STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285019	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas County Health Center	4102 Woolworth Avenue Omaha, NE 68105

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285019	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas County Health Center	4102 Woolworth Avenue Omaha, NE 68105

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H) Based on interview and record review the facility failed to administer pain medication according to the practitioner's orders for 2 (Resident 4 and 5) of 5 residents sampled. The facility census was 233. The findings are:A.Record review of Resident 4's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 08-27-2025 revealed the facility staff assessed the following about the resident:-BIMS was scored at an 11/15. According to the MDS Manual, a score of 8-12 indicated moderate cognitive impairment.-The resident required limited assistance with dressing and hygiene.-The resident required extensive assistance with toileting, bathing, bed mobility and transfers. Record review of Resident 4's Progress Notes (PN) dated 10-01-2025 revealed Resident 4 had an order to discontinue their gabapentin (an anticonvulsant medication used to treat nerve pain). Record review of Resident 4's Office Visit Neurology Clinic (OVNC) dated 10-03-2025 revealed an order to stop gabapentin since Resident 4 was already taking Lyrica (a medication used for nerve pain). Record review of Resident 4's MAR for October 2025 revealed their order for gabapentin 100 mg capsule for pain was discontinued on 10-01-2025. The MAR also revealed Lyrica 150 mg by mouth twice a day for pain was placed on hold starting 10-03-2025 at 9:00 PM and remained on hold through 10-07-2025 for a total of 9 doses. Record review of Resident 4's Medication Error Report (MER) dated 10-07-2025 revealed Resident 4 returned from a neurology appointment on 10-03-2025 with orders to discontinue the gabapentin, and the orders were faxed to the pharmacy. Furthermore, on 10-03-2025 the pharmacist put a hold on the Lyrica, we called on that date about the hold and the pharmacy did not address, we called again on 10-06-2025 and tried to explain the Lyrica was not discontinued and should not have been held. Today, 10-07-2025 the resident is presenting more confused and not eating. The resident was in withdrawals from having gabapentin and Lyrica stopped abruptly. An interview with Unit Manager (UM) D on 10-30-2025 at 12:57 PM confirmed Resident 4 was receiving Lyrica for pain and was held from 10-03-2025 through 10-07-2025 for a total of 9 doses without an order to do so. B. Record review of Resident 5's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-The resident had a diagnosis of Congestive Heart Failure.-BIMS was scored as a 13/15. According to the MDS Manual, a score of 13 to 15 indicates a person is cognitively intact.-The resident required extensive assistance with bed mobility and transfers.-The resident required total assistance with eating, dressing, toileting, bathing and dressing.-The resident was receiving an opioid medication (a medication to help moderate-to-severe pain).-The resident was taking a hypnotic medication (a class of psychoactive medications primarily used to induce and maintain sleep). Record review of Resident 5's MAR for October 2025 revealed an order for Buprenorphine 10 micrograms (mcg)/hour patch (an opioid medication used to manage severe or chronic pain). Apply topically every 7 days on Sundays for chronic pain. Record review of Resident 5's Progress Note (PN) dated 10-12-2025 revealed Resident 5's Buprenorphine 10mcg/hour patch was changed on 10-12-2025. The patch found on the resident's chest was dated 09-30-2025 and was to be changed on 10-07-2025. Record review of Resident 5's MER dated 10-12-2025 revealed Buprenorphine 10 mcg/hour patch was omitted on 10-07-2025, a new patch was placed on 10-12-2025 and the MAR was updated to reflect the new dates to change the patch going forward. An interview with UM-F on 10-30-2025 at 11:55 AM confirmed Resident 5's Buprenorphine 10mcg/hour patch was not changed on 10-07-2025 and should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285019	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas County Health Center	4102 Woolworth Avenue Omaha, NE 68105

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285019	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas County Health Center	4102 Woolworth Avenue Omaha, NE 68105

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 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D). Based on interview and record review the facility failed to ensure residents were free of significant medication errors for 3 (Resident 1, 4 and 5) of 5 residents sampled. The facility census was 233. The findings are:Record review of the facility's policy dated 02-22-2022 titled Medication Administration revealed medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Staff are to obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. Staff are to compare the medication source (bubble pack, bottle) with the Medication Administration Record (MAR) to verify resident name, medication name, form, dose, route and time. 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), high risk drug classes include antipsychotics, hypnotics, anticoagulants, opioids, and diuretics (a medication that increases the production and excretion of urine) and residents taking these medication categories are at risk of side effects that can adversely affect, health, safety and quality of life. A.Record review of Resident 1's 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 09-16-2025 revealed the facility staff assessed the following about the resident:-The resident was admitted to the facility on [DATE]. -The resident had a traumatic hemorrhage of the cerebrum (bleeding that occurs within the brain tissue). -Brief Interview of Mental Status (BIMS) was scored as a 2/15. According to the RAI Manual, a score of 0-7 indicated severe cognitive impairment. Record review of Resident 1's Transition Orders and Information for the Continuation of Patient Care (TOICPC) dated 09-10-2025 revealed an order for apixaban (an anticoagulant medication used to keep blood from clotting) 5 milligrams (mg) twice a day, wait to take this medication until your doctor or other care provider tells you to start again. The TOICPC also indicated Resident 1 had an appointment with neurology with a follow up head Computed Tomography scan (CT scan: a test used to diagnose blood clots or internal bleeding) on 09-19-2025. Record review of Resident 1's MAR for September 2025 revealed an order for apixaban 5mg tablet take 1 tablet by mouth for atrial fibrillation. Hold until neurosurgery restarts. The MAR also revealed apixaban 5mg was administered twice a day at 9:00 AM and 9:00 PM from 09-19-2025 through 09-28-2025 and apixaban 5mg was administered on 09-29-2025 at 9:00 AM for a total of 21 doses. Record review of Resident 1's Office Visit in Neurosurgery (OVN) dated 09-29-2025 revealed Resident 1 was to return to the office in 1 week for a new CT scan of the head to determine if there is any worsening in the subdural hematoma or subdural hygroma and to revisit operative intervention at that point if appropriate. Record review of Resident 1's OVN dated 10-07-2025 revealed the current imaging indicated a progression of the left sided subdural hematoma. Record review of Resident 1's Physician's Orders dated 10-08-2025 revealed an order to consult hospice for evaluation and treatment for an increased brain hemorrhage. Record review of Resident 1's Medication Error Report (MER) dated 09-10-2025 revealed Resident 1's family representative had changed the neurology appointment from 09-19-2025 to 09-29-2025 and had accompanied Resident 1 to the appointment. Furthermore, the family representative brought the medication error to the facility's attention after the neurologist pointed out the apixaban had not been held at the appointment on 09-29-2025. Further review of the MER revealed the pharmacy had filled the label out as the following: hold until neurosurgery appointment instead of not filling it at all and was not correct as to what the actual orders read on the TOICPC which was a simple Hold order. The medication should not have been filled by the pharmacy at all. The medication should not have been sent to the floor at all. The medication should not have been chart checked or confirmed as per nursing did with such a tenuous and delayed start date. The medication should not have been confirmed as written to prevent administration of the medication. An interview conducted on 10-30-2025 at 11:30 AM with Unit Manager (UM) B confirmed Resident 1 received 21 doses of apixaban in error. According to Bristol [NAME] Squibb, the manufacturer of apixaban, apixaban's serious side effects include increased bleeding which can be serious and may lead to death and is contraindicated for individuals with pathological bleeding. B.Record review of Resident 4's MDS dated [DATE] revealed the facility staff assessed the following about the