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	03/24/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Licensure Reference Number 175 NAC 12-006.12(D)(i)(2)Based on record review and interview; the facility failed to accurately account for narcotic medications. This had the potential to affect all residents receiving narcotic medications in the facility. The facility sample size was 4 and the census was 36.Findings are:A.Review of the facility policy Controlled Substance Administration and Accountability Policy dated April 2025 revealed the following:-It was the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility would have safeguards in place to prevent loss, diversion or accidental exposure of controlled substances.-Inventory verification for areas without automated dispensing systems would be completed by two licensed nurses accounting for all controlled substances and the nurses would exchange keys at the end of each shift.B.Review of the Controlled Drug-Count Record form (signatures verified that staff had counted the narcotics and the count had been verified by both nurses coming on and going off shift to be correct) for Hall 200 dated February 2026 revealed the following:- The Nurse coming on from 6A-6P did not sign the Narcotic Count form 12 out of 28 days. -The Nurse coming on from 6P-6A did not sign the Narcotic Count form 2 out of 28 days.-The Nurse going off from 6A-6P did not sign the Narcotic Count form 12 out of 28 days.-The Nurse going off from 6P-6A did not sign the Narcotic Count form 2 out of 28 days. Review of the Controlled Drug-Count Record form for Hall 100 dated March 2026 revealed the following:- The Nurse coming on from 6A-6P did not sign the Narcotic Count form 3 out of 24 days. -The Nurse coming on from 6P-6A did not sign the Narcotic Count form 1 out of 23 days.-The Nurse going off from 6A-6P did not sign the Narcotic Count form 5 out of 23 days.-The Nurse going off from 6P-6A did not sign the Narcotic Count form 2 out of 24 days. Review of the Controlled Drug-Count Record form for Hall 200 dated March 2026 revealed the following:- The Nurse coming on from 6A-6P did not sign the Narcotic Count form 1 out of 24 days. -The Nurse coming on from 6P-6A did not sign the Narcotic Count form 5 out of 23 days.-The Nurse going off from 6A-6P did not sign the Narcotic Count form 1 out of 23 days.-The Nurse going off from 6P-6A did not sign the Narcotic Count form 1 out of 24 days. Review of Controlled Drug-Count Record form for Hall 300 March 2026 revealed the following:- The Nurse coming on from 6A-6P did not sign the Narcotic Count form 2 out of 24 days. -The Nurse coming on from 6P-6A did not sign the Narcotic Count form 2 out of 23 days.-The Nurse going off from 6A-6P did not sign the Narcotic Count form 2 out of 23 days.-The Nurse going off from 6P-6A did not sign the Narcotic Count form 1 out of 24 days. An interview with the Director of Nursing (DON) on 3/24/26 at 12:30 PM confirmed that the nurse coming on and the nurse going off would count all the narcotic medications. When the nurses confirmed that the count was correct the nurses would sign the Controlled Drug-Count Record confirming that all narcotic medication were accounted for. Further interview confirmed that the Controlled Drug-Count Record forms were not completed/signed off as required to confirm the narcotic count was correct.

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D)Based on record review and interview; the facility failed to ensure 1 resident (Resident 4) of 4 sampled was free of significant medication errors. The facility had a census of 36. Findings are:A. Review of the facility policy Medication Error dated September 2024 revealed a medication error was the preparation, provision, or administration of medications that was not in accordance with the following:-Physician Orders;-Manufacturer's specifications regarding the preparation or administration of the drug;-Accepted professional standards that apply to professionals providing services; and-The five rights which included the right resident, the right drug, the right dosage, the right route and the right time. B.Review of the facility policy Medication Administration dated September 2024 revealed medications were administered by licensed nurses, or other staff who were legally authorized as ordered by the physician and in accordance with standards of practice. Compliance Guidelines included:-Ensure the six rights of medication administration were followed which included the right resident, the right drug, the right dosage, the right route, the right time, and the right documentation;-Review the Medication Administration Record (MAR) to identify the medication to be administered;-Compare the medication with the MAR to verify the resident name, medication form, dose, route and time;-Administer the medication as ordered;-Observe the resident consumption of medication;-Sign the MAR after administration;-If the medication is a controlled substance, sign the narcotic book;-Report and document any adverse side effects or refusals; and-Correct any discrepancies and report to nurse manager. C.Review of Resident 4's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 2/12/26 revealed the resident was admitted on [DATE] with diagnoses of Urinary Tract Infection, Seizure Disorder, Anxiety and Depression; the resident had moderate cognitive impairment; required assistance with toileting, dressing, transfers and hygiene; and received antibiotic and anticonvulsant (medications to prevent seizures) medications. Review of Resident 4's Care Plan last revised 2/6/26 revealed the resident had a seizure disorder with a history of seizures and interventions included to give medications as ordered; the resident required staff assistance with bed mobility, dressing, toileting, transfers and personal hygiene; and had diagnoses of Urinary Tract Infection, Genetic Intellectual Disability, Anxiety Disorder, Autistic Disorder, Major Depressive Disorder, and Seizures. Review of the facility form Order Summary Report with Active Medication Orders for Resident 4 revealed the resident had orders for the following anticonvulsant medications:-Brivaracetam (a controlled substance/anti-seizure medication) give 50 milligrams (mg) two times a day (8:00 AM {morning} and 8:00 PM {afternoon or evening});-Clobazam (a controlled substance/benzodiazepine class used to treat seizures) give 20mg two times per day (7:00 AM and 7:00 PM);-Lamictal (anti-seizure/mood stabilizer medication) 200mg give 3 tablets every day (8:00 AM);-Perampanel (a controlled substance/ anti-seizure medication) 8mg every night at bedtime (8:00 PM); and-Zonisamide (anti-seizure medication)100mg give 3 capsules two times per day (9:00 AM and 8:00 PM). Review of Resident 4's MAR for February 2026 revealed the following documentation regarding anticonvulsant medications 2/12/26 through 2/16/26:-Brivaracetam- received 11 out of 12 doses (did not receive the 8:00 AM on 2/14/26 and was charted as medication not available);-Clobazam- received 12 out of 12 doses;-Lamictal- received 5 out of 6 doses (did not receive the 8:00AM dose on 2/17/26);-Perampanel- received 6 out of 6 doses; and-Zonisamide- received 12 out of 12 doses. Review of the facility forms Resident Narcotic Record for Resident 4 revealed the following doses were not signed out as given:-on 2/12/26 the 8:00 AM dose of Brivaracetam was not given/signed out;-on 2/13/26 the 7:00 AM dose of Clobazam was not given/signed out;-on 2/14/26 the 8:00 PM doses of Brivaracetam and Perampanel were not given/signed out;-on 2/15/26 the 8:00 PM doses of Brivaracetam and Perampanel were not given/signed out; and-on 2/16/26 the 8:00 AM dose of Brivaracetam was not given/signed out. Review of Resident 4's Progress Notes revealed the (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	following entries:-On 2/17/26 at 11:00 PM the residents call light was on. The resident was found on the floor and post-seizure activity was present which included deep, loud snoring respirations were present and lasted 5 minutes. The resident was drowsy but was responding verbally to questions. The Physician and the residents Guardian were updated of the fall and seizure activity.-On 2/18/26 at 8:05 AM, the resident had a seizure at 6:00 AM that lasted 55 seconds and was witnessed. Between 6:00 AM and 7:50 AM two additional smaller seizures were observed. The residents Physician was called and ordered to send the resident to the hospital for increased seizure activity. The resident's Guardian was also called.-On 2/18/26 at 10:53 AM the Director of Nursing Services (DNS) received a call from the emergency room Physician stating they were admitting the resident to the hospital; and-On 2/18/26 at 1:35 PM the residents Guardian stated the resident would not be returning to the facility. Review of the facility Incident Report dated 2/18/26 revealed the facility updated the Physician, who is the facility Medical Director, of the medication errors resulting in seizure activity for Resident 4 on 2/18/26. The Physician/Medical Director's response was that the facility needed to treat the incident as a medication error. Review of the facility forms Verbal Counseling for Medication Aide (MA) -D dated 2/18/26 revealed MA-D received verbal counseling for signing off Brivaracetam on 2/12/26 at 8:00 AM and Clobazam on 2/13/26 at 7:00 AM as given but did not take the medication from the narcotic locked box and sign the medications out on the narcotic count sheets. MA-D was verbally reminded to complete the 6 rights of medication administration and not to sign off the medications as given until after the resident takes the medications. MA-D was given a copy of the Medication Administration Policy. Review of the facility forms Verbal Counseling for MA- I dated 2/18/26 revealed MA-I received verbal counseling for signing off Brivaracetam in the computer as given on 2/16/26 at 8:00 AM but did not take the medication out of the narcotic locked box and sign it out on the narcotic sheet. The corrective action was verbal counseling to complete the 6 rights of medication pass and to only sign the medications as given after the medication was administered. The facility gave MA-I a copy of the Medication Administration Policy. Review of the facility form Meeting dated 3/18/26 revealed the facility Pharmacist lead a meeting titled Medication Information. The staff were updated on a new process the facility put into place for pill cassettes. The staff were to pop out the pill from the numbered window that would correspond to the date. Interview on 3/24/26 at 7:30 AM with the DNS revealed the facility had identified the medication errors the day the resident went to the hospital. Further interview confirmed the facility put a process in place to account for the medications which included new cassettes for the medications so that the medications would be popped out of the numbered window that corresponded to the current date so the staff could track which medications were given/not given. The DNS confirmed 7 medication errors occurred between 2/12/26 and 2/16/26. MA-D and MA-I were verbally counseled and given a copy of the Medication Administration Policy. An agency Registered Nurse (RN) made the omission errors on 2/14/26 and 2/15/26. The Administrator called the agency, spoke to the supervisor and told them the facility would not allow that RN back to the facility. Interview on 3/24/26 at 12:30 PM with the DNS and the Administrator confirmed the anticonvulsant medications were omitted 7 times between 2/12/26 and 2/16/26 which resulted in Resident 4 being transferred to the hospital for seizure activity. Further interview confirmed the errors were a significant medication error.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 12-006.10(A)(ii) Licensure Reference Number 175 NAC 12-006.10(A)(iii) Licensure Reference Number 175 12-006.10(C) Based on record review and interview; the facility failed to ensure 1 (Resident 4) of 4 sampled residents records had accurate documentation of medication administration. The facility census was 36. Findings are:A.Review of the facility policy Medication Administration dated September 2024 revealed medications were administered by licensed nurses, or other staff who were legally authorized as ordered by the physician and in accordance with standards of practice. Compliance Guidelines included:-Ensure the six rights of medication administration were followed which included the right resident, the right drug, the right dosage, the right route, the right time, and the right documentation;-Review the Medication Administration Record (MAR) to identify the medication to be administered;-Compare the medication with the MAR to verify the resident name, medication form, dose, route and time;-Administer the medication as ordered;-Observe the resident consumption of medication;-Sign the MAR after administration;-If the medication is a controlled substance, sign the narcotic book;-Report and document any adverse side effects or refusals; and-Correct any discrepancies and report to nurse manager. B.Review of Resident 4's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 2/12/26 revealed the resident was admitted on [DATE] with diagnoses of Urinary Tract Infection, Seizure Disorder, Anxiety and Depression; the resident had moderate cognitive impairment; required assistance with toileting, dressing, transfers and hygiene; and received antibiotic and anticonvulsant (medications to prevent seizures) medications.Review of Resident 4's Care Plan last revised 2/6/26 revealed the resident had a seizure disorder with a history of seizures and interventions included to give medications as ordered; the resident required staff assistance with bed mobility, dressing, toileting, transfers and personal hygiene; and had diagnoses of Urinary Tract Infection, Genetic Intellectual Disability, Anxiety Disorder, Autistic Disorder, Major Depressive Disorder, and Seizures.Review of the facility form Order Summary Report with Active Medication Orders for Resident 4 revealed the resident had orders for the following anticonvulsant medications:-Brivaracetam (a controlled substance used to treat seizures) give 50 milligrams (mg) two times a day (8:00 AM and 8:00 PM);-Clobazam (a controlled substance/benzodiazepine class used to treat seizures) give 20mg two times per day (7:00 AM and 7:00 PM);-Lamictal (anti-seizure/mood stabilizer medication) 200mg give 3 tablets every day (8:00 AM);-Perampanel (a controlled substance/ anti-seizure medication) 8mg every night at bedtime (8:00 PM); and-Zonisamide (anti-seizure medication)100mg give 3 capsules two times per day (9:00 AM and 8:00 PM). Review of Resident 4's MAR for February 2026 revealed the following documentation regarding anticonvulsant medications 2/12/26 through 2/16/26:-Brivaracetam- received 11 out of 12 doses (did not receive the 8:00 AM on 2/14/26 and was charted as medication not available);-Clobazam- received 12 out of 12 doses;-Lamictal- received 5 out of 6 doses (did not receive the 8:00AM dose on 2/17/26);-Perampanel- received 6 out of 6 doses; and-Zonisamide- received 12 out of 12 doses. Review of the facility forms Resident Narcotic Record for Resident 4 revealed the following doses were not signed out as given:-on 2/12/26 the 8:00 AM dose of Brivaracetam was not given/signed out;-on 2/13/26 the 7:00 AM dose of Clobazam was not given/signed out;-on 2/14/26 the 8:00 PM doses of Brivaracetam and Perampanel were not given/signed out;-on 2/15/26 the 8:00 PM doses of Brivaracetam and Perampanel were not given/signed out; and-on 2/16/26 the 8:00 AM dose of Brivaracetam was not given/signed out. Interview on 3/24/26 at 12:30 PM with the Director of Nursing Services (DNS) and the Administrator confirmed the medications were signed as given in the MAR, but the medications were not administered. Further interviews confirmed Resident 4's Medical Record documentation was not accurate to reflect that the resident did not receive the medications.