I - Active Diagnoses, documented the resident had a diagnosis of PTSD. Resident #12's clinical record lacked documentation a trauma assessment, based on the resident's PTSD diagnosis, had been completed. On 05/14/2026 at 11:25 AM, the Director of Nursing (DON) confirmed a trauma assessment should have been completed for Resident #12 related to the resident's PTSD diagnosis, and the importance of assessing the resident's triggers to establish the appropriate interventions to help the resident cope, and decrease the potential of re-traumatizing the resident. Cross reference with Fag F656 Resident # 88 Resident # 88 was admitted to the facility on [DATE] with diagnoses congestive heart failure, cardiomegaly, chronic kidney disease, stage four, generalized anxiety and psychoactive substance dependence. On 04/20/2026 a psychiatric assessment confirmed Resident # 88's chronic illness (depression) was exacerbated due to the recent violent death of Residents grandson. On 04/20/2026 the physician ordered psychotherapy. On 05/13/2026 at 2:58 PM, the Administrator verbalized a trauma assessment would be completed upon admission by the Director of Nursing. On 05/13/2026 at 3:10 PM, the Assistant Director of Nursing, verbalized being aware of the assessments and confirmed trauma assessments were completed by the Social Worker. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/2026 at 3:58 PM, the Director of Social Services confirmed a trauma assessment had not been done upon admission for Resident #88, or after a traumatic event which occurred after admission. The Director of Social Services verbalized Resident # 88 did not have interventions in place in the Care Plan related to the traumatic life event. The facility policy titled Trauma Informed Care, implemented 06/15/2025, documented the facility is to provide care using approaches that address the needs of trauma survivors by minimizing triggers for re-traumatization. Cross reference F 656

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on personnel record review and interview, the facility failed to ensure a Certified Nursing Assistant (CNA) employed for more than one year had an annual performance review completed annually for 1 of 4 CNAs reviewed for completed performance reviews (Employee #9). This deficient practice had the potential to affect all residents when the facility did not identify areas of CNA performance in need of in-service education or training. Findings include:Employee #9Employee #9 was hired by the facility on 11/04/2025, as a CNA.Employee #9's personnel record documented a performance review completed on 11/14/2024.On 05/13/2026 at 2:46 PM, the Human Resource Coordinator (HRC) verbalized all CNAs were required to have a performance review completed by the CNAs anniversary date and confirmed Employee #9's performance review was completed 10 days late.On 05/14/2026 at 10:24 AM, the Administrator verbalized the facility did not have a policy related to CNA performance reviews; however, the facility followed all federal regulations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure 1) a medication was not left on a resident's bedside table and unattended by authorized staff for 1 of 3 residents observed during medication administration (Resident #4) and 2) expired medications were removed from 1 of 2 medication storage rooms and 1 of 2 medication carts inspected for medication storage. This deficient practice had the potential to result in residents and staff without authorization to have unsupervised access to medications and for expired medications to be administered to residents.Findings include:Medication left unattendedResident #4Resident #4 was admitted to the facility on [DATE], with a diagnosis of spinal stenosis, lumbar region with neurogenic claudication.An Order Summary Report for Resident #4 documented GlycoLax Powder (Polyethylene Glycol 3350), give 17 grams by mouth one time a day for constipation. The start date was 05/12/2026.On 05/13/2026 at 8:17 AM, a Registered Nurse (RN) began preparing medications for Resident #4 during the morning medication administration pass. The medications prepared by the RN included 17 grams of GlycoLax powder dissolved in six and a half ounces of water.On 05/13/2026 at 8:27 AM, the RN entered Resident #4's room and explained which medications had been prepared for the resident. After administering all other prepared medications, the RN handed the cup containing the GlycoLax powder dissolved in water to the resident and exited the room.On 05/13/2026 at 8:33 AM, the RN confirmed the RN left the GlycoLax in Resident #4's room. The RN verbalized the RN typically left medications such as laxative powders dissolved in liquids in residents' rooms as it was a lot of liquid for the residents to take in within just a few minutes and the RN had to continue with the medication pass.On 05/14/2026 at 1:17 PM, the Director of Nursing (DON) denied any medications were to be left in resident rooms. The DON explained it was important not to leave medications unattended by staff as staff would not know if the resident took the medication. Medication administration and refusals needed to be documented accurately and if medications were left at bedside, residents could store multiple doses and overdose.Expired medicationsOn 05/13/2026 at 1:26 PM, during an inspection of the Brookside unit medication storage room, a bottle of cherry flavored sore throat spray was found in an upper cabinet. An expiration date of 03/2026 was printed on the label. The Chief Nursing Officer (CNO) verbalized an expiration date written as month and year expired at the end of the month. The CNO confirmed the sore throat spray had expired.On 05/13/2026 at 1:41 PM, the DON verbalized if medications had expired the facility would dispose of the medication using drug buster (a solution to deactivate and destroy medications). The DON confirmed all expired medications were to be removed from medication carts and cabinets in the medication storage rooms in which active/current medications were stored. The medications were to be removed no later than the expiration date printed on the container.On 05/13/2026 at 1:44 PM, during an inspection of the Classics unit - 200 hall medication cart, a bottle of Vitamin D 25 microgram tablets was found. The expiration date printed on the bottle was 02/2026. A Licensed Practical Nurse confirmed the medication had expired and verbalized the medication should have been previously removed from the cart.The facility policy titled Medication Storage, reviewed/revised 05/06/2026, documented during a medication pass, medications were to be under the direct observation of the person administering medications or locked in the medication storage area/cart. Medication carts and rooms were routinely inspected by the consultant pharmacist or designee for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications would be destroyed in accordance with the facility's destruction of unused drugs policy.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and document review, the facility failed to ensure a dietary recommendation was followed. This deficient practice had the potential to affect the resident's wellbeing and overall health.Findings include: On 05/13/2026 at 11:40 AM, during observation of the lunch tray line, a resident's diet ticket indicated a regular diet with no added salt. However, dietary staff placed two extra salt packets on the resident's tray. On 05/13/2026 at 11:45 AM, the dietary staff member confirmed the meal tray contained two salt packets. On 05/13/2026 at 12:00 PM, the Dietary Manager confirmed the resident's meal did not match the diet ticket and stated the ticket should have been followed to support resident health and comply with provider orders. A facility policy titled, Therapeutic Diet Orders, implemented 04/11/2025, documented the facility provided all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician.

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review the facility failed 1) to prepare food as required for residents on a physician ordered therapeutic diet, 2) to ensure a resident received a minced and moist diet as ordered and failed to prepare or serve meals in a form that met the resident's need for 1 of 19 sampled residents (Resident # 3). This deficient practice had the potential for reduced meal intake due to not following the prescribed diet order, and increased the risk of difficulty swallowing, which could lead to choking and/or aspiration.Findings include:On 05/13/2026 at 11:40 AM, during an observation of lunch tray line, dietary staff served a whole chicken breast, green peas, and cornbread to three residents with a meal ticket indicating a minced and moist diet. The Dietician approved menu for 05/13/2026 documented minced and moist level five diet (MM5) was to include baked chicken, garlic mashed potatoes, sliced carrots, soaked cornbread, margarine, vanilla pudding, and coffee and milk. On 05/13/2026 at 11:50 AM, the Dietary [NAME] verbalized being unaware of what the MM5 diet was. On 05/13/2026 at 12:00 PM, the Dietary Manager confirmed residents' meals did not match their diet tickets and stated the tickets should have been followed to prevent a choking hazard. A facility policy titled, Therapeutic Diet Orders, implemented 04/11/2025, documented therapeutic diets, including mechanically altered diets where appropriate, would be based on the resident's individual needs as determined by the resident's assessment. Resident #3 Resident #3 was admitted to the facility on [DATE], with diagnoses including paraplegia, unspecified, adult failure to thrive, and atherosclerotic heart disease of native coronary artery without angina pectoris. On 05/11/2026 at 12:29 PM, Resident #3 was in bed, in the resident's room, with a meal tray on a table next to the resident. The food on the tray was untouched. Resident #3 verbalized the food was horrible and hard to chew. Resident #3's diet order dated 04/23/2026, documented a regular diet, Level 5 Minced & Moist (MM5) texture, Regular/Level 0 Thin consistency for difficulty chewing. The Nutritionally At-Risk Resident Interdisciplinary Team Review dated 05/07/2026, documented the resident was to be provided and served the diet as ordered with intake monitoring at each meal. On 05/12/2026 at 12:21 PM, Resident #3's meal tray was delivered to the resident's room. The tray had a whole ham steak with gravy on the top, Brussel sprouts, sweet potato mash, a dinner roll, and a bowl of baked apples. The meal ticket documented a regular diet, thin liquids, and no hard to chew foods. On 05/12/2026 at 12:25 PM, Resident #3 explained the resident had dentures and the dentures fit (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	well; however, food collected underneath the dentures, and it was painful to eat. The resident preferred to eat without the dentures; however, the food was hard to chew. The resident verbalized a willingness to eat the brussels sprouts and the ham steak if the resident would be able to chew the food. On 05/12/2026 at 1:21 PM, the resident's lunch tray demonstrated the resident had consumed approximately 1/4 cup of brussels sprouts, one bite of ham steak, and the sweet potato mash. Resident #3 verbalized the brussels sprouts were burnt and the ham was too hard to chew. On 05/12/2026 at 2:18 PM, a Registered Nurse (RN) explained all staff were instructed to document meal consumption for Resident #3, after each meal provided. The RN reviewed the meal consumption log and verbalized staff had documented 26-50% intake for lunch the previous day. The RN confirmed Resident #3 had a current and active diet order for minced and moist foods. On 05/13/2026 at 11:40 AM, during trayline, the [NAME] was taking temperatures of the food prior to plating and serving to residents for lunch service. The [NAME] obtained temperatures of three foods to be served for residents on a minced and moist diet. The [NAME] verbalized residents on a minced and moist diet were to be served chicken and carrots cut up into very small pieces, and mashed potatoes. On 05/13/2026, the Kitchen Manager explained all residents receiving a minced and moist diet would be served the food cut up into small pieces and verbalized residents on minced and moist diets should not ever receive a whole piece of chicken. The Kitchen Manager verbalized dietary aids would call out the diet orders, the [NAME] would plate the diet order onto the resident plate, and lastly, the dietary aide would flip the ticket on the resident's plate so the [NAME] was able to verify correct plating. On 05/13/2026 at 12:11 PM, the [NAME] plated Resident #3's plate. The plate contained a full chicken breast and pieces of sliced carrot. The dietary ticket for the lunch meal documented regular diet, thin liquids, and no hard to chew foods. On 05/13/2026 at 12:21 PM, the Kitchen Manager verbalized Resident #3 was on a regular diet; however, would go to the Kitchen Manager's office to verify validity of the resident's diet. The Kitchen Manager returned and confirmed Resident #3 was on a minced and moist diet and the food being served to the resident did not follow the resident's prescribed diet order. The Kitchen Manager explained not serving the prescribed diet could result in weight loss for the resident and other hazards due to swallowing difficulties. The facility policy titled Therapeutic Diet Orders, implemented on 04/11/2025, documented therapeutic diets, including mechanically altered diets would be provided to residents as prescribed. Therapeutic diets would be considered for inadequate nutrition, nutritional deficits, weight loss, medical conditions, and difficulty swallowing. The dietary staff and nursing staff were responsible for providing resident diets in the appropriate form to a resident.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and document review, the facility failed to ensure the outside garbage receptacles were sealed (lid closed) and free of debris on the surrounding pavement. This deficient practice had the potential to affect all residents in the facility by increasing the risk of pest and foodborne illnesses.Findings include: On 05/11/2026 at 9:22 AM, two dumpsters were located at the back of the facility. One dumpster had an open lid with exposed trash, and the second dumpster had trash on the ground around it, including gloves, cans, and paper. On 05/11/2026 at 9:30 AM, the Dietary Supervisor explained it was important to keep the dumpster area clean and the lids closed to prevent animals and pests. A facility policy titled, Disposal of Garbage and Refuse, implemented 04/08/2026, documented refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers. Containers and dumpsters shall be covered when not being loaded. Surrounding areas shall be kept clean to minimize the accumulation of debris and insect/rodent attractions.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on document review and interview, the facility failed to update the facility assessment following a change in the medical provider group. This deficient practice had the potential to result in the facility assessment not accurately reflecting the current medical provider or clinical responsibilities of the newly contracted medical provider group providing necessary services to residents. Findings include: The facility's assessment updated 03/19/2026, documented a third-party vendor as the primary medical practitioners providing care to residents. The assessment documented the facility would review and update the facility assessment whenever changes required modifications to any part of the assessment. On 05/13/2026 at 12:33 PM, the Administrator confirmed the facility had recently changed the contracted medical group and provider as of 03/11/2026, and the third-party vendor was no longer the contracted medical provider group for the facility. The Administrator verbalized having been responsible for updating the facility assessment but had missed updating the change of provider group in the language of the assessment. The facility assessment updated 03/19/2026, lacked documented language the assessment had been updated following a change in its medical provider structure, including the transition of the facility's primary attending physician and associated onˆcall coverage. The facility assessment referenced the previous medical group and did not reflect the qualifications, availability, scope of services, or clinical responsibilities of the newly contracted medical provider group necessary to meet resident needs. The facility policy titled, Facility Assessment revised 03/10/2026, documented the facility assessment would be reviewed and updated as necessary, or at least annually, or whenever the facility plans for or has a change that required a modification or update to the assessment.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and document review, the facility failed to designate a member of the facility's interdisciplinary team responsible for coordinating the care of residents receiving hospice services. This deficient practice had the potential to result in uncoordinated care and a lack of communication between the facility and the hospice providers, delays of resident care, inadequate monitoring, and an increased risk of unmet physical, emotional, and psychosocial needs for residents receiving hospice services.Findings include: On 05/12/2026 at 12:57 PM, the Assistant Director of Nursing (ADON) verbalized the ADON was not the facility's hospice coordinator and was unaware who was responsible as the facility's hospice coordinator. On 05/12/2026 at 2:00 PM, the Administrator confirmed having been aware of the requirement for the facility to have a hospice coordinator, but the facility did not currently have a hospice coordinator. The Administrator verbalized hospice services were coordinated as a team effort with several facility staff but the oversite of hospice care to residents should have been the Director of Nursing. On 05/12/2026 at 2:06 PM, the DON verbalized the DON was not the hospice coordinator, and it was the responsibility of the respective ADONs to manage the residents on hospice care within their units. On 05/12/2026 at 4:26 PM, the Administrator verbalized the facility did not have a policy on the requirement of a hospice coordinator, only the Coordination of Hospice Services policy. On 05/14/2026 at 11:33 AM, the DON confirmed the facility did not currently have a hospice coordinator and as a result had the potential of a resident on hospice not receiving the proper coordinated care.The facility policy titled, Coordination of Hospice Services, dated 04/11/2025, lacked documented language of the requirement of the facility designating a member of the interdisciplinary team to have been responsible for coordinating the care of residents receiving hospice services.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify and address system-level issues related to 1) the facility's lack of a designated hospice coordinator, and 2) concerns related to the personnel training requirements on abuse, cardiopulmonary resuscitation (CPR) and first-aid certifications. This deficient practice had the potential to prevent the QAPI committee from implementing an ongoing, dataˆdriven process to monitor performance concerns and develop corrective actions, limiting the facility's ability to recognize patterns, prevent recurrence of problems, and ensure sustained improvement in resident care and facility operations related to employee requirements.Findings include: Hospice Coordinator On [DATE] at 2:52 PM, the Administrator confirmed the facility did not have a designated hospice coordinator. The Administrator verbalized the lack of a hospice coordinator was a concern the facility would be addressing, but had not been addressed in the QAPI process. The Administrator confirmed understanding the requirement of a hospice coordinator was to ensure continuity and coordination of resident care between the facility and the hospice provider. Cross reference with Tag F849 Personnel Requirements On [DATE] at 3:06 PM, the Administrator verbalized the facility was unable to access employee documents including abuse prevention trainings and CPR and first-aid certifications, due to the change of ownership of the facility in [DATE]. The Administrator verbalized as of [DATE], the facility still did not have access to employee documentation prior to [DATE]. The Administrator confirmed having been aware of the concern of the facility's lack of access to the employee documentation, and the concern had not been addressed in the QAPI process. Cross reference with Tags F678 and F943. The facility policy titled, Quality Assurance and Performance Improvement (QAPI), dated [DATE], documented the QAPI committee would identify, address, and correct problem areas by tracking and measuring performance, setting improvement goals, identifying and prioritizing quality issues, analyzing the causes of deficiencies, implementing corrective or improvement actions, monitoring effectiveness, and revising actions as needed.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview, the facility failed to provide the Quality Assurance and Performance Improvement (QAPI) committee member signature attendance sheets for the second, third, and fourth quarters of 2025. This deficient practice had the potential to result in the facility's failure to demonstrate the required QAPI committee members had participated in the quarterly meetings as required.Findings include: On 05/14/2026 at 2:30 PM, the Administrator verbalized not having access to the monthly QAPI meetings attendees list from April 2025 to [DATE], due to the change of ownership of the facility having taken place in January 2026. The Administrator could not confirm which committee members had participated in or attended the meetings during those months. The facility's QAPI Facility Plan, dated April 2026, documented the committee shall maintain written documentation of the meetings attendance records.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and document review, the facility failed to maintain the ice machine in good repair. This deficient practice had the potential to result in contamination of the ice and affect resident safety. Findings include:On 05/11/2026 at 8:30 AM, the kitchen ice machine had white mineral deposits on its exterior surfaces and door, and similar deposits were present on the ground surrounding the machine. On 05/11/2026 at 8:36 AM, the Dietary Supervisor confirmed the ice machine should have been cleaned and maintenance and kitchen staff were responsible for the task. The Dietary Supervisor further stated keeping the ice machine clean was necessary to prevent residents from becoming ill. A facility policy titled, Sanitation Inspection, Implemented 12/22/2025, documented all food service areas shall be kept clean and sanitary.

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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. Based on personnel record review and interview, the facility failed to ensure elder abuse prevention training was completed timely for 6 of 20 sampled employees (Employee #2, #3, #16, #17, #18, and #19). This deficient practice had the potential to place all residents at risk for abuse and neglect.Findings include:Employee #2Employee #2 was hired by the facility on 12/30/2025, as the Director of Nursing.Employee #2's personnel record documented initial elder abuse training completed on 02/16/2026.Employee #3Employee #3 was hired by the facility on 09/15/2025, as the Assistant Director of Nursing/Infection Preventionist.Employee #3's personnel record documented initial elder abuse training completed on 02/06/2026.Employee #16Employee #16 was hired by the facility on 01/30/2026, as a Registered Nurse (RN).Employee #16's personnel record documented initial elder abuse training completed on 02/13/2026.Employee #17Employee #17 was hired by the facility on 01/30/2026, as an RN.Employee #17's personnel record documented initial elder abuse training completed on 02/12/2026.Employee #18Employee #18 was hired by the facility on 04/07/2026, as a Social Services Staff.Employee #18's personnel record documented initial elder abuse training completed on 04/12/2026.Employee #19Employee #19 was hired by the facility on 01/27/2026, as the Housekeeping Supervisor.Employee #19's personnel record documented initial elder abuse training completed on 02/02/2026.On 05/13/2026 at 2:46 PM, the Human Resources Coordinator (HRC) verbalized all staff were required to complete elder abuse training upon hire, prior to starting work on the floor, and annually thereafter. The HRC confirmed Employee's #2, #3, #16, #17, #18, and #19 did not complete initial elder abuse training timely, prior to start on the floor, and no previous elder abuse trainings could be located.On 05/14/2026 at 10:24 AM, the Administrator verbalized the facility did not have a policy related to elder abuse training; however, the facility followed all federal regulations.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview the facility failed to provide a Notice of Medicare Non-Coverage (NOMNC) upon discharge for 1 of 3 sampled residents (Resident #13). This deficient practice had the potential to limit the resident's ability to understand and exercise their Medicare appeal rights regarding termination of covered services.Findings include:Resident #13Resident #13 was admitted to the facility 04/07/2026 and discharged [DATE].Resident #13's clinical record lacked documented evidence a NOMNC notification was given to the resident for termination of Medicare Part A services provided. On 05/12/2026 at 11:07 AM, the Administrator confirmed Resident #13 did not have notification of NOMNC prior to discharge from the facility.The facility form Notice of Medicare Non-Coverage (NOMNC) documented Your provider and /or health plan determined that Medicare probably won't pay for your skilled services after the above date. You may have to pay for any services you get after this date. You have the right to appeal the decision to end Medicare coverage of your services. This means you'll get an Independent medical review right away. Your services will continue during the appeal.