

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Emerald Nursing & Rehab Brookside LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4735 South 54th Street Lincoln, NE 68516	

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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>47312</p> <p>Licensure Reference Number 175 NAC 12-009.11(A)</p> <p>Based on observation and interview; the facility failed to ensure a bathroom floor was maintained in a clean and sanitary manner for 1 (Resident 1) of 3 sampled residents. The facility census was 97.</p> <p>Findings are:</p> <p>In an observation on 1/21/25 at 3:27 PM of Resident 1's bathroom floor revealed the following:</p> <ul style="list-style-type: none"> -4 cracked tiles in front of the toilet with one tile having a missing area -Large brown stained area out from base of toilet -Caulking around base of toilet with cracks and brown stains around the front of the toilet <p>In an observation on 1/22/25 at 8:08 AM of Resident 1's bathroom floor revealed the same concerns as listed above.</p> <p>In an interview on 1/22/25 at 8:08 AM, the Administrator confirmed that the above-mentioned areas were present and confirmed that Resident 1's bathroom floor was not maintained in a clean and sanitary manner.</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
---	-------	-----------