STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORMSBY POST ACUTE REHAB	3050 N ORMSBY CARSON CITY, NV 89703

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F 0559 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure a resident was notified and consented to a room change prior to being moved into a new room for 1 of 46 residents (Resident #12). Findings include: Resident #12 Resident #12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Facility Reported Incident (FRI) dated 0[DATE], documented Resident #12 had notified staff the resident's roommate was cussing at the resident when the resident made noises at night. A Nursing progress note dated 03/02/20 documented the interdisciplinary team met to review the incident between the resident and his roommate. The residents had been separated prior to the incident being reported to staff due to Resident #12 having an infection requiring isolation. The clinical record for Resident #12 lacked a consent for room change or room change notification. On 03/02/20 at 11:54 AM, the Assistant Director of Nursing (ADON) and Director of Nursing (DON) verbalized the resident had been moved prior to staff notification of the incident and no room change notification was given to the resident. The facility policy, titled Room Changes/New Roommate, dated 11/2016, documented the center interdisciplinary team would notify the resident and/or resident representative of the new room change or roommate (prior to the change), document the decision and notification in the medical record, and monitor the resident's acclimation to the new environment/roommate for 72 hours and document findings in the medical record. FRI # 439
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 protect a resident from being smacked on the hands and being yelled at by other residents for 1 of 46 sampled residents (Resident #14), failed to protect a resident against rough and abrupt care for 2 of 46 sampled residents (Resident #2 and #3) and to prevent a resident from being deprived necessary and immediate medical services for 2 of 46 sampled residents (Resident #31 and #1). Findings include: Resident #14 Resident #14 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #15 Resident #15 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #16 Resident #16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A facility reported incident, dated 02/20/20, documented Resident #14 had a history of [REDACTED]. Resident #15 yelled at Resident #14 and told Resident #14 to go away. Resident #14 then wandered to another table and Resident #16 hit Resident #14 on the hands. The incident was witnessed by a nurse. A Nursing Progress Note for Resident #14, dated 02/20/20, documented during lunch, the resident was attempting to grab food from another resident's while the other residents were eating. One resident yelled at Resident #14 to go away. Resident #14 was then removed from the other resident's table and moved to a different table. There resident went back to the other resident's table and the resident yelled at Resident #14. Staff removed Resident #14 from the resident's table again. Resident #14 then went to another resident's table and tried to grab the resident's food. The resident hit Resident #14 on the hands. A Nursing Progress Note for Resident #15, dated 02/20/20, documented during lunch Resident #15 yelled at another resident because the resident was touching Resident #15's food. The resident was removed to a different table and then went back to Resident #15's table and Resident #15 yelled at the resident. A Nursing Progress Note for Resident #16, dated 02/20/20, documented during lunch Resident #16 hit another resident for touching Resident #16's food. The other resident had been removed from Resident #16's table for touching Resident #16's food. The resident then went back to Resident #16's table and Resident #16 hit the resident on the hands. A Care Plan for Resident #14, initiated on 12/26/19, documented Resident #14 was at risk for abuse. Interventions for the Care Plan included staff would ensure the resident's safety in social settings and during meals. On 03/04/20 at 1:40 PM, two Certified Nursing Assistants assisting the residents in the dining room during lunch, verbalized if a resident was becoming agitated the staff would watch the resident more closely and keep the resident separated from other residents to prevent altercations. On 03/04/20 at 2:59 PM, the Administrator verbalized staff should redirect residents when residents became agitated to prevent altercations. Resident #1 Resident #1 was admitted to the facility on [DATE] and discharged on [DATE], with [DIAGNOSES REDACTED]. Employee #15 Employee #15 was hired at the facility on 04/25/19, as a Licensed Practical Nurse (LPN). A FRI dated 0[DATE], documented Resident #1 had filed a grievance with the facility after the LPN was rude and inappropriate with the Resident. On 03/04/20 at 9:30 AM, the Administrator verbalized Resident #1 had requested a pain pill from the LPN. The LPN told the resident they would retrieve a pain pill to administer to the resident and left the resident's room. The LPN did not return to the resident's room and the Resident was not administered the pain pill they had requested. The Administrator confirmed the interaction between Resident #1 and the LPN and verbalized the treatment was inappropriate toward the Resident. The LPN's personnel record lacked documented evidence of current Elder Abuse training. Resident #2 Resident #2 was admitted to the facility on [DATE] and discharged on [DATE], with [DIAGNOSES REDACTED]. A FRI dated 01/13/20, documented Resident #2 had complained a Certified Nursing Assistant (CNA) was rough and abrupt with the resident while providing peri care. The CNA had pulled on the resident's brief causing the briefs to tear down the sides and the CNA had pulled the brief out from underneath the resident harshly. On 03/04/20 at 9:38 AM, the Administrator explained the CNA had denied providing care to the resident and upon further investigation, it was proven the CNA in fact had provided care to the resident. Upon further research, there had been some reports against the CNA for the same type of behavior. The Administrator confirmed the CNA had mistreated Resident #2 during peri care. Resident #3 Resident #3 was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A FRI dated 02/11/20, documented Resident #3 reported there were two CNA's transferring the resident via a Hoyer lift and were rough with the transfer. During the care being provided, the residents pants were removed roughly. On 03/04/20 at 8:12 AM, Resident #3 explained while preparing to go to [MEDICAL TREATMENT] a staff member was helping to transfer the resident from the bed to the wheelchair. While the resident was being transferred using a Hoyer Lift, the resident was spinning circles and had asked the staff member what they were doing. The staff member told the resident to relax, they have done this a million times and to calm down. When the resident was placed in their wheelchair, the resident had a bowel movement. The resident had asked for help to change the brief. The resident waited 45 minutes to be changed. The same staff member assisted to clean up the resident and during the brief change, the staff member had yanked the resident's pants down, hurting the resident's ankle. The resident kept telling the staff member they were hurting Resident #3, but the staff member acted like they didn't care how the resident was feeling. The resident expressed feeling low, like the resident doesn't matter to the staff at the facility. On 03/04/20 at 9:48 AM, the

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

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.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Administrator verbalized staff were assisting Resident #3 with transferring from the bed to their wheelchair. During the process, staff had swung the resident around while they were in the Hoyer lift. The resident had requested to get their leg down out of the Hoyer lift and staff had told the resident we got this, you're fine. In addition, during a brief change with the resident, the resident had felt like the staff member had pulled the brief too hard causing their ankle to hurt. On 03/04/20 at 2:09 PM, a CNA helping to transfer the resident verbalized they were helping the resident transfer using the Hoyer lift. The resident had complained to the CNA they were in pain from sitting in their wheelchair for an extended amount of time. The CNA verbalized they did not help change the resident's brief. Resident #31 Resident # 31 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An Advanced Registered Nurse Practitioner (ARNP) progress note, dated [DATE] at 1:29 PM, documented Resident #31 expressed not feeling well for a couple of days and Resident #31 had a decreased appetite. A physician order [REDACTED]. A nursing progress note dated 11/15/19 at 2:23 AM, documented Licensed Practical Nurse (LPN) #2 was unable to start an IV. An ARNP progress note, dated 11/15/19 at 12:29 PM, documented the IV fluids ordered STAT on 11/1[DATE]9 for hydration due to Resident #31 having decreased oral intake had not been given and LPN #3 had expressed to the ARNP it was because an IV pump was not available. Resident #31's clinical record lacked documented evidence the ARNP was notified Resident #31 had not received the IV fluids as ordered. An ARNP progress note, dated 11/18/19 at 1:18 PM, documented Resident #31 was experiencing crackles at the bases of both lungs and had audible gurgling. On 11/1[DATE]9, the ARNP had ordered one liter of IV fluid and the order was not completed. The ARNP documented the resident had worsening pneumonia, decreased mental status, and lethargy. Resident #31's Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. On 03/02/20 at 10:52 AM, the ARNP verbalized the IV fluids ordered STAT on 11//1[DATE]9 were not administered until 11/15/19. The ARNP verbalized STAT orders should be done right now and notification to the practitioner of an inability to complete an order should have been done within one or two hours. The ARNP verbalized any order not completed in the timeframe requested by a practitioner had a potential to negatively impact the outcome of the resident. On 03/04/20 at 1:49 PM, the Regional Director of Nursing verbalized STAT was defined as immediately, no medication or fluids ordered STAT should wait for twenty-four hours before being administered, and nursing staff would not wait for an IV pump to be delivered before administering STAT IV fluids. The RDNS confirmed [MED] Solution 0.9%, IV tubing, and IV flow regulators were stocked on-site in the CUBEX (an automated medication dispensing machine). The RDNS verbalized the pharmacy would deliver any medication to the facility within a couple of hours if it was not in the CUBEX. The facility policy titled Medication Ordering and Receiving From Pharmacy Provider, dated 01/20, documented STAT medications that were available onsite would be administered from onsite stock prior to the next pharmacy delivery. The facility policy titled Administration of IV Fluids and Medications, dated 08/16, documented continuous IV fluids could be administered by flow regulator tubing until a pump arrived from the pharmacy. A facility policy titled CUBEX Station Policies and Procedures, revised 09/18. Documented the CUBEX station was to be used for emergency, first-doses, and other situations where medications were needed prior to the next scheduled pharmacy delivery. A facility form titled Inventory on Hand, C11, dated 03/02/20, documented 0.9% [MED] was a stocked medication and available in the CUBEX machine. A facility form titled Inventory on Hand, C11, dated 03/02/20, documented IV rate flow regulators (Dial A Flo) were a stocked item and available in the CUBEX machine. A facility care path titled Change in Condition: When to report to the MD/NP/PA, dated 2003, documented that any marked change unrelieved by measures prescribed with an acute or sudden onset were to be reported immediately. A facility form titled Interact 4.0 SBAR communication Form, dated 2014, documented decreased urine output as a reportable change in condition. The facility policy titled, Abuse, Corporal Punishment, Involuntary Seclusion, Mistreatment, Neglect, Misappropriation of Resident Property, and Exploitation, las updated September 2017, documented each resident would have the right to be free from abuse, including verbal, mental sexual or physical abuse, corporal punishment, involuntary seclusion, mistreatment, neglect, misappropriation of resident property, exploitation and any physical or chemical restraining not required to treat the resident's medical condition. FRI # 044 FRI # 980 FRI # 271 FRI # 375
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interview and document review the facility failed to implement the facility abuse policy and ensure that employees received abuse training at the time of hire and annually for 77 of 78 employees. Findings include: Seventy-seven employee records lacked documented evidence of completion of abuse training at the time of hire and annually. On 03/05/20 at 1:59 PM, the Administrator and Regional Director of Nursing Services (RDNS) verbalized the facility abuse trainer was the Administrator. The Administrator verbalized being responsible for ensuring that abuse training was completed. To document abuse training, each employee file would have a cover sheet that listed abuse training and a check mark was placed beside it when the training was completed. Staff had not received certificates after successfully completing the training and the Administrator verbalized the facility had not used certificates that listed the number of training hours the employee had completed initially or annually. The Administrator verbalized the Staff Development Coordinator (SDC) was responsible for grading any post abuse training quizzes validating the training was successfully completed and if the tests were not graded the Administrator and SDC could not assure the staff member understood the training or was fully trained. The Administrator verbalized Initial abuse training was an hour of training and the yearly abuse training was 30 minutes. On 03/04/20 at 9:50 AM, the SDC verbalized abuse training was included in the annual training and documentation would be in the employee files. The SDC verbalized there had been no outline or course plan for abuse training and the SDC did not grade the tests that employees completed at the end of the training. The facility policy titled Abuse Training, updated September 2017, documented staff, students, and volunteers would be trained on abuse prevention at the time of hire and annually.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview, record review and document review the facility failed to submit Facility Reported Incidents (FRI) final reports within the five-day requirement for 2 of 26 FRI's. Findings include: An initial FRI dated 0[DATE], documented rude and inappropriate interactions from an employee to a resident. A final report was submitted to the State Agency on 01/24/20, concluding the investigation was unsubstantiated. On 03/04/20 at 9:30 AM, the Administrator confirmed the final report was reported late and verbalized final FRI's were to be submitted no later than five days from the initial FRI report being reported to the Stage Agency. An initial FRI dated 01/09/20, documented a resident had fallen and was injured as a result. A final report was submitted to the State Agency on 01/16/20, concluding the investigation was substantiated. On 03/04/20 at 10:04 AM, the Administrator confirmed the final report was reported late and verbalized final FRI's were to be submitted no later than five days from the initial FRI report being reported to the State Agency. The facility policy titled Abuse Reporting and Response, published September 2017, documented the facility was to report all final investigations to the State Agency within five working days of an incident occurring. FRI # NV 044 FRI # NV 927
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 observation, interview, clinical record review and document review, the facility failed to have interventions in place to prevent further resident to resident verbal and physical abuse for 1 of 45 residents (Resident #14). Findings include: Resident #14 Resident #14 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #15 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A facility reported incident, dated [DATE], documented Resident #14 had a history of [REDACTED]. Resident #15 yelled at Resident #14 and told Resident #14 to go away. Resident #14 then wandered to another table and Resident #16 hit Resident #14's hands. The incident was witnessed by a nurse. A Nurse Practitioner Note, [DATE], documented the Nurse Manager was made aware of the incident between Resident #14 and two other residents on [DATE]. The Nurse Manager would ensure the resident would be engaged in redirection activities to prevent further altercations. A Care Plan for Resident #14, initiated on [DATE], documented Resident #14 was at risk for abuse. Interventions for the Care Plan included staff would ensure the resident's safety in social settings and during meals. On [DATE] at 12:55 PM, residents were being served lunch in the Advantage dining room. A Certified Nursing Assistant (CNA) was pushing Resident #14 in the resident's wheelchair and sat the resident at a table next to Resident #15 and Resident #16 was seated at a table directly behind

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Resident #14. On [DATE] at 1:40 PM, two CNA's assisting the residents in the dining room verbalized the CNA's were unaware of any altercations between Resident #14 and Resident's #15 and #16. The CNA's verbalized if there was a resident to resident altercation, the CNA's would be notified through CNA to CNA reports or by the nurse working with the resident. On [DATE] at 1:50 PM, a Licensed Practical Nurse (LPN) for the Resident's verbalized the LPN was unaware of any altercations involving the residents. The LPN verbalized the incident would have been part of the Alert Charting completed by the nurse at the time of the incident. The LPN reviewed the resident's record and verbalized the Alert charting expired 24 hours after the alert was entered and was no longer visible to staff working with the residents. On [DATE] at 2:59 PM, the Administrator verbalized an Individual Service Plan for the CNAs should have been initiated to ensure the CNAs were aware of the potential for altercations between the residents. The Administrator verbalized the Alert charting should have remained active for longer than 24 hours to ensure staff were aware of behaviors to monitor to prevent further altercations between the residents. The facility policy titled Abuse, Corporal Punishment, Involuntary Seclusion, Mistreatment, Neglect, Misappropriation of Resident Property, and Exploitation, dated ,[DATE], documented the procedure for protecting a resident from further abuse included protecting the resident from physical and psychosocial harm during and after an investigation. FRI # 375

F 0684

Level of harm - Immediate jeopardy

Residents Affected - Some

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 interview, clinical record review and document review, the facility failed to ensure high risk medications were administered timely for 10 of 46 residents (Resident #18, #12, #17, #4, #5, #32, #35, #26, #34, and #33). Findings include: Resident #18 Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A medication order for Resident #18, dated 02/08/20, documented: - [MEDICATION NAME] Sod-Tazobactam So Solution Reconstituted 4.5 grams, use 4.5 grams intravenously every six hours for open wound/culture results pending for bacterial infection. The medication administration audit report, dated 02/17/20-03/01/20, documented: - [MEDICATION NAME] Sod-Tazobactam So Solution Reconstituted 4.5 grams was scheduled to be administered on 02/17/20 at 7:00 AM and was administered at 12:03 PM. - [MEDICATION NAME] Sod-Tazobactam So Solution Reconstituted 4.5 grams was scheduled to be administered on [DATE] at 7:00 AM and was administered at 9:15 AM. A medication order for Resident #18, dated 02/07/20, documented: - [MEDICATION NAME] [MED] Solution 1000 milligrams (mg)/milliliter (ml), use 1000 mg intravenously every eight hours related to pressure ulcer of right buttock, stage 4. The medication administration audit report, dated 02/17/20-03/01/20, documented: - [MEDICATION NAME] [MED] Solution 1000mg/ml was scheduled to be administered on 02/17/20 at 8:00 AM and was administered at 12:03 PM. - [MEDICATION NAME] [MED] Solution 1000 mg/10 ml was scheduled to be administered on [DATE] at 8:00 AM and was administered at 10:38 AM. - [MEDICATION NAME] [MED] Solution 1000 mg/10 ml was scheduled to be administered on [DATE] at 4:00 PM and was administered at 7:52 PM. A medication order for Resident #18, dated 02/10/20, documented: - [MEDICATION NAME] tablet 800 mg give one tablet by mouth every four hours related to neuralgia and neuritis. The medication administration audit report, dated 02/17/20-03/01/20, documented: - [MEDICATION NAME] Tablet 800 mg was scheduled to be administered on 02/17/20 at 8:00 AM and was administered at 12:03 PM. - [MEDICATION NAME] Tablet 800 mg was scheduled to be administered on [DATE] at 4:00 PM and was administered at 7:52 PM. - [MEDICATION NAME] Tablet 800 mg was scheduled to be administered on 02/22/20 at 8:00 AM and was administered at 10:04 AM. - [MEDICATION NAME] Tablet 800 mg was scheduled to be administered on 02/25/20 at 8:00 AM and was administered at 10:37 AM. - [MEDICATION NAME] Tablet 20 mg was scheduled to be administered on 02/29/20 at 4:00 PM and was administered at 6:05 PM. A medication order for Resident #18, dated 02/07/20, documented: - [MEDICATION NAME] tablet 20 mg give 1 tablet by mouth every four hours for musculoskeletal therapy agents/muscle spasms and pain. The medication administration audit report, dated 02/17/20-03/01/20, documented: - [MEDICATION NAME] Tablet 20 mg was scheduled to be administered on 02/17/20 at 8:00 AM and was administered at 12:03 PM. - [MEDICATION NAME] Tablet 20 mg was scheduled to be administered on [DATE] at 4:00 PM and was administered at 7:52 PM. - [MEDICATION NAME] Tablet 20 mg was scheduled to be administered on 02/22/20 at 8:00 AM and was administered at 10:04 AM. - [MEDICATION NAME] Tablet 20 mg was scheduled to be administered on 02/25/20 at 8:00 AM and was administered at 10:37 AM. On 03/04/20 at 3:22 PM, Resident #18 verbalized medications were frequently administered late. The resident verbalized being most aware of the [MEDICATION NAME] and [MEDICATION NAME] being administered late. The resident verbalized when the [MEDICATION NAME] and [MEDICATION NAME] were given late the resident experienced muscle spasms and nerve pain. The resident verbalized when the [MEDICATION NAME] was given late the resident's pain would increase to an 11 out of 10 on a scale of one to 10. The resident verbalized when the resident's pain became greater than an 8 out of 10 it could take several hours before the resident's pain was at a level the resident considered bearable. Resident #12 Resident #12 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A medication order for Resident #12, dated 02/21/20, documented: - Meropenem Solution Reconstituted 1 gram, use 1 gram intravenously every 12 hours for extended spectrum beta-lactamases (ESBL) in the urine for 14 days. A medication order for Resident #12, dated 03/01/20, documented: - Meropenem Solution Reconstituted 1 gram, use 1 gram intravenously every 12 hours for ESBL in the urine for 14 days. The medication administration audit report, dated 02/17/20-03/01/20, documented: - Meropenem 1 gram was scheduled to be administered on 02/25/20 at 8:00 AM and was administered on 02/25/20 at 10:28 AM. - Meropenem 1 gram was scheduled to be administered on 03/01/20 at 8:00 PM and was missed. On 03/04/20 at 3:15 PM, Resident #12 verbalized the resident's antibiotics were sometimes administered late. The resident verbalized the resident was never given an explanation for the late administration but the resident felt angry because the resident knew the resident needed the antibiotics to get better and the late administration meant the resident's needs were not important to the staff. Resident #17 Resident #17 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A medication order for Resident #17, dated 12/20/19, documented: - Humalog Solution [LOC]/ml inject as per sliding scale subcutaneously before meals and at bedtime for diabetes mellitus. The medication administration audit report, dated 02/17/20-03/01/20, documented: - Humalog Insulin was scheduled to be administered on 02/17/20 at 4:00 PM and was administered at 6:52 PM. - Humalog Insulin was scheduled to be administered on 02/17/20 at 8:00 PM was administered at 10:22 PM. - Humalog Insulin was scheduled to be administered on [DATE] at 4:00 PM and was administered at 6:34 PM. - Humalog Insulin was scheduled to be administered on 02/21/20 at 4:00 PM and was administered at 7:04 PM. - Humalog Insulin was scheduled to be administered on 02/21/20 at 8:00 PM and was administered at 10:16 PM - Humalog Insulin was scheduled to be administered on 02/23/20 at 8:00 PM and was administered at 11:26 PM. - Humalog Insulin was scheduled to be administered on 0[DATE] at 4:00 PM and was administered at 6:50 PM. - Humalog Insulin was scheduled to be administered on 0[DATE] at 8:00 PM and was administered at 10:27 PM. - Humalog Insulin was scheduled to be administered on [DATE] at 8:00 PM and was administered at 10:41 PM. - Humalog Insulin was scheduled to be administered on 0[DATE] at 5:00 AM and was missed. A medication order for Resident #17, dated 07/30/18, documented: - [MEDICATION NAME] Acid capsule 250 mg give 2 capsules by mouth one time a day related to [MEDICAL CONDITION]. The medication administration audit report, dated 02/17/20-03/01/20, documented: - [MEDICATION NAME] Acid 500 mg was scheduled to be administered on 02/17/20 at 8:00 PM and was administered at 10:31 PM. - [MEDICATION NAME] Acid 500 mg was scheduled to be administered on 02/21/20 at 8:00 PM and was administered at 10:09 PM. - [MEDICATION NAME] Acid 500 mg was scheduled to be administered on 02/23/20 at 8:00 PM and was administered at 11:22 PM. - [MEDICATION NAME] Acid 500 mg was scheduled to be administered on 0[DATE] at 8:00 PM and was administered at 10:29 PM. - [MEDICATION NAME] acid 500 mg was scheduled to be administered on [DATE] at 8:00 PM and was administered at 10:44 PM. - [MEDICATION NAME] Acid 500 mg was scheduled to be administered on 03/01/20 at 8:00 PM and was administered at 10:35 PM. A medication order for Resident #17, dated 07/2[DATE]9, documented: - [MEDICATION NAME] [MED] tablet 5 mg, give 1 tablet by mouth two times a day for chronic pain. The medication administration audit report, dated 02/17/20-03/01/20, documented: - [MEDICATION NAME] 5 mg was scheduled to be administered on 02/17/20 at 8:00 PM and was administered at 10:35 PM. - [MEDICATION NAME] 5 mg was scheduled to be administered on 02/21/20 at 8:00 PM and was administered at 10:12 PM. - [MEDICATION NAME] 5 mg was scheduled to be administered on 02/23/20 at 8:00 PM and was administered at 11:25 PM. - [MEDICATION NAME] 5 mg was scheduled to be administered on 0[DATE] at 5:00 AM and was missed. - [MEDICATION NAME] 5 mg was scheduled to be administered on 0[DATE] at 8:00 PM and was administered at 10:31 PM. - [MEDICATION NAME] 5 mg was scheduled to be administered on [DATE] at 8:00 PM and was administered at 10:49 PM. - [MEDICATION NAME] 5 mg was scheduled to be administered on 03/01/20 at 8:00 PM and was administered at 10:39 PM.

Resident #4 Resident #4 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #4 physician order

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) [REDACTED]. Give 5 mg by mouth once a day related to unspecified dementia without behavioral disturbance. The Medication Administration Audit Report documented Resident #4 was administered [MEDICATION NAME] 5 mg tablet administration time on the following days: -February 22, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 9:40 PM. -February 23, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 6:33 PM. -February 24, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 12:02 AM. -February 25, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 6:07 PM. -February 26, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 6:27 PM. Resident #4's physician order [REDACTED]. Give 0.1 mg by mouth once a day related to orthostatic [MEDICAL CONDITION]. The Medication Administration Audit Report documented Resident #4 was administered fludrocortisone acetate tablet 0.1 mg administration time on the following days: -February 24, 2020, fludrocortisone acetate was scheduled to be administered at 8:00 AM and was not administered until 2:25 PM. -February 28, 2020, fludrocortisone acetate was scheduled to be administered at 8:00 AM and was not administered until 10:53 AM. -February 29, 2020, fludrocortisone acetate was scheduled to be administered at 8:00 AM and was not administered until 10:22 AM. -March 1, 2020, fludrocortisone acetate was scheduled to be administered at 8:00 AM and was not administered until 10:25 AM. Resident #4's physician order [REDACTED]. Give 5 mg by mouth two times a day for dementia. The Medication Administration Audit Report documented Resident #4 was administered memantine HCl tablet 5 mg administration time on the following days: -February 24, 2020, memantine HCl was scheduled to be administered at 7:00 AM and was not administered until 2:27 PM. -February 24, 2020, memantine HCl was scheduled to be administered at 7:00 PM and was not administered until 12:02 AM. -February 28, 2020, memantine HCl was scheduled to be administered at 7:00 AM and was not administered until 3:54 PM. -February 29, 2020, memantine HCl was scheduled to be administered at 7:00 AM and was not administered until 1:34 PM. Resident #4's physician order [REDACTED]. Give 0.5 mg by mouth two times a day related to tumor. The Medication Administration Audit Report documented Resident #4 was administered ropinirole HCl tablet 0.5 mg administration time on the following days: -February 20, 2020, ropinirole HCl was scheduled to be administered at 4:00 PM and was not administered until 9:40 PM. -February 22, 2020, ropinirole HCl was scheduled to be administered at 4:00 PM and was not administered until 6:33 PM. -February 24, 2020, ropinirole HCl was scheduled to be administered at 4:00 PM and was not administered until 12:02 AM. -February 24, 2020, ropinirole HCl was scheduled to be administered at 8:00 AM and was not administered until 2:26 PM. -February 25, 2020, ropinirole HCl was scheduled to be administered at 4:00 PM and was not administered until 6:07 PM. -February 26, 2020, ropinirole HCl was scheduled to be administered at 4:00 PM and was not administered until 6:28 PM. -February 28, 2020, ropinirole HCl was scheduled to be administered at 8:00 AM and was not administered until 10:55 PM. -February 29, 2020, ropinirole HCl was scheduled to be administered at 8:00 AM and was not administered until 10:23 AM. -March 1, 2020, ropinirole HCl was scheduled to be administered at 8:00 AM and was not administered until 10:26 AM. Resident #4's physician order [REDACTED]. Give 10 mg by mouth three times a day for orthostatic hypertension. The Medication Administration Audit Report documented Resident #4 was administered [MEDICATION NAME] HCl 5 mg tablet administration time on the following days: -February 20, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 9:40 PM. -February 21, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 12:00 PM and was not administered until 4:26 PM. -February 22, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 6:33 PM. -February 24, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 2:25 PM. -February 24, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 12:02 AM. -February 25, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 6:27 PM. -February 28, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 10:55 AM. -February 28, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 12:00 PM and was not administered until 2:25 PM. -February 29, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 10:36 AM. -February 29, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 12:00 PM and was not administered until 2:05 PM. Resident #4's physician order [REDACTED]. Give one tablet by mouth once a day for [MEDICAL CONDITION]. The Medication Administration Audit Report documented Resident #4 was administered [MEDICATION NAME] 5 mg tablet administration time on the following days: -February 20, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 6:33 PM. -February 22, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 6:33 PM. -February 24, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 12:02 AM. -February 25, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 6:07 PM. -February 26, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 6:28 PM. -March 1, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 10:26 AM. Resident #4's physician order [REDACTED]. Give one capsule by mouth every 6 hours for recurrent [MEDICAL CONDITION] (C. Diff) for 14 days. The Medication Administration Audit Report documented Resident #4 was administered [MEDICATION NAME] HCl 125 mg capsule more than two hours late from the original administration time on the following days: -February 26, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 PM and was not administered until 2:12 AM. -February 28, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 10:55 AM. -February 29, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 10:37 AM. -February 27, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 2:00 AM and was not administered until 4:49 AM. -March 1, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 10:26 AM. Resident #5 Resident #5 was admitted to the facility on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. Resident #5's physician order [REDACTED]. Give 10 mg by mouth one time a day for hypertension. The Medication Administration Audit Report documented Resident #5 was administered [MEDICATION NAME] 10 mg tablet administration time on the following days: -February 17, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 10:05 AM. -February 19, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 10:27 AM. -February 22, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 11:43 AM. -February 24, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 10:09 AM. -February 25, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 11:47 AM. -February 26, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 10:17 AM. -February 27, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 10:40 AM. -March 1, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 12:41 PM. Resident #5's physician order [REDACTED]. Give 10 mg by mouth three times a day for spasms/pain. The Medication Administration Audit Report documented Resident #5 was administered [MEDICATION NAME] HCl 10 mg tablet administration time on the following days: -February 17, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 10:06 AM. -February 17, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 6:56 PM. -February 18, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 6:21 PM. -February 19, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 10:27 AM. -February 19, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 7:32 PM. -February 20, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 7:35 PM. -February 21, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 12:00 PM and was not administered until 3:06 PM. -February 21, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 6:53 PM. -February 22, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 8:03 PM. -February 24, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 10:09 AM. -February 25, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 11:47 AM. -February 26, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 10:17 AM. -February 26, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 6:40 PM. -February 27, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 10:40 AM. -February 27, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 10:47 PM. -February 28, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 1:25 PM. -February 28, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM and was not administered until 10:40 PM. -March 1, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 8:00 AM and was not administered until 12:51 PM. -March 1, 2020, [MEDICATION NAME] HCl was scheduled to be administered at 4:00 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORMSBY POST ACUTE REHAB	3050 N ORMSBY CARSON CITY, NV 89703

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) and was not administered until 6:51 PM. Resident #5's physician order [REDACTED]. Give 100 mg by mouth two times a day for hypertension. The Medication Administration Audit Report documented Resident #5 was administered [MEDICATION NAME] 100 mg tablet administration time on the following days: -February 17, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 10:05 AM. -February 17, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 6:56 PM. -February 18, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 6:21 PM. -February 19, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 10:27 AM. -February 19, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 7:32 PM. -February 20, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 7:35 PM. -February 21, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 6:53 PM. -February 22, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 11:43 AM. -February 22, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 8:03 PM. -February 24, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 10:09 AM. -February 25, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 11:47 AM. -February 25, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 7:36 PM. -February 26, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 10:17 AM. -February 26, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 6:40 PM. -February 27, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 10:40 AM. -February 27, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 10:47 PM. -February 28, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 1:24 PM. -February 28, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 10:40 PM. -March 1, 2020, [MEDICATION NAME] was scheduled to be administered at 8:00 AM and was not administered until 12:51 PM. -March 1, 2020, [MEDICATION NAME] was scheduled to be administered at 4:00 PM and was not administered until 6:51 PM. Resident #32 Resident #32 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician order [REDACTED]. - [MED] Tablet 3.125 mg was scheduled to be administered on 02/22/20 at 8:00 PM and was administered at 10:45 PM. - [MED] Tablet 3.125 mg was scheduled to be administered on 02/24/20 at 8:00 PM and was administered at 12:06 AM on 02/25/20. - [MED] Tablet 3.125 mg was scheduled to be administered on 02/25/20 at 8:00 PM and was administered at 10:09 PM. - [MED] Tablet 3.125 mg was scheduled to be administered on [DATE] at 8:00 AM and was administered at 10:24 AM. - [MED] Tablet 3.125 mg was scheduled to be administered on [DATE] at 8:00 PM and was administered at 10:02 PM. - [MED] Tablet 3.125 mg was scheduled to be administered on 02/29/20 at 8:00 AM and was administered at 10:18 AM. - [MED] Tablet 3.125 mg was scheduled to be administered on 03/01/20 at 8:00 AM and was administered at 10:20 AM. A physician order [REDACTED]. - [MEDICATION NAME] Capsule 100 mg was scheduled to be administered on 02/24/20 at 8:00 PM and was administered on 02/25/20 at 12:06 AM. - [MEDICATION NAME] Capsule 100 mg was scheduled to be administered on 02/25/20 at 8:00 PM and was administered at 10:09 PM. - [MEDICATION NAME] Capsule 100 mg was scheduled to be administered on [DATE] at 8:00 AM and was administered at 10:24 AM. - [MEDICATION NAME] Capsule 100 mg was scheduled to be administered on [DATE] at 8:00 PM and was administered at 10:02 PM. - [MEDICATION NAME] Capsule 100 mg was scheduled to be administered on 02/29/20 at 8:00 AM and was administered at 10:18 AM. - [MEDICATION NAME] Capsule 100 mg was scheduled to be administered on 03/01/20 at 8:00 AM and was administered at 10:20 AM. - [MEDICATION NAME] Capsule 100 mg was scheduled to be administered on 02/29/20 at 8:00 AM and was administered at 10:18 AM. A physician order [REDACTED]. - [MEDICATION NAME] [MED] Tablet 100 mg was scheduled to be administered on 02/22/20 at 8:00 PM and was administered at 10:45 PM. - [MEDICATION NAME] [MED] Tablet 100 mg was scheduled to be administered on 02/24/20 at 8:00 PM and was administered on 02/25/20 at 12:06 AM. - [MEDICATION NAME] [MED] Tablet 100 mg was scheduled to be administered on 02/25/20 at 8:00 PM and was administered at 10:09 PM - [MEDICATION NAME] [MED] Tablet 100 mg was scheduled to be administered on [DATE] at 8:00 AM and was administered at 10:24 AM. - [MEDICATION NAME] [MED] Tablet 100 mg was scheduled to be administered on [DATE] at 8:00 PM and was administered at 10:02 PM. - [MEDICATION NAME] [MED] Tablet 100 mg was scheduled to be administered on 02/29/20 at 8:00 AM and was administered at 10:18 AM. - [MEDICATION NAME] [MED] Tablet 100 mg was scheduled to be administered on 03/01/20 at 8:00 AM and was administered at 10:18 AM. A physician order [REDACTED]. - [MEDICATION NAME] Tablet 10 mg was scheduled to be administered on 02/29/20 at 8:00 AM and was administered at 10:18 AM. - [MEDICATION NAME] Tablet 10 mg was scheduled to be administered on 03/01/20 at 8:00 AM and was administered at 10:20 AM. Resident #35 Resident #35 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician order [REDACTED]. - Apixaban 5 mg was scheduled to be administered on 02/25/20 at 8:00 AM and was administered at 10:11 AM. - Apixaban 5 mg was scheduled to be administered on [DATE] at 8:00 AM and was administered at 12:34 PM. - Apixaban 5 mg was scheduled to be administered on 03/01/20 at 8:00 AM and was administered at 10:49 AM. A physician order [REDACTED]. - [MEDICATION NAME] Sodium Solution 1 gm was scheduled to be administered on 0[DATE] at 8:00 AM and was administered at 11:59 AM. - [MEDICATION NAME] Sodium Solution 1 gm was scheduled to be administered on 0[DATE] at 8:00 PM and was administered at 10:30 PM. - [MEDICATION NAME] Sodium Solution 1 gm was scheduled to be administered on [DATE] at 8:00 PM and was administered at 11:15 PM. - [MEDICATION NAME] Sodium Solution 1 gm was scheduled to be administered on 03/01/20 at 8:00 AM and was administered at 10:59 AM. A physician order [REDACTED]. A physician order [REDACTED]. - Duloxetine [MED] Capsule was scheduled to be administered on [DATE] at 8:00 AM and was administered at 12:34M. - Duloxetine [MED] Capsule was scheduled to be administered on 03/01/20 at 8:00 AM and was administered at 10:49 AM. A physician order [REDACTED]. - Calorie Dense Medication Pass 60 ml was scheduled to be administered on [DATE] at 8:00 AM and was administered at 11:59 AM. - Calorie Dense Medication Pass 60 ml was scheduled to be administered on [DATE] at 4:00 PM and was administered at 6:42 PM. - Calorie Dense Medication Pass 60 ml was scheduled to be administered on 03/01/20 at 8:00 AM and was administered at 10:49 AM. Resident #26 Resident #26 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The medication administration audit report, dated 02/17/20-03/01/20, documented: - A FSBS was scheduled to be completed on 02/17/20 at 7:00 AM and was completed at 11:49 AM. - A FSBS was scheduled to be completed on 02/21/20 at 7:00 AM and was completed at 10:18 AM. - A FSBS was scheduled to be completed on 02/22/20 at 7:00 AM and was completed at 11:12 AM. - A FSBS was scheduled to be completed on 03/01/20 at 7:00 AM and was completed at 9:20 AM. A physician's orders [REDACTED].

F 0694 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide for the safe, appropriate administration of IV fluids for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, document review and clinical record review the facility failed to ensure a resident received intravenous (IV) fluids as ordered by a physician for 1 of 1 resident (Resident #31). Findings include: Resident #31 Resident #31 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A progress note, written by the Advanced Registered Nurse Practitioner (ARNP), dated [DATE] at 1:29 PM, documented Resident #31 expressed not feeling well for a couple of days and Resident #31 had a decreased appetite. A progress note dated 11/15/19 at 1:49 AM, documented Licensed Practical Nurse (LPN) #1 was unable to obtain a urine sample due to no urine output. A progress note dated 11/15/19 at 2:23 AM, documented LPN #2 was unable to start an IV line. A progress note by the ARNP, dated 11/15/19 at 12:29 PM, documented the IV fluids were ordered for immediate administration (STAT) on 11/1[DATE]9 for hydration due to Resident #31 having decreased oral intake had not been given and LPN #3 had expressed to the ARNP it was because an IV pump was not available. Resident #31's clinical record lacked documented evidence the ARNP was notified Resident #31 had no urinary output, or the IV fluids, and the UA were not completed as ordered. A progress note written by the ARNP, dated 11/18/19 at 1:18 PM, documented Resident #31 was experiencing crackles at the bases of both lungs and had audible gurgling. On 11/1[DATE]9, the ARNP had ordered one liter of IV fluid and a urinalysis with a culture but both were not completed as ordered. The ARNP documented the resident had worsening pneumonia, decreased mental status, and lethargy. Resident #31's Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. On 03/02/20 at 10:52 AM, the ARNP verbalized the ARNP was not notified Resident #31 had not received the IV fluids STAT until the ARNP asked LPN #3 about it the next day. The ARNP confirmed the ARNP had not been notified by nursing staff Resident #31 had no urine output on 11/15/19. The ARNP verbalized Resident #31 would have been sent to the emergency room immediately after the ARNP was notified because the resident had a history of [REDACTED]. The ARNP confirmed the IV fluids ordered STAT on 11//1[DATE]9 were not administered until 11/15/19. The ARNP verbalized STAT orders should be done right now and notification to the practitioner of an inability to complete an order should have been completed within one or two hours. On 03/04/20 at 1:49 PM, the Regional Director of Nursing verbalized STAT was defined as immediately and no medication or fluids ordered STAT should wait for twenty-four

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORMSBY POST ACUTE REHAB	3050 N ORMSBY CARSON CITY, NV 89703

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0694 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 5) hours before being administered. The facility policy titled Medication Ordering and Receiving From Pharmacy Provider, dated 01/20, documented STAT medications that were available onsite would be administered from onsite stock prior to the next pharmacy delivery. The facility policy titled Administration of IV Fluids and Medications, dated 08/16, documented continuous IV fluids could be administered by flow regulator tubing until a pump arrived from the pharmacy. A facility policy titled CUBEX Station Policies and Procedures, revised 09/18. Documented the CUBEX (an automated medication dispensing machine) station was to be used for emergency, first-doses, and other situations where medications were needed prior to the next scheduled pharmacy delivery. The facility Inventory on Hand, C11, dated 03/02/20, documented 0.9% [MED] was a stocked medication and available in the CUBEX machine. The facility Inventory on Hand, C11, dated 03/02/20, documented IV rate flow regulator (Dial A Flo) was a stocked item and available in the CUBEX machine. The facility care path titled Change in Condition: When to report to the MD/NP/PA, dated 2003, documented that any marked change unrelieved by measures prescribed with an acute or sudden onset were to be reported immediately. The facility form titled Interact 4.0 SBAR communication Form, dated 2014, documented decreased urine output as a reportable change in condition. The facility lacked documented evidence of a definition that included specified timeframes for a STAT administration of medication. Complaint #NV 417
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review the facility failed to ensure nursing staff had appropriate competencies to provide nursing services to the residents for 26 of 26 licensed nursing staff and documented evidence of intravenous (IV) training and certification for 1 of 1 Licensed Practical Nurse (LPN). Findings include: Resident #46 Resident #46 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Resident #46's Medication Administration Record [REDACTED]. On [DATE] at 7:22 AM, a (LPN) verbalized the LPN was IV certified and routinely administered IV medications and fluids to residents. On [DATE] at 10:50 AM, the Staff Development Coordinator (SDC) verbalized the LPN gave IV medications to residents whenever needed. The SDC confirmed the facility had no certificate or evidence of IV training on site. The SDC explained the SDC knew the LPN was competent because the SDC had worked with the LPN at another facility and the LPN had informed the SDC that the LPN was competent and certified. On 3/3/20 at 3:00 PM, the Administrator verbalized the LPN IV certification was not on site prior to the LPN administering IV medications or fluids, no one in the facility had verified the LPN was certified for IV therapy and the LPN's employee training file lacked documented evidence the LPN had received training or certification for administering IV therapy. On 03/04/20 at 12:50 PM, the LPN verbalized the facility did not have the LPN's IV training or certification documentation onsite when the LPN provided the IV medication to Resident #46. Resident #26 Resident #26 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A nursing progress note dated [DATE] at 6:30 AM, documented Resident #26 complained of left shoulder and arm pain. A nursing progress note dated [DATE] at 12:05 PM, documented Resident #26 was complaining of shortness of breath. An Advanced Registered Nurse Practitioner (ARNP) progress note dated [DATE], documented Resident #26 was found crying, seated in a wheelchair, was experiencing shortness of breath, and had a dull chest pain radiating to the left shoulder. The ARNP obtained a pulse oximetry that indicated Resident #26's [MED]gen saturation was low. The ARNP administered [MEDICATION NAME] to the resident, placed the resident on a non-rebreather mask, and arranged for Resident #26 to go to the hospital. Resident #26's facility care plan dated 12/20/19, documented Resident #26 had [MEDICAL CONDITION] and interventions included monitoring heart rate, [MEDICAL CONDITION], [MED]gen saturation, and shortness of breath. On 03/02/20 at 9:08 AM, the Director of Nursing verbalized the facility standard of practice for nursing was Lippincott Manual of Nursing Practice, 11th edition. On 03/05/20 at 7:31 AM, a Licensed Practical Nurse (LPN#1) verbalized the LPN#1 had not been trained on pharmacy policies, standards of practice, or facility policies. On 03/05/20 at 8:08 AM, a Licensed Practical Nurse (LPN#2) verbalized the LPN#2 had not been trained or educated on current quality improvement initiatives, pharmacy policies, standards of practice, or facility policies. On 03/05/20 at 8:17 AM, a Registered Nurse (RN) verbalized the RN had not been trained or educated on current quality improvement initiatives, pharmacy policies, standards of practice, or facility policies. On 03/05/20 at 8:20 AM, a Licensed Practical Nurse (LPN#3) verbalized the LPN#3 had not been trained or educated on current quality improvement initiatives, pharmacy policies, standards of practice, or facility policies. Lippincott Manual of Nursing Practice, 11th edition documented any complaint of chest pain was to be thoroughly evaluated, the resident was to rest, and the resident given [MEDICATION NAME]. Twenty-six licensed nursing employee files lacked documented evidence of training and education to the facilities standards of practice. Complaint #NV 417
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Observe each nurse aide's job performance and give regular training.** Based on interview and document review the facility failed to provide 12 hours of in-service training and annual performance reviews for 37 of 37 certified nursing assistants (CNA). Findings include: Thirty-seven CNA employee files lacked documented evidence of completion of 12 hours of facility provided in-service training during the past 12 months. On 03/05/20 at 12:04 PM, the Regional Director of Nursing Services (RDNS) verbalized 12-hours of CNA in-services were required to be provided by the facility annually. On 03/05/20 at 2:09 PM, the Staff Development Coordinator (SDC) verbalized the SDC coordinated the staff development for the CNA's and was responsible for coordinating the 12 hours of annual CNA in-services. On 03/05/20 at 2:10 PM, the Administrator verbalized annual evaluations were to be completed annually based on the anniversary month of the employee's initial hire date. Annual evaluations were handled through human resources (HR), tracked by HR, and no report was provided to the administrator listing outstanding annual evaluations. On 03/04/20 at 12:48 PM, the Human Resources representative verbalized HR gave the evaluations due to each supervising manager monthly, kept a list of the evaluations given to the managers for tracking, and when the next month's evaluations were given to the managers they would also be reminded of the outstanding evaluations due to HR. The HR representative verbalized evaluations were frequently not completed, and the Administrator was given a list of outstanding employee evaluations monthly. The facility job description titled Nursing Assistant, updated March 2017, documented 12 hours of continuing education per year was provided by the facility. A facility report titled Evaluations Given to Managers, dated 02/05/19, documented four employee evaluations given to managers and were not completed or returned to HR. A facility report titled Evaluations Given to Managers, dated 03/06/19, documented five employee evaluations given to managers and were not completed or returned to HR. A facility report titled Evaluations Given to Managers, dated 0[DATE]1/19, documented one employee evaluation given to managers and were not completed or returned to HR. A facility report titled Evaluations Given to Managers, dated 05/22/19, documented five employee evaluations given to managers and were not completed or returned to HR. A facility report titled Evaluations Given to Managers, dated 06/26/19, documented one employee evaluation given to managers and were not completed or returned to HR. A facility report titled Evaluations Given to Managers, dated 10/23/19, documented eleven employee evaluations given to managers and were not completed or returned to HR. A facility report titled Evaluations Given to Managers, dated 12/05/19, documented four evaluations given to managers and were not completed or returned to HR. A facility report titled Evaluations Given to Managers, dated 02/05/19, documented six employee evaluations given to managers and were not completed or returned to HR. A facility report titled Evaluations Given to Managers, dated 12/31/19, documented one evaluation given to managers and were not completed or returned to HR. A facility report titled Evaluations Given to Managers, dated 01/29/20, documented four evaluations given to managers and were not completed or returned to HR.
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Based on observation, interview and document review the Administrator, Director of Nursing (DON), and Regional Director of Nursing Services (RDON) failed to ensure staff had the pharmacy resources, standards of practice and references accessible to nursing staff for providing care to residents and the Administrator failed to act on the high rate of late medication administration through submission and review by the Quality Assurance and Process Improvement committee. The facility report titled Medication Administration Report, dated 02/17/20 - 03/01/20, documented 495 pages of late medication administration for the facility that occurred during the timeframe 02/17/20 through 03/01/20. On [DATE] at 1:16 PM, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORMSBY POST ACUTE REHAB	3050 N ORMSBY CARSON CITY, NV 89703

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) Director of Nursing (DON) verbalized the DON reviewed the medication administration report daily and was aware of the number of late medications administered. The DON verbalized the medication administration report was consistently over 400 pages of late medications weekly. The Administrator and quality improvement committee had been advised of the ongoing problem of late medication administration since October of 2019, however, no Performance Improvement Project had been started. On 03/05/20 at 1:59 PM, the Administrator verbalized the quality assurance and performance improvement committee (QAPI) had not consistently reviewed or evaluated the pharmacy reports or medication administration reports and had not identified late administration of medications as an area of concern to be addressed. The Administrator verbalized the only area of concern addressed by QAPI for medications was missed documentation on resident medication administration records. On 03/05/20 at 2:10 PM, the Regional Director of Nursing Services (RDNS) verbalized QAPI had not addressed or reviewed late administration of medications and it was an expectation QAPI would address any issue which generated a late medication report that was 495 pages long for a two week period. On 03/02/20 at 9:08 AM, the DON verbalized the facility standard of practice for nursing was Lippincott Manual of Nursing Practice, 11th edition. The DON verbalized the book was kept in the DON's office, not at the nursing stations and was not accessible to staff online. The DON verbalized no pharmacy policies were accessible to staff for reference. On 03/05/20 at 7:31 AM, a Licensed Practical Nurse (LPN#1) verbalized the LPN#1 had not been trained on pharmacy policies, standards of practice, or facility policies. On 03/05/20 at 8:08 AM, a Licensed Practical Nurse (LPN#2) verbalized the LPN#2 had not been trained or educated on current quality improvement initiatives, pharmacy policies, standards of practice, or facility policies. On 03/05/20 at 8:17 AM, a Registered Nurse (RN) verbalized the RN had not been trained or educated on current quality improvement initiatives, pharmacy policies, standards of practice, or facility policies. On 03/05/20 at 8:20 AM, a Licensed Practical Nurse (LPN#3) verbalized the LPN#3 had not been trained or educated on current quality improvement initiatives, pharmacy policies, standards of practice, or facility policies. Twenty-six licensed nursing employee files lacked documented evidence of training and education to the facilities standards of practice, pharmacy policies or facility policies. The facility job description Executive Director, updated May 2012, documented the Executive Director was responsible for the quality of care delivered by the facility and leading the process to implement programs to provide quality care. The facility policy titled Nursing Personnel Education and Training, published 11/2016, documented nursing personnel would receive education and training to provide care in line with professional standards of practice.
F 0943 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.** Based on interview, record review and document review, the facility failed to ensure Certified Nursing Assistants (CNA) obtained Elder Abuse training upon hire and annually thereafter for 14 of 14 CNA's. Findings include: Employee #1 Employee #1 was hired at the facility on 01/11/18, as a CNA. Employee #1 lacked documented evidence Elder Abuse Training was completed in 2019. The last Elder Abuse training was taken on 11/28/18. Employee #2 Employee #2 was hired at the facility on 12/16/19, as a CNA. Employee #2's personnel file lacked documented evidence Elder Abuse Training was completed upon hire. Employee #3 Employee #3 was hired at the facility on 03/29/19, as a CNA. Employee #3's personnel filed lacked documented evidence Elder Abuse training had been completed upon hire. Employee #4 Employee #4 was hired at the facility on 07/18/19, as a CNA. Employee #4's personnel file lacked documented evidence Elder Abuse training was completed upon hire. Employee #5 Employee #5 was hired at the facility on 01/27/20, as a CNA. Employee #5's personnel filed lacked documented evidence Elder Abuse training was completed upon hire. Employee #6 Employee #6 was hired at the facility on 01/02/20, as a CNA. Employee #6's personnel filed lacked documented evidence Elder Abuse Training was completed upon hire. Employee #7 Employee #7 was hired at the facility on 01/31/19, as a CNA. Employee #7's personnel filed documented Elder Abuse training was completed on 01/31/19, however lacked documented evidence Elder Abuse training was completed annually for 2020. Employee #8 Employee #8 was hired at the facility on 02/05/20, as a CNA. Employee #8's personnel file lacked documented evidence Elder Abuse training was completed upon hire. Employee #9 Employee #9 was hired at the facility on 11/29/17, as a CNA. Employee #9's personnel file documented Elder Abuse training was last completed on 11/28/28, however lacked documented evidence of Elder Abuse training completed annually thereafter. Employee #10 Employee #10 was hired at the facility on 02/24/20, as a CNA. Employee #10's personnel filed lacked documented evidence Elder Abuse Training was completed upon hire. Employee #11 Employee #11 was hired at the facility on 05/28/19, as a CNA. Employee #11's personnel filed lacked documented evidence Elder Abuse training had been completed upon hire. Employee #12 Employee #12 was hired at the facility on 05/28/19, as a CNA. Employee #12's personnel file lacked documented evidence Elder Abuse training was completed upon hire. Employee #13 Employee #13 was hired at the facility on 02/10/20, as a CNA. Employee #13's personnel filed lacked documented evidence Elder Abuse training had been completed upon hire. Employee #14 Employee #14 was hired at the facility on 01/27/20, as a CNA. Employee #14's personnel filed lacked documented evidence Elder Abuse training was completed upon hire. On 03/05/20 at 1:59 PM, the Administrator explained the Administrator was responsible for reviewing staff Elder Abuse training and documenting the training was completed for each employee. The only requirement expected of staff was to sign off on a piece of paper indicating the training was completed and to complete the quiz. However, as the responsible party, the Administrator explained they were not checking the quiz for accuracy or maintaining certificates indicating completion of Elder Abuse training. The Administrator confirmed there was no documented evidence employees had completed Elder Abuse training upon hire nor annually thereafter. On 03/05/20 at 1:59 PM, the Administrator and Regional Director of Nursing Services (RDNS) verbalized the facility abuse trainer and coordinator was the Administrator. The facility policy titled Abuse Training, last updated September 2017, documented as a part of the employee screening process for hire, the facility was to train staff upon hire and annually thereafter in accordance with state and federal guidelines.