

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Arbor Care Centers-O'Neill LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1102 North Harrison Street O' Neill, NE 68763	

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)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42360</p> <p>Licensure Reference Number 175 NAC 12-006.06B</p> <p>Based on record review and interviews; the facility failed to maintain a system to identify repeat resident grievances, and to ensure sustainable resolutions of resident concerns. The sample size was 7 and the facility census was 34.</p> <p>Findings are:</p> <p>Review of the facility's undated Grievance Policy revealed the following:</p> <ul style="list-style-type: none"> <li>-It was the facilities policy that each resident had the right to voice grievances without discrimination or fear of reprisal.</li> <li>-The facility ensured prompt resolution to all grievances and kept the resident and/or resident representatives informed throughout the investigation and resolution process.</li> <li>-The facility grievance process included a designated person to receive and track grievances through their conclusion, lead necessary investigations, maintain confidentiality, communicate with residents throughout the process, and coordinate with other State and Federal Agencies as required.</li> <li>-The objective of the grievance policy was to ensure the facility made prompt efforts to resolve resident grievances, and the facility reviewed the facility Grievance Policy with the Resident Council annually or as needed.</li> <li>-All grievances identified during Resident Council meetings were immediately submitted to the grievance official for investigation and resolution.</li> <li>-The facility strived for prompt resolutions for all grievances and completed written responses to the resident/s or resident representative/s which included the date of the grievance, a summary, steps of the investigation, findings, and dated resolutions, outcomes, and actions.</li> </ul> <p>Review of the Resident Council Meeting Minutes from 3/2/23 through 4/5/24 revealed the following concerns:</p> <p>(continued on next page)</p>

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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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-3/2/23 -cold food especially at breakfast, not answering call lights in a timely manner, not getting [NAME] and ice every day, television channels not working properly, and 6 residents reported missing laundry/clothing.</p> <p>-4/6/23 -cold food especially for breakfast, meat being tough and hard to eat, not answering call lights in a timely manner, not getting fresh water and ice daily, and snacks not being offered daily. In addition, there was no evidence old business was discussed, or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>-5/4/23 -pasta not being fully cooked, meat being tough and hard to eat, not answering call lights in a timely manner, getting ice but not fresh water daily. In addition, there was no evidence old business was discussed or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>-6/9/23 -not answering call lights in a timely manner, getting ice but no fresh water, and missing clothing/personal items. In addition, there was no evidence old business was discussed or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>-7/7/23 -residents needed help filling out menus, one hallway not receiving fresh ice water, and missing laundry. In addition, there was no evidence old business was discussed or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>-8/4/23 -residents needed help filling out menus, not answering call lights in a timely manner, and loud environment during mealtime. In addition, there was no evidence old business was discussed or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>-9/1/23 -call lights were not answered in a timely fashion and not left within reach of residents, staff being loud at the nurses' station, ordered treatments not being completed, and medications not re-ordered in a timely manner. In addition, there was no evidence old business was discussed or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>-10/12/23 -snack cart not always coming around on time, overcooked meat and undercooked pasta, call lights not being answered in a timely manner, treatment not being completed as orders, medications not getting reordered such as bedside items, residents not being notified of medication changes, and clothing but put away in the wrong closets. In addition, there was no evidence old business was discussed or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>-11/3/23 -options available on the snack cart, call lights being answered in a timely manner, convenience of medication administration times, and timely reordering of medications. In addition, there was no evidence old business was discussed or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>-12/1/23 -snack cart options, call lights being answered in a timely manner, variety of available activities, and missing laundry/clothing items. In addition, there was no evidence old business was discussed or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-1/18/24 -snack cart options and availability times, overcooked and hard to eat food, linen availability, call lights being answered in a timely manner, ice availability in resident room, not respecting resident choice to not eat in the dining room, adequacy of staff, and beds not getting made in the mornings. In addition, there was no evidence old business was discussed or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>-2/2/24 -snack cart not available until after residents were in bed, linen availability, and staff's attitude towards resident's needs. In addition, there was no evidence old business was discussed or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>-3/1/24 -cold, undercooked and or overcooked food, snack cart not offered until 10:00 PM or later, not getting ice, staff had not provided assistance to walk residents to meals, availability of linens, and availability of activities. In addition, there was no evidence old business was discussed or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>-4/5/24 -available options on the snack carts, and occasional missing laundry. In addition, there was no evidence old business was discussed or included what the facility did to resolve the resident's concerns from the previous month.</p> <p>Review of the facility Grievance log dated June 2023 through April 2024 revealed the facility received 16 grievances involving call light response times and availability, 9 grievances involving food options and palatability, 7 grievances involving snack cart options and availability, 6 grievances involving treatment and medication concerns, 4 grievances involving missing laundry items, and 4 grievances involving the availability of fresh water/ice. There was no evidence the facility had implemented corrective actions or sustained resolutions to the grievances to prevent repeat concerns from occurring.</p> <p>On 4/17/24 at 10:15 AM Surveyor 42360 met with 7 Resident Council Residents Representatives (Resident's 4, 6, 22, 25, 27, 31, and 33). The primary concern was timely resolution of resident grievances, or concerns occurring during the Resident Council meetings. The concerns revolved around resolution of missing laundry, palatability of food including tough meat, food temperatures, and snack choices. The group was also concerned about timely response to call lights. The members were aware of the grievance process. During the meeting all residents in attendance agreed the facility had not come up with solutions to grievances or got back to them to see if they were in agreement with the facility plan or resolution.</p> <p>During an interview on 4/17/24 at 12:45 PM the facility Administrator confirmed the facility had not implemented a grievance process that had consistently identified repeat grievances, or implemented a sustainable process to ensure repeat grievances were consistently resolved. In addition, the facility had no evidence the facility presented sustainable resolutions to the Resident Council to ensure the resolutions were acceptable to those involved in the grievance process.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42679</p> <p>Licensure Reference Number 175 NAC 12-006.05(1)</p> <p>Based on record review and interview, the facility failed to provide Resident 35 or the resident's representative the required bed hold notification when the resident was transferred to the hospital. The sample size was 1 and the facility census was 34.</p> <p>Findings are:</p> <p>Review of the undated facility policy Bed Hold Notice Upon Transfer revealed the facility would provide the resident and/or resident representative written notice at the time of transfer for hospitalization or therapeutic leave, which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. In the event of an emergency transfer, written notice will be provided within 24 hours.</p> <p>Review of Resident 35's Hospital Transfer Form revealed the resident was transferred to the hospital on 1/29/24 at 4:00 PM after the resident had a fall. Further review revealed no documented evidence the resident or the resident's representative had been notified in writing of the facility's bed hold policy and information addressing the return of the resident.</p> <p>An interview with the Director of Nurses (DON) on 4/18/24 at 12:30 PM confirmed residents and/or resident representatives should be provided with a written bed-hold notification at the time a resident is hospitalized . In addition, the DON confirmed Resident 35 was hospitalized on [DATE] and there is no documented evidence the resident/representative was provided written notification regarding the bed-hold policy and information that addressed the resident's return.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42679</p> <p>Licensure Reference Number 175 NAC 12-006.09B</p> <p>Based on interview and record review, the facility failed to ensure a PASARR [Preadmission Screening and Resident Review - used to determine individuals with a mental disorder, intellectual disability, or a related condition receives care and services in a setting appropriate to their needs] had been completed after 2 residents (Residents 22 and 24) were diagnosed with a serious mental disorder and received antipsychotic medications (used to treat psychiatric conditions) while residing in the facility. The sample size was 2 and the facility census was 34.</p> <p>Findings are:</p> <p>A. Review of the undated facility policy Resident Assessment-Coordination with PASARR Program revealed the following:</p> <ul style="list-style-type: none"> <li>-The facility coordinated assessments with the PASARR program to ensure that individuals with a mental disorder, intellectual disability, or a related condition received care and services in a setting appropriate for their needs.</li> <li>-The Social Services Director (SSD) would be responsible for keeping track of each resident's PASARR.</li> <li>-Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition would be referred promptly to the state mental health or intellectual disability authority for review. Examples include: 1) a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder and 2) a resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.</li> </ul> <p>B. Review of Resident 22's medical record revealed the following:</p> <ul style="list-style-type: none"> <li>-Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used to develop a resident's plan of care) dated 1/25/24, Section N indicated the resident received an antipsychotic medication and Section I indicated the resident had a diagnosis of Post Traumatic Stress Disorder (PTSD).</li> <li>-Diagnosis Report with a print date of 4/17/24 indicated the resident's PTSD diagnosis occurred during the residents stay at the facility and was dated 3/14/23.</li> <li>-Medication Administration Record (MAR) dated 4/1/24 to 4/30/24 indicated the resident had been taking an antipsychotic medication (Seroquel 25 milligrams [mg] 1/2 tablet daily for PTSD) since 2/13/24.</li> <li>-There was no evidence a new PASARR was completed after the PTSD diagnosis was identified on 3/14/23 and the resident had received an antipsychotic medication while residing at the facility.</li> </ul> <p>(continued on next page)</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/17/24 at 10:25 AM the SSD confirmed Resident 22 did not have a new PASARR completed after the resident was diagnosed with PTSD and had been taking an antipsychotic medication.</p> <p>An interview with Registered Nurse (RN)-O on 4/17/24 at 1:15 PM confirmed residents identified with a new mental illness diagnosis, significant change in behaviors and/or started on antipsychotic medication should have a new PASARR completed promptly. In addition, RN-O confirmed Resident 22 had been diagnosed with PTSD on 3/14/23, had been taking an antipsychotic medication and a new PASARR should have been completed at that time.</p> <p>45739</p> <p>C. Review of Resident 24's MDS dated [DATE] revealed the following:</p> <ul style="list-style-type: none"> <li>-an admitted [DATE],</li> <li>-level 1 PASARR,</li> <li>-diagnoses of anxiety disorder, depression, bipolar disorder, psychotic disorder and Alzheimer's disease,</li> <li>-received an antipsychotic and antidepressant medications.</li> </ul> <p>Review of Resident 24's MAR for April 2024 revealed the resident received antipsychotic medication 17 out of 17 days for bipolar disorder. Further review of the MAR revealed the resident was taking Quetiapine 25mg daily for bipolar disorder with a start date of 3/15/23 and Quetiapine 50mg twice per day for bipolar disorder with a start date of 3/14/23.</p> <p>Review of Resident 24's Care Plan last revised 3/8/24 revealed the resident had a PASRR Level 1 and used psychotropic medications, was at risk for behavior and mood problems related to Alzheimer's Disease, Bipolar Disorder, Delusional Disorder, Anxiety Disorder and Depressive Disorder. Staff were to monitor for target behaviors of self-isolation, withdrawn, agitation, aggression associated with dementia and anxiety. Further review revealed no documentation that a new screen had been completed with the new diagnosis of bipolar disorder.</p> <p>Review of the facility facsimile (fax) form dated 3/13/23 revealed the physician wrote a diagnosis of bipolar disorder for use of the quetiapine.</p> <p>Review of Resident 24's PASRR screen dated 3/24/22 revealed the resident had no signs or suspicion of a serious mental illness.</p> <p>Interview on 4/17/24 at 1:15 PM with RN-O confirmed the resident had a bipolar disorder diagnosis. Further interview at 2:40 PM confirmed there was no documentation that a new PASRR had been completed with the new diagnosis of bipolar disorder and a new PASRR should have been completed with the new diagnosis.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42679</p> <p>Licensure Reference Number 175 NAC ,d+[DATE].12B2</p> <p>Based on observation, interview and record review, the facility failed to ensure 8 residents (Residents 12, 138, 139, 140, 141, 142, 143 and 144) medications had a record of accounting to prevent loss or theft of medications while awaiting disposition. The sample size was 8 and the facility census was 34.</p> <p>Findings are:</p> <p>Review of the undated facility policy Destruction of unused medications revealed the following:</p> <ul style="list-style-type: none"> <li>-All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations.</li> <li>-A Non-Controlled Medication Destruction Record must be maintained for all non-controlled drugs destroyed and such record must be verified by the consultant pharmacist.</li> <li>-Information included on the record consisted of; name and address of facility, date medication destroyed, prescription number, name, strength and quantity of the medication being destroyed, and signature of persons witnessing the destruction.</li> </ul> <p>An observation of the medication storage room on [DATE] at 10:55 AM revealed a locked cabinet inside labeled destroyed medications with a large quantity of medications stored inside. There was no evidence of record keeping/accounting for each medication awaiting destruction.</p> <p>An interview with the Director of Nurses (DON) on [DATE] at 11:00 AM confirmed there was no evidence of documentation related to medications awaiting destruction for the following residents and medications:</p> <ul style="list-style-type: none"> <li>-Resident 12 [Bisacodyl (laxative) 10 suppositories].</li> <li>-Resident 138 [Insulin Aspart 4 pens and Insulin Lantus 3 pens].</li> <li>-Resident 139 [Milk of Magnesia 355 doses].</li> <li>-Resident 140 [Aloe Vesta 1 bottle].</li> <li>-Resident 141 [Maalox 1 bottle, Antacid-antigas 1 bottle, [NAME]-Na (used to treat low sodium levels) 8 packets, Lasix (used to remove excess fluid) 30 tablets, Melatonin 30 tablets, Tylenol 30 tablets, antacid 56 tablets, anti-gas 28 tablets].</li> <li>-Resident 142 [Tylenol 6 tablets].</li> </ul> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident 143 [ Aspercreme 4 ounces, zinc oxide cream 16 ounces, tylenol suppositories 12, Baza (antifungal) cream ,d+[DATE] bottle, Biofreeze gel ,d+[DATE] bottle, biofreeze gel 1 bottle, Desitin cream 4 ounces, Vaseline jelly 1.75 ounces, triamcinolone cream (anti-itch) 8 ounces, Nystatin (fungal) cream 1 and , d+[DATE] bottle, Betamethasone cream (anti-itch/swelling) 1 bottle, Nystatin powder .15 grams, Insulin Aspart 1 pen, Gabapentin (treats seizures) 58 tablets, Omeprazole (treats acid production in stomach) 20 tablets].</p> <p>-Resident 144 [Bisacodyl 3 suppositories, Biofreeze gel ,d+[DATE] bottle, Nystatin 1 bottle, Tylenol 7 tablets].</p> <p>In addition, the DON confirmed the residents' medications were at risk of potential loss or theft without the required documentation and should have included the residents' name, date, medication name, dosage, and quantity of each medication.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42360</p> <p>Licensure Reference Number 175 NAC 12-006.11E</p> <p>Based on observation, interview, and record review; the facility failed to ensure food service equipment was cleaned and maintained, outdated food was not available for consumption, and staff safe handling of ready to eat food was in place to prevent the potential spread of food borne illness. The sample size was 28 and the facility census was 34.</p> <p>Findings are:</p> <p>Review of the facility policy Dietary Employee Personal Hygiene dated 2019 revealed the following:</p> <ul style="list-style-type: none"> <li>-the facility utilized guidelines for employees to prevent contamination of food by employees, including monitoring of employee health for communicable diseases, ensuring clean clothing, and ensuring hand/fingernails hygiene.</li> <li>-hand hygiene included handwashing prior to work, always after using the restroom, eating, drinking, or smoking, after sneezing/coughing, and before putting on and after removing gloves, and</li> <li>-employees were never to use bare hand contact with any foods, ready to eat or otherwise.</li> </ul> <p>Review of the facility policy Dietary Sanitation with a revision date of 5/2021 revealed the following.</p> <ul style="list-style-type: none"> <li>-the food service area would be maintained in a clean and sanitary manner.</li> <li>-all kitchen, kitchen areas and dining areas would be kept clean,</li> <li>-all equipment, food contact surfaces and utensils were washed to remove soil using manual or mechanical means necessary,</li> <li>-specific equipment that required cleaning by an outside vender such as the exhaust hoods would be cleaned semi-annually or sooner as determined by the facility,</li> <li>-the Food Services Manager was responsible for scheduling staff for regular cleaning of the kitchen and dining areas to maintain cleanliness throughout the kitchen.</li> </ul> <p>During an observation of dining on 4/15/24 at 8:40 AM Nurse Aide-F delivered a tray to a resident, offered to butter the toast, then picked up the toast with bare hands and buttered it, then returned it to the resident's plate, then picked a slice of bacon from the resident's plate and handed it to the resident.</p> <p>During the initial kitchen tour on 4/15/24 at 8:54 AM a large container of egg salad dated 4/9/24 was noted in the facility walk in refrigerator.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42679</p> <p>Licensure Reference Number 175 NAC 12-006.17</p> <p>Based on record review and interview; the facility failed to develop/implement a water management program which identified a risk assessment and control measures/testing protocols to address potential hazards. This had the potential to affect all facility residents. The facility census was 34.</p> <p>Findings are:</p> <p>Review of the facility policy Water Management Program dated 9/2022 revealed the Water Management Plan referred to the documents that contained all the information pertaining to the development and implementation of the facility's water management activities for reducing the risk of Legionella (bacterium which causes Legionnaires disease, a serious type of pneumonia. The bacteria can be found in human-made building water systems such as sink, shower heads, decorative fountains, hot tubs, or large complex plumbing systems). The policy indicated the facility was to develop a risk assessment to identify where Legionella and/or other opportunistic pathogens could grow and spread in the facility's water system. In addition, the facility was to develop/implement control measures and testing protocols to address potential hazards.</p> <p>Review of the facility's water management program revealed no evidence of documentation the facility had 1) developed a risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems and 2) implemented control measures and testing protocols to address potential hazards.</p> <p>During an interview on 4/18/24 at 11:15 AM the administrator confirmed no risk assessment had been completed to identify and prevent the potential development of Legionella related to the water management plan and there was no evidence control measures and testing protocols were implemented to address potential hazards.</p>		