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. (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	**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 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]

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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.