STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285049	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Brookside LLC	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 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 12-006.02 (H) The facility failed to report an allegation of abuse on two residents (Resident 1 and Resident 2), out of four sampled residents. The facility census was 102. Findings: A.A record review of Resident 1's Clinical Census revealed an admission date of 5/16/2023. A record review of Resident 1's Minimum Data Set (MDS) (this comprehensive assessment evaluates each resident's functional capabilities) dated 6/03/2025 revealed a brief interview for mental status (BIMS) score of five which indicated the resident had severe cognitive impairment. A record review of Resident 1's Care Plan with an admission date of 5/16/2023 and a revision date of 3/26/2025 revealed a diagnosis of dementia, psychotic disturbance, mood disturbance, adjustment disorder, anxiety, and depressed mood and a focus area to include mood problem relating to dementia. Interventions included redirecting/separating from another resident. A record review of Resident 1's Progress Notes dated 6/16/2025 at 5:30 PM revealed that Resident 1 was found standing next to own bed, pulling pants up while Resident 2 was lying on Resident 1's bed. Resident 1 and resident 2 were separated. Resident's not able to give much information about incident due to confusion and medical history. B.A record review of Resident 2's Clinical Census revealed an admission date of 12/12/2024. A record review of Resident 2's MDS dated [DATE] revealed a BIMS score of zero which indicated the resident had severe cognitive impairment and required supervision or touch assist to ambulate 150 feet. A record review of Resident 2's Care Plan with an admission date of 12/12/2024 revealed a diagnosis of Alzheimer's disease, depression, and dementia with agitation. A focus area with a revision date of 12/16/2024 included impaired cognitive function or decision making. Interventions included observing for any changes in cognitive function: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, inattention, disorganized thinking, and mental status changes. A record review of Resident 2's Progress Notes dated 6/16/2025 at 5:20 PM revealed Resident 2 was found in Resident 1's room, on the bed with pants/brief down. Resident 1 was standing next to the bed, in the process of pulling up own pants. Writer stated, Residents not able to give details of the incident due to mental status/ medical history of dementia. Resident 1 and Resident 2 were separated and assisted to the dining room for supper. A record review of Resident 2's progress notes dated 6/16/2025-9/15/2025 revealed no resident assessment completed regarding the incident on 6/16/2025 at 5:20 PM. In an interview on 9/15/2025 at 11:00AM with the administrator (ADM), confirmed there had been issues with the charge nurse and inaccurate documentation. ADM stated there was no contact between Resident 1 and Resident 2 and the incident did not need to be reported. In an interview on 9/15/2025 at 1:40 PM with the assistant director of nursing (ADON), confirmed there was no body assessment completed on Resident 2 after the incident on 6/16/2025. Due to the completion of the investigation, it was determined there was no contact and no need to report the incident. An interview on 9/16/2025 at 10:00 AM with medication aide (MA)-A confirmed the details of the incident on 6/16/205 at approximately 5:00 PM with Resident 1 and 2: Resident 1 and Resident 2 were both sitting outside holding hands. The staff separated Resident 1 and 2. A while later, while passing medications, it was noted that Resident 2 was not in own room. Another nurse aide (NA)-B requested me to come to Resident 1's room quick, and I assumed that Resident 1 had fallen. When I arrived at Resident 1's room, NA-B stated that Resident 1's door was mostly closed. While opening the resident's door, Resident 2 was found with pants and brief pulled down, on top of Resident 1, who was fully dressed. MA-A confirmed witnessing Resident 1 leaving the room and Resident 2 pulling up pants. Charge nurse was notified immediately of the event. On 6/17/2025, Resident 2 was found in resident 1's room, again with pants down. Resident 1 was in room, but no interaction was observed. This occurred at approximately 7:00 PM and was reported to the charge nurse. MA-A confirmed the actions of Resident 1 and Resident 2 were inappropriate and could not understand why it took so long to move Resident 1 to another unit. MA-A confirmed Resident 1 was transferred to another unit about one week later. In a record review of the Facility's Abuse, Neglect, and Exploitation policy dated 11/2017 and a revision date of 1/2024 revealed: Each resident has the right to be free from abuse. Residents must not be subject to abuse by anyone, including, but not limited to other residents. Alleged Violation refers to a situation or occurrence that is observed or reported by staff or others but has not yet been investigated. Any investigation of an allegation of resident sexual abuse must start with a determination of whether the sexual activity was consensual on the part of the resident. A facility is required to investigate and protect a resident