

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Emerald Nursing & Rehabilitation Mercy		STREET ADDRESS, CITY, STATE, ZIP CODE 7410 Mercy Road Omaha, NE 68124	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(F)(i)(5).</p> <p>Based on record review and interview the facility failed to notify the resident's physician of a change of condition for 2 (Resident 1 and 3) of 4 sampled residents. The facility census was 101.</p> <p>The findings are:</p> <p>A.</p> <p>Record review of the Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 05-22-2025 revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13-15 indicates a person is cognitively intact. -required total assistance with bathing and removing footwear. -required extensive assistance with lower body dressing. -was at risk of developing pressure ulcers. -had one or more unhealed pressure ulcers. <p>Record review of Resident 3's Skin-Wound Weekly Observation (SWWO) dated 05-28-2025 revealed Resident 3 had a deep tissue injury (a pressure ulcer where the skin and underlying tissue are damaged but the skin is intact) measuring 0.5 centimeters (cm) in length by 0.5 cm in width to the right heel.</p> <p>Record review of Resident 3's progress notes dated 06-03-2025 which revealed the area to Resident 3's right heel was open and weeping green/yellow discharge and had a foul odor.</p> <p>Record review of Resident 3's Electronic Health Record (EHR) revealed no indication Resident 3's physician was updated about the change in condition to the right heel.</p> <p>(continued on next page)</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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Wound Nurse (WN) on 06-05-2025 at 2:30 PM confirmed Resident 3's physician should have been called when the right heel wound worsened.</p> <p>B.</p> <p>Record review of Resident 1's MDS dated [DATE] revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -BIMS was scored as an 11. According to the MDS Manual a score of 8-12 indicates moderate cognitive impairment. -required total assistance with hygiene, bathing, dressing, bed mobility and transfers. <p>Record review of Resident 1's SWWO dated 03-29-2025 revealed the facility staff had identified a stage 1 pressure ulcer to the coccyx measuring 6 cm in length by 5 cm in width.</p> <p>Record review of Resident 1's EHR revealed no indication that Resident 1's physician was notified of the wound to the coccyx.</p> <p>An interview with the WN on 06-05-2025 at 12:30 PM revealed the staff did not update the physician about the wound and confirmed the expectation when identifying a new wound was to contact the physician or practitioner for treatment orders.</p> <p>Record review of the facility policy titled Notification of Changes Policy dated 01-2024 revealed it is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition. Requirements for notification of the resident's physician include a significant change in the resident's physical, mental or psychosocial status, and a need to alter treatment significantly such a to commence a new form of treatment.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2).</p> <p>Based on observation, interview and record review the facility failed to evaluate, monitor and implement interventions for pressure ulcer prevention and to promote wound healing for 1 (Resident 3) of 4 resident sampled. The facility census was 101.</p> <p>The findings are:</p> <p>Record review of the Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 05-22-2025 revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -admitted to the facility on [DATE]. -Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13-15 indicates a person is cognitively intact. -required total assistance with bathing and removing footwear. -required extensive assistance with lower body dressing. -was at risk of developing pressure ulcers. -had one or more unhealed pressure ulcers. <p>Record review of Resident 3's Comprehensive Care Plan (CCP) dated 05-29-2025 revealed the following about Resident 3</p> <ul style="list-style-type: none"> -had an impairment of skin integrity related to impaired mobility, edema, fragile skin, diabetes and lymphedema. -The goal was Resident 3 would have no complications related to skin injury through the next review date. -Interventions listed were to avoid scratching, keep fingernails short, educate the resident/family/caregivers of causative factors and measures to prevent skin injury, keep skin clean and dry, use caution during transfers and bed mobility to prevent injury, layered compression wraps to bilateral lower extremities. <p>Further review of the CCP revealed no indication the facility implemented pressure relieving measures to prevent pressure ulcer development.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident 3's Nursing admission Data Collection (NADC) dated 05-16-2025 revealed on admission Resident 3 had a stage 2 pressure ulcer (a pressure ulcer involving partial thickness skin loss of the outer layer of skin) to the right heel measuring 2 centimeters (cm) in length by 2 cm in width.</p> <p>Record review of Resident 3's physician notes dated 05-23-2025 revealed the right lower extremity had no active open ulcerations and gave orders to elevate bilateral lower extremities.</p> <p>Record review of Resident 3's Skin-Wound Weekly Observation (SWWO) dated 05-24-2025 revealed a new pressure ulcer to the right heel and a scabbed area to the right heel as well. The SWWO did not have a description or measurements for the new pressure ulcer.</p> <p>Record review of Resident 3's SWWO dated 05-28-2025 revealed Resident 3 had a deep tissue injury (DTI, a pressure ulcer where the skin and underlying tissue are damaged but the skin is intact) measuring 0.5 centimeters (cm) in length by 0.5 cm in width.</p> <p>Record review of Resident 3's progress notes dated 06-03-2025 revealed the area to the right heel was open and weeping greenish yellow discharge that was foul smelling.</p> <p>Record review of Resident 3's progress notes, orders, medication and treatment administration records, physician visits and faxes revealed no orders for the care and treatment of the pressure ulcer to the right heel.</p> <p>An observation on 06-05-2025 of Resident 3 at 10:30 AM revealed Resident 3 was in the room sitting in the wheelchair. Resident 3 lifted the right foot to reveal the right heel had a gauze bandage in place with a round area of brownish discoloration where the gauze had adhered to the wound, approximately 3 cm in length by 2 cm in width. There was a foul odor from the right heel.</p> <p>An interview with the Wound Nurse on 06-05-2025 at 3:45 PM confirmed the lack of treatment orders for the pressure ulcer to the right heel, and causal factors and interventions were not reviewed or modified and the wound worsened. Furthermore, the WN confirmed that the CCP did not include interventions for pressure redistribution, monitoring of the pressure ulcers, or prevention and treatment strategies.</p> <p>Record review of the facility policy titled Skin and Wound Management-Prevention of Pressure dated 06-07-2024 revealed the following:</p> <p>-Purpose- the purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors.</p> <p>-Preparation-review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.</p> <p>-Monitoring- Evaluate, report and document potential changes in the skin and review the interventions and strategies for effectiveness on an ongoing basis.</p>		