STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285058	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehabilitation Mercy	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference: 175 NAC 12-006.04(F)(i)(5) Based on record review and interview, the facility failed to ensure notification of physician of sliding scale insulin not being administered to 1 [Resident 4] of 6 sampled residents. The facility had a total census of 92. Findings are:A review of Resident 4's admission Record revealed Resident 4 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus and dependence on renal dialysis. A review of Resident 4's 7/2025 Medication Administration Record (MAR) revealed orders for sliding scale insulin 3 times per day per the following sliding scale: 150-200=1 unit; 251-300=3 units; 301-350=4 units; 351-400=5 units; 401-450=6; greater than 450=7 units and call provider. A review Resident 4's 7/2025 between 7/1/25 and 7/28/25 revealed Resident 4's sliding scale insulin not provided at 5 PM on the following days:-Wednesday 7/2/25 noted to be out of facility,-Monday 7/7/25 noted to be out of the facility,-Wednesday 7/9/25 noted to out of facility,-Friday 7/11/25 blank,-Wednesday 7/16/25 out of facility,-Friday 7/18/25 blank,-Monday 7/21/24 out of the facility,-Wednesday 7/23/25 blank,-Saturday 7/26/25 blank. A review of Progress Notes for Resident 4 from 7/1/25-7/28/25 did not reveal documentation of Resident 4's provider being notified that sliding scale insulin had not been provided to Resident 4. In interviews on 7/28/25 at 12:23 PM, 2:50 PM, and 4:08 PM, the Director of Nursing (DON) reported Resident 4 goes to dialysis around 1 PM and comes back around dinner time. The DON reported an expectation that Resident 4's blood sugar be checked and sliding scale insulin provided after Resident 4 returned from dialysis. The DON confirmed not administering Resident 4's sliding scale insulin would be considered a significant medication error. The DON reported a mass email had been sent out to providers reporting that medications had been administered to residents. In a follow-up interview on 7/28/25 at 4:27 PM, the DON reported that the documentation could not be located that notified Resident 4's provider of the missed insulin. A review of facility policy titled Medication Error reviewed 1/3/2019 revealed resident attending physician and responsible party are to be notified of medication errors.

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
	285058	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehabilitation Mercy	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Licensure reference: 175 NAC 12-006.10 (A)(ii) Based on observation, interview, and record review, the facility failed to ensure insulin was administered in accordance with standards of practice for 3 [Residents 1, 3, and 4] of 6 sampled residents. The facility had a total census of 92 residents. Findings are:-A review of Resident 1's 7/2025 MAR [Medication Administration Record] revealed an order for Lispro insulin 5 units to be given 3 times daily with meals scheduled for 8 AM 12 PM, and 5 PM. Observations on 7/28/25 at 7:27 AM revealed LPN [Licensed Practical Nurse] A dialing up 5 units of insulin without priming the insulin pen. LPN A administered insulin into back of Resident 1's right arm. In an interview on 7/28/25 at 8:10 AM, LPN confirmed insulin pen was not primed before dialing insulin to be administered. -A review of Resident 3's 7/2025 MAR revealed an order for Novlog flex pen inject per sliding scale 4 times a day at 8 AM, 12 PM, 5 PM, and 8 PM per sliding scale as follows: 150-199 =1 units; 200-249=2 units, 250-299=3 units; 300-349=4 units; 350-399=5 units; 400-999=6 units, call provider if blood sugar greater than 400. Observations on 7/28/25 at 7:39 AM revealed LPN A dialed up 1 unit of insulin without priming the insulin pen for blood sugar of 161. LPN A administered insulin into Resident 3's back of right arm. In an interview on 7/28/25 at 8:10 AM, LPN confirmed insulin pen was not primed before dialing insulin to be administered. -A review of Resident 4's 7/2025 MAR revealed an order for Admelog Solo inj pen inject per sliding scale 3 times a day at 8 AM, 12 PM, and 5 PM per sliding scale as follows: 150-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; 401-450=6 units; greater than 450=7 units and call provider. Observations on 7/28/25 at 7:57 AM revealed LPN B dialing up 4 units of insulin without priming the insulin pen for a blood sugar of 320. LPN B administered insulin into Resident 4 lower left abdomen. In an interview on 7/28/25 at 8:05 AM, LPN B confirmed that LPN B had not primed the insulin pen and reported that only insulin syringes need to be primed. -In an interview on 7/28/25 at 3:09 PM, RN Nurse Consultant C confirmed that insulin pens needed to be primed and that it is a standard of practice. -A review of undated facility competency for Insulin Administration revealed the following procedure:- Ensure to prime insulin pen with 2 units of insulin and waste for verification of functioning insulin pen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285058	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehabilitation Mercy	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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference: 175 NAC 12-006.10(D) Based on record review and interview, the facility failed to ensure medications were provided in accordance with physician's orders for 2 [Resident 4 and 6] of 6 sampled residents. The facility had a total census of 92. Findings are:A.A review of Resident 6's admission Record revealed Resident 6 was admitted to the facility on [DATE] with a diagnosis of pneumonia and type 1 diabetes mellitus with diabetic polyneuropathy [a complication of diabetes that involved nerve damage in the arms, hands, legs, and feet]. A review of Resident 6's 7/2025 MAR [Medication Administration Record] revealed Resident 6 was not administered the following medications on 7/18/25:-Cefdinir [an antibiotic] 300 mg, 1 capsule every 12 hours scheduled for 8 PM.-Lantus insulin [long acting] 25 units subcutaneously at bedtime scheduled for 6 PM. A review of Resident 6's Progress Note dated 7/19/25 at 1:11 AM revealed Resident blood sugar was 349 when checked with glucometer. According to Resident 6's Progress Note, the on-call provider was notified with no new orders. A review of Resident 6's Progress Note dated 7/19/25 at 12:58 PM revealed insulin orders were received for sliding scale insulin. The 7/19/25, 12:58 PM note stated that Resident 6 was administered 4 units of insulin before lunch for blood sugar of 346. A review of Resident 6's Progress Note dated 7/19/24 at 4:15 PM revealed Resident 6's family member reported Resident 6 had a blood sugar of 400 on Dexcom and wanted Resident 6 to go to the hospital. A review of American Diabetes Association on 7/31/25 website revealed the following target blood sugar:-Before a meal: 80-130-1-2 hours after beginning of the meal: less than 180 mg/dl A review of Resident 6's Progress Note dated 7/20/25 revealed Resident 6 was admitted to the hospital with a diagnosis of diabetic ketoacidosis [a life-threatening complication of diabetes that develops when your body doesn't have enough insulin to allow blood sugar into your cells for use as energy]. In interviews on 7/28/25 at 12:11 PM, 4:15 PM, and 4:29 PM, the DON [Director of Nursing] confirmed Resident 6 did not get medications ordered for evening of 7/18/25. The DON confirmed that Lantus insulin was available in the emergency medication kit and Resident 6's orders were entered between 5-6 PM therefore not providing the insulin would be a significant medication error. Further, the DON reported Resident 6's Cefdinir had been delivered to the facility at 7:52 PM on 7/18/25 and not administering it to Resident 6 would be considered a significant medication error. - A review of Resident 4's admission Record revealed Resident 4 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus and dependence on renal dialysis. A review of Resident 4's 7/2025 MAR revealed orders for sliding scale insulin 3 times per day at scheduled times of 8 AM, 12 PM, and 5 PM per the following sliding scale: 150-200=1 unit; 251-300=3 units; 301-350=4 units; 351-400=5 units; 401-450=6; greater than 450=7 units and call provider. A review Resident 4's 7/2025 between 7/1/25 and 7/28/25 revealed Resident 4's sliding scale insulin not provided at 5 PM on the following days:-Wednesday 7/2/25 noted to be out of facility, -Monday 7/7/25 noted to be out of the facility,-Wednesday 7/9/25 noted to out of facility,-Friday 7/11/25 blank, -Wednesday 7/16/25 out of facility,-Friday 7/18/25 blank,-Monday 7/21/24 out of the facility,-Wednesday 7/23/25 blank,-Saturday 7/26/25 blank. In interviews on 7/28/25 at 12:23 PM, 2:50 PM, and 4:08 PM, the DON reported Resident 4 goes to dialysis around 1 PM and comes back around dinner time. The DON reported an expectation that Resident 4's blood sugar be checked and sliding scale insulin provided after Resident 4 returned from dialysis. The DON confirmed not administering Resident 4's sliding scale insulin would be considered a significant medication error.