STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285117	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Care Centers-Valhaven, LLC	300 West Meigs Street Valley, NE 68064

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48271 Licensure Reference Number 175 NAC 12-006.09D Based on observation, record review and interview; the facility failed to identify the use of personal alarms on the residents Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) for 1 (Resident 18) of 4 sampled residents. The facility census was 43 Findings are: A record review of the Admission Record with the printed date of 7/22/24 revealed Resident 18 was admitted to the facility on [DATE] with the diagnoses of: Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), Schizoaffective disorder(mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression), Obsessive-compulsive disorder(Excessive thoughts (obsessions) that lead to repetitive behaviors (compulsions), Vascular dementia(Brain damage caused by multiple strokes), Major Depressive Disorder with severe psychotic symptoms (distinct type of depressive illness in which mood disturbance is accompanied by either delusions, hallucinations). A record review of Resident 18's MDS dated [DATE] revealed in Section C- Brief Interview for Mental Status (BIMS, a test used to get a quick snapshot of a residents cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 3 indicating severe cognitive impairment. Further review of the MDS revealed that in section P- Restraint and alarms, the wander guard is marked 0 (not used). An observation on 7/17/24 at 2:30 PM revealed that Resident 18 had a wanderguard (alert system) on (genders) left wrist. A record review of the Physicians orders dated 7/7/21 revealed an order to check that the wanderguard device is working every day and evening shift. A record review of the Care Plan (written instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care) dated 11/02/23 revealed focus of elopement risk/wanderer, with the intervention of a Wanderguard alarm bracelet. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 7/22/24 at 1:30 PM with Registered Nurse-B verified that the MDS section P should of been marked as yes to the use of the wanderguard and section P was marked as no to the use of the wanderguard.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50683 Based on record review and interview, the facility failed to ensure a Preadmission Screening Resident Review (PASARR, a federally mandated screening process to ensure Nursing Home residents with mental illness and/or developmental disabilities) receive the care and services they need in the most appropriate setting was accurately completed for 1 (Resident 17) out of 4 record reviews of PASARR screens. The facility census was 43. Findings are: A record review of facility's undated policy labeled Resident Assessment-Coordination with PASARR Program revealed the following information: Policy: The facility coordinated assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder (MD), intellectual disability (ID), or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level 1 Screen-initial pre-screening that is completed prior to admission. i. Negative Level I Screen- permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level 1 Screen- necessitates a PASARR Level II evaluation prior to admission. b. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (Cannot be completed by the facility) that determines where the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. 2. The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission. A record review of admission data revealed Resident 17 was admitted to the facility on [DATE]. Resident 17's admission diagnoses included: Anxiety Disorder, Unspecified, Metabolic Encephalopathy, Panic Disorder (Episodic Paroxysmal Anxiety), Delusional Disorders, Post-Traumatic Stress Disorder, Unspecified. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A PASARR screen completed by facility staff on 06/29/2023 revealed that a PASARR Level II Evaluation and Determination was not required at that time because there was no diagnosis or suspicion of Serious mental Illness (SMI) or intellectual Disability or related condition (ID/RC) indicated. An interview on 07/18/2024 at 2:30 PM with Registered Nurse-B confirmed that the initial PASARR completed on 06/29/2023 should have included admission diagnosis of: anxiety disorder, panic disorder, delusional disorder, and post-traumatic stress disorder and that a PASARR Level II screen would have triggered and should have been completed prior to the Resident 17 admitting to the facility. Record review of Resident 17's medical record on 07/18/2024 revealed no other completed PASARR screens since 06/29/2023.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50683 Licensure Reference Number 175 NAC 12-006.10D Based on observation, record review and interview; the facility staff failed to ensure it was free of a medication error rate of 5% or greater. Observations of 30 medications administered revealed 2 errors resulting in a medication error rate of 6.67 %. The medication errors affected 2 (Resident 148 and 31) of 9 residents sampled. The facility identified a census of 43. Findings are: A. A record review of Resident 148's Medication Administration Record dated 7/1/2024 - 7/31/24 revealed an order for Hydrocortisone (perianal) External Cream 2.5%. Apply to hemorrhoids topically every 8 hours as needed for pain, itching with a start date of 4/30/2024. An observation on 07/18/2024 at 12:10 PM revealed Medication Aide (MA)-C prepared medications for Resident 148 that included Procto- Medication Cream, apply three times a day for hemorrhoids. With assistance from facility staff members, Resident 148 was assisted into bed and staff wiped the rectal area of the resident with personal care wet wipes. MA-C opened the brand-new tube of Procto- Medication Cream, which is equivalent to Hydrocortisone (Perianal) External Cream 2.5%. MA-C then squeezed the tube of the Procto- Medication Cream onto Resident 148's rectum which left small tubular strands of the medication around the rectum. MA-C then raised Resident 148's brief back in place and then with staff member assistance, staff repositioned Resident 148 in bed. MA-C did not apply a thin layer of the medication with gloved fingers to hemorrhoids. Interview with the Director of Nursing (DON) on 07/18/2024 at 02:30 PM conducted. DON reports that the expectation on administering a topical medication is to apply a small amount of the cream or ointment onto a gloved hand/fingers and then apply medication using gloved fingers to the affected area as prescribed. DON reports that squirting a tube of medication directly onto the affected area and not lightly rubbing the medication to the area is incorrect. DON confirmed that the improper administration of this medication would be considered a medication error. B. A record review of Resident 31's Medication Administration Record dated 7/1/2024 -07/31/2024 revealed an order with a start date of 6/20/2020 for Aspirin EC (Enteric Coated) tablet delayed release 81 MG (milligram), give 1 tablet by mouth one time a day related to Venous Insufficient (Chronic) (Peripheral). The order further revealed instructions as follows: do not crush. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 7/22/2024 at 8:39 AM revealed that Meducatuib Aide (MA)-D was preparing medications for Resident 31 that included Aspirin EC 81 mg. MA-D then took a small medication cup that contained Resident 31's morning medications to the dining room where Resident 31 was sitting at a dining room table. MA-D began to spoon one of the resident's pills into [gender] mouth. Resident 31 accepted the Tylenol tablet, but the resident started to chew the medication and spit out half of the pill (Tylenol). MA-D then took the one half of the un-swallowed Tylenol and the other medications and reported that [gender] is going to crush these medications. MA-D went back to the medication cart and crushed Resident 31's pills, which contianed Aspirin EC, and placed them in a small amount of applesauce. MA-D returned to Resident 31 and offered [gender] a small bite of applesauce that included all of morning medications which consisted of the Aspiring EC. Resident 31 opened [gender] mouth and accepted the spoon with the crushed medications in applesauce and swallowed them. An interview with the Director of Nursing on 7/22/2024 at 10:45 AM confirmed that enteric coated medications should not be crushed and that crushing and then administering an Enteric Coated Aspirin would be considered a medication error. A record review of facility policy labeled Medication Errors, date implemented: 10/23, date reviewed/revised: 2/23 revealed a definition: Medication Error means the observed or identified preparation or administration of medications or biologics which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services.

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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. 47406 Licensure Reference Number 175 NAC 12-006.11E Based on observations, interviews and record review; the facility failed to perform hand hygiene, wear hair and beard nets in the kitchen to prevent food-borne illness for all the residents. This had the potential to affect all resident that ate out of the kitchen. The facility census was 43. Findings are: An observation on 7/17/24 at 8:35 AM revealed the Dietary Manager (DM)-H in the kitchen without a beard net on while food was out during breakfast meal service. An observation on 7/17/24 at 11:37 AM revealed DM-H did not have a beard net on during meal preparation for lunch services. An observation on 7/18/24 at 8:36 AM with Cook-I revealed Cook-I washed [gender] hands with soap and water for 10 seconds then donned (put on) clean gloves and touched toast with [gender] gloved hands. An observation on 7/18/24 at 8:56 AM revealed Cook-I removed [gender] gloves, and washed [gender] hands with soap and water for 6 seconds then donned gloves and continued to cook French toast. An interview on 7/18/24 at 2:17 PM with DM-H revaled the facilities expectation is to wash hands for 30 seconds. DM-H stated they can sing happy birthday during this to ensure enough time. An interview on 7/18/24 at 2:20 PM with DM-H revealed that the facility does have an expectation for staff to wear a beard net if they have a beard. An observation on 7/22/24 at 10:18 AM revealed Cook-K returned to kitchen after a break and picked up clean plates. The obersvation did not reveal that Cook-K washed [gender] upon return from break. An interview on 7/22/24 at 10:21 AM with Cook-K confirmed [gender] should have washed [gender] hands when [gender] returned to kitchen. An observation on 7/22/24 at 12:28 PM of the Dietary Aide (DA)-N and Cook-L revealed both staff came into kitchen without a hair nets on during lunch service in which food was being served. The observation did not reveal that hand hyigene was completed by DA-N and Cook-L with return to the kitchen. An interview on 7/22/24 at 12:32 PM with DA-N and Cook-L revealed they should have washed their hands when entering the kitchen, donned a hair net prior to entering the kitchen. Hand hygiene Policy updated 2021 revealed: 2. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Hand hygiene technique when using soap and water: c. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Dietary Employee Personal Hygiene Policy copyright date 2019 from The Compliance Store revealed: It is the policy of this facility to utilize the following as guidelines for employee personal hygiene to prevent contamination of food by foodservice employees. Hair Restraints - a. All dietary staff must wear hair restraints (e.g., hairnet, hat and/or beard restraint) to prevent hair from contacting food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50683 Licensure Reference Number 175 NAC 1-005.06D Based on observation, interview and record review, the facility staff failed to ensure hand hygiene and glove changes were performed during personal cares for 1 (Resident 3) of 4 residents. The facility census was 43. Findings are: Record review of facility Hand Hygiene Policy updated 2021 revealed: Policy: Hand Hygiene Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, resident and visitors. Policy Explanation and Compliance Guidelines included: Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standard of practice. An observation on 7/18/2024 at 9:00 AM of Infection Preventionist (IP)-E revealed IP-E entered Resident 3's room. IP-E put on a pair of gloves without washing hands and gathered paper towels from the bathroom and placed paper towels and a graduate cylinder (a plastic container that typically measures excreted or generated body fluids) on the resident's bedside tray table. IP-E removed gloves and then washed hands with soap and water for greater than 20 seconds, dried hands, applied gloves, and put on (donned) an isolation gown, and face shield. IP-E emptied the contents from Resident 3's urostomy (an opening in the belly (abdominal wall) that's made during surgery) bag into the graduate cylinder. EP-E then took the graduate cylinder into the bathroom and emptied the contents into the toilet, rinsed out the graduate cylinder with water from the adjacent sink and emptied the graduate cylinder into the toilet then left the graduate cylindar in the bathroom. IP-E then asked Resident 3 if [gender] would like a drink of water. IP-E grabbed the water pitcher without changing gloves and held the straw with IP-E's fingers and brought the straw to the resident's lips. IP-E attempted to give water to the resident two more times. Resident 17 refused the water by closing [gender] lips shut and turning [gender] head away from IP-E. IP-E placed water pitcher back on the bedside table. An interview on 7/18/2024 at 9:15 AM with IP-E confirmed [gender] should have changed gloves and performed and hygiene after emptying the urostomy bag. An interview on 7/18/2024 at 2:30 PM with Director of Nursing revealed that after emptying urostomy contents, IP-E should have removed gloves, performed hand hygiene with soap and water for at least 20 seconds before offering Resident 3 some water.

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F 0906 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough power supply for lighting all entrances and exits; equipment for fire detection and alarm systems, and extinguishers. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50683 Licensure Reference Number 175 NAC 12-007.04 (F) Based on observation, record review, and interview, the facility failed to ensure that the emergency electrical power system activated within 10 seconds to supply emergency power during a power outage for all residents. Facility census was 43. Finding are: The National Fire Protection Association's (NFPA) Life Safety Code 99, 2012 edition located at 6.5.3 and 6.5.3.1 reveal that the life safety and equipment branches shall be installed and connected to the alternate source of power specified in 6.4.1.1.4 and 6.4.1.1.5 so that all functions specified [NAME] for the life safety and equipment branches are automatically restored to operation within 10 seconds after interruption of the normal source. The above requirement is mandated for an emergency generator as part of the Essential Electrical System that is defined as a system of alternate sources of power and all commercial distribution systems and ancillary equipment, designed to ensure continuity of electrical power to designated areas and functions of a health care facility during disruption of normal power sources, and also to minimize disruption with the internal wiring system. An observation on 07/22/24 at 10:00 AM revealed a complete power outage to the entire facility. Nursing staff observed going into resident rooms for residents who had oxygen to switch the resident's oxygen concentrator (a medical device that uses the air in the atmosphere, filters it, and converts the air to 90% to 95% Oxygen) into the Red Outlets (outlets that are supplied power from the emergency generator during a power outage), or to switch the resident to a portable tank of oxygen. The emergency generator for the facility became operational at 10:02 AM. During this two-minute time span (between 10:00 AM to 10:02 AM) there was no electrical power to supply emergency exit signs, lighted means of egress (path to exit the building), or any electric powered medical equipment such as an oxygen concentrator. An interview with the facility's Administrator on 07/22/2024 at 12:01 PM confirmed that the entire facility lost electrical power for approximately 2 minutes around 10:00 AM that morning. Facility's Administrator stated that their expectation is that the emergency generator should activate within 10 second after a power outage. A record review of an undated facility policy labeled Emergency Generator Malfunction/Failure revealed: Policy: If the facility loses emergency back-up power (i.e. facility generator) or malfunctions, the facility will (continued on next page)

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F 0906 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1) Contact Administrator and 2) following discussion with the Maintenance Director/designee contact an outside generator contractor to obtain a portable generator of equivalent size or bigger to provide emergency back-up power to the facility. Procedure: If the electrical power is interrupted at the facility and the facility loses power and the emergency generator does not restore power within 10 seconds of the power outage, the Charge Nurse will immediately contact the Facility Administrator and Maintenance Director about the facility power outage and the emergency generator malfunction. Record review of facility's Emergency Generator -Monthly Test Log from January 4, 2023 through July 2, 2024 revealed the seconds to transfer range (how long does it take for the emergency generator to start after disruption of electrical power) ranged from 3-5 seconds.