STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285094	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Maples at Centennial	510 Centennial Circle North Platte, NE 69101

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 0760 Level of Harm - Minimal harm or potential for 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 observation, interview, and record review; the facility failed to ensure 2 (Residents 3 & 2) of 8 sampled residents were free of significant medication errors. The facility census was 74.Findings Are: A record review of facility policy Medication Reordering dated 2025 revealed a policy statement of It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of the resident. The policy guidelines states acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. Each time a nurse is administering medications and observes 6 or less doses left of one kind, that nurse will reorder the medication, time permitting. In the event of new orders, the facility is allowed 24 hours to begin a medication unless otherwise specified by the physician. A.A record review of Resident 3's admission Record dated 1/21/2026 revealed the resident was admitted to the facility on [DATE]. An observation on 1/21/26 at 7:34 AM revealed Licensed Practical Nurse (LPN)-A preparing medications for Resident 3. Upon entering Resident 3's room, the resident stated to LPN-A that their jaw was hurting really bad. LPN-A replied that it can take some time for antibiotics to begin working and the resident replied that no one had given them their antibiotic yet. The LPN stated that they would look into this as the antibiotic had been ordered the day prior. After completion of Resident 3's medication and cares, LPN-A returned to the medication cart and confirmed that there was no antibiotic listed in Resident 3's orders. An interview on 1/21/2026 at 7:38 AM with LPN-A revealed that when new orders are received the orders are sent to the pharmacy, the pharmacy staff enters the order into the resident's medical records and then brings the medication to the facility. LPN-A confirmed that Resident 3 had been seen by the dentist on 1/20/2026 and that LPN-A had personally faxed the new antibiotic order to the pharmacy during their 6 AM to 6 PM shift, so LPN-A was unsure why the order was not in the resident's order list to administer. An observation on 1/21/2026 at 7:43 AM revealed LPN-A had logged onto the computer at the nurse's station and then called the pharmacy. LPN-A explained to the pharmacy that Resident 3 had an antibiotic order that had been faxed to the pharmacy the day prior but there was no order in their medical records. The pharmacist told LPN-A that the medication was at the facility and LPN-A reminded the pharmacy that they could not administer the medication until the pharmacy entered the order into the medical record. The pharmacy told LPN-A that they would get the order entered. A record review of Resident 3's Progress Note dated 1/20/2026 revealed the resident had returned to the facility from a dental appointment with a new order for Augmentin (an antibiotic medication) twice a day (BID) for 10 days and that the medication was to be delivered by the pharmacy. A record review of a dental provider note for Resident 3 dated 1/20/2026 revealed the resident had been evaluated for pain/infection of lower teeth. The provider prescribed an antibiotic and was going to schedule the resident for teeth extraction. A record review of a fax dated 1/20/26 (continued on next page)

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
	285094	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Maples at Centennial	510 Centennial Circle North Platte, NE 69101

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the fax had been sent to the pharmacy and stated Resident 3 had a dental order for Augmentin 875/160 BID for 10 days and was to be delivered by the pharmacy. The document was noted by LPN-A. An interview on 1/21/26 at 12:17 PM with Resident 3 revealed the resident was wanting to know if they had any medications due at that time because they were needing something for their pain. An interview on 1/21/26 at 2:05 PM with the Director of Nursing (DON) confirmed that the pharmacy did enter the facility's medication orders and that there had been some breakdowns in this process. The DON stated that the day nurse on 1/20/2026 should have reported off to the night nurse about Resident 3's antibiotic order to ensure it was entered into the medical record by the pharmacy that day. The DON confirmed Resident 3 should have received their first dose of the antibiotic the same day it was ordered. B.A record review of Resident 2's admission Record dated 1/21/2026 revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of Type 2 Diabetes Mellitus (a common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production). A record review of Resident 2's January 2026 Medication Administration Record revealed the resident had an order for Ozempic (a non-insulin diabetic medication) 8 milligrams/ 3 milliliters. The order stated to inject 2 milligrams every 7 days for Type 2 Diabetes Mellitus. The order had a start date of 9/3/2025 and an administration time of 7:00 AM. An observation on 1/21/26 at 7:22 AM revealed LPN-A preparing to administer medications to Resident 2. LPN-A was unable to locate the resident's Ozempic injection on the medication cart or in the medication storage room. An interview on 1/21/2026 at 7:22 AM with LPN-A confirmed they had not been able to locate Resident 2's Ozempic injection that was due to be administered that morning. LPN-A stated that normally this medication would be reordered when the last dose was administered since it was a once weekly injection, but it appeared this had not been done. An interview on 1/21/26 at 12:02 PM with LPN-A revealed the LPN had confirmed Resident 2's Ozempic had not been reordered when the last dose was administered the week prior, that the LPN had contacted the pharmacy and that the pharmacy would be delivering the medication later that day. A record review of Resident 2's Progress Note dated 1/21/2026 at 12:35 PM revealed LPN-A had been unable to give the resident their Ozempic injection and that it was reordered from the pharmacy. The note also revealed the pharmacy had confirmed the reorder and that it would be delivered that evening with drop off meds. An interview on 1/21/26 at 2:05 PM with the DON confirmed that last person to administer Resident 2's Ozempic would have been responsible for reordering the medication, and that this had not occurred.