STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285165	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of North Platte	2900 West E Street 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 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 12-006.17(E)(v) Based on observations and interview, the facility failed to ensure resident bathrooms were well-ventilated for resident rooms on the 100 and 200 halls for 14 sampled residents. The facility identified a census of 55 residents. An observation on 6/4/26 at 10:30 AM in the bathroom of resident room [ROOM NUMBER] revealed the ceiling exhaust vent was not moving any air, as evidenced by no movement of a single ply of a toilet tissue square held up to the vent. No residents were assigned to room [ROOM NUMBER] at that time. An observation on 6/2/2026 at 11:00 AM in the bathroom of resident room [ROOM NUMBER] revealed the ceiling exhaust vent was not moving any air. room [ROOM NUMBER] was occupied by Resident 14. An observation on 6/2/2026 at 11:05 AM in the bathroom of resident room [ROOM NUMBER] revealed the ceiling exhaust vent was not moving any air. room [ROOM NUMBER] was occupied by Resident 46. An observation on 6/4/2026 at 11:10 AM in the bathroom of resident room [ROOM NUMBER] revealed the ceiling exhaust vent was not moving any air. room [ROOM NUMBER] was occupied by Resident 26. An observation on 6/2/2026 at 11:10 AM in the bathroom of resident room [ROOM NUMBER] revealed the ceiling exhaust vent was not moving any air. room [ROOM NUMBER] was occupied by Resident 64. An observation on 6/2/2026 at 11:05 AM in the bathroom of resident room [ROOM NUMBER] revealed the ceiling exhaust vent was not moving any air. room [ROOM NUMBER] was occupied by Resident 42. An observation on 6/1/2026 at 1:47 PM in the bathroom of resident room [ROOM NUMBER] revealed the ceiling exhaust vent was not moving any air. room [ROOM NUMBER] was occupied by Resident 43. An observation on 6/4/2026 at 11:05 AM in the bathroom of resident room [ROOM NUMBER] revealed the ceiling exhaust vent was not moving any air. room [ROOM NUMBER] was occupied by Resident 48. An observation on 6/4/2026 at 11:02 AM in the bathroom of resident room [ROOM NUMBER] revealed the ceiling exhaust vent was not moving any air. room [ROOM NUMBER] was occupied by Residents 22 and 61. An observation on 6/1/2026 at 3:57 PM in the bathroom of resident room [ROOM NUMBER] revealed the ceiling exhaust vent was not moving any air. room [ROOM NUMBER] was occupied by Residents 40 and 38. An observation on 6/1/2026 at 2:52 PM in the bathroom of resident room [ROOM NUMBER] revealed the ceiling exhaust vent was not moving any air. room [ROOM NUMBER] was occupied by Resident 4. An observation on 6/1/2026 at 1:45 PM in the bathroom of resident room [ROOM NUMBER] revealed the ceiling exhaust vent was not moving any air. room [ROOM NUMBER] was occupied by Residents 6 and 17. An interview on 6/4/26 at 11:00 AM with the Maintenance Director (MTC) confirmed the bathroom exhaust ventilation was not functioning. MTC stated they usually checked the ventilation weekly, but that there was no documentation to confirm the efforts.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Licensure Reference Number 175 NAC 12-006.09 Based on record review and interview, the facility failed to ensure pre-and post-dialysis assessments were completed as required for one (Resident 30) of one sampled resident. The facility identified a census of 55. A record review of Resident 39's admission Record dated 6/4/2026 revealed an admission date of 5/4/2026. The admission record also revealed the following relevant diagnoses:-End stage renal disease-Malignant neoplasm of left kidney, except renal pelvis-Secondary malignant neoplasm of left kidney and renal pelvis-Dependence on Renal Dialysis-Acquired absence of kidney Record review of Resident 39's Physician's Orders revealed the following:-Assess dialysis site every (q) shift, Assess thrill/bruit (medical terms used to describe the signs of turbulent blood flow, usually related to a narrowed artery or an abnormal connection between an artery and a vein). Chart + if present and - if absent. Notify the dialysis center if absent. Assess access site and document N for normal, B for signs and symptoms (s/sx) bleeding, or I for s/sx infection and notify dialysis for bleeding or s/sx infection. The order had a start date of 5/4/26.-Remove pressure dressing at dialysis site 2 hours after dialysis. The order had a start date of 5/6/26.There was no evidence in Resident 39's orders of an order for the resident to receive dialysis. A record review of Resident 39's undated Care Plan revealed a focus area stating the resident needed hemodialysis Monday, Wednesday, and Friday related to renal failure. The relevant interventions for this focus included the following:-Monitor/document/report as needed (PRN) for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Record review of a facility document dated 12/3/25 labeled Dialysis: Care and Monitoring of Resident revealed the following information:-Obtain a set of vital signs upon return to the facility,-Assess residents' physical condition upon return to the facility,-Assess residents vascular access site- report any bleeding or swelling- document condition of site and/or dressing dry and intact,-Re-assess residents' physical condition and VS as warranted with any change in condition and report to the resident's physician or physician on-call,-Document VS and assessment in progress notes- report to the physician any abnormalities and report to on-coming nurse to ensure follow up. Document any contact with physician and/or family members, and-If dialysis report sheets are not received upon return to the facility, notify dialysis unit to send to facility or notify DON (Director of Nursing) to follow up. A record review conducted on 6/2/2026 of Resident 39's pre- and post-dialysis assessments revealed two entries that were both dated for 5/20/26. One entry was labeled ?pre-dialysis' and the other was labeled ?post dialysis'. The pre-dialysis assessment revealed the following information:-Most recent blood pressure was obtained on 5/16/2026,-Most recent temperature was obtained on 5/9/2026,-Most recent pulse was obtained on 5/9/2026,-Most recent respirations were obtained on 5/9/2026, and-Most recent weight was obtained on 5/17/2026.-Thrill and Bruit were marked present and it was marked that the resident was not experiencing any muscle cramping, itching, discomfort or pain.The post-dialysis assessment revealed the following information:- Most recent weight was obtained on 5/17/26,-Most recent blood pressure was obtained on 5/16/26,-Most recent temperature was obtained on 5/9/26, -Most recent pulse was obtained on 5/9/26, and -Most recent respirations were obtained on 5/9/26.-The resident was marked as not experiencing any symptoms and Thrill and Bruit were marked present. An interview with the Director of Nursing (DON) and the Administrator (ADM)on 6/3/26 at 11:00 AM confirmed that the residents who received dialysis had a specified chair time that was communicated to the facility, and the dialysis center also communicated if the resident's chair time ever changed. The DON also confirmed there were pre and post-dialysis assessments that were to be completed by staff before the resident was sent to dialysis and after the resident returned from dialysis. There was an expectation for these assessments to be completed every time the resident left for dialysis and every time they came back from dialysis. The assessments included the residents' vital signs (Blood pressure, heart rate, respirations, temperature) alertness/ orientation status, the bruit/thrill for the fistula to be checked, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or for the central venous catheter to be checked. The DON confirmed that a new set of vital signs was to be completed every time a new assessment was completed. On 6/3/26 at 11:35 AM the ADM confirmed that the pre-and post-dialysis assessments had not been getting completed for Resident 39.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** L:icensure Reference Number 175 NAC 12-006.18(B)Licensure Reference Number 175 NAC 1-005.06 Based on record review, observation, and interview, the facility failed to ensure catheter bags were maintained in a manner to prevent the potential for cross contamination and/or infection for two (Residents 4 and 13) of three sampled residents. The facility identified a census of 55. Findings are: Record reviews of facility policies related to catheters (including infection control and catheter care) revealed no evidence of an expectation to ensure catheter bags were maintained in a manner to prevent the potential for cross contamination and/or infection. An interview with Infection Preventionist (IP) on 6/03/2026 at 3:14 PM confirmed that catheter bags were to be hung from the side pocket of the recliner when a resident was in their recliner. IP confirmed that when residents were in bed, the catheter bags were to be hung from the side of the bed. A. Record review of Resident 4's admission Record dated 6/4/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 4's Diagnosis List dated 6/3/2026 revealed diagnoses of: Obstructive and Reflux Uropathy (Obstructive uropathy is a structural or functional blockage of urine flow anywhere in the urinary tract, which causes urine to back up and exert pressure on the kidneys. Reflux uropathy occurs when urine flows backward from the bladder up into the ureters and toward the kidneys, which can cause kidney scarring and infection) was added on 3/26/2026. Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms (the natural, non-cancerous enlargement of the prostate gland that occurs as men age. As the prostate grows, it can pinch the urethra and squeeze the bladder, leading to a cluster of conditions known as lower urinary tract symptoms) was added on 3/20/2026. Acute Kidney Failure (a sudden crash in kidney function causing toxic waste and excess fluids to build up in the bloodstream) was added on 3/20/2026. Retention of Urine (the inability to completely empty the bladder) was added on 3/20/2026. Altered Mental Status (a significant, acute change from a person's baseline level of awareness, cognition, or consciousness) was added on 3/20/2026. Record review of a Modified Admission/Medicare – 5 Day 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 3/27/2026, revealed Resident 4 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14, which indicated the resident was cognitively intact. Resident 4 required partial/moderate (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance for sit to stand transfer and toileting. A record review of Resident 4's orders revealed an order for 16F (French) catheter with 30 bulb to bedside drainage bag with a start date of 4/16/2026. Record review of Resident 4's Care Plan Report, undated, revealed Resident 4 had: An Activities of Daily Living (ADL) self-care performance deficit (initiated/revised on 3/26/2026). Interventions included Resident request bed to be removed from room and only recliner for sleep (initiated/revised on 3/26/2026), The resident requires 1 staff with personal hygiene (initiated/revised on 3/26/2026), The resident requires 1 staff for toileting (initiated/revised on 3/26/2026). An Indwelling Catheter (initiated/revised on 4/30/2026). Interventions included positioning catheter bag below the level of bladder and away from entrance room door (initiated/revised on 4/30/2026). An observation on 6/01/2026 at 2:52 PM revealed Resident 4 sitting in their recliner with the catheter bag hanging from the side of the trash can next to the resident's recliner. An observation on 6/2/2026 at 11:20 AM and 12:56 PM revealed Resident 4 sitting in their recliner with the catheter bag hanging from the side of the trash can with the bottom of the catheter bag touching the floor. An observation on 6/2/2026 at 4:16 PM revealed Resident 4 sitting in their recliner with the catheter bag laying on the floor, on its side. The bag was 1/4 full of yellow fluid. An observation on 6/3/2026 at 7:45 AM revealed Resident 4 sleeping in their recliner with the catheter bag hanging from the side of the trash can, and the bottom of the bag touching the floor. An observation on 6/04/2026 at 7:59 AM revealed Resident 4 sleeping in their recliner with the catheter bag hanging from the side of the trash can, and the bottom of the bag touching the floor. An interview with Nurse Aide (NA)-A on 6/04/2026 at 9:36 AM confirmed that Resident 4's catheter bag was hanging from the side of the trash can, and that the bag should not be hung there. NA-A confirmed the catheter bag needed to hang from the side pocket of the recliner without touching the floor. NA-A put on gloves and moved the catheter bag to hang on the side pocket of the recliner. B. A record review of Resident 13's admission Record dated 6/4/2026 revealed an admission date of 5/1/26. The admission record also revealed the following relevant diagnoses: -Overactive bladder -Unspecified urinary incontinence -Varicose veins of unspecified lower extremity with ulcer of unspecified site. Record review of Resident 13's Progress Note dated 5/17/26 revealed the physician agreed to have (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an indwelling catheter placed for Resident 13 due to wound healing. Observations made of Resident 13's catheter revealed the catheter bag was touching the floor at the following times and days: -On 6/1/26 at 12:37 PM, -On 6/3/26 at 7:49 AM. -On 6/3/26 at 12:24 PM, and -On 6/4/26 at 10:03 AM An interview on 6/4/26 at 10:50 AM with Nurse Aide (NA)-B confirmed that Resident 13 hangs their catheter on the bed frame in a way that allows it to touch the floor. NA-B stated, the catheter is new for (gender).