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	05/19/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Licensure Reference Number 175 NAC 12-006.09(H)(iii)(3)Based on record review and interview, the facility failed to perform or document skin assessments for Resident 1. This affected 1 of 4 residents reviewed for skin protection. The facility census was 92.Findings are:A record review of Resident 1's admission Record printed 05/18/2026 revealed the facility admitted the resident on 04/09/2026.A record review of Resident 1's Discharge Summary with effective date 04/26/2026 revealed that the facility discharged the resident on 04/21/2026.A record review of a Progress Note from 04/21/2026 at 11:22 AM revealed Resident 1 went to a doctor's appointment and was transferred to the hospital from there.A record review of Resident 1's admission Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities) dated 04/15/2026 revealed the resident was frequently incontinent (lacking control) of both bladder and bowel. Further review of the MDS revealed that the resident required substantial to maximal assistance (the helper does more than half of the effort for care) with toileting hygiene (cleaning themselves up and adjusting clothing before and after urinating or having a bowel movement).A record review of Resident 1's Nursing admission Data Collection dated 04/09/2026 revealed in Section 2, Skin Conditions, that on admission the resident had bruising to both arms, scabs to both knees, had redness to the skin in the abdominal folds and under the breasts, and had an area described as bottom red, not open. There were no measurements or further descriptions of any of these areas. Further review revealed in Section 14, Interim Care Plan/Baseline (a plan of care for the resident that includes the minimum information needed to provide effective, person-centered care immediately upon admission), Part C, Skin, that the resident was identified as being at risk for impaired skin integrity.A review of Resident 1's Progress Notes revealed there were Skilled Observations completed 04/10/2026, 04/11/2026, 04/12/2026, 04/13/2026, 04/14/2026, 04/15/2026, 04/16/2026, 04/18/2026, 04/19/2026, and 04/20/2026. The areas reviewed on these assessments were as follows:04/10 - Cardiac/Circulatory (Heart) and Respiratory (Breathing)04/11 - Respiratory, Pain Management and Psych/Mood/Behavior04/12 - Respiratory, Pain Management and Psych/Mood/Behavior04/13 - Respiratory, Pain Management and Psych/Mood/Behavior04/14 - Respiratory, Pain Management, Psych/Mood/Behavior, and Infection04/15 - Respiratory, Pain Management, and Psych/Mood/Behavior04/16 - Respiratory, Pain Management, Psych/Mood/Behavior, and Infection04/17 - not done04/18 - Respiratory, Pain Management, Psych/Mood/Behavior, and Infection04/19 - Respiratory, Pain Management, Psych/Mood/Behavior, and Infection04/20 - Respiratory, Pain Management, and Psych/Mood/Behavior.There was no documentation of skin observations in any of the Skilled Observations.Further review of Resident 1's Progress Notes revealed documentation of the resident refusing incontinence cares on 04/10/2026, 04/12/2026, and 04/16/2026.A record review of Resident 1's bathing record revealed documentation that the resident was bathed on 04/15/26 and 04/18/26.A record review of Resident 1's Electronic Health Record revealed a Skin/Wound Weekly Observation dated 04/16/2026 that stated the resident had refused the skin assessment. The form was created 04/23/2026.An interview on 05/19/2026 at 8:37 AM with Nurse Aide (NA) D confirmed that whoever provides a bath to a resident should report any skin integrity issues to the nurse.An interview on 05/19/2026 at 8:39 AM with NA E confirmed that whoever provides a bath to a resident should report (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any skin integrity issues to the nurse.An interview on 05/19/2026 at 10:10 AM with the Director of Nursing confirmed that it was the expectation for staff performing a bath or toileting a resident to look at skin and report any skin integrity issues to the nurse. The DON further confirmed that the nurse should follow up on a red area that was present on admission, and that the nurse should look at a wound every shift with a full assessment done weekly. The DON further confirmed there was no documentation of Resident 1's skin being observed or assessed between 04/09/2026 and 04/21/2026.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Licensure reference number 175 NAC 4-006.12(D)(i) Based on observations, interviews, and record review, the facility failed to ensure all medications were stored and locked in a secure manner to provide resident safety. The facility census was 92. Findings are:An observation on 05/18/2026 at 8:02 AM revealed three medication carts in the three hundred hall were left unattended and unlocked with two of the carts having had computer screens left open with resident information displayed.An interview on 05/18/2026 at 8:05 AM with Licensed Practical Nurse-B (LPN-B) revealed that all three medication carts were left unattended and unlocked, and that two of the computer screens were open with resident information displayed. LPN-B confirmed that the medication carts should always be locked with resident information hidden.An observation on 5/18/26 at 9:56 AM revealed an unlocked and unattended medication cart outside of Resident 2's room with a piece of paper that contained resident information on top.An interview on 5/18/26 at 9:57 AM with the Director of Nursing (DON) confirmed that the medication carts should have been locked when left unattended and resident information should be concealed.Record review of facility's Medication Storage & Security policy that was undated, revealed medication carts were to be locked when not in use and access was limited to authorized personnel.

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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. Licensure Reference Number 175 NAC 12-006.18Based on observations, record review, and interviews, the facility failed to follow infection control standards of practice during wound care for Resident 2 and during wound care and resident care for Resident 4. This affected 2 of 4 residents reviewed for wound care. The facility census was 92.Findings are:A record review of the facility's Infection Control: Standard Precautions policy revised 01/2024 revealed that hand hygiene was to be performed: -before and after contact with the resident-before performing an aseptic task-after contact with items in a resident's room-after removing PPE -Gloves were to be changed as necessary or during the care of a resident to prevent cross-contamination (when moving from a dirty site to a clean one) from one body site to another.-Gloves were to be removed promptly after each use and before touching non-contaminated items and environmental surfaces.-Gowns were to be worn to protect skin and to prevent soiling of clothing during procedures and resident care activities that were likely to generate splashes or sprays of blood, body fluids, secretions, excretions, or cause soiling of clothing. A. An observation on 05/18/2026 at 9:51 AM revealed Licensed Practical Nurse (LPN) B performing wound care to Resident 2. The LPN performed hand hygiene on the way into the room prior to putting on gloves. After washing Resident 2's wounds, the LPN changed gloves without performing hand hygiene and completed the treatment to the wounds. An interview 05/18/2026 at 9:58 AM with LPN B confirmed the LPN should have performed hand hygiene when changing gloves and did not. B. Record review of facility policy titled Infection Control: Standard Precautions revised 01/2024 revealed hand hygiene was to be performed: -before and after contact with the resident-before performing an aseptic task-after contact with items in a resident's room-after removing PPE -Gloves were to be changed as necessary or during the care of a resident to prevent cross-contamination (when moving from a dirty site to a clean one) from one body site to another.-Gloves were to be removed promptly after each use and before touching non-contaminated items and environmental surfaces.-Gowns were to be worn to protect skin and to prevent soiling of clothing during procedures and resident care activities that were likely to generate splashes or sprays of blood, body fluids, secretions, excretions, or cause soiling of clothing. An observation on 5/19/2026 at 6:58 AM of the DON and RN-A in Resident 4's room revealed them at the bedside in the act of a complete bed change without a gown on. An observation of wound care completed on 05/19/2026 from 7:34 AM to 7:44 AM revealed Registered Nurse-A (RN-A) performing wound care on Resident 4. Present in the room was also the Director of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON). During observation: -RN-A was at the resident bedside, with a gown and gloves on.-Resident 4 independently rolled to the left side, exposing their buttock with no dressing in place.-RN-A cleaned the wound with a Vasche (a wound cleansing solution) soaked gauze, three separate times. A new gauze was used each time the wound was cleaned. Each time the used gauze was placed on the disposable pad on the bed.-RN-A doffed (removed) gloves, then performed hand hygiene.-RN-A donned (applied) new gloves.-RN-A touched the residents foot with clean gloves but did not change gloves.-RN-A then packed the wound (a technique used where gauze is gently stuffed into an open wound, so the body can heal from the inside out).-RN-A used the same gloves and reached into their pocket for scissors (on a key chain) to then cut the excess gauze off from the wound bed. RN-A then placed the used scissors on the disposable pad on Resident 4's bed.-RN-A doffed the gloves and then performed hand hygiene.-RN-A donned new gloves.-RN-A then placed the used scissors back in their pocket with the clean gloves on. -RN-A then touched the clean Mepilex (a soft foam dressing used to treat open wounds) and applied it to the buttock wound.-RN-A doffed the gloves, and no hand hygiene was completed.-RN-A touched Resident 4's glasses, bedside remote, call light, and pillow. RN-A then removed the dirty garbage bag with their bare hands, then touched the box of clean gloves by the top (touching the clean gloves inside the box) and carried clean supplies out of the room; placing them outside of the door. - RN-A removed the gown and performed hand hygiene. An interview with RN-A on 5/19/2026 at 8:09 AM revealed that neither the DON nor RN-A had a gown on when observed completing Resident 4's bed change that morning around 6:58 AM. RN-A also confirmed that the wound had been cleaned during the bed change. RN-A revealed the wound was exposed and not covered, confirming a gown should have been on with direct patient care. RN-A confirmed that the dirty scissors were removed from their pocket with clean gloves then used during wound care without being cleaned, and that no hand hygiene was completed at the end of wound care prior to touching the resident items, surfaces, and clean supplies. An interview with the DON on 5/19/2026 at 8:13 AM confirmed that the expectation was for staff to use personal protective equipment (PPE, includes clothing, gloves, face shields, goggles, facemasks, respirators, and other equipment to protect front-line workers from injury, infection, or illness) with Resident 4 who was on Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes) and that PPE's were not used for the entirety of the complete bed change. The DON confirmed that there was cross contamination during wound cares to the buttock on Resident 4.