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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.19Based on record review, interviews and observations, the facility failed to ensure cleanliness in the dining room; failed to ensure that room wall fans/ventilation were clean; and failed to ensure that the bath house was cleaned thoroughly to remove the buildup on the tub handles and the exhaust fans were free of dust. This had the potential to affect all facility residents. The facility census was 39. Findings are:A.Observation on 9/22/2025 at 9:55 AM in the 400-hallway bath house revealed the exhaust vent was covered with fuzzy, grey-colored particulates. The bathtub had a buildup on the knobs that was white in color, looked like soap scum or build-up of hard water deposits, and could be easily scraped off when scratched. Interview with Bath Aide (BA)-F on 9/22/2025 at 9:55 AM revealed that the bath house was cleaned between residents with the tub being sanitized for 10 to 15 minutes or more between residents. At the end of each day the entire bath house is to have a terminal (final thorough clean) daily by housekeeping. BA-F agreed that there were fuzzy particles on the exhaust fan in the 400 bath house. BA-F also agreed that there was a white build up on the plastic handles of the tub where the water is turned on and off. Interview with the Admin and Maint while touring the 400 hall bathhouse on 09/23/2025 at 9:45 AM confirmed that there was a white build up on the bathtub handles and the exhaust fan was not clean and had grey fuzzy particles on it. B.Observation in the dining room on 09/22/2025 at 12:25 PM revealed the windowsills were covered in a dusty and oily feeling build-up with dead bugs on the windowsill. Observation in the dining room on 09/23/2025 at 8:20 AM revealed the windowsills in the dining room continued to have a dusty, oily like residue on the windowsills and the dead bugs remained on the windowsills. Interview on 09/23/2025 at 9:27 AM with the Facility Administrator (Admin) who confirmed the windowsills in the dining area do have dusty residue and there are some dead bugs in the windowsills. C.Observation on 09/22/2025 at 10:30 AM of the ventilation fan covers in the hallway revealed there was a dusty and fuzzy build up in the hallway vent covers near the north and south outside emergency exits beside room [ROOM NUMBER]. Observation on 09/22/2025 at 10:40 AM of the room ventilation cover in room [ROOM NUMBER] revealed there was a fuzzy build up on the wall fans vent covers and the ventilation fan in the bathroom had a fuzzy dust build-up on the exhaust vent. Observation on 09/22/2025 at 12:10 PM of the room ventilation cover in room [ROOM NUMBER] revealed there was a fuzzy build up on the wall fans vent covers and the ventilation fan in the bathroom had a fuzzy dust build-up on the exhaust vent. Observation on 09/22/2025 at 12:12 PM of the room ventilation cover in room [ROOM NUMBER] revealed there was a fuzzy build up on the wall fans vent covers and the ventilation fan in the bathroom had a fuzzy dust build-up on the exhaust vent. Observation on 09/22/2025 at 12:15 PM of the room ventilation cover in room [ROOM NUMBER] revealed there was a fuzzy build up on the wall fans vent covers and the ventilation fan in the bathroom had a fuzzy dust build-up on the exhaust vent. Observation on 09/22/2025 at 12:30 PM of the room ventilation cover in room [ROOM NUMBER] revealed there was a fuzzy build up on the wall fans vent covers and the ventilation fan in the bathroom had a fuzzy dust build-up on the exhaust vent. Observation on 09/22/2025 at 12:40 PM of the room ventilation cover in room [ROOM NUMBER] revealed the ventilation fan in the bathroom had fuzzy dust like build up on the exhaust vent.

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(A)(iii)(3)Based on interview and record review, the facility failed to follow the facility policy and complete criminal background checks, and [NAME] (Sex Offender Registry) checks for 1 of 5 personnel files reviewed. This had the potential to affect all of the facility residents. The facility census was 39. Findings are: A record review of an active employee roster dated 09/12/2025 revealed Medication Aide (MA)-A had a current status of active. Record review of personnel files for MA-A revealed a date of hire of 10/28/2024. Further review of MA-A personnel file revealed no evidence of a criminal background check or [NAME] checks. An interview with the Administrator (Admin) on 9/23/2025 at 4:30 PM revealed the criminal background check and [NAME] check for MA-A had not been completed. An interview with the Admin on 9/24/2025 at 9:45 AM revealed corporate staff had not completed background check or [NAME] checks for MA-A prior to hire and/or working with facility residents. A review of the facility policy titled, Abuse-Neglect-and-Exploitation Policy dated September 2024 revealed a policy statement of It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. This included:Screening:-Potential employees will be screened for history of abuse, neglect, exploitation, or misappropriation of resident property.-Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students, students affiliated with academic institutions, volunteers, and consultants.-Screening may be conducted by the facility itself, third party agency or academic institution.-The facility will maintain documentation of proof that the screening occurred.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Licensure Reference Number 175 NAC12-006.04(H)(ii) Based on record review and interview, the facility failed to employ a Director of Food and Nutrition Services that met the regulatory educational requirements. This had the potential to affect all of the residents receiving meals from the kitchen. The facility census was 39. Findings are:A record review of a facility supplied document titled Department Heads revealed an employee name listed as the Dietary Manager (DM). A record review of facility supplied documents revealed no evidence of the DM having received the required education and no evidence of a qualified dietitian being employed full time. In an interview completed on 09/22/2025 at 10:15 AM with the DM, the DM confirmed they had not completed an educational program that met regulatory requirements. The DM also confirmed that the Registered Dietitian was not employed full time and completed facility visits and resident reviews on a monthly basis.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006.11(E) Based on record review, interviews, and observations; the facility failed to store and prepare food in safe and sanitary conditions. This had the potential to affect all residents receiving meals from the kitchen. The facility census was 39.Findings Are: A.Record review of an undated facility policy titled Food Safety Requirements revealed food safety practices shall be followed throughout the facility's entire food handling process. Food will be stored in a manner that helps prevent deterioration or contamination of the food. Record review of an undated facility policy titled Defrosting Freezers revealed freezers that are opened and closed frequently, or are located in humid environments, may need to be defrosted every 3 to 6 months. In an observation completed on 09/22/2025 at 10:00 AM an upright single door standard freezer was present in the facility dry food storage area. The interior of the freezer was observed to have a 3-4-inch layer of frost present to the inner top of the freezer. All items visible in the freezer were observed to have a thin opaque white layer of frost present covering their exposed packaging. In an interview completed on 09/22/2025 at 10:15 AM with the facility Dietary Manager (DM), the DM confirmed the layer of frost present on the single door standard freezer. The DM stated knowledge of it needing to be defrosted and cleaned stating had not been completed due to inability to store items while it was being defrosted. The DM confirmed that there should not be a buildup of frost on the interior of the freezer or the packaged items being stored in it and there was. B.Record review of an undated facility policy titled Food Safety Requirements revealed when preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce or eliminate potential hazards. Record review of a facility policy titled Hand Hygiene and dated September 2024 revealed all staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. Hand hygiene technique when using soap and water rub hands together vigorously for at least 20 seconds covering all surfaces of the hands and fingers. In an observation completed on 09/25/2025 at 9:25 AM of meal preparation [NAME] C placed a white piece of rectangle wax paper on the stainless-steel table they were using to prepare the afternoon meal. The cook used a white handled scoop to scoop out solid/frozen peach-colored cubes from a clear plastic bag. The cook placed these cubes in a clear plastic container to be weighed. The cook then placed the scoop that was used opening down on the piece of wax paper setting on the stainless-steel table. The cook then moved the scoop from one area of the wax paper to the other side. The cook removed their gloves and disposed of them in the trash. The cook returned to the stainless-steel table and placed their unwashed bare hand on the wax paper where the scoop had been lying. The cook then removed the clear plastic container from the scale and emptied the peach cubes into a rectangular baking pan. The cook then placed the pan into the convection oven. The cook then walked over to the sink and completed hand hygiene using soap and water for 10 seconds. In an interview completed on 09/25/2025 at 9:50 AM with [NAME] C, [NAME] C confirmed that the peach cubes were frozen raw chicken pieces. The cook confirmed that they did not complete hand hygiene after removing their gloves and placed their hand on the wax paper where the scoop had been placed potentially contaminating their hand with raw chicken and did not complete hand hygiene. The cook confirmed that hand hygiene with soap and water should include rubbing the hands with soap for at least 20 seconds. The cook confirmed that when they completed hand hygiene with soap and water they did not rug their hands for at least 20 seconds with soap. In an interview completed on 09/25/2025 at 9:55 AM with the DM, the DM confirmed that the cook should have washed their hands after removing their gloves and after touching the wax paper where the scoop used on frozen raw chicken had been placed and did not. The DM confirmed when [NAME] C did complete hand hygiene with soap and water they did not rub their hands with soap for at least 20 seconds.

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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.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Licensure Reference Number 175 NAC 12-006.05(B) Based on interview and record review, the facility staff failed to provide documentation that a written notice of Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN, a notice issued to a resident and/or their responsible party to inform them that Medicare will likely no longer pay for their services) for 3 (Residents 25, 28, and 46) of 3 sampled residents when their Medicare A services ended. The facility census was 39. Findings are: A record review of Centers for Medicare and Medicaid Services (CMS) Guidelines with the Admin on notification of non-coverage (NOMNC, SNF ABN, ABN, DENC) undated revealed the following: Purpose: to comply with CMS regulations on proper notification of coverage termination to Medicare beneficiary and to release facility from financial responsibility. Standard: Timely and proper completion of CMS forms by facility as it related to CMS guidelines. Advance Beneficiary Notice provides written notice to beneficiary that therapy services may not be covered by Medicare. Allows the beneficiary to make an informed decision about whether to get the item or service that is not covered and accept financial responsibility if Medicare does not pay. Should be provided to Beneficiary when an item or service is not considered reasonable and necessary under Medicare Program Standards. A record review of the Entrance Conference Worksheet Beneficiary Notice-Residents discharged in the Last 6 Months received from the Administrator (Admin) revealed Resident 25, Resident 28, and Resident 46 were listed as having been discharged from Medicare A services with Medicare A days remaining. A.A record review of the SNF Beneficiary Notification Review for Resident 25 revealed the Medicare Part A Skilled Services Episode Start Date was 02/28/2025 and the last covered day of Part A Service was 3/31/2025. The Medicare Part A Service Termination/Discharge determined was listed as: the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. The SNF ABN was not provided with the reason being listed as Resident had Med A days left, facility error. Resident 25 remained in the facility after their Medicare A services ended. B.A record review of the SNF Beneficiary Notification Review for Resident 28 revealed the Medicare Part A Skilled Services Episode Start Date was 06/03/2025 and the last covered day of Part A Service was 07/25/2025. The Medicare Part A Service Termination/Discharge determined was listed as: the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. The SNF ABN was not provided with the reason being listed as Resident had Med A days left, facility error. Resident 28 discharged from the facility to home when Medicare A services ended. C.A record review of the SNF Beneficiary Notification Review for Resident 46 revealed the Medicare Part A Skilled Services Episode Start Date was 05/07/2025 and the Last covered day of Part A Service was 06/20/2025. The Medicare Part A Service Termination/Discharge determined was listed as: the Resident initiated the discharge from Medicare Part A Services when benefit days were not exhausted. The SNF ABN was not provided with the reason being listed as Resident had Med A days left, facility error. Resident 46 discharged from the facility to home after their Medicare A services ended. Interview with the Administrator (Admin) on 09/23/2025 at 10:40 AM revealed this was a facility error in not providing this information to the resident when revealed they had not issued the SNF ABN to Residents 25, 28, and 46.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-007.04(D) Based on observation and interview, the facility failed to ensure that that exhaust fans in the resident rooms on the 400 hallway were in working order. This affected 12 (Residents 3, 5, 10, 14, 17, 18, 19, 30, 31, 39, 40, and 45) of 12 sampled residents. The facility census was 39. Findings are: A.Observation on 09/22/2025 at 10:15 AM in resident room [ROOM NUMBER] revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. B.Observation on 09/22/2025 at 10:35 AM in resident room [ROOM NUMBER] revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. C.Observation on 09/22/2025 at 10:40 AM in resident room [ROOM NUMBER] revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. D.Observation on 09/22/2025 at 12:10 PM in resident room [ROOM NUMBER] revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. E.Observation on 09/22/2025 at 12:12 PM in resident room [ROOM NUMBER] revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. F.Observation on 09/22/2025 at 12:15 PM in resident room [ROOM NUMBER] revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. G.Observation on 09/22/2025 at 12:30 PM in resident room [ROOM NUMBER] revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. H.Observation on 09/22/2025 at 12:40 PM in resident room [ROOM NUMBER] revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. I.Observation on 09/22/2025 at 1:10 PM AM in resident room [ROOM NUMBER] revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. Interview on 09/23/2025 at 9:25 AM with the Maintenance Supervisor (Maint) who revealed they were not aware that the vents in these rooms were not working as required. Interview on 09/23/2025 at 9:27 AM with the Facility Administrator who confirmed not knowing the ventilation fans were not working in the 400 hallway.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Licensure Reference Number 175 NAC 12-006.02(H) Based on record review and interview the facility failed to report incidents and/or accidents as required to the regulatory agency for 1 resident (Resident 38) of 2 sampled residents. The facility census was 39. Findings are:A record review of a facility policy titled Incidents and Accidents revealed the purpose of incident reporting includes meting regulatory requirements for the reporting of incidents and accidents. A record review of a facility policy titled Abuse revealed the facility will report all alleged violations to the state agency, adult protective services and to all other required agencies with in specified time frames. A record review of an admission Record revealed the facility admitted Resident 38 on 12/12/2022 with a diagnosis of quadriplegia, which is a form of paralysis that affects all for limbs and the torso often resulting from a spinal cord injury in the neck region. A record review of Resident 38's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 07/10/2025 revealed Resident 38 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15/15, indicating the resident was cognitively intact. The resident was dependent on staff assistance with bed mobility, transfers, and toilet use. A record review of Resident 38's Progress Notes for the month of September 2025 revealed documentation that on 09/17/2025 the resident was observed to have a red raised area to the dorsal surface of their right hand. The resident informed staff they had fallen asleep with their blow dryer on and the blow dryer caused the burn on their hand. Record review of a facility supplied document titled Incidents and Accidents revealed documentation of a incident report being completed on 09/17/2025 consistent with the documentation present in the progress notes. In an interview completed on 09/25/2025 at 11:00 AM with the facility Administrator (Admin), the Admin confirmed that Resident 38 had a self inflected burn to their right hand on 09/17/2025. The Admin confirmed that this incident was not reported to the necessary regulatory agencies as outlined in the facility abuse policy. The Admin confirmed that this incident should have been reported per the facility policy and was not.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Licensure Reference Number 175 NAC 12-006.09(H)(vi)(2) Based on interview and record review the facility failed to provide activities in accordance with the residents expressed interests for 1 (Resident 1) of 2 sampled residents. The facility census was 39. Findings are:A record review of a facility policy titled Activities and not dated revealed it is the policy of the facility to provide and ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. A record review of an admission Record revealed the facility admitted Resident 1 on 02/21/2025 with diagnoses of Type 2 Diabetes Mellitus (a condition where the body does not produce enough insulin for the body to utilize sugar in the blood stream), hypertension (High blood pressure), and generalized muscle weakness. A record review of Resident 1's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 08/28/2025 revealed Resident 1 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15/15, indicating the resident was cognitively intact. The resident utilized a wheelchair for mobility and was dependent on staff assistance propelling the wheelchair throughout the facility. A record review of Resident 1 Care Plan revealed a focus of personalized care with an intervention listed of participating in religious services to be very important to the resident. In an interview completed on 09/22/2025 at 1:45 PM with Resident 1, Resident 1 stated that they wished the facility offered religious services other than Catholic Mass. The resident stated they really missed going to church and would enjoy attending church services. Record review of the facility supplied activities calendar for the month of July 2025 revealed Catholic Communion being offered every Sunday. No other religious services or activity offerings were listed on the calendar for the month. Record review of the facility supplied activities calendar for the month of August 2025 revealed Catholic Mass being offered every Sunday and Bible Study to be offered every Tuesday. No other religious services or activity offerings were listed on the calendar for the month. Record review of the facility supplied activities calendar for the month of September 2025 revealed Catholic Communion being offered every Sunday and Bible Study was offered on the last Tuesday of the month. No other religious services or activity offerings were listed on the calendar for the month. In an interview completed on 09/25/2025 at 1:45 PM with the facility Administrator (Admin), confirmed the only religious services offered in the facility for the last 3 months was Catholic Mass or Communion and Bible Study.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(g) Based on record review, observation, and interview, the facility failed to ensure that reusable respiratory equipment was labeled, cleaned, and stored per facility policy after use to prevent the potential for infection. This affected one (Resident 5) of one resident sampled. The facility census was 39. Findings are: Record review of the facility policy Infection Prevention and Control Program dated February 2025 stated this facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted [NAME] standards and guidelines. On page 3 of 5, subsection Equipment Protocol, the policy stated: All reusable items and equipment requiring special cleaning, disinfection or sterilization shall be cleaned in accordance with out current procedures governing the cleaning and sterilization or soiled or contaminated equipment. Reusable items potentially contaminated with infections materials shall be placed in an impervious clear plastic bag. Observation in the room of Resident 5 on 9/22/2025 at 10:00 AM revealed a nebulizer (A device used to deliver aerosolized respiratory medications) that had been used for a medication treatment sitting on top of the nebulizer machine. The nebulizer was not labeled, had been used and was not clean, and was not in a plastic bag. Interview with the Infection Control Preventionist (IP) on 09/23/2025 at 2:45 PM confirmed that nebulizers and all oxygen equipment and tubing were to be labeled and dated, cleaned after use, and then stored per the facility policy. Interview on 09/23/2025 at 7:53 PM with the Facility Administrator (Admin) confirmed the nebulizer should have labeled, cleaned, then put into a plastic bag after use.

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(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 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 (continued on next page)

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	285294	A. Building B. Wing	11/18/2025

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(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	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 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 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Licensure Reference Number 175 NAC 12-006.10(D) Based on record review, observation, and interview; the facility failed to ensure the medication administration error rate was 5% or less. Of the 25 medication administration opportunities, there were 13 errors and the error rate was 52%. This affected 2 (Residents 31 and 16) of 4 sampled residents. The facility census was 39.Findings are: Record review of the facility policy Medication Administration dated September 2024 revealed that within the policy explanation and compliance guidelines the following:Ensure the six rights of medication administration are followed:-Right resident-Right drug-Right dosage-Right route-Right time-Right documentationReview the Medication Administration Record (MAR) to identify medication to be administered. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician. A.Record review of the September 2025 Medication Administration Record (MAR) for Resident 31 revealed that medications were due for administration at 8:00 AM. The medications due at 8:00 AM were aspirin 31 milligrams (mg), Qulipta (a medication to prevent migraines) 60 mg, baclofen (a muscle relaxant and antispasmodic) 10 mg, Vitamin B-12 250 micrograms (MCG), ferrous sulfate 325 mg, fluoxetine (an antidepressant) 30 mg, gabapentin (an anticonvulsant medication) 100 mg, lamotrigine (a medication for epilepsy) 100 mg, pantoprazole (decreases stomach acid) 40 mg, Xarelto (prevents blood clots) 10 mg, senna docusate (for constipation) 8.6-50 mg oral 2 tablets, and Vitamin D3 1000 unit capsules 2 capsules. Observation on 09/24/2025 beginning at 9:27 AM of Licensed Practical Nurse (LPN)- T who prepared and administered medications the above listed medications to Resident 31. Interview on 9/24/2025 at 9:48 AM with LPN-T confirmed that the medications given to Resident 31 at 9:43 AM were all administered late and at the wrong time. B.Record review of the September 2025 MAR for Resident 16 revealed a medication order for Voltaren cream 4 grams to be administered twice a day topically and twice a day as needed 4 grams topically. Observation on 09/25/2025 at 8:15 AM of Medication Aide (MA) B who took the tube of Voltaren cream, squirted approximately a quarter sized dollop of the medication into MA-B's gloved hand, then applied the medication to the back of the neck of Resident 16. After rubbing the medication onto Resident 16, MA-B removed both gloves, performed hand hygiene, and then charted the medication. Interview on 09/25/2025 at 8:20 AM with MA-B who stated it was the experience of MA-B that about a quarter-sized dollop of the medication was approximately 4 grams. MA-B stated the medication did come with a medication measuring card but MA-B did not know where that card was located. MA-B confirmed the order for Resident 16 did read that there was to be 4 grams applied and without the use of the medication card to measure the medication it was unknown if the resident had received 4 grams. MA-B confirmed this was a medication error due to the wrong dose being administered.

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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 Number175 NAC 12-006.10(D) Based on record review, interviews, and observations, the facility failed to ensure that there were no significant medication errors. This affected one (Resident 17) of 7 sampled residents. 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 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. 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 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[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. 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. 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 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 the facility had an issue realizing that the medication had slipped off of the MAR and that there were several doses that were missed during the months of November and December 2024. Interview on 09/23/2025 at 2:45 PM with IP confirmed that there had been many doses not given and significant medication errors were made with the medication administration of lenalidomide for Resident 17.