

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Linden Court		STREET ADDRESS, CITY, STATE, ZIP CODE 4000 West Philip Avenue 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49766</p> <p>Licensure Reference 175 NAC 12-006.09(E)(iii)</p> <p>Based on record reviews and interviews, the facility failed to develop comprehensive care plans (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) that reflected Resident 97's dialysis treatment and Resident 99's anticoagulant use. This affected 2 (Resident 97 and 99) of 21 sampled residents. The facility identified a census of 104.</p> <p>Findings are:</p> <p>A record review of a facility policy, Comprehensive Care Plans with a date implemented of 11/28/2016, indicated that is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that includes measurable objectives and timeframes to meet each resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The CCP will include services that are to be furnished and any specialized services the nursing facility will provide to maintain the resident's highest practicable physical, mental and psychosocial well-being.</p> <p>A.</p> <p>A record review of an Admission Record revealed the facility admitted Resident 99 on 11/18/2024 with diagnoses of cardiac arrhythmia (an abnormal heart rhythm, characterized by an irregular, too fast, or too slow heartbeat), a history of blood clots, and long term (current) use of anticoagulants (blood thinners.)</p> <p>A record review of Resident 99's admission 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) with an Assessment Reference Date (ARD) of 11/24/2024 revealed Resident 99 was taking an anticoagulant.</p> <p>A record review of Resident 99's undated Care Plan revealed no focus care area for anticoagulant use.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 1/29/2025 at 3:44 PM with MDS-A confirmed Resident 99's care plan did not include a care focus area for their anticoagulant use and should be included.</p> <p>51560</p> <p>B.</p> <p>A record review of Resident 97's admission face sheet revealed an admitted [DATE].</p> <p>A record review of an MDS dated [DATE] revealed in Section C a BIMS score of 15; indicating that Resident 97 is cognitively intact. Section GG revealed Resident 97 uses a walker for ambulation and is independent with most cares and activities apart from toileting, for which Resident 97 is dependent. Section 0 reveals Resident 97 to be on hemodialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are no longer able to do so).</p> <p>A record review of Resident 97's current pertinent diagnoses include:</p> <ul style="list-style-type: none"> -Discitis (an inflammation of the intervertebral discs). -End stage renal disease (a condition where the kidneys have permanently lost most of their function and can no longer adequately filter waste products from the blood). -Moderate protein-calorie malnutrition (a condition where a person is not consuming enough protein and calories). -Type 2 Diabetes Mellitus (a chronic condition that affects how the body uses sugar (glucose) for energy). -Malignant Neoplasm of the Bladder (a type of cancer that develops in the bladder, the organ that stores urine). <p>A record review of Resident 97's Care Plan dated 1/27/25 revealed no evidence of hemodialysis being a focus area with subsequent interventions or monitoring.</p> <p>An observation and interview with Resident 97 on 1/27/25 at 2:05 PM in Resident 97's room revealed Resident 97 is scheduled for dialysis every Monday, Wednesday, and Friday and had been on dialysis since admission to the facility.</p> <p>An Interview with the Minimum Data Set Nurse (MDS-A) on 1/28/24 at 10:00 A.M confirmed that Resident 97 was on dialysis and that it was not on the care plan as an area of focus. MDS-A confirmed that the MDS-A was responsible for ensuring the comprehensive care plan was complete and confirmed that dialysis would fall under the role of Nursing to complete.</p> <p>An interview with the Director of Nursing (DON) on 1/28/25 at 3:00 PM confirmed Resident 97 was on dialysis, which has many side effects and potential complications to monitor for. The DON confirmed that dialysis was not listed in the care plan as a focus area and that it should have been.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51560</p> <p>Licensure Reference Number 12.006.04(F)</p> <p>Based on observation, interview, and record review; the facility failed to ensure that 1 (Resident 94) of 21 sampled residents care plan was reviewed and revised to reflect significant weight loss. The facility identified a census of 104.</p> <p>The findings are:</p> <p>A record review of a Comprehensive Care Plan Policy dated 11/28/2016 revealed that the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive, quarterly MDS (MDS- a Federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes) assessment, and as needed.</p> <p>A record review of Resident 94's admission face sheet revealed an admitted [DATE].</p> <p>A record review of Resident 94's diagnoses included pneumonia (an inflammation of the lungs that causes the air sacs (alveoli) to fill with fluid or pus), altered mental status (a change in a person's level of consciousness, awareness, and cognitive function), and functional diarrhea (a chronic condition characterized by frequent, loose, and watery stools without an underlying structural or biochemical abnormality).</p> <p>A record review of a MDS dated [DATE] revealed in Section C that Resident 94 had a Brief Interview for Mental Status (BIMS-a cognitive screening tool that helps identify cognitive impairment in patients and residents) score of 7; indicating moderate to severe cognitive impairment. Section D revealed a Patient Health Questionnaire 2-9 (PHQ 2-9-a tool used to screen for and diagnose depression) score of 0, indicating that Resident 94 was likely not experiencing symptoms of depression. Section GG revealed Resident 94 needed some help with self-care and was independent with eating. Section K revealed no evidence of swallowing concerns. Section K revealed Resident 94's height was 67 inches and weight was 135 pounds (lbs.). Section K recorded no weight loss.</p> <p>Record review of a Physician Notification Communication Form dated 12/18/24 revealed that Resident 94's weight was 126 pounds (lbs) that day and that Resident 94 was triggering for a 9.5 lbs. or 7% weight loss in 30 days. The communication stated that Resident 94's food intake was poor and that Resident 94 was currently being offered an oral house supplement twice a day. The communication further stated that Resident 94 was continuing to have loose to liquid stools. There was a request attached to the communication requesting to add Metamucil to aid with stools and to change oral nutritional supplement to 237 milliliters of Ensure Plus twice a day to prevent further weight loss. The physician was noted to have agreed to the request.</p> <p>A record review of a Physician Notification Communication Form dated 1/7/25 revealed a request to change Resident 94 to a mechanical soft and thin liquid diet as Resident 94 was having difficulty chewing regular texture diet due to no teeth. The request was agreed to by the physician.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident 94's care plan dated 1/27/25 revealed a Focus area dated 10/7/24 stating at risk for potential impaired nutritional status related to pneumonia and altered mental status.</p> <p>Interventions for risk for impaired nutritional status included:</p> <ul style="list-style-type: none"> -Notify Doctor with significant weight loss as needed- date initiated 10/7/24. -Dietician to evaluate for nutritional needs as needed- date initiated 10/7/24. -Monitor and document food intake- date initiated 10/7/24. -Lab work as ordered by physician- date initiated 10/7/24. -Allow adequate time to ingest meal and offer assistance as needed- date initiated 10/7/24. -Provide diet as ordered- regular diet with texture and fluids- date initiated 10/7/24. -Provide supplement as ordered- date initiated 10/24/24. -Review pharmacological regiment and note any medications that may interfere with food intake. Document and report findings to physician- date initiated 10/7/24. -Weigh per facility protocol and as needed- date initiated 10/7/24. <p>A record review of Resident 94's care plan dated 1/27/25 revealed no evidence of revision or updating of the care plan to reflect Resident 94's weight loss or any subsequent interventions and strategies developed by the interdisciplinary team related to that weight loss.</p> <p>An interview with the Minimum Data Set (MDS-A) Nurse on 1/28/24 at 10:00 A.M revealed that they are responsible for the oversight of the entire care plan, however, each department is responsible for entering their own data and interventions. MDS-A is responsible for ensuring the entirety of the care plan is complete and reminding departments when a specific portion of the care plan is missing. MDS-A nurse stated they do this during the MDS documentation period. MDS-A stated that revisions were done at the facilities Risk meeting, after care conferences, and as needed.</p> <p>An interview with the Registered Dietician (RD) on 1/29/25 at 11:15 A.M revealed the RD thought the information currently on the care plan was sufficient to address weight loss and noted they were following the interventions in the care plan. The RD did confirm that Resident 94 was now on a mechanical soft diet and that the care plan reflected a regular texture diet. The RD did confirm that the initiation date of the focus area and interventions were at admission or shortly after and that there were no revisions since that time.</p> <p>An interview with the Director of Nursing (DON) on 1/29/25 at 12:30 P.M revealed that the DON's expectation of the care plan is that the interdisciplinary team will add or revise it as needed. The DON confirmed that it is considered to be the facilities plan of care for each resident and confirmed that the weight loss should have been added under the core focus area.</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>49766</p> <p>Licensure Reference 175 NAC 12-006.09(G)(i)</p> <p>Based on record reviews and interview, the facility failed to develop and provide a discharge summary (a detailed document with individualized care instructions to ensure continuity of care and a safe return home for the resident) that included a recapitulation of stay; information regarding the resident's physical functioning and assistance level needs, continence, and skin condition; and a reconciliation of the resident's medications as required for 1 (Resident 102) of 1 sampled resident. The facility identified a census of 104.</p> <p>Findings are:</p> <p>A record review of an Admission Record indicated the facility discharge Resident 102 on 10/31/2024 at 2:00 PM. Resident 102 had diagnoses of a history of a right femur (thigh bone) fracture with surgical correction and high blood pressure.</p> <p>A record review of Resident 102's Discharge 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) with an Assessment Reference Date of 10/31/2024 indicated Resident 102 required supervision with bathing, setup assistance with eating, and was independent with oral hygiene, toileting, dressing, and personal hygiene. The MDS also indicated Resident 102 was occasionally incontinent of urine, had no skin conditions, and was on a high-risk medication of an anticoagulant (blood thinner.)</p> <p>A record review of Resident 102's Nursing Discharge Summary - V2 completed on 10/31/2024 by Licensed Practical Nurse (LPN) - D revealed the following:</p> <ul style="list-style-type: none"> - Under the section Physical Functioning Status, the boxes regarding whether Resident 102 did or did not require assistance with Activities of Daily Living (ADLs) were not marked. - There was no information included under the section Skin/Foot Care. - There was no information included under the section Recapitulation Summary. - There was no information regarding Resident 102's continence needs. - The box for Reconciliation of all pre-discharge medication and post-discharge medications have been completed (both prescribed and over-the counter) box was not marked. <p>An interview on 1/28/2025 at 12:40 PM with LPN-D confirmed the recapitulation of stay and skin condition sections were left blank, Resident 102's reconciliation of medications was not completed, and the level of assistance Resident 102 required with ADLs was not indicated. LPN-D was unaware these sections were required as part of the discharge summary.</p> <p>(continued on next page)</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 1/29/2025 at 10:48 AM with the Director of Nursing (DON) confirmed the discharge summary should include a recapitulation of stay, reconciliation of the resident's medications, the level of assistance needed with ADLs, and a review of the resident's skin condition, noting if there are no skin concerns.</p> <p>An interview on 1/29/2025 at 9:50 AM with the Administrator revealed the facility does not have a policy regarding discharges but does a discharge checklist the facilities utilize to ensure all steps of discharge are completed.</p> <p>A record review of an undated facility-used checklist, Nursing Planned Discharge to Home revealed steps to complete both User-Defined Assessments (UDAs) in the Electronic Health Records (EHR) titled Discharge Instruction for Home Care and Nursing Discharge Summary with a special note to ensure to include medications, treatments, skin condition, and injection status on both, then save, sign, and lock and exit.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49766</p> <p>Licensure Reference 175 NAC 12- 002.10D</p> <p>Based on record reviews, observations, and interviews, the facility failed to administer medications to Resident 3 and Resident 99 according to their physician's order and administer the proper dosage of medication to Resident 96. The facility also failed to ensure a medication error rate of less than 5 percent (%) for 3 (Residents 3, 96, and 99) of 5 sampled residents. There were 32 opportunities observed with 3 errors observed, a total medication error rate of 9.38%. The facility identified a census of 104.</p> <p>Findings are:</p> <p>A record review of a policy provided by the facility Oral Drug Administration with a date of 5/20/2024 indicated the personnel administering the medication should verify the medication is being administered at the proper time, prescribed dose, and by the correct route to reduce the risk of medication errors.</p> <p>A.</p> <p>A record review of a Drug Safety Update for Rivaroxaban (Xarelto) from the Medicines and Healthcare Products Regulatory Agency with a date of 7/17/2019 indicated that rivaroxaban (a blood thinner) in the 15 milligram (mg) or 20 mg dose should be given with food as studies have shown a lack of efficacy for thromboembolic (blood clot) events when given on an empty stomach.</p> <p>A record review of an Admission Record indicated the facility admitted Resident 99 to the facility on [DATE] with diagnoses of dementia, a cardiac arrhythmia (an abnormal heart rhythm, characterized by an irregular, too fast, or too slow heartbeat), a history of blood clots, and long term (current) use of anticoagulants (blood thinners.)</p> <p>A record review of Resident 99's Order Summary Report with an active orders date of 1/29/2025 revealed an order for rivaroxaban 20 mg with direction to give one tablet by mouth one time a day and administer with food for a history of blood clots. This medication had a start date of 12/21/2024.</p> <p>An observation on 1/29/2025 at 7:40 AM revealed Licensed Practical Nurse (LPN) - E administer Resident 99's rivaroxaban at this time. Resident 99 had been seated at the dining room table without food. Breakfast had not begun being served at this time.</p> <p>An interview on 1/29/2025 at 7:50 AM with LPN-E confirmed Resident 99's rivaroxaban was not administered with food as breakfast is not served until after 8:00 AM.</p> <p>B.</p> <p>A record review of Potassium Supplement (Oral route, parental route) article by Mayo Clinic with a last revised date of 12/31/2024 indicated potassium supplements should be given immediately after a meal or with food to lessen the possible stomach upset.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of an Admission Record indicated the facility admitted Resident 3 to the facility on [DATE] with diagnoses of Dementia and Gastro-Esophageal Reflux Disease (GERD, a chronic condition where stomach contents flow back up into the esophagus, causing irritation and discomfort.)</p> <p>A record review of Resident 3's Care Plan revealed a focus area for potential alteration in gastrointestinal status related to GERD with a last revised date of 7/13/2021. An intervention included to give medications as ordered.</p> <p>A record review of Resident 3's Order Summary Report with an active order date of 1/29/2025 revealed an order for Potassium Chloride 20 milliequivalents with directions to give one tablet by mouth one time a day with or after food to avoid gastrointestinal irritation. This medication had a start date of 9/3/2024.</p> <p>An observation on 1/29/2025 at 7:46 AM revealed LPN-E administer Resident 3's Potassium Chloride at this time. Resident 3 had been seated at the dining room table without food. Breakfast had not begun being served at this time.</p> <p>An interview on 1/29/2025 at 7:50 AM with LPN-E confirmed Resident 3's potassium chloride was not administered with food as breakfast is not served until after 8:00 AM.</p> <p>C.</p> <p>A record review of a Drug Fact - MiraLAX by the manufacture, [NAME], with a date of 11/1/2021 revealed directions for MiraLAX (a laxative for constipation) to fill to the top of the white section in the cap which is marked to indicate the correct dosage of 17 grams (g.)</p> <p>A record review of an Admission Record indicated the facility admitted Resident 96 on 10/16/2024 with diagnoses of a non-traumatic subarachnoid hemorrhage (brain bleed) and constipation.</p> <p>A record review of Resident 96's Order Summary Report with an active order date of 1/29/2025 revealed an order for MiraLAX 17 g with direction to give by mouth one time a day for constipation. This medication had a start date of 10/22/2024.</p> <p>An observation on 1/29/2025 at 8:09 AM revealed Registered Nurse (RN) - F had taken Resident 3's MiraLAX and poured the powder into a medication cup to the 30 cubic centimeters (cc) line instead of measuring into the lid of the MiraLAX bottle. At 8:16 AM, RN-F mixed the measured powder into Resident 3's drink and administered it to Resident 3.</p> <p>An interview on 1/29/2025 at 10:30 AM with RN-F revealed RN-F was not aware of how 30 cc would convert to 17 g and that MiraLAX should be measured in the lid to provide 17 grams.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51122</p> <p>Licensure Reference Number NAC 175 12-006.11E</p> <p>Based on observations, interviews, and record review, the facility failed to perform hand hygiene as required after handling uncooked meat and failed to wear hair restraints in the kitchen as required to prevent the potential for food-borne illness. This had the potential to affect all 104 residents who resided within the facility and were served out of the kitchen.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of an undated facility policy titled, Hand Washing Importance and Technique, revealed that hand washing was indicated after handling uncooked foods including raw meat, fish, poultry, and produce.</p> <p>An observation on 1/28/25 at 7:37 AM revealed Culinary Lead-B (CL-B) was preparing the ingredients for meat loaf. The observation revealed CL-B performed the following:</p> <ul style="list-style-type: none"> -CL-B completed hand hygiene prior to food preparation using soap and water. -CL-B opened a 10-pound tube of uncooked ground beef while wearing gloves and emptied it into a bowl. -CL-B removed their gloves, then discarded their gloves and packaging at the same time. -CL-B entered the walk-in cooler and returned with a carton of eggs. CL-B then cracked 6 eggs into the bowl containing the meat. -CL-B measured additional ingredients, including breadcrumbs, salt, spices, Worcestershire sauce, and chopped onion, handling all packages with their bare hands. CL-B used a ladle to measure and remove tomato sauce from a plastic bulk container. -CL-B then mixed the ingredients, dumped the mixture into a pan and formed it into loaves. -CL-B completed hand hygiene using soap and water. <p>An observation on 1/28/25 at 7:52 AM revealed CL-B entered the walk-in cooler and returned with one and a half 10-pound tubes of uncooked ground beef. The observation revealed CL-B was not wearing gloves. CL-B opened the tubes with a knife, then emptied the meat into a mixing bowl. CL-B added the additional ingredients, touching eggs, containers, and utensils with their ungloved hands. The CL-B completed hand hygiene using soap and water at the end of meat loaf preparation.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview on 1/28/25 at 8:10 AM with CL-B confirmed they did not complete hand hygiene after handling uncooked meat and should have.</p> <p>An interview on 1/28/25 at 8:25 AM with the Culinary Director (CD) confirmed CL-B should have completed hand hygiene after handling uncooked meat and before handling other items.</p> <p>B.</p> <p>A record review of an undated, facility-provided excerpt from the 2017 Nebraska Food Code revealed that food employees were required to wear hair restraints. This document was provided in lieu of a facility-specific policy for hair restraints in the kitchen.</p> <p>An interview on 1/30/25 at 10:30 AM with the Administrator confirmed that the 2017 Nebraska Food Code was what the facility utilized for hair restraint guidance and that the facility did not have a policy for this topic.</p> <p>An observation on 1/29/25 at 11:30 AM revealed Culinary Assistant-C (CA-C) walked through the food preparation area of the kitchen without wearing a hair restraint.</p> <p>An interview on 1/29/25 at 11:31 AM with CD confirmed that they were also present to observe CA-C not wearing a hair restraint while in the food preparation area and that CA-C should have been wearing one.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51560</p> <p>Licensure Reference Number 1-005.06(D)</p> <p>Based on observations and interviews, the facility failed to follow infection control practices during environmental cleaning, disinfection, and with the application of Personal Protection Equipment (PPE). This had the potential to affect all the residents. The facility identified a census of 104.</p> <p>Findings Are:</p> <p>A continuous observation on 1/28/25 from 10:20 AM to 10:45 AM of the 100 Hall revealed at 10:22 AM a housekeeping staff (HSK-H) coming out of a residents' room with gloves on both hands. HSK-H was then observed renewing supplies at the housekeeping cart and returning to a different room with the same gloves on. HSK-H was observed using this technique to clean three resident rooms. At 10:40 AM a Nurses Assistant (NA-I) was observed applying PPE to enter an Enhanced Barrier Precautions room (EBP). NA-I was observed applying gown to shoulder length without tying it up to the neck before entering the room.</p> <p>An interview on 1/28/25 at 10:35 AM with HSK-H confirmed that the observed technique was not the facility policy and that HSK-H should have removed the gloves and washed hands.</p> <p>An interview on 1/28/25 at 10:45 AM with NA-I confirmed was it was not policy to wear gown in that fashion and stated I didn't think I'd be in there that long. NA-I confirmed that was not how the facility trained regarding the application of PPE.</p> <p>Interview with Infection Preventionist (IP) nurse on 1/29/25 at 3:00 PM confirmed that HSK-H was to perform hand hygiene and new glove application between cleaning rooms. IP further confirmed that NA-I should have tied gown around the neck and not allowed to drape around shoulders.</p>		