| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285207 | A. Building<br>B. Wing | 08/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Care Centers-Countryside LLC | 703 North Main Street<br>Madison, NE 68748 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638<br><br>Licensure Reference Number 175 NAC 12-006.02(H)<br><br>Based on record review and interview: the facility failed to investigate an allegation of potential abuse/misappropriation/exploitation for Resident 2 and then to submit the results of the investigation to the State Agency. The sample size was 4 and the facility census was 39.<br><br>Findings are:<br><br>A. Review of the facility policy Abuse, Neglect, Exploitation, Mistreatment and Misappropriation dated [DATE] revealed the following;<br><br>-The facility encouraged and supported all residents, staff, families, visitors, volunteers, and resident representatives to report suspected acts of abuse, neglect, exploitation, involuntary seclusion, or misappropriation of resident property.<br><br>-Neglect is the failure of the facility, it's employees or service providers to provide services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.<br><br>-Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of resident belongings or money without the resident's consent.<br><br>-The facility administrator or designee will report abuse to the state agency per state and federal guidelines.<br><br>- Reports of abuse would be promptly and thoroughly investigated and then provide a written report of the investigation within 5 working days of the occurrence of the incident to the State Agency.<br><br>B. Review of Resident 2's Minimum Data Set (MDS- federally mandated comprehensive assessment used to develop resident Care Plans) dated 7/25/24 revealed the resident was admitted [DATE] with diagnoses of osteomyelitis, gas gangrene (bacterial infection that destroys blood cells and soft tissue), major depressive disorder, anxiety, and diabetes. The resident was assessed as cognitively intact with delusions. The resident was identified as having a diabetic foot ulcer with infection to the foot and a surgical wound. In addition, the resident received an antidepressant and an antipsychotic medication.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285207 | A. Building<br>B. Wing | 08/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Care Centers-Countryside LLC | 703 North Main Street<br>Madison, NE 68748 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 2's Social Service Progress Notes revealed the following:<br><br>-8/5/12 at 1:17 PM the resident continues to talk/text/call random men on the resident's phone who appear to be scammers. The note further indicated the resident had bought Apple cards to send to them. The Social Service Director (SSD) and the Director of Nursing (DON) spoke with the resident regarding potential scammers and encouraged the resident not to send money or Apple cards to these individuals.<br><br>-8/5/24 at 4:11 PM the resident had asked the SSD if staff could take the resident to cash the resident's Social Security check as the resident needed to pick up a couple of things. The resident was in the process of divorcing their spouse as the resident was hoping to start a relationship with someone else.<br><br>-8/8/24 at 5:17 PM the resident was upset as wanted to cash Social Security check. When SSD offered to assist with purchasing items the resident required, the resident became more upset and indicated a need to move to another facility. The SSD sent an email to the State Ombudsman (resident advocate) to request guidance regarding potential exploitation of the resident.<br><br>-8/9/24 at 4:34 PM per suggestion of the Ombudsman, the SSD called Adult Protective Services (APS) and the local police to notify of the potential exploitation of the resident.<br><br>Review of the facility investigations from 11/14/23 through 8/21/24 revealed no evidence an investigation had been completed regarding the resident's potential exploitation or that an investigation was sent to the State Agency within 5 working days of the allegation.<br><br>During an interview with the SSD on 8/21/24 at 3:00 PM, the SSD confirmed calling APS regarding concerns about Resident 2 as the State Ombudsman had suggested this action. In addition. the SSD confirmed no written investigation had been completed or sent to the State Agency within the required time frame.<br><br>Interview with the facility Administrator on 8/22/24 at 9:00 AM also confirmed the facility had called APS on recommendation of the Ombudsman but had not completed an investigation related to the potential abuse/misappropriation/exploitation and submitted to the State agency. |