STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285115	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Care Centers-Fullerton LLC	202 North Esther Fullerton, NE 68638

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.19 Based on observations, record review and interview; the facility failed to maintain the cleanliness and the condition of the bathroom ceiling ventilation covers, the bathroom floors and toilets and the walls in 14 (Rooms 2, 4, 6, 8, 10, 11, 12, 13, 18, 19, 20, 21, 32 and 35) of 38 occupied resident rooms in the facility. In addition, the facility failed to address missing dentures for Resident 35. The total sample size was 16 and the facility census was 57. Findings are: A. A record review of the facility Maintenance Log revealed the following concerns were reported by the staff: -10/1/24 the toilet in the bathroom of resident room [ROOM NUMBER] was leaking around the base of the toilet. -12/16/24 water was leaking around the base of the toilet in the bathroom of room [ROOM NUMBER] and from under the tiles of the bathroom flooring. -12/27/24 there was a severe leak at the base of the toilet in the bathroom of room [ROOM NUMBER]. B. Observations of resident rooms during the initial pool on 12/30/24 from 9:00 AM to 2:30 PM revealed the following: -The ventilation covers were coated with a collection of a dark fuzzy substance which resembled dust in shared bathroom of resident rooms 2/4, 6/8, 10/12, 11/13, 18/20, and 19/21. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the shared bathroom in resident rooms 18/20, the base of the toilet was leaking and was no longer secured to the floor. Water damage was observed to the linoleum around the base of the toilet and towels/bath blankets were tucked behind and around the toilet base to help absorb the leaking water. -In resident room [ROOM NUMBER], the paint was peeled away with scrapes and gouges in the drywall next to the resident's bed. A shelf above the sink of the bathroom had a silver finish which was worn off and no longer a cleanable surface. -In the bathroom of resident room [ROOM NUMBER], the caulking around the base of the toilet was stained, cracked, and broken, and the ventilation cover was coated with a collection of a dark fuzzy substance resembling dust. C. A record review of a facility Grievance/Concern Form dated 1/2/25 revealed a concern regarding the leaking toilet in the shared bathroom of resident rooms [ROOM NUMBERS]. Concerns by the staff and residents regarding potential trip hazards with constant water on the floor and towels left on the floor to soak up the water. The issue had been reported several times since the beginning of October of 2024. The Maintenance staff had looked at the toilet but had not fixed the problems. The concern was reported to the Executive Director and the Maintenance Director. D. Environmental Tour with the Maintenance Director (MD) on 1/6/25 from 8:43 AM to 9:22 AM revealed the following: -The ventilation covers were coated with a collection of a dark fuzzy substance which resembled dust in shared bathroom in rooms 2/4, 6/8, 10/12, 11/13, 18/20 and 19/21. -In the shared bathroom in rooms 18/20, the base of the toilet was leaking and was no longer secured to the floor. Water damage was observed to the linoleum around the base of the toilet and towels/bath blankets were tucked behind and around the toilet base. A dark brown substance was observed to the seat of the toilet and the bowl of the toilet with a strong of smell of feces. -In the shared bathroom of rooms 6/8, a dark brown substance was observed to the bowl of the toilet with a strong of smell of feces. In addition, the trash was overflowing onto the floor and there were several towels lying on the floor. -In room [ROOM NUMBER], the paint was peeled away with scrapes and gouges in the drywall next to the resident's bed. The shelf above the sink of the bathroom had a silver finish which was worn off and was no longer a cleanable surface. -In the bathroom of room [ROOM NUMBER], the caulking around the base of the toilet was stained, cracked, and broken, and the ventilation cover was coated with a collection of a dark fuzzy substance resembling dust. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the MD on 1/6/25 at 9:30 AM confirmed the dust coated ventilation covers in resident bathrooms 2, 4, 6, 8, 10, 12, 18, 20, 19, 21, 32, and 35 and that the bathrooms of rooms [ROOM NUMBERS] and rooms [ROOM NUMBERS] needed to be cleaned. The MD indicated either someone from Housekeeping or the Maintenance department should be cleaning these areas. In addition, the MD confirmed the caulking around the toilet of room [ROOM NUMBER], the shared toilet in rooms [ROOM NUMBERS] and the wall and bathroom shelf in room [ROOM NUMBER] required repair. The MD further confirmed knowledge of the broken toilet in the shared bathroom of rooms [ROOM NUMBERS] and indicated a part had been ordered and was now available to fix the concern. 51391 E. A record review of the undated facility policy Valuables and Personal Property Policy revealed the following regarding the system used to report missing items: -All lost or missing items were to be reported to the Social Services Director (SSD) or the charge nurse for that resident as soon as it was noted that the item was missing or lost. -Lost or missing item forms were to be filled out and turned in to the listed staff member. F. A record review of the undated facility policy Grievance Policy revealed the following: -The intent of the grievance process was to support each resident's right to voice grievances, those about treatment, care, lost clothing or violations of rights and to assure that after receiving the complaint or grievance the facility would actively seek a resolution and keep the resident updated on the progress of resolution. -Any employee of the facility who received a complaint should immediately attempt to resolve the complaint within their role and authority. If a complaint could not be immediately resolved the employee should escalate that complaint to their supervisor and to the facility's Grievance Official. G. A record review of Resident 35's Care Plan revealed an intervention of: - Oral Hygiene: Partial/Moderate assistance to use suitable items to clean teeth or insert and remove dentures into and from the mouth and manage denture soaking and rinsing with use of equipment. The care plan further indicated the resident did have dentures. A record review of Resident 35's Inventory Sheet dated 3/5/2020 revealed that resident had an upper denture and a lower partial. An interview with Resident 35 on 12/30/24 at 9:00 AM revealed that Resident 35 was missing the resident's dentures and wanted them back. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 12/30/24 at 9:00 AM revealed Resident 35 was sitting in room eating breakfast, there were no teeth and/or dentures in the resident's mouth. An observation on 12/30/24 at 12:45 PM revealed Resident 35 was in the dining room eating dinner, there were no teeth and/or dentures in the resident's mouth. An interview on 12/30/24 at 12:45 PM with Medication Aide (MA)-A confirmed that Resident 35 was missing an upper denture and lower partial. MA-A was unsure how long they had been missing. An interview on 12/31/24 at 10:10 AM with MA-A and MA-B confirmed that when an item was missing staff were to look for the item and if unable to find the item the charge nurse was to be notified. An interview on 12/31/24 at 10:20 AM with SSD-C confirmed that Resident 35 was missing an upper denture and lower partial and was unsure how long they had been missing. SSD-C verified that a grievance form and missing items form should have been filled out but was not and there was not any documentation completed in Resident 35's chart that the teeth were missing. An interview on 12/31/24 at 10:30 AM with Registered Nurse (RN)-E confirmed that if staff voiced an item was missing the resident's room was searched and if unable to find the item the SSD was notified. An observation on 12/31/24 at 12:30 PM revealed Resident 35 was eating in the resident's room with no teeth and/or dentures in the resident's mouth. An interview on 12/31/24 at 2:00 PM with MA-A confirmed that Resident 35's teeth were kept in the bathroom in a denture cup at night, the resident did remove the bottom partial at times during the day, if the resident refused to put partial back in staff cleaned the partial and put them in the denture cup in the bathroom. An interview on 12/31/24 at 2:30 PM with SSD-C and RN-R confirmed that the facility was unsure how long the dentures had been missing, but it had been for several months, and no documentation had been done regarding the missing upper denture and lower partial.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 29638 Licensure Reference Number 175 NAC 12-006.09(F)(iii) Based on record review and interviews; the facility failed to develop new interventions and/or revise current interventions to prevent ongoing falls for Resident 32. The sample size was 7 and the facility census was 57. Findings are: A. A record review of the facility Fall Prevention Program with a revised date of 9/22, revealed each resident was to be assessed for fall risk and was to receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. At the time of admission, each resident's risk for falls was to be evaluated. If the resident's score was 10 or greater, they were considered high risk for falls. A fall risk care plan was to be developed for all residents as deemed appropriate. The following procedure was indicated after a resident fall: -Complete the Nursing Advantage Post Fall Evaluation. -The Nursing Advantage Post Fall Evaluation was to be reviewed at the next Department Clinical Meeting for interdisciplinary review. -Current fall interventions were to be reviewed and determined if there was a need for additional interventions and/or revision of current interventions. B. A record review of Resident 32's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning) dated 12/19/24 revealed diagnoses of osteoarthritis of the knees, heart failure, morbid obesity, peripheral vascular disease, and diabetes. The following was assessed for Resident 32: -The resident was cognitively intact. -The resident was incontinent of bowel and bladder. -The resident had behaviors which included rejection of cares and wandering. -The resident required setup or clean-up assistance with toileting and personal hygiene. -The resident had 2 falls without injury since the previous assessment. -The resident had a weight of 471 pounds. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of a Nursing Progress Note dated 3/31/24 at 10:21 AM revealed Resident 32 had an unwitnessed fall in the resident's room. The resident had been lying in bed, attempted to reposition self, and then rolled self out of bed onto the floor. A new intervention was developed to educate the resident to lay in the center of the bed and to ensure the resident was away from the edge of the bed before turning self. A record review of a Nursing Progress Note dated 5/8/24 at 1:45 PM revealed Resident 32's roommate reported the resident had rolled out of bed and was on the floor. The resident indicated again rolling out of bed when repositioning self. A new intervention was identified for a repositioning bar to be placed on the right side of the resident's bed to assist with repositioning and to define the edge of the bed. A record review of a Nursing Progress Note dated 5/23/24 at 2:59 PM revealed the Activity Director called out for help as Resident 32 had rolled out of bed and was on the floor. A record review of a Risk Meeting Note dated 5/29/24 (6 days after Resident 32's fall on 5/23/24) at 10:11 AM revealed Resident 32 had refused the previous intervention for a positioning bar to be placed on the resident's bed. Staff were to re-educate the resident on the need for the positioning bar to promote safety and prevent falls. A record review of a Progress Note dated 10/26/24 at 6:41 PM revealed the Charge Nurse heard Resident 32 coming down the hall and the resident was short of breath. Staff tried to get the resident to sit down in a chair and rest, but the resident refused. A few minutes later, the staff heard a noise and witnessed the resident go down to the floor. An order was identified for a therapy referral. A record review of a Progress Note dated 10/27/24 (no time) revealed Resident 32 was sent to the emergency room with increased weakness and shortness of breath and was hospitalized . A record review of a Nursing Progress Note dated 11/11/2024 at 6:45 AM revealed Resident 32's call light was on and staff found the resident laying on the floor at the side of the bed. The resident indicated sitting on the edge of the bed, closed eyes and the next thing the resident was on the floor. A referral for Occupational Therapy (OT) was sent regarding use of the lift recliner in the room. Staff encouraged resident to sit in the recliner instead of sitting on the edge of the bed for safety. A record review of a Nursing Progress Note dated 11/26/24 at 5:55 PM revealed Resident 32 had an unwitnessed fall in the resident's room. The resident was again seated on the edge of the bed, fell asleep and then fell to the floor. The resident was re-educated on the need to sit in the recliner instead of on the edge of the bed and staff were to conduct frequent safety rounds. During an interview with the Director of Nursing (DON) on 1/2/25 at 2:44 PM the DON confirmed the following: -Resident 32 rolled out of bed and onto the floor on 3/31/24 and staff educated the resident to stay in the center of the bed and to ensure the resident was not too close to the edge of the bed when repositioning. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/8/24 Resident 32 again rolled out of bed when repositioning. An intervention was indicated for a positioning bar to be placed on the resident's bed. -On 5/9/24 Resident 32 refused to have the positioning bar placed on the resident's bed. No other interventions were identified. -On 5/23/24 Resident 32 was on the floor again after rolling out of bed. A risk meeting was held on 5/29/24, 6 days after the resident's fall and staff attempted to re-educate the resident regarding need for the assist bar. -Resident 32 continued to refuse placement of the positioning bar. Current fall interventions were not revised, and no new interventions were initiated. -On 10/26/24 Resident 32 fell in the corridor due to weakness and increased shortness of breath. A new order was obtained for a therapy evaluation. The resident was then sent to the hospital on 10/27/24. -On 11/11/23 Resident 32 was sitting on the edge of the bed, fell asleep and fell . OT was to evaluate the resident's safety with use of the lift recliner and the resident was encouraged to sit in the recliner instead of on the edge of the bed. -On 11/26/24 Resident 32 had an unwitnessed fall in the resident's room. The resident was again seated on the edge of the bed, fell asleep and then fell to the floor. The resident remained non-compliant with use of the recliner. Staff re-educated the resident on need to sit in the recliner and not on the edge of the bed. New intervention for frequent safety rounds by staff.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360 Licensure Reference Number 175 NAC 12-006.10(D) Based on observation, interview, and record review; the facility failed to prime Resident 19's insulin pen to ensure delivery of accurate dosing and to ensure a medication error rate of less than 5 percent (%). There were 25 observed opportunities with 2 error observed. The sample size was 12 and the facility census was 57. Findings are: A record review of the facility policy Administering Medications with a revision date of [DATE], revealed the following: -Medications were to be administered in a safe and timely manner, and as prescribed. -Only licensed personnel permitted by the state prepared, administered, and documented medications. -Medications were administered in accordance with prescribers, including within any required time frames. -Medication errors were documented, reported, and reviewed by the Quality Assurance Performance Improvement (QAPI) committee to inform process changes and or the need for additional staff training. -Medication carts were kept closed and locked when out of sight of the personnel administering medications. A record review of the facility policy Medication Error dated [DATE], revealed the preparation, provision, or administration of medication, which was not in accordance with the physicians' orders, manufacturers specifications, and accepted professional standards including the five rights of administration were considered medication errors. A record review of the facility policy Insulin Pen dated 2021, revealed the following: -The facility used insulin pens to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare resident for self-administration of insulin therapy upon discharge. -Insulin pens were primed prior to each use to avoid collection of air in the insulin reservoir. -Priming the insulin pen consisted of dialing 2 units by turning the dose selector clockwise and with the needle pointing upward, push the plunger, and watch to see that a least one drop of insulin appeared on the needle tip and then turn the dose selector to the ordered dose, check the dose again and inject the dose after cleansing the skin site with an alcohol pad. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 19's Care Plan, which had a last reviewed date of 11/26/2024, revealed Resident 19 had diabetes and received insulin. A record review of Resident 19's Order Summary Report dated 1/6/25 revealed orders for the following insulin medications: -Fiasp injection- inject 30 units subcutaneously (beneath the skin) 3 times daily, -Fiasp injection- inject per sliding scale (dependent on current blood glucose levels) 3 times daily, and -Tresiba injection- inject 100 units 2 times daily. During an observation of medication provision on 1/6/24 at 7:45 AM Registered Nurse (RN)-N retrieved 3 insulin injection pens from the medication cart. The Fiasp was calibrated to 55 units (30 units regular dosing and 25 units based on the resident current blood glucose levels) to prepare for administration and the Tresiba pens were calibrated to 15 units and 85 units (for a total of 100 units) to prepare for administration. Both medications were given as ordered, however RN-N did not first prime the insulin pens prior to use, to ensure the proper dosing per the facility policy. During an interview on 1/6/25 at 10:55 AM RN-N confirmed the RN had not primed the insulin pens used for Resident 19 and revealed the RN does not routinely prime insulin pens prior to administering insulin. During an interview on 1/6/25 at 11:05 AM the Director of Nursing confirmed that insulin pens must be primed prior to administering the dose of insulin ordered to ensure the exact dose of insulin was administered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 29638 Licensure Reference Number 175 NAC 12-006.11(E) Based on observation, record review and interview; the facility failed to ensure measures were implemented to prevent the potential for food borne illness related to the proper storage and labeling of food items and the maintenance and cleaning of kitchen equipment. This had the ability to affect all residents that ate from the facility kitchen. The total sample size was 16 and the facility census was 57. Findings are: A. A record review of the Nebraska Food Code dated 2017, used as an authoritative reference for food service sanitation practices, revealed the following: -3-201.11(C) Packaged Food shall be labeled as specified by law, including 21 CFR 101 Food labeling, 9 CFR 317 Labeling, Marking Devices, and Containers and 9 CFR 381 Subpart Labeling and Containers. -4-602.13 revealed that non-food contact surfaces of equipment shall be cleaned at a frequency necessary to prevent the accumulation of soil residues. B. A record review of the facility policy Date Marking for Food Safety with a revision date of 3/20, revealed the facility adhered to a date marking system to ensure the safety of food. Compliance guidelines included the following: -Food was to be clearly marked to indicate the date or day by which food was to be consumed or discarded. -The individual opening or preparing food was to be responsible for date marking the food at the time the food was opened or prepared. -The discard date or day may not exceed the manufacturer's use-by-date, or 4 days, whichever is earliest. The date of opening or preparation counts as day 1. C. A record review of the facility's cleaning schedule revealed the following tasks were to be completed daily: -Clean the microwave oven, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Clean food carts, and -Sweep and mop the floor. A record review of the facility's cleaning schedule revealed the following tasks were to be completed on a weekly basis: -Clean the microwave cart, -Clean ice machine, and -Sweep and mop out the walk in refrigerator and freezer. D. Observations during the initial kitchen tour on 12/30/24 at 8:48 AM revealed the following: -Walk-in refrigerator with 2 slices of homemade bread (gluten free) dated 12/19/24, 2 bowls of chicken noodle soup which were not labeled or dated, and 2 bowls with fruit which were not labeled or dated. -The bottom, outside surface of the walk-in freezer door was dented and in need of repair with missing areas to the inside seal of the door which prevented the door from sealing all the way when closed. A rag was wedged into the handle of the door to provide a minimal seal of the door when closed. Inside of the freezer was a heavy layer of frost/ice to the floor, the ceiling, the walls, the outside surfaces of all boxes stored in the freezer, the shelves and to the strip curtain at the front of the unit. -A storage rack in the corridor outside of the walk-in freezer with a clear storage bag with what appeared to be muffins which was unlabeled and was dated 11/15/2024. Observations during the follow-up kitchen tour on 12/31/24 from 11:10 AM to 12:20 PM revealed the following: -Concerns unchanged related to the walk-in freezer. -White stand-up freezer with a clear storage bag which was unlabeled and undated. The Dietary Manger (DM) indicated the bag contained gluten free pancakes. -Snack refrigerator with a clear storage bag which contained what appeared to be muffins. The bag was unlabeled and was dated 12/17/24. -A wheeled cart positioned next to a food prep area. The top shelf of the cart had a microwave which had a layer of debris to the outside surface as well as to the shelf the microwave rested on. A green service tray was on the top of the microwave and held a toaster. A layer of breadcrumbs was observed to the outer surfaces of the toaster and to the tray which held the toaster. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-On the floor beneath the stove and the convection ovens was a brown discoloration with dirt and food debris. -The ice machine in the corridor outside of the kitchen and next to the DM's office had a filter to the back of the machine. The filter had a gray fuzzy substance which resembled dust/debris. -There were multiple baking pans with a significant carbon build up to the outside and the inside surfaces of the pans. Interview with the Administrator and the DM on 1/2/25 at 3:00 PM confirmed the door to the walk-in freezer was broken. The staff were unable to keep the door closed without inserting a rag into the door handle to wedge the door closed. The weather stripping around the door was broken with missing pieces. There was no way to securely close the door due to these concerns and resulted in the heavy layer of frost/ice to all inside surfaces. This concern had been ongoing over the prior 12 months and a new door had been ordered but not yet installed. No other interventions were implemented to assure safe food storage. The DM also confirmed the following: -All repackaged food items were to be labeled and dated. The items were to be stored for 4 days with day one being the date the items were repackaged. -All kitchen equipment was to be cleaned and maintained in accordance with the facility cleaning policy.