STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285294	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Care Centers - Ord, LLC	220 South 26th Street Ord, NE 68862

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12 Based on record review, observations, and interviews; the facility failed to ensure medications were ordered, available, and administered as ordered by a physician for 1 (Resident 17) of 1 sampled resident. The facility census was 39. Findings are: Record review of the Medical Diagnoses for Resident 17 revealed Resident 17 had a diagnosis of multiple myeloma (a type of cancer that develops in the plasma cells, which are white blood cells that produce antibodies to fight infections), not yet in remission. Record review of Resident 17's Physician Telemed visit with their oncologist (physician who specializes in cancers and blood disorders) dated 08/16/2024 revealed Resident 17 started lenalidomide (a specialized medication used to treat multiple myeloma) for multiple myeloma during the month of 07/2023. This medication was ordered to be given on a 28-day cycle where Resident 17 received lenalidomide 10 mg capsule oral daily for 21 days and then had 7 days with no medication before starting another 28-day cycle. Record review of the September 2024 Medication Administration Record (MAR) revealed that the medication was ordered to be given on a 28 day cycle with Resident 17 receiving 21 days of the medication and then having 7 days off before beginning a new cycle. The order stated: Revlimid Oral Capsule 10 MG (lenalidomide) give 1 capsule orally one time a day related to Multiple Myeloma not having achieved remission (C90.00) for 21 days. The order had a start date of 09/12/2024 and no end date. Resident 17 started a 28 day cycle on Thursday, 09/12/2024. A record review of the October 2024 MAR revealed that Resident 17's order for the medication administration of lenalidomide 10 mg daily for 21 days and off 7 days ended on Wednesday, 10/02/2024. There was to be a 7-day break with no medication and then medication was ordered to restart on Thursday, 10/09/2024. The October MAR revealed this medication did not restart until Tuesday, 10/22/2024, 13 days past the date that the medication should have started and continued through the end of the month. A record review of the November 2024 MAR revealed that Resident 17's order for the medication administration of lenalidomide 10 mg daily for 21 days and off 7 days was on the MAR and the medication administration ended on Monday, 11/11/2024. This was to be followed by 7 days with no medication administration and then restarted on Monday, November 18, 2024. The lenalidomide was not restarted in the month of November 2024. A record review of Resident 17's Physician Orders revealed no evidence of an order to stop the administration of the lenalidomide. A record review of the December 2024 MAR revealed that Resident 17 did not receive any of the lenalidomide during this period. A record review of the January 2025 MAR revealed that Resident 17's order for the medication administration of lenalidomide 10 mg daily for 21 days with 7 days off was on the MAR and the medication administration started on Thursday, 01/03/2025 and ended on Wednesday, 01/23/2025. The medication should have been restarted on 01/30/2025, but the medication was not restarted in the month of January. A record review of the February 2025 MAR revealed that Resident 17's order for the medication administration of lenalidomide 10 mg daily for 21 days with 7 days off was on the MAR and (continued on next page)

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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medication administration started on Saturday, 02/01/2025, and should have been started on 01/30/2025. A record review of the March 2025 MAR revealed that Resident 17's order for the medication administration of lenalidomide 10 mg daily for 21 days with 7 days off was on the MAR and the medication administration started on Saturday, 03/01/2025. The medication was stopped on Friday, 03/21/2025. The next 28-day cycle started on Sunday, 03/30/2025. A record review of Resident 17's April 2025 MAR revealed the order for lenalidomide 10 mg daily for 21 days with 7 days off was on the MAR. The 21 day cycle started on March 30, 2025 and stopped on April 19, 2025.The medication was not given on 04/15, 04/16, or 04/17. The nurses noted revealed the medication was unavailable. Record review of a medication error report dated 04/14/2025, was sent to Resident 17's primary care physician and revealed that there was an order for the medication lenalidomide that was to be given in 28-day cycles for Resident 17's multiple myeloma, not in remission. The errors started in the month of October 2024 and continued throughout the month of December 2024. This significant medication error stated: Concerning Revlimid take 21 days of (off) 7 days regimen. Medication should have started the 10th of October for a 21 day cycle supply but was started on the 22nd of October and completed on 11/11/2024. Revlimid 10 mg should have been restarted on 11/19/2024 and went through until 12/9 off until 12/16 restarted on 12/17 given for 21 days which would have been until 12/28 stop 12/29 and restarted on 1/4/2025. Was restarted on 1/3/2025 off 1/22 and restarted on 1/30/25 but was restarted 2/1/25. Has been on track regimen since 2/1/25. Staff has been educated and medication regimen in computer until [DATE] finishing on 10/10 with an alert if medication is continued to input order after 10/10/2025. A record review of Resident 17's medical records revealed no evidence of the resident's oncologist being notified of the medication errors. Interview on 09/23/2025 at 10:30 AM with Infection Control and Preventionist (IP) revealed that Resident 17 took this medication for 21 days, then had a rest period for 7 days, then the cycle started again. The medication and rest cycle was a 28-day cycle. There was no order to stop the medication at any point. IP confirmed the facility made a mistake by not getting the lenalidomide back on the MAR as the facility could only put about 3 or 4 months into the medication order system to show up on the MAR and then fell off. The facility would then have to manually input that order back into the system. IP stated this medication only came from one source, a specialty pharmacy, and the facility had to call to have it delivered for each cycle. IP stated the facility could not order it in advance, as in 2 or 3 months at a time, the facility had to order it as each cycle ended and the next cycle was about to begin. IP confirmed Resident 17 missed a couple of 28-day cycles. Interview on 09/23/2025 at 4:40 PM with the IP confirmed that the medication is ordered from only one pharmacy, a specialty pharmacy, and that 21 pills at a time are delivered prior to each 28-day cycle. IP receives an email from the specialty pharmacy that states it is time to reorder the medication. However the IP does not keep these emails after the medication is delivered. These medications can only be ordered one cycle at a time and must be ordered just before starting a cycle. Interview on 09/23/2025 at 5:15 PM with a representative of the specialty pharmacy in the office of the IP with the IP in the room. This interview was conducted with the phone on speaker. The pharmacy representative stated medications had been ordered and delivered on the following dates, 21 pills at a time, each order was enough to complete one 28-day cycle (Also included are the dates when medications were documented but there were no deliveries from the pharmacy.);-08/29/2024 delivered (for the cycle administered 09/12/2024 to 10/10/2024-No medication delivered during the month of September 2024-No medication delivered for the cycle documented as administered from 10/22/2024 to 11/11/2024-No medication delivered during the month of October 2024-No medication delivered during the month of November 2024-12/24/2024 delivered (for the cycle administered 01/03/2025 to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/23/2025)-01/16/2025 delivered (for the cycle administered 02/01/2025 to 02/21/2025)-No medication delivered during the month of February 2025.-No medication delivered during the month of March 2025-No medication delivered for the cycle documented as administered from 03/01/2025 to 03/21/2025-No medication delivered for the cycle documented as administered from 03/30/2025 to 04/19/2025-04/20/2025 delivered (for the cycle administered 04/27/2025 to 05/17/2025)-05/15/2025 delivered (for the cycle administered 05/26/2025 to 06/15/2025)-06/06/2025 delivered (for the cycle administered 06/24/2025 to 07/14/2025)-07/15/2025 delivered (for the cycle administered 07/23/2025 to 08/12/2025)-08/142025 delivered (for the cycle administered 08/21/2025 to 09/10/2025)-09/17/2025 delivered (for the cycle administered 09/19/2025 to be completed on 10/10/2025)The pharmacy representative confirmed that no medications had been ordered or sent to the facility during the months of September 2024, October 2024, November 2024, February 2025, or March 2025. Interview with on 09/23/2025 which started at 4:40 PM with the IP continued following the phone call with the pharmacy representative. The IP could not state when or where the medications for the medications were obtained for the months the pharmacy representative stated there were no deliveries. The IP was unable to show medication receipts to show that these medications were ordered or received. Interview on 9/25/2025 at 11:10 AM with Registered Nurse (RN) H stated knowing there were times when there was no medication available for Resident 17. Interview with RN-H on 9/25/2025 at 4:45 PM confirmed that the medication only comes one bottle at a time and that there are only 21 pills that are sent for each cycle. RN-H had never seen any extra medication in the medication cart at any time. Interview on 9/25/2025 at 5:15 PM with Medication Aide (MA) B who stated a couple of months ago, unsure of the dates but only that it was a couple of months ago, there was an extra bottle of medication in the medication cart. That extra medication was kept in a baggy in the back of the top drawer of the medication cart for Resident 17. There was a second bottle that was at that time being used and was only about 1/2 full we were in the middle of a 28-day cycle of the lenalidomide.

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F 0844 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. Licensure Reference Number 175 NAC 12-006.01(G)&(H) Based on record review and interview, the facility failed to notify the State Agency within 5 working days when there was a change in Administrator position. This had the potential to affect all facility residents. The facility census was 39. Findings are:A record review of the facility's undated Change of Administrator or Director of Nursing Notification Form revealed the facility had a change in administrator on 11/19/2025-11/20/2024. An interview on 9/24/2025 at 4:25 PM with the administrator and the facility owner (via telephone) confirmed the change in administrator form for the change that occurred on 11/19/2025-11/20/2024 was not sent to the State Agency until 12/16/2025. The owner confirmed this was outside of the required timeframe. A record review of the facility's undated Change of Administrator or Director of Nursing Notification Form revealed the facility had a change in administrator on 6/10/2025-6/11/2025. An interview on 9/24/2025 at 4:30 PM with the administrator and the facility owner (via telephone) confirmed the change in administrator form for the change that occurred on 6/10/2025-6/11/2025 was not sent to the State Agency until 7/12/2025. The owner confirmed this was outside of the required timeframe.