STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285083	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Court	4000 West Philip Avenue North Platte, NE 69101

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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 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Number 175 NAC 12-006.11(E) Based on observations, interviews and record review, the facility failed to ensure outdated food items were not available for use, opened items were dated, and failed to do to complete hand hygiene and change gloves while preparing food to prevent potential cross contamination and food-borne illness. The facility identified a census of 113. This had the potential to affect all residents who ate out of the kitchen.Findings are: A. During the initial tour on 4/13/2026 from 11:21 AM until 12:00 PM, the following concerns were identified: -Walk-in refrigerated was found to have a half gallon bottle of buttermilk dated best by 4/11/2026. A tray of hamburger on the top shelf with a pan of cheesecake below it that had saran wrap loosely on top of it, not sealed.-Walk-in freezer was found to have box of hamburger patties opened in package and not sealed.-In dry storage, a bottle Coffee Mate hazelnut liquid creamer found with the lid caved in and available for use.-Opened package of penne and rotini pasta opened, resealed, but no date indicating date it was opened. A interview on 4/13/2026 at 11:55 AM with Culinary and Dining Coordinator (CDC)-N confirmed the expired buttermilk, the meat above the cheesecake, opened package of hamburger patties, concaved lid of creamer, and undated, opened pasta bags. B. During an observation of meal preparation on 4/14/2026 from 7:30 AM to 7:50 AM revealed Culinary Lead (CL)-P obtained two 10 pound tubes of raw hamburger meat from the refrigerator and placed them on to counter. CL-P completed hand hygiene for 10 seconds under running water and applied a new pair of gloves. CL-P cut open a package of the meat and dumped the meat into pan, and with same soiled gloves on, broke up the meat in the pot. CL-P removed the soiled gloves and performs hand hygiene for 12 seconds under running water and applies new gloves. CL-P cut open the second package of meat and dumped half the package into the pot and sets the other half of the package on the counter. Using the same soiled gloves to grab the meat from inside the package and set it into pot. CL-P removed the gloves and washes hands for 10 seconds. Observation of food preparation on 4/14/2026 from 8:20 AM until 8:45 AM revealed CL-P stirred a pan of casserole with spoon and without gloves. CL-P after finishing stirring pan 1, sat the soiled spoon on top of the casserole on pan 2. CL-P took the spoon sitting on top of pan 2 and wiped the handle with a paper towel and used that to stir pan 3. CL-P washed their hands for 20 seconds, puts on gloves on and stirs additional meat into the pans. CL-P grabbed a bag of parmesan cheese out of refrigerator, dumped parmesan cheese into measuring cup and used the same soiled gloves to sprinkle parmesan cheese with the casserole in 2 pans. Cl-P sat the measuring cup down and stirred pan 3 with same gloves and spoon.CL-P picked up cup with parmesan cheese and sprinkles pan 3 casserole with cheese using same soiled gloves. A interview with Chef-O, on 4/14/2026 at 8:40 AM confirmed hands need to be washed for 20 seconds and gloves should have been changed before touching meat and cheese. An observation during meal cart preparation inside the main kitchen on 4/15/2026 at 11:21 AM revealed CA-T reaching over clothing protectors on food transport cart and touches them with uncovered arms. Observation of meal service in Dogwood satellite kitchen on 4/15/2026 from 11:25 until 12:33 revealed Culinary Assistant (CA)-T grab different sized scoops for each food item based on kitchen spreadsheet reference scoop size for meal items. CA-T placed the scoops into steam table pans and washes hands for 10 seconds then grabs (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dessert out of refrigerator. An interview with Chef-O on 4/16/2026 at 8:00 AM confirmed the concerns with initial kitchen tour storage and hand hygiene. Chef-O will begin working on correcting these concerns.Record review revealed a poster above every sink in the main kitchen and satellite kitchens to ensure proper hand hygiene referencing steps for hand washing with pictures. The poster referenced the World Health Organization and stated All it takes is 20 seconds.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 1-005.06(E&F), 12-006.18(B), and 1-005.06(D) Based on record review, interview, and observation, the facility failed to change their personal protective equipment when transitioning from infectious rooms to non-infectious rooms, failed to perform hand hygiene, and failed to ensure housekeeping services were provided to non-infectious rooms prior to infectious rooms. This had the potential to affect all residents residing within the facility. The facility census was 113. Findings Are: A. A record review of the Nebraska Infection Control Assessment and Promotion Program (ICAP) Nebraska Medicine 2026 website revealed a hyperlink in the COVID-19 Resources for Healthcare Settings section. The hyperlink was https://www.cdc.gov/covid/hcp/infection-control/. A record review of the CDC Infection Control Guidance: SARS-CoV-2 (COVID-19) document found at https://www.cdc.gov/covid/hcp/infection-control/ and dated 6/24/2024 revealed the guidance applied to all United States settings where healthcare is delivered, including nursing homes. In the section titled Implement Source Control Measures the document states a respirator with N95 filters or higher should be worn during the care of a patient with SARS-CoV-2 infection and states the respirator should be removed and discarded after the patient care encounter and a new one should be donned (put on). Further record review of the Nebraska ICAP website under the COVID-19 Resources for Long Term Care Settings section revealed a link to Zones PPE (Personal Protective Equipment, includes clothing, gloves, face shields, goggles, facemasks, respirators, and other equipment to protect front-line workers from injury, infection, or illness) and Testing. This link revealed the following guidance: -Red Zone Isolation (residents with a positive COVID-19 test), Staff PPE: COVID-19 full PPE is a respirator, eye protection, isolation gown, and gloves before entering resident room. Respirator and eye protection may be used according to extended use guidance if they are not touched. -Light Red Zone Isolation (symptomatic residents with a COVID-19 test pending), Staff PPE: COVID-19 full PPE is a respirator, eye protection, isolation gown, and gloves. Respirator and eye protection may be used according to extended use guidance if they are not touched. A record review of the Nebraska Medicine COVID-19 PPE Guidance: Extended Use and Reuse of Facemasks, KN95s, Respirators (PAPR, N95) and Protective Eyewear for Healthcare Personnel updated 1/14/2022 revealed the recommendations in the guidance are temporary while there are national and international shortages of personal protective equipment. An observation on 4/13/2026 at 12:00 PM revealed the following residents with signage on their room doors: -Resident 101 in room [ROOM NUMBER] had a sign stating Red Zone on their door. -Resident 99 in room [ROOM NUMBER] had a sign stating Red Zone on their door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Resident 11 in room [ROOM NUMBER] had a sign stating Red Zone on their door. -Resident 12 in room [ROOM NUMBER] had a sign stating Red Zone on their door. -Resident 42 in room [ROOM NUMBER] had a sign stating Red Zone on their door. -Resident 86 in room [ROOM NUMBER] had a sign stating Light Red Zone on their door. -Resident 49 in room [ROOM NUMBER] had a sign stating Red Zone on their door. -Resident 22 in room [ROOM NUMBER] had a sign stating Red Zone on their door. -Resident 34 in room [ROOM NUMBER] had a sign stating Red Zone on their door. -Resident 87 in room [ROOM NUMBER] had a sign stating Red Zone on their door. -Resident 38 in room [ROOM NUMBER] had a sign stating Red Zone on their door. An observation on 4/13/2026 at 1:01 PM revealed Nurse Aide (NA)-G was exiting resident room [ROOM NUMBER] wearing full PPE (gown, gloves, eyewear, and an N95 mask) and carried dishes to a rolling cart that was parked outside room [ROOM NUMBER]. NA-G placed the dishes on the cart, applied Alcohol Based Hand Rub (ABHR) to their gloved hands and then entered Resident 49's room while wearing the same PPE, obtained dishes from this room and handed them to another staff. NA-G applied ABHR to their gloved hands and entered room [ROOM NUMBER] wearing the same PPE, turned off the resident's light switch, then exited the room closing the door behind them. NA-G applied ABHR to their gloved hands, then entered room [ROOM NUMBER] while continuing to wear the same PPE, obtained the resident's dishes and handed them to NA-E. NA-G then entered room [ROOM NUMBER] wearing the same PPE, obtained the resident's dishes and handed them to NA-E upon exiting the room. NA-G applied ABHR to their gloved hands, then entered room [ROOM NUMBER], obtained dishes, exited the room and handed the dishes to NA-E. While continuing to wear the same PPE, NA-G stood in the hallway talking to another staff who was less than 2 feet away from them, then removed their gown and gloves and discarded them in room [ROOM NUMBER]. NA-G touched their eyewear with their bare hand and then performed hand hygiene (HH) via ABHR. A continuous observation on 4/14/2026 from 7:43 AM until 8:18 AM revealed the following: -At 7:43 AM NA-C entering room [ROOM NUMBER] wearing full PPE and closing the door. NA-C exited room [ROOM NUMBER] at 8:01 AM after removing their gown and gloves. NA-C entered the nurse's station, removed their eyewear and set it on the desk, then picked it back up and walked to the PPE cabinet near room [ROOM NUMBER]. NA-C put on a gown, put their eyewear back on, performed HH via ABHR, and put on gloves. NA-C then entered room [ROOM NUMBER] without first disinfecting their eyewear or changing their mask. -At 7:58 AM the Director of Nursing (DON) and the Infection Preventionist (IP) were observed pushing a rolling cart containing covered dishes with food on them onto the 100 hallway. -At 8:11 AM, NA-D entered room [ROOM NUMBER] with a plate of food while wearing full PPE. NA-D then leaned out of the room and obtained a cup of fluids from other staff and requested condiments then went back into the room. At 8:12 AM, NA-D exited room [ROOM NUMBER] in full PPE and stood (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in the hallway with their gloved hand holding the handrail outside the room and talked to the DON. IP approached NA-D in the hallway and put condiments into NA-D's gloved hand. NA-D re-entered room [ROOM NUMBER] with the condiments. NA-D exited the room at 8:13 AM, removed their gown and gloves, and performed HH via ABHR. NA-D then pushed the rolling cart around the corner and down the other part of the 100 hallway without changing their mask or disinfecting their eyewear. At 8:15 AM, Assistant Director of Nursing (ADON)-A entered the 100 hallway, spoke with another staff while grabbing the same handrail outside room [ROOM NUMBER] that NA-D had their gloved hand on, then continued walking down the 100 hallway. An observation on 4/14/2026 at 10:08 AM revealed NA-C entering the 100 hallway wearing a mask and eyewear. NA-C put on a gown and gloves and then entered room [ROOM NUMBER]. NA-C exited room [ROOM NUMBER] carrying bags with laundry and trash at 10:21 AM after removing their gown and gloves, opened the unmarked door of a room and put the bags in the room. Next, NA-C performed HH via ABHR and entered the nurse's station to talk to another staff without changing their mask or disinfecting their eyewear. NA-C then went to a cupboard, put on a gown and gloves and entered room [ROOM NUMBER]. B. A record review of the ICAP Summary of Recommendations for COVID-19 in a Long-Term Care Facility dated 3/11/2026 revealed if environmental services (EVS) staff is performing cleaning in the red zone, they should also be dedicated to this unit (or if unable to dedicate, may plan daily activity in a way that they enter the red zone towards the end of their shift after they are done with rest of the facility). An observation on 4/14/2026 at 8:19 AM revealed Housekeeper (Hskp)-F exiting room [ROOM NUMBER] carrying housekeeping supplies and wearing full PPE. Hskp-F placed the cleaning supplies in their housekeeping cart without first disinfecting them, then removed their gown and gloves and performed HH via ABHR. Hskp-F put on a new gown and gloves, obtained cleaning supplies from their cart, and entered room [ROOM NUMBER] without first changing their mask or disinfecting their eyewear. An observation on 4/14/26 at 10:24 AM revealed Hskp-F putting on a gown and gloves, obtaining cloths, spray bottles, and a scrub brush out of their housekeeping cart, and entering room [ROOM NUMBER]. At 10:27 AM, Hskp-F exited room [ROOM NUMBER], put their spray bottles back in their cart, obtained a mop, and went back into room [ROOM NUMBER]. The resident residing in room [ROOM NUMBER] was not on transmission-based precautions (additional infection control measures used in healthcare settings beyond standard precautions to prevent the spread of known or suspected highly transmissible pathogens, such as COVID-19). An interview on 4/15/2026 at 8:24 AM with Hskp-F revealed they were to change their gown and gloves between cleaning each resident's room. Hskp-F stated that when there were only 1 or 2 rooms containing residents with infections, housekeepers were to clean these rooms at the end of the day, but when there were a large number of residents with infections there was not enough time to go back and forth in the building so the rooms were cleaned in order on the hallway. Hskp-F confirmed that by doing this, they cleaned rooms in the Red Zone or Light Red Zone interspersed with rooms that were not on transmission-based precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. A record review of a facility document dated 4/13/2024 revealed the following Covid positive Resident rooms/locations: -100,102,103,104,105,109,110,112,114,115,125,201,204,205A,205B,208,300B,310A,401A,500,506,514A,70(A record review of an undated facility document labeled 'Standard and Transmission based precautions' revealed a small paragraph on the bottom that read: Hang hygiene is the single most important practice for preventing the transmission of potentially infectious microorganisms from one person to another. Studies have found that hand hygiene reduces the incidence of healthcare-associated infections. This document revealed references to CDC guidelines on hand hygiene procedures and when to clean hands with soap and water vs alcohol-based hand rubs, and provides examples that reference certain infections. During an interview with the Infection Preventionist (IP) and DON at 7:50 AM on 4/14/2026, the IP confirmed that hang hygiene is to be performed before and after resident contact, before and after using Personal Protective Equipment (PPE), after toileting, and before eating, and in between resident rooms. An observation made at 8:57 AM on 4/14/2026 revealed a staff member entering room [ROOM NUMBER], with a gown, mask, goggles, and gloves. The unidentified staff member left room [ROOM NUMBER] at 8:59AM and did not change their mask or clean their eye protection. That same staff member then entered another resident room at 8:59 AM wearing the same mask and eye protection. An observation made on 4/14/2026 at 11:40 AM revealed Nurse Aide (NA)-U leaving room [ROOM NUMBER] and not performing hand hygiene. An observation made at 12:05 PM on 4/15/2026 revealed Licensed Practical Nurse (LPN)-H walking out of a red zone room without cleaning eye protection or changing mask. An observation made at 12:09 PM on 4/15/2026 revealed a NA walking out of room [ROOM NUMBER] and not performing hand hygiene.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the ombudsman of 2 (Residents 116 and 118) of 3 sampled residents' discharge from the facility. The facility census was 113.Findings Are: A. A record review of Resident 116's admission Record dated 4/15/2026 revealed the resident was admitted to the facility on [DATE]. The document revealed the resident was discharged from the facility on 3/17/2026. A record review of a fax sent to the ombudsman by the Social Services Supervisor (SSS) on 4/1/2026 revealed no evidence of the ombudsman being notified of Resident 116's discharge from the facility. An interview on 04/14/2026 at 2:22 PM with the Administrator confirmed the ombudsman had not been notified of Resident 116's discharge from the facility. B.A record review of Resident 118's admission Record dated 4/15/2026 revealed the resident was admitted to the facility on [DATE]. The document revealed the resident was discharged from the facility 3/13/2026. A record review of a fax sent to the ombudsman by SSS on 4/1/2026 revealed no evidence of the ombudsman being notified of Resident 118's discharge from the facility. An interview on 04/14/2026 at 2:22 PM with the Administrator confirmed the ombudsman had not been notified of Resident 118's discharge from the facility. An interview on 4/15/2026 at 2:00 PM with the DON confirmed the facility did not have a policy related to discharge of a resident. The DON revealed the nursing department utilized a checklist for discharges, but the checklist did not encompass the duties for resident discharge for departments outside of nursing.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(B) Based on record review and interview, the facility failed to ensure the 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) was coded accurately for Resident 3's medication and Resident 5's Pre-admission Screening and Resident Review (PASRR, a process which requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have Serious Mental Illness or Intellectual Disability). The sample size was 23 and the facility census was 113.Findings Are: A.A record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities) dated October 2025 revealed in Chapter 3, Section N that the line item Antiplatelet should be coded as Yes if the resident received antiplatelet medications during the 7-day lookback period. A record review of Davis's Drug Guide for Nurses, 19th edition dated 2026 revealed the medication Plavix (clopidogrel) was in the antiplatelet agent therapeutic class. A record review of Resident 3's admission Record dated 4/15/2026 revealed the resident was admitted to the facility on [DATE] with a diagnosis of non-ST elevation (NSTEMI) myocardial infarction (a type of heart attack caused by a partial blockage of a coronary artery, leading to reduced blood flow and damage to the heart muscle). A record review of Resident 3's Medication Administration Record for March 2026 revealed an order for clopidogrel bisulfate tablet, 75 milligrams to be given once a day for NSTEMI myocardial infarction. The medication was documented as administered daily from March 4th through March 29th, 2026. A record review of Resident 3's MDS dated [DATE] revealed in Section N the line item for Antiplatelet was marked as No, indicating the resident had not received this medication during the 7-day lookback period. An interview on 4/15/2026 at 3:18 PM with MDS-L confirmed Resident 3's antiplatelet medication, clopidogrel should have been marked as Yes on their MDS dated [DATE] and was not. B. A record review of the CMS's Resident Assessment Instrument Version 3.0 Manual dated October 2025 revealed that on page A-30 to A-32 in Chapter 3, Section A that the line A1500. Preadmission Screening and Resident Review (PASRR) should be coded as 1. Yes if the resident is currently considered by the state level II PASRR process to have serous mental illness and/or intellectual disability or a related condition and to continue to A1510, Level II PASRR Conditions. Section A1510: Level II PASRR Conditions revealed to check all that apply: serious mental illness, intellectual disability, or other related conditions. Record review of Resident 5's census data revealed the resident was admitted on [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 5's diagnoses list revealed a diagnosis of Bipolar Disorder (a condition characterized by dramatic shifts in mood, energy, and activity levels that affect a person's ability to carry out day-to-day tasks. These shifts in mood and energy levels are more severe than the normal ups and downs that are experienced by everyone) was added on 10/24/2025. Record review of Resident 5's annual MDS completed on 11/26/2025 revealed in Section A1500 the code was marked as 1. Yes. Section A1510 revealed that the line serious mental illness was marked. A record review of Resident 5's medical record revealed a Preadmission Screening and Resident Review (PASRR) Level II Determination Notification completed on 12/5/2025. The resident was approved of 180 days at a nursing home without any additional services. The facility will need to complete another Level II on or before 6/30/2025 per the PASRR Level II report. A record review of Resident 5's medical record revealed a significant change MDS completed on 2/24/206. In Section A1500 the code was marked as 0. No skip to A15550, indicating that the resident is not currently considered by the state level II PASRR process, to have serious mental illness, revealing that section A1510 was skipped. An interview with MDS nurse-K, on 4/15/206 at 7:58 AM, confirmed MDS nurse-K did not think that Resident 5 was a PASRR Level II. MDS nurse -K also confirmed that the social work handles the PASRR section of the MDS, but if social work was busy, MDS nurse-K would just mark things on the PASRR section. An interview with Social Service Staff, on 4/15/2026 at 9:13 AM confirmed that the PASRR sections on the annual MDS dated [DATE] and the significant change MDS dated [DATE] should have been marked as yes, indicating Resident 5 as PASRR Level II. An interview with Director of Social Services-Consultant on 4/15/2026 at 9:20 AM confirmed that Resident 5 is a Level II and that it needed to be marked on the MDS until not approved, but it was missed on the significant change MDS dated [DATE]. An interview with the Director of Nursing on 4/15/2026 at 2:00 PM revealed the facility does not have an MDS policy as they follow the Resident Assessment Instrument (RAI) Manual to complete the MDS's.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Licensure Reference Number 175 NAC 1-009.02(F)Based on observation, interview, and record review the facility failed to provide an environment free of accident hazards related to chemicals in the resident bathrooms for 3 residents (Resident 18, 92, 113) of 8 residents sampled. The facility census was 113. Findings are:An observation on 4/13/26 at 3:08 PM in the bathroom for Resident 92 revealed a cylindrical container titled, Micro-Kill D1 Germicidal Wipes sitting on the toilet tank. The container had a wipe hanging out of the lid of the container at the time.An interview with Resident 92 on 4/13/26 at 3:08 PM about the Micro-Kill D1 Germicidal Wipes in the bathroom revealed the resident smiling stating not knowing anything about it.An interview on 4/13/26 at 3:10 PM with Registered Nurse (RN)-V revealed the Micro-Kill D1 Germicidal Wipes are used for residents that occupy bathrooms with transmissible bacteria. RN-V further revealed Resident 92 has Extended-Spectrum Beta-Lactamase (ESBL; an enzyme produced by certain bacteria, that make them resistant to many common antibiotics with a high transmissible rate often found on contaminated hands, surfaces, or medical equipment often causing urinary tract infections (UTI; a bacterial infection of the urinary system causing pain and frequent urges to urinate)).A record review of Resident 92's admission Record dated 4/16/26 revealed diagnosis information of ESBL.A record review of Resident 92's Care Plan Report dated 4/14/26 revealed a focus on paralysis, unaware of safety needs; and an intervention to maintain an environment free of clutter and safety hazards.An observation on 4/13/26 at 3:15 PM in the bathroom for Resident 18 and Resident 113 revealed a cylindrical container titled, Micro-Kill D1 Germicidal Wipes sitting on the toilet tank.An interview with Resident 18 on 4/13/26 at 3:15 PM about the Micro-Kill D1 Germicidal Wipes in the bathroom revealed the resident not knowing anything about it.An interview with Resident 113 on 4/13/26 at 3:15 PM about the Micro-Kill D1 Germicidal Wipes in the bathroom revealed the resident was sleeping, unable to be aroused.A record review of Resident 18's admission Record dated 4/16/26 revealed diagnosis information of ESBL and dementia (a decline in mental ability such as memory, reasoning, and communication severe enough to interfere with daily life).A record review of Resident 18's Care Plan Report dated 4/16/26 revealed interventions to maintain environment free of clutter and safety hazards.A record review of Resident 113's admission Record dated 4/16/26 revealed diagnosis information of macular degeneration (cause of vision loss in people 60 years and older, destroying vision through damage to the retina).A record review of Resident 113's Care Plan Report dated 4/14/26 revealed a focus that the resident has the potential for impaired visual function related to untreated macular degeneration with an intervention to maintain an uncluttered environment free of obstacles and safety hazardsAn observation with Maintenance (Maint)-I on 4/16/26 at 8:20 AM confirmed a cylindrical container titled, Micro-Kill D1 Germicidal Wipes sitting on the toilet tank in the bathroom for Resident 18, 113 and 92.An interview with Maint-I on 4/16/26 at 8:20 revealed not knowing if the Micro-Kill D1 Germicidal Wipes were acceptable to keep in the bathroom with residents who have memory or vision issues.A record review of a Safety Data Sheet (SDS; a standardized document that provides comprehensive information about a hazardous substance or mixture), for Micro-Kill D1 Germicidal Wipes revealing:Section 1: Identification; recommended use: disinfectantSection 2: Hazardous Identification; classification: eye irritationSection 3: Ingredients; Benzyl alcohol (a solvent, preservative, and fragrance ingredient); Dodecyl benzenesulfonic Acid (a powerful detergent)Section 4: First Aide Measures; rinse with water, tret symptomaticallySection 7: Handling and Storage; advice on safe handling: wash hands thoroughly, keep out of reach of childrenSection 11: Toxicological Information; Potential Health Effects: Eyes: cause eye irritation, Skin: health injuries are not known or expected under normal use.Section 15: Regulatory Information; Caution: causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, tobacco, or using the toilet.During an interview with Administrator on 4/16/26 at 8:45 AM, the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285083	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Court	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administrator agreed that a confused or visually impaired resident could inadvertently mistaken the container of Micro-Kill D1 Germicidal Wipes with personal cleansing wipes when accessible and in plain view.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285083	A. Building B. Wing	04/16/2026

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Licensure Reference Number 175 NAC 1-005.06(C)Based on record review and interviews, the facility failed to ensure a stop date for the use of antibiotics medication. This affected 1 (Residents 15)) of 5 sampled residents. The facility census was 113. Findings are: Record review of Resident 15's undated care plan revealed an admission date of 4/12/2021 with the following diagnoses: -FREQUENCY OF MICTURITION-AUDITORY HALLUCINATIONS-UNSPECIFIED URINARY INCONTINENCE -COGNITIVE COMMUNICATION DEFICIT-LONG TERM (CURRENT) USE OF ANTIBIOTICS -UNSPECIFIED DEMENTIA, SEVERE, WITH OTHER BEHAVIORAL DISTURBANCE-UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH OTHER BEHAVIORAL -DISTURBANCEA record review of Resident 15's orders revealed an order dated 1/24/2025 with an order summary stating Bactrim Tablet 400-80 Milligrams (mg). Give 1 tablet by mouth one time a day related to long term use of antibiotics, continue this order. Leave as prescribed. There was no stop date identified for the use of the antibiotic medication. A record review of a document The core elements of Antibiotic Stewardship for Nursing Homes from the CDC revealed information recommending a reduction in antibiotic use in asymptomatic bacteriuria (ASB) (The presence of bacteria in the urine without UTI. It is common in older adults and usually doesn't require treatment). Antibiotic use for ASB does not confer any long-term benefits in preventing symptomatic UTI or improving mortality, and may actually increase the incidence of adverse drug events and result in subsequent infections with antibiotic-resistant pathogens.Very few studies support antibiotic use for UTI prophylaxis, especially in older adults, and many studies have shown this antibiotic exposure increases risk of side effects and resistant organisms. Therefore, efforts to educate providers on the potential harm of antibiotics for UTI prophylaxis could reduce unnecessary antibiotic exposure and improve resident outcomes'. An interview at 1:35 PM on 4/14/2026 with the Director of Nursing (DON) confirmed that Resident 15 was admitted to the facility with an antibiotic for UTI prophylaxis, which was changed to Bactrim after admission. The DON confirmed there has not been a stop trial on the Antibiotic since Resident 15's admission. The DON also confirmed that there has been no attempt at alternatives recommended by the Pharmacist for other medications as listed on the MRR. An interview at 7:50 AM on 4/15/2026 with the Infection Preventionist (IP) and the DON confirmed that when an antibiotic order is placed for a resident, a case is opened and tracked in Point Click Care (The charting system used in this facility). The IP looks at progress notes and reviews the reason for the antibiotic prescription. The IP nurse confirmed they follow the case until signs and symptoms for the resident's infection are no longer present. The IP confirmed there is not continuous observation or tracking of antibiotics for residents on long term antibiotic therapy. During the same interview, the DON confirmed there was no additional follow up for medication reviews, or trials off the antibiotic for Resident 15.