STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285207	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Care Centers-Countryside LLC	703 North Main Street 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(i)(3)Based on record review and interview, the facility failed to provide bathing assistance to Resident 45 at intervals to meet the resident's needs. The sample size was 13 and the facility census was 38. Findings are: Review of the undated facility Bathing Policy Statement revealed the facility provided each resident with bathing services at a frequency that met the residents' individual needs and preferences. Additional baths were provided as needed for incontinent episodes, skin care needs, or physician's orders Review of Resident 45's Care Plan dated 9/28/25 revealed the resident was admitted on [DATE], had dementia, bladder incontinence and self-care deficits related to a recent hip fracture, infections, and dementia. The resident was unable to bear weight on the left leg and staff were to provide the resident with assistance with Activities of Daily Living (ADL's) including bathing. Review of Resident 45's Bathing Records revealed bathing occurred on 10/10 (13 days after admission), 10/16, 10/23, 11/5 (13 days after the previous bath, and 11/18 (13 days after the previous bath). During an interview on 12/17/25 at 11:32 AM the Director of Nursing confirmed Resident 45 was incontinent, and dependent on the staff for ADL's including bathing, and the facility had no evidence the resident was being bathed at least weekly.

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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensure Reference Number 175 NAC 12-006.09Based on observation, record review and interview; the facility failed to provide evidence of follow up evaluations and condition assessments to identify potential complications following a fall for Resident 10 and failed to follow physician's orders for treatment of a foot ulcer for Resident 7. The sample size was 13 and the facility census was 38. Findings are:A. Review of the facility policy Fall Prevention Program dated September 2024 revealed the following:-Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. -When any resident experiences a fall, the facility would complete the following:A. Assess the resident.B. Complete a post-fall assessment.C. Complete an incident report.D. Notify physicians and family.E. Review the resident's care plan and update as indicated.F. Document all assessments and actions.G. Obtain witness statements in the case of an injury. B. Record review of nursing documentation for Resident 10 on 12/16/25 at 6:09 PM revealed that Resident 10 slipped and fell in room, resident was alert and oriented times 3, denied hitting head, no neuro assessments were needed, and no injuries were present. Vital signs were completed, Director of Nursing notified, and fax was sent to the physician. An observation of Resident 10 on 12/17/25 at 7:20 AM revealed that the resident had dry red drainage to the right facial cheek and shirt, Resident 10 confirmed that the injury occurred with the fall the prior evening. An interview with the Administrative Assistant (AA-N) on 12/17/25 at 7:50 AM confirmed that Resident 10 did have a fall on 12/16/25 around 6:00 PM, red drainage was noted on the side of right cheek, Licensed Practical Nurse (LPN-D) was notified. An interview with the Director of Nursing (DON) on 12/17/25 at 7:50 AM confirmed that neuro assessments and vital signs should have been completed related to resident fall being unwitnessed with an injury. An interview with the DON on 12/17/15 at 3:50 PM confirmed that the physician was notified of the resident injury and vital signs were being completed every shift for 72 hours. Record review of nursing documentation on 12/18/25 at 9:00 AM revealed that there were not any follow up documentation, assessments or vital signs completed related to the fall on 12/16/25 for Resident 10. An interview with the DON on 12/18/25 at 9:45 AM confirmed that there were not any follow up charting or vital signs completed related to Resident 10's fall from 12/16/25 and there should have been vital signs with an assessment completed. An interview with the Administrator on 12/18/25 at 10:30 AM confirmed that a post fall evaluation was not completed after the resident had a fall on 12/16/25. C. Record review of Resident 7's Treatment Administration Record (TAR) for 10/25 revealed the following order: Cleanse left heel with dial soap and water. Apply xeroform (non-adherent, sterile, petrolatum gauze dressing) and waterproof foam dressing. Wrap heel with gauze. Change dressing daily. The treatment was not signed off in the TAR on 10/3/25, 10/7/25, 10/8/25, 10/11/25, 10/16/25, 10/17/25, 10/22/25, 10/23/25 and 10/27/25. Record review of Resident 7's TAR for 11/25 revealed the following order: Cleanse left heel with 1/2 Dakins (antimicrobial wound cleanser) soaked gauze. Apply Gentelle Blue (antimicrobial dressing) to wound bed, cover with pad, secure with Coban. Change Monday, Wednesday and Friday. The treatment was not signed off as completed on 11/7/25, 11/10/25 and 11/12/25. On 11/21/25 the treatment order to the left heel was changed to: Cleanse with 1/2 Dakins soaked gauze, apply Triad (absorbs moisture and softens skin) paste to skin surrounding the open area, apply 1/2 Dakins soaked gauze to wound bed, cover with pad, secure with gauze wrap and tape 2 times daily. The treatment was not signed off as completed on 11/23/25 and 11/24/25. The treatment was not completed at 8:00 PM on 11/22/25 and 11/29/25 due to the resident sleeping. Record review of Resident 7's TAR for 12/25 revealed the following order: Cleanse left heel with 1/2 Dakins soaked gauze, apply Triad paste to skin surrounding the open area, apply 1/2 Dakins soaked gauze to wound bed, cover with pad, secure with gauze wrap and tape 2 times daily. The treatment to the left heel was not signed off as being completed on 12/1/25, 12/4/25, 12/8/25 and 12/11/25. The treatment was not completed at 8:00 PM on 12/1/25, 12/2/25, 12/9/25, 12/13/25, 12/15/25 and 12/16/25 due to the resident sleeping. An interview on 12/18/25 at 11:45 AM with the DON confirmed that if the treatment to the left heel was not signed off it was not completed and signing off that the treatment was not completed due to the resident sleeping was not appropriate and confirmed the staff are not following the physician orders.

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	285207	A. Building B. Wing	12/18/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18(B)(D) Based on observation, record review and interview; the facility failed to implement Enhanced Barrier Precaution (EBP-involved gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multidrug resistant organism (MDRO-bacteria that have become resistant to certain antibiotics) as well as those at increased risk for MDRO, residents with wounds or indwelling medical devices) during toileting assistance for Resident 2, catheter cares for Resident 10 and wound care for Resident 7; failed to provide cleaning of resident care equipment to prevent cross-contamination and or potential infections for Resident 10 and failed to complete gloving and hand hygiene at appropriate intervals during the provision of care for Residents 1,7,10 and 41. The sample size was 13 and the facility census was 38.Findings are: A. Review of the facility policy Enhanced Barrier Precautions revised May 20, 2024, revealed the following: - EBP would be used for residents with any of the following: wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers or unhealed surgical wounds) and/or indwelling medical devices (urinary catheters, feeding tubes, tracheostomy tubes) even if the resident is not known to be infected or colonized with an MDRO. - Personal Protective Equipment (PPE-gown and gloves) for EBP is only necessary when performing high-contact activities and may not need to be put on prior to entering the resident's room. High Contact activities include the following: -Dressing, -Bathing, -Transferring, -Providing hygiene, -Changing linens, -Changing briefs or assisting with toileting, -Device care or use: urinary catheters, feeding tubes, tracheostomy tubes and -Wound care: any skin opening requiring a dressing. B. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy CPAP (Continuous positive airway pressure-a respiratory intervention used to provide an airway during periods of sleep apnea. It used air pressure generated by a machine, delivered through a tube into a mask that fits over the nose) Cleaning Policy dated 2024 revealed the following: -It was the policy of this facility to clean CPAP equipment in accordance with current CDC (Centers for Disease Control) guidelines and manufacturer's recommendations to prevent the occurrence or spread of infection. Guidelines to clean the CPAP are as follows: -Equipment could become colonized with infectious organisms and serve as a source of respiratory infections. -Staff were to wash hands and wear gloves whenever touching the equipment. -Dust the machine as needed and wipe clean with damp cloth and mild detergent. -If humidification was required, distilled or sterile water would be used to fill the humidifier chamber. Empty after each use and wipe dry. -Clean the mask frame daily after use with CPAP cleaning wipe or soap and water, dry well, cover with a plastic bag or completely enclose in machine storage when not in use. Weekly cleaning activities include: -Wash headgear/straps in warm, soapy water and air dry. -Wash tubing with warm soap water and air dry. Follow the manufacturers' recommendations for the frequency of cleaning/replacing filters and servicing the machine. Replace the equipment immediately if it is broken, malfunctions or if visible soiling remains after cleaning. Replace equipment routinely in accordance with manufacturers' recommendations. General guidelines: Face mask and tubing-once every 3 months. Headgear, non-disposable filters and humidifier chamber-once every 6 months and the disposable filters twice a month. C. Review of the Hand Hygiene Policy dated June 2025 revealed the following: (continued on next page)

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	285207	A. Building B. Wing	12/18/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hand hygiene is a general term for washing hands with soap and water or the use of an alcohol-based hand rub (ABHR). -Hand hygiene should be completed before contact with residents, putting on gloves and inserting or manipulating a device. -Hand hygiene should be completed after contact with resident's skin, bodily fluids or excretions, personal items, non-intact resident's skin, wound dressings or contaminated items and after removing gloves. D. Review of Resident 10's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 12/13/25 revealed the resident had an indwelling catheter and a surgical wound with surgical wound care. Review of Resident 10's Care Plan dated 11/29/25 revealed the following: -The resident was in EBP, staff were to wear a gown and gloves when urinary bag was emptied/catheter cares completed and when wound treatment was completed. -The resident had an indwelling catheter related to surgery. -The resident had altered respiratory status related to Sleep Apnea. CPAP settings per preprogrammed settings via full face mask. Review of Medication Administration Record (MAR) dated 12/25 revealed an order to ensure CPAP mask is on at bedtime (no cleaning instructions identified). Review of Treatment Administration Record (TAR) dated 12/25 revealed an order for dressing change to left superior scrotum. Clean with normal saline, lightly pack wound with calcium alginate, secure with paper tape. Change daily. The following observations revealed the CPAP machine not being cleaned: -12/15/25 at 7:45 AM revealed residents CPAP laid on the bedside table, mask connected to the tubing and the water chamber was dry. -12/15/25 at 12:45 PM CPAP remained on the bedside table connected to the tubing. -12/16/25 at 7:45 AM CPAP mask/tubing laid on the floor with the machine on the dresser by the bed. -12/16/25 at 10:30 AM CPAP mask/tubing remained on the floor. -12/16/25 at 11:15 AM CPAP mask/tubing continued to lay on the floor beside the bed. -12/17/25 at 10:40 AM CPAP mask/tubing laid in the top drawer of the dresser beside the bed. (continued on next page)

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	285207	A. Building B. Wing	12/18/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of provision of care for Resident 10 on 12/17/25 at 7:20 AM Registered Nurse (RN-L) put on gown and gloves, removed old dressing from surgical area to scrotum, changed gloves, completed treatment to surgical area, removed gloves and exited the room. (No hand washing or hand hygiene was observed with cares.) During an observation of provision of care for Resident 10 on 12/17/25 at 7:30 AM, Nursing Assistant (NA-M), entered resident room, put on gloves, emptied resident's catheter bag, emptied the graduate cylinder (a container used to collect and measure urine or other bodily fluids), removed gloves and washed hands. (No gown was worn when cares were completed with catheter bag and urine.) E. Review of Resident 7's MDS dated [DATE] revealed the resident had a stage 4 unstageable pressure ulcer with eschar. Review of Resident 7's Care Plan dated 9/12/25 revealed the resident was on EBP related to open wounds. Always wear a gown and gloves for cares when in resident's room. Review of resident's TAR dated 12/25 revealed an order to cleanse left heel with 1/2 Dakin's (antimicrobial wound cleanser) soaked gauze, apply Triad (absorbs moisture and softens skin) paste to skin surrounding the open area, apply 1/2 Dakin's-soaked gauze to wound bed, cover with pad, secure with gauze wrap and tape 2 times daily. During an observation of provision of care for Resident 7 on 12/16/25 at 11:00 AM Licensed Practical Nurse (LPN-D) entered resident room, put on gloves, (no hand hygiene was completed or gown put on), removed dressing from left heel, poured Dakins solution on wound, changed gloves, (did not wash hands), completed treatment to left heel, put sock and boot on left foot and removed gloves. (Did not wash hands prior to exiting the room). F. Review of Resident 41's record revealed an admission date of 12/12/25. Care Plan revealed that the resident was incontinent of bladder related to cancer and weakness, was on EBP related to have a tracheostomy (opening in the neck to provide an airway) and a g-tube (feeding tube inserted into the abdomen used to deliver nutrition). During an observation of provision of care for Resident 41 on 12/16/25 at 3:00 PM, NA-V and NA-W, entered the room, put on gown and gloves, completed incontinent cares and repositioned resident to comfort, removed gloves and gown and left the room. (No handwashing was completed). G. An interview with RN-L on 12/17/25 confirmed that staff have not cleaned Resident 10's CPAP per the facility policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with RN-O, Infection Control Nurse, on 12/17/25 at 10:30 AM confirmed that Resident 7 and Resident 10 were on EBP and staff should have worn gown and gloves with Resident 7 when wound treatment was completed and with Resident 10 when catheter bag was emptied. Further interview confirmed that staff should have completed hand hygiene when entering the room, before and after removing gloves, and when exiting the room. H. Review of Resident 1's Care Plan with a revision date of 10/15/25 revealed the resident had a Multidrug Resistant Organism (MDRO- infection/organism resistant to many antibiotics) to open skin areas and staff were to exercise Enhanced Barrier Precautions (EBP-use of Personal Protective Equipment during high contact care to prevent the potential spread of MRDO infections). The EBP's were to remain in effect during the duration of the resident's stay or resolution by the physician. Staff were to use a gown and gloves for all cares including bathing, transferring, providing hygiene care, changing linens, changing briefs or assisting with toileting in the resident's room. The resident was dependent on staff with Activities of Daily Living (ADLs). The resident utilized a mechanical lift and an electric wheelchair. In addition, the resident was involuntary of bowel and incontinent of bladder. During an observation of care for Resident 1 on 12/16/25 at 9:45 AM Nurse Aides (NA)-F and Medication Aide (MA)-E entered the room, performed hand hygiene and put on gowns, gloves and masks. They transferred the resident to bed using a full-body mechanical lift. The resident was wearing a disposable brief and was noted to be involuntary of bowel and incontinent of bladder. The resident's soiled brief was changed, and the resident was cleaned with disposable wipes, then without changing gloves or performing hand hygiene NA-F applied a clean brief. I. Review of Resident 2's Care Plan with a revision date of 4/22/25 revealed the resident received EBP due to an inactive MRDO. The precautions were to remain in effect during the duration of the resident's stay or resolution by the physician. Staff were to use a gown and gloves for all cares including bathing, transferring, providing hygiene care, changing linens, changing briefs or assisting with toileting in the resident's room. During an observation of care for Resident 2 on 12/17/25 at 12:40 PM NA-F responded to the resident's call light hand sanitized, entered the resident's room put on disposable gloves, but no gown. The resident was sitting on the toilet and NA-F assisted the resident to stand and provide perineal care and pull up the resident's pants all while not wearing a gown. The resident was assisted into a wheelchair and then into an easy chair. NA-F then removed the disposable gloves, hand sanitized and exited the room. During an interview on 12/17 at 12:46 PM, NA-F revealed being unaware Resident 2 was on EBP and confirmed being aware that residents on EBP should have care while staff were wearing both gowns and gloves. J. (continued on next page)

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	285207	A. Building B. Wing	12/18/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/18/25 at 11:40 the Infection Preventionist Register Nurse (RN-0) confirmed staff should always change gloves, complete hand hygiene and put on clean gloves after completing a task involving soiling, and prior to proceeding with a clean task. In addition, staff were to wear a gown and gloves during high contact care such as toileting and perineal care for residents on EBP's.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** License Reference Number 175 NAC 12-006.18(A)Based on record review and interview; the facility failed to have evidence Resident 4 and 7 were up to date and/or offered/given pneumococcal vaccinations. The sample size was 5 and the facility census was 38. Findings are:A. Review of the facility policy Vaccination dated September 2024 revealed each nursing facility would annually, no later than October 1, offer onsite vaccinations for pneumococcal to all residents. B. Review of Resident 4's Minimum Data Set (MDS- a federally mandated assessment tool used in care planning) dated 10/1/25 revealed the resident was admitted [DATE] with diagnoses of Heart Failure, High Blood Pressure, and Kidney Disease; had moderate cognitive impairment; and their pneumococcal vaccination was not up to date and it was not offered. Review of Resident 4's Medical Record revealed no evidence the resident had been offered or received/declined the pneumococcal vaccination. C. Review of Resident 7's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of Anemia, High Blood Pressure, Diabetes, Alzheimer's Disease, Dementia, Depression, and Chronic Lung Disease; had severe cognitive impairment; and their pneumococcal vaccination was not up to date and it was not offered. Review of Resident 7's Medical Record revealed no evidence the resident had been offered or received/declined the pneumococcal vaccination. D. Interview with Registered Nurse-O and the Director of Corporate Services on 12/18/25 at 1130 AM confirmed Residents 4 and 7 were not offered (and should have been) and did not receive the pneumococcal vaccination.