

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>285117</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>08/06/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>ARBOR CARE CENTERS-VALHAVEN, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP <b>300 WEST MEIGS STREET VALLEY, NE 68064</b>	
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 0584  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Some	<b>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</b> **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18 Based on observation and interview, the facility failed to maintain walls and bathroom doors in good condition in 8 (resident rooms 101, 103, 107, 108, 109, 112, 201 and 204) of 27 occupied rooms. The facility census was 47. Findings are: Observation on 08/05/20 between 9:30 and 09:56 AM with the facility administrator revealed the following: - Scrapes and gouges on the walls behind the beds in rooms [ROOM NUMBERS]. - Scrapes and gouges on the lower portion of the bathroom doors in rooms [ROOM NUMBERS]. - Scrapes and gouges on the walls near the baseboards in resident bathroom in rooms 101, 108, 109 and 204. Interview on 08/05/20 at 10:01 AM with the facility Administrator confirmed the presence of scrapes and gouges in the walls and doors in rooms 101, 103, 107, 108, 109, 112, 201 and 204. The Administrator confirmed that those areas needed repair		
F 0684  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Provide appropriate treatment and care according to orders, resident's preferences and goals.</b> **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09D Based on observation, record review and interview; the facility failed to ensure that wound treatments were completed in accordance with Physician orders [REDACTED]. The facility census was 47. Findings are: Record review of Resident 31's MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 6/23/20 revealed the presence of a surgical wound with surgical wound care in place. [DIAGNOSES REDACTED]. Record review of a hospital Discharge Summary for Resident 31 dated 3/16/20 revealed a right lower extremity wound debridement procedure had been completed. The Discharge Summary indicated that Resident 31 had developed Necrotizing Fascitis (a serious bacterial infection that destroys tissue under the skin) of the right lower extremity (RLE) with wound vac (a device that decreases the air pressure on a wound and helps with wound healing) placement on 3/2/20. Observation on 08/03/20 at 10:33 AM revealed Resident 31 laying in bed with a wound vac attached to the right lower leg. Record review of Resident 31's Treatment Administration record (TAR) dated May 2020 revealed a Physicians order for a wound vac dressing change to be completed every Monday, Wednesday and Friday and as needed. The order included to change the canister with each dressing change and continuous irrigation with Normal Saline (a medicine used to clean wounds and can reduce bacteria) 30 millimeters per hour via the wound vac system. Record review of Resident 31's Treatment Sheets dated May, June and July 2020 revealed that the treatment sheets for the wound care and dressing change were blank on 5/27/20, 6/22/20, 6/24/20, 6/26/20, 7/3/20 and 7/8/20. Interview on 08/04/20 at 09:59 AM with the Director of Nursing (DON) confirmed the blank spots on Resident 31's treatment sheets and was unable to find a note regarding the treatments done on those days to confirm that the treatments had been completed as ordered. The DON confirmed the expectation that staff document a note in the residents chart after the treatments were completed. Interview on 08/04/20 at 10:11 AM with the MDS Coordinator and the Infection Control Director confirmed that they did the wound treatment for [REDACTED]. The MDS Coordinator confirmed that they had not signed off that the treatments had been done. The MDS Coordinator and the Infection Control Director confirmed that if the treatment sheets had not been signed off as completed that it could not be verified that they had been completed as ordered.		
F 0801  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Many	<b>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</b> Licensure Reference number 175 NAC 12-006.04D2 Based on record review and interview, the facility failed to ensure the Dietary Manager (DM) held the required certification credentials for the position or employed a full time dietician. This had the potential to affect all residents that resided in the facility. The facility census was 47. Findings are: Interview on 08/04/20 at 07:25 AM with the facility Dietary Manager (DM) revealed that the DM was hired on 2/20/20 and was not currently certified as a DM. The DM stated (gender) was going to start working on it again soon. The DM stated the Dietician comes to the facility every Friday and is not a full time employee. Record review of the employee file for the DM revealed a hire date on 2/20/20 as the Dietary Manager and revealed no current certification in Dietary Management. Record review of a Job Description for the Director of Dietary (Dietary Manager), signed by the Administrator and the newly hired Director of Dietary on 2/20/20, revealed the person hired into that position must provide proof of certification / credentials on an annual basis and must maintain a level of continuing education as defined by the credentialing organization. Interview on 08/04/20 at 03:07 PM with the facility Administrator confirmed that the DM was not certified and the Dietician was not a full time employee.		
F 0880  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Many	<b>Provide and implement an infection prevention and control program.</b> **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.17D Based on record review and interview, based on observation, interview and record review the facility failed to establish a comprehensive infection surveillance program this had the potential to affect all residents residing in the facility. The facility census was 47. Findings are: An interview with the Director of Nursing and the Infection Preventionist was conducted on August 5th 2020 at 10:00 AM. This interview was to review the infection surveillance program of the facility. The review of the monthly infection surveillance tracking form revealed the facility was currently tracking each order for antibiotics with the following information; The date the order was received, the Resident's name, the Resident's room number, the medication ordered, the [DIAGNOSES REDACTED]. The record review of the infection surveillance form found the information required was not completed for the months reviewed. The Director of Nursing and Infection Preventionist were interviewed and acknowledged the facility failed to complete the infection surveillance form completely and were not tracking all required data (i.e. specific site of infection, pathogen, signs and symptoms, and resident location).		
F 0923  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Some	<b>Have enough outside ventilation via a window or mechanical ventilation, or both.</b> Licensure Reference Number 175 NAC 12-007.04D Based on observation and interview, the facility failed to maintain an operational ventilation system on the 100 hall of the facility in 9 (resident bathrooms 101, 102, 103, 107, 108, 109, 110, 111 and 112) of 27 occupied rooms. The facility census was 47. Findings are: Observation on 08/05/20 between 9:30 and 09:56		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>285117</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>08/06/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>ARBOR CARE CENTERS-VALHAVEN, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP <b>300 WEST MEIGS STREET VALLEY, NE 68064</b>	
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 0923</p> <p><b>Level of harm</b> - Minimal harm or potential for actual harm</p> <p><b>Residents Affected</b> - Some</p>	<p>(continued... from page 1)</p> <p>AM with the facility Administrator revealed that the ventilation system in rooms 101, 102, 103, 107, 108, 109, 110, 111, 112 on the 100 wing of the facility did not draw a 1 ply square of tissue to the surface of the ventilation cover. The fact that the tissue square was not drawn to the cover indicated that the system was non-operational at the time of the observation. Interview on 08/05/20 at 10:01 AM with the facility Administrator confirmed that the ventilation system did not draw in resident bathrooms in rooms 101, 102, 103, 107, 108, 109, 110, 111, 112. Interview on 08/05/20 at 10:45 AM with the facility Administrator confirmed that the facility did not have a system to document when the vents are checked and were unable to determine when they were last checked. The Administrator stated they had installed a new system 3 weeks ago. The Administrator stated the system was checked at 10:30 AM on 8/5/20 and verified that it was not working at that time.</p>		