

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285287	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER Mitchell Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1723 23rd Street Mitchell, NE 69357	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on record review and interviews, the facility failed to implement policies and procedures to prevent the potential for further abuse to occur during the investigation of abuse allegations. This had the potential to affect all residents. The facility identified a census of 45.</p> <p>Findings Are:</p> <p>A record review of an undated facility Abuse Policy revealed no documented evidence regarding procedures for how residents would be protected from further abuse while allegations of abuse were investigated, as per regulatory requirements. The policy revealed the facility was to include how the residents were protected in the report to the State Agency.</p> <p>A record review of an Investigative Summary dated 4/25/25 revealed no documented evidence of how residents were protected during investigative process. The summary describes the Director of Nursing's (DON) interviews with staff and effected residents regarding an incident that occurred on 4/19/2025 involving Licensed Practical Nurse (LPN-E) and Residents 3 and 4. The DON further revealed that LPN-E was called on the phone regarding the incident and was questioned. The date and times of these interviews was not observed on the summary. The summary concluded by saying that LPN-E was educated that when they are talking/yelling at residents they needed to slow down and have more patience with them and talk to them with respect.</p> <p>An interview with Nurse Aide (NA)-A, on 06/16/2025 at 12:30 PM revealed NA-A had concerns involving an incident they witnessed in April 2025. NA-A stated they were giving a bath down the 300 hall, with the water running when they heard their nurse, LPN-E yelling at a resident clear down the hall, NA-A stated that even the resident they were bathing heard it and asked what was going on. NA-A further revealed they heard LPN-E yelling at a resident that they needed to respect the staff. NA-A confirmed they reported their concerns to the registered nurse on shift who stated they had heard it too and would take care of it.</p> <p>An interview with the Director of Nursing (DON) on 06/16/2025 at 2:30 PM revealed they were aware of a incident involving a nurse and a resident that occurred on 04/19/2025. The DON stated that on 4/25/2025 they performed several interviews and all said nothing happened. The DON stated they turned their documented findings to the Nursing Home Administrator (NHA) for review. The DON confirmed the alleged employee had not been suspended during the investigation because nothing happened.</p> <p>(continued on next page)</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Nursing Home Administrator (NHA) on 06/16/2025 at 4:30 PM revealed that at present there is no documentation for the investigation that the DON stated took place on 04/25/2025 but they would continue to look. The NHA stated they would look into whether or not the employee was suspended during the course of the investigation.</p> <p>An interview with NHA on 06/16/2025 at 5:15 PM revealed that they were able to find the investigation summary and stated they reached out to the staff who were interviewed on 04/25/2025 to re-obtain their statements. The NHA presented three statements from employees that were dated 06/16/2025 and further presented the investigation summary. The NHA states according to the schedule LPN-E was not scheduled to work from 04/25/2025 through 04/28/2025 and confirmed this was the facility's original schedule and that LPN-E was not formerly placed on suspension pending the investigation.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Licensure Reference Number 175 12-006.02(H)</p> <p>Based on record review and interviews, the facility failed to report an allegation of abuse as per regulatory requirements. This had the potential to affect all residents. The facility identified a census of 45.</p> <p>Findings Are:</p> <p>A record review of the facility's undated Abuse Policy revealed the following:</p> <p>External Reporting:</p> <p>-Initial reporting of allegations:</p> <p>If an incident or allegation is considered reportable the Administrator or designee will make initial (immediate or within 24 hours) report to the State Agency. A follow up investigation will be submitted to the State Agency within 5 working days.</p> <p>A record review of an Investigative Summary that concluded on 04/28/2025 revealed no documented evidence of abuse allegations being reported to the State Agency. The investigation revealed that the Director of Nursing (DON) was notified on 4/25/25 of an event that occurred on 4/19/25 regarding allegations of abuse from LPN-E to Resident 4 and Resident 3. The investigation revealed that LPN-E was observed speaking firmly to Resident 4 and said a curse word to Resident 3 after Resident 3 said the same curse word to LPN-E. The summary went on to detail interviews with two staff in which one recalled hearing LPN-E talking loudly to Resident 4 and it made them come out of the bath house. The other staff denied that LPN-E was verbally abusing residents and that LPN-E was educating Resident 4 to quit being rude/mean to staff. That staff member denied that LPN-E said a curse word to Resident 3 but rather told them not to say that. The DON detailed a phone call to LPN-E who denied verbally abusing Resident 3 and 4 and stated they were sternly educating them not to talk rudely/bad to the staff. The DON revealed that LPN-E was educated that if they were talking/yelling at the residents that they needed to slow down and have more patience with them and talk to them with respect.</p> <p>An interview with the Director of Nursing (DON) on 06/16/2025 at 2:30 PM revealed they were aware of a incident involving a nurse and a resident that occurred on 04/19/2025. The DON stated they were aware that LPN-E has had numerous complaints lodged against them in the past and thought perhaps it was LPN-E 's personality. The DON confirmed that LPN- E is their sibling and stated because of that fact, all disciplinary action taken on LPN-E went through the administrator. The DON went on to reveal that they were made aware of the 04/19/2025 incident on 04/25/2025 by the former nursing home administrator (FNHA) who instructed them to investigate the allegations. The DON stated they performed several interviews and all said nothing happened. The DON stated they turned their documented finding to the FNHA for review. The DON confirmed the allegations of abuse were not reported to the State Agency and stated it was not reported because nothing happened.</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Nursing Home Administrator (NHA) on 06/16/2025 at 4:30 PM revealed that at present there is no documentation for the investigation that the DON stated took place on 04/25/2025 but they would continue to look. The NHA confirmed that the incident had not been reported to the State Agency, and it should have been.		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>Licensure Reference Number 175 12-006.02(H)</p> <p>Based on record review and interviews, the facility failed to protect residents from further potential abuse during an investigation of alleged violations of abuse as per regulatory requirements. This had the potential to affect all residents. The facility identified a census of 45.</p> <p>Findings Are:</p> <p>A record review of a facility undated Abuse Policy revealed the following:</p> <p>The facility must include the following investigative components-</p> <ul style="list-style-type: none"> -Have evidence that all investigative components have been thoroughly investigated. -Prevent further abuse, neglect, exploitation, or mistreatment while the investigation is in progress. <p>An interview with the Director of Nursing (DON) on 06/16/2025 at 2:30 PM revealed they were aware of an incident involving a nurse and a resident that occurred on 04/19/2025. The DON stated they were aware that LPN -E has had numerous complaints lodged against them in the past and thought perhaps it was LPN-E 's personality. The DON confirmed that LPN-E is their sibling and stated because of that fact, all disciplinary action taken on LPN-E went through the Former Nursing Home Administrator (FNHA). The DON went on to reveal that they were made aware of the 04/19/2025 incident on 04/25/2025 by the FNHA who instructed them to investigate the allegations. The DON stated they performed several interviews and all said nothing happened. The DON stated they turned their documented finding to the FNHA for review. The DON confirmed the alleged employee had not been suspended during the investigation because nothing happened. Regarding access to residents, the DON revealed that while on shift LPN-E had the potential to provide care for all residents in the building but was formerly assigned to half the building.</p> <p>An interview with the Nursing Home Administrator (NHA) on 06/16/2025 at 4:30 PM revealed that at present there is no documentation for the investigation that the DON stated took place on 04/25/2025 but they would continue to look.</p> <p>An interview with NHA on 06/16/2025 at 5:15 PM revealed that they were able to find the investigation summary and stated they reached out to the staff who were interviewed on 04/25/2025 to re-obtain their statements. The NHA presented three statements from employees that were dated 06/16/2025 and further presented the investigation summary. The NHA stated that according to the schedule LPN-E was not scheduled to work from 04/25/2025 through 04/28/2025 and confirmed this was the facility's original schedule and that LPN-E was not placed on suspension pending the investigation.</p>		