

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  03/18/2026
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure reference: 12-006.10A(i)Based on observation, interview, and record review, the facility to ensure 1 [Resident 3] of 6 sampled residents was evaluated for ability to self-administer laxative medication. The facility had a total census of 115 residents. Findings are: Findings are: A review of Resident 3's admission Record revealed Resident 3 was admitted to the facility on [DATE] with a diagnosis of hemiplegia [paralysis], unspecified affecting right dominant side. A review of Resident 3's MDS [Minimum Data Set; a comprehensive assessment used for care planning] dated 3/2/26 revealed a score of 8 on the Brief Interview for Mental Status which a score of 8-12 means moderate problems with thinking and memory. A review of Resident 3's Care Plan did not reveal any focus area related to self-administration of medication. A review of Resident 3's Self-Medication Administration Evaluation dated 3/3/26 revealed Resident 3 had been evaluated and determined Resident 3 could self-administer the medication nystatin powder (a prescription antifungal medications used to treat skin infections usually caused by yeast). Resident 3's Self-Medication Administration Evaluation did not identify that Resident 3 had been evaluated to self-administer a laxative medication. Observations on 3/17/26 at 8:14 AM revealed a container of Gavilyte-G solution [laxative] with pharmacy label for Resident 3 located on the bathroom sink in Resident 3's bathroom. The container had approximately 1 inch of solution in the bottom. A review of Resident 3's 3/2026 MAR [Medication Administration Record] revealed an order dated 3/10/26 for Gavilyte-G solution take 4000 ml by mouth x 1 dose. Resident 3's 3/2026 MAR was initialed one time on 3/10/26 to indicate that medication was administered. In an interview on 3/17/26 at 2:25 PM, LPN E [Licensed Practical Nurse] E reported that LPN E had mixed Resident 3's Gavilyte-G with apple juice and provided Resident 3 with the solution. LPN E reported that when LPN E checked on Resident 3. Resident 3 had reported drinking 2 glassfuls and throwing it up. LPN E reported at the next morning it appeared that Resident 3 had not drank anymore of the Gavilyte-G. LPN E had passed that along to the next shift. In an interview on 3/18/26 at 1:08 PM, ADON A reported that the facility did not have a policy on self-administration of medication only the evaluation form. ADON A confirmed that Resident 3 had not been evaluated for self-administration of Gavilyte-G laxative.</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>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.04(F)(i)(5). Based on record review and interview, the facility failed to notify the provider of new pressure ulcers for 1 (Resident 2) of 2 residents sampled. The facility census was 115. The findings are:A.Record review of the facility policy titled Notification of Changes 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. Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or resident representative, and the resident's physician to ensure best outcomes of care for the resident. The objective of the notification policy is to ensure that the facility staff makes appropriate notification to the physician and immediate notification to the resident and/or resident representative when there is a change in the resident's condition, or an accident that may require physician intervention. The intent of the policy is to provide appropriate and timely information about changes relevant to the residents condition to the parties who will make decisions about care, treatment and preferences to address the changes. Requirements for notification of resident, resident representative, their physician:-an accident involving the resident, which results in injury and has the potential for requiring physician intervention.-a significant change in the resident's physical, mental, or psychosocial status. -a need to alter treatment significantly. B.Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 01-04-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-Brief Interview of Mental Status (BIMS) was scored as 13. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required extensive assistance with toileting, bathing, dressing, hygiene, bed mobility, and transfers. -was at risk of developing a pressure ulcer.-had 2 venous ulcers. Record review of Resident 2's Electronic Health Record (EHR) under the section census revealed Resident 2 was at the hospital from [DATE] to 03-04-2026. Record review of Resident 2's readmission assessment dated [DATE] under the section skin conditions revealed Resident 2 had unmeasured pressure ulcers to the right outer ankle, right lateral foot and the right 5th toe. Record review of Resident 2's Transition Orders and Information for the Continuation of Patient Care (TOIPC) dated 03-04-2026 revealed Resident 2 had two open wounds on both the right and left buttocks, an incision to the left below the knee amputation (BKA) site, an unstageable pressure ulcers to the right lateral ankle, the right lateral foot, the right lateral 5th toe, and the right heel. Further review of the TIOPC revealed the absence of treatment orders for the right foot and ankle. Record review of Resident 2's Order Summary (OS) printed on 03-16-2026 revealed the absence of orders for the treatment of the unstageable pressure ulcers on the right lateral ankle, the right heel, the right lateral foot, the right lateral 5th toe. Record review of Resident 2's Treatment Administration Record for March of 2026 revealed no evidence of a treatment for Resident 2's unstageable pressure ulcers. An interview conducted with the facility Wound and Infection Nurse (WIN) on 03-18-2026 at 2:20 PM confirmed Resident 2 did not have treatment orders for the pressure ulcers to the right foot and ankle and confirmed the facility should have called the physician to obtain orders.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.09F(iii). Based on record review and interview, the facility failed to review and revise the care plan related to pressure ulcers, amputation, and infection for 1 (Resident 2) of 3 residents sampled. The facility census was 115. The findings are: A. Record review of the facility's policy titled Care Plan Process revealed the plan of care must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. Interim care plans are developed within 24 hours of admission for high-risk problems, including major medications and diagnosis. The resident's family or legal representative is involved if the resident is unable to participate and/or the resident approves. High risk areas such as falls, skin/wounds, pain, safety and weight loss must be care-planned immediately upon identifying risk via evaluation. The interdisciplinary team reviews the plan of care quarterly, annually, significant change and upon identification that the desired outcome is not met. B. Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 01-04-2026 revealed the facility staff assessed the following about the resident: -admitted to the facility on [DATE]. -Brief Interview of Mental Status (BIMS) was scored as 13. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required extensive assistance with toileting, bathing, dressing, hygiene, bed mobility, and transfers. -was at risk of developing a pressure ulcer. -had 2 venous ulcers. Record review of Resident 2's Electronic Health Record (EHR) under the section census revealed Resident 2 was at the hospital from [DATE] to 03-04-2026. Record review of Resident 2's Transition Orders and Information for the Continuation of Patient Care (TOIPC) dated 03-04-2026 revealed Resident 2 had undergone a left Below the Knee Amputation (BKA) and had a Peripherally Inserted Central Catheter (PICC) placed to receive antibiotics for a Methicillin Resistant Staph Aureus (MRSA) infection and had two open wounds on both the right and left buttocks, an incision to the left BKA site, unstageable pressure ulcers to the right lateral ankle, the right lateral foot, the right lateral 5th toe, and the right heel. Record review of Resident 2's Comprehensive Care Plan (CCP) dated 03-17-2026 revealed the absence of Resident 2's left BKA, the MRSA infection, and the use of Intravenous (IV) antibiotics. An interview conducted with the MDS Coordinator (MDSC) on 03-18-2026 at 1:00 PM confirmed Resident 2's care plan had not been revised to reflect the care and services for a resistant infection, the need for IV medications, a new BKA site and pressure ulcers to the right foot and ankle and should have been.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident?s preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.09 Based on interview and record review, the facility failed to evaluate weight changes according to practitioner orders and failed to monitor and provide ongoing PICC line care for 1 (Resident 2) of 1 residents sampled. The facility census was 115. The findings are:A.Record review of the facility's undated policy titled Overview of Infusion Therapy revealed for a Peripherally Inserted Central Catheter (PICC) the patient's upper arm circumference is measured on insertion, admission to the facility and whenever clinically indicated. The external catheter length is measured on admission and weekly to monitor for outward migration of the catheter. B.Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 01-04-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-Brief Interview of Mental Status (BIMS) was scored as 13. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required extensive assistance with toileting, bathing, dressing, hygiene, bed mobility, and transfers. -was at risk of developing a pressure ulcer.-had 2 venous ulcers. Record review of Resident 2's Order Summary (OS) printed on 03-16-2026 revealed an order dated 03-06-2026 for a PICC line dressing change every 7 days while on Intravenous (IV) antibiotics. Record review of Resident 2's OS printed on 03-16-2026 revealed the absence of orders to change the caps of the PICC line and to measure the external length of the catheter. An interview conducted with the Wound and Infection Nurse (WIN) on 03-18-2026 confirmed Resident 2 did not have orders for PICC line cap changes and measure the external length of the catheter weekly and should have. C. Record review of Resident 2's OS printed on 03-16-2026 revealed an order for daily weights, notify provider if gained more than 3 to 5 pounds (lb) in a week. Record review of Resident 2's Electronic Health Record (EHR) under the section weights and vitals revealed on 03-09-2026 Resident 2 weighed 133.9 lbs and on 03-10-2026 Resident 2 weighed 152 lbs for a gain of 18.1 lbs. An interview conducted with Assistant Director of Nursing (ADON) B on 03-17-2026 at 2:30 PM confirmed the facility did not monitor Resident 2's weight changes and did not inform the provider of the weight gain and should have.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1) and 12-006.09(H)(iii)(2). 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 2 (Resident 2 and 3) of 2 residents sampled. The facility census was 115. Findings are:A.Record review of the facility's policy titled Skin and Wound Management dated 01-2024 revealed the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. In addition, the nurse shall describe, document and report the following:-a full assessment of the pressure ulcer including location, length, width and depth, presence of exudate or necrotic (dead) tissue. Under the section Treatment and Management the physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. Under the section Monitoring the staff are to evaluate, report and document potential changes in the skin and review the interventions and strategies for effectiveness on an ongoing basis. B. Record review of the Matrix ALAL Mattress System quick reference guide revealed instructions to calibrate the mattress to the patient's body weight using 35-pound (lb) increments. C.Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 01-04-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-Brief Interview of Mental Status (BIMS) was scored as 13. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -Required extensive assistance with toileting, bathing, dressing, hygiene, bed mobility, and transfers,-was at risk of developing a pressure ulcer,-had 2 venous ulcers. Record review of Resident 2's Electronic Health Record (EHR) under the section census revealed Resident 2 was at the hospital from [DATE] to 03-04-2026. Record review of Resident 2's Hospital Wound Ostomy Nurse Consult (HWNC) dated 02-26-2026 revealed the following:-an unstageable pressure ulcer to the right lateral ankle measuring 2.0 centimeters (cm) in length and 2.5 cm in width that was black and brown in color.-an unstageable pressure ulcer to the right lateral foot measuring 3.5 cm in length and 6.0 cm in width, that was black and brown in color.-an unstageable pressure ulcer to the right 5th toe measuring 3.0 cm in length and 2.5 cm in width, that was black and brown in color.-a pressure ulcer to the right heel that was 5.0 cm in length and 7.0 cm in width that was red in color and non-blanchable (a skin condition where red, purple, or brown spots do not fade or turn white when pressed) and was questionable if the wound was a stage 1 pressure ulcer (According to the MDS Manual a stage 1 is an early, reversible sign of skin damage over a bony prominence, characterized by intact skin with non-blanchable redness) or a deep tissue injury (DTI: a serious, often rapidly evolving wound caused by intense/prolonged pressure or shear). Record review of Resident 2's Transition Orders and Information for the Continuation of Patient Care (TOIPC) dated 03-04-2026 revealed Resident 2 had two open wounds on both the right and left buttocks, an incision to the left below the knee amputation (BKA) site, an unstageable pressure ulcers to the right lateral ankle, the right lateral foot, the right lateral 5th toe, and the right heel. Record review of Resident 2's readmission assessment dated [DATE] under the section skin conditions revealed Resident 2 had unmeasured pressure ulcers to the right outer ankle, right lateral foot and the right 5th toe. Record review of Resident 2's Order Summary (OS) printed on 03-16-2026 revealed the absence of orders for the treatment of the unstageable pressure ulcers on the right lateral ankle, the right heel, the right lateral foot, the right lateral 5th toe. Record review of Resident 2's Treatment Administration Record for March of 2026 revealed no evidence of a treatment for Resident 2's unstageable pressure ulcers. Record review of Resident 2's Skin/Wound Weekly Observation (SWWO) dated 03-11-2026 revealed Resident 2 had Maceration Associated Skin Damage (MASD) to the right and left buttocks and a diabetic wound to the left outer ankle and no mention of the left BKA site or wounds to the right foot and ankle. An observation (continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>conducted on 03-17-2026 at 2:30 PM with the Wound and Infection Nurse (WIN) and Assistant Director of Nursing (ADON) B assessing Resident 2's wounds to the right foot and ankle revealed the following pressure ulcers:-A denuded area to the top of the right foot measuring 4 cm in length and 5 cm in width.-Right lateral ankle black area measuring 2 cm in length and 2 cm in width.-Right heel a black area measuring 5 cm in length and 7 cm in width.-Black skin in between all 5 toes.-Right lateral 5th black area measuring 2 cm in length and 2 cm in width.-Right anterior ankle black area measuring 2 cm in length and 2 cm in width. An interview with the WIN on 03-18-2026 at 2:20 PM confirmed the pressure ulcers to the right foot had not been treated from 03-04-2026 to 03-17-2026 for a total of 13 days. D.Record review of Resident 3's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE]-had a diagnosis of mononeuropathies of the bilateral lower limbs (damage affecting single nerves in both leg simultaneously causing weakness, numbness and pain).-BIMS was scored at 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -Required limited assistance with bed mobility and upper body dressing,-required total assistance with toileting, bathing, lower body dressing, and transfers,-was at risk of developing a pressure ulcer,-had no pressure ulcers,-weight was 145 lbs. Record review of Resident 3's Comprehensive Care Plan (CCP) dated 01-19-2026 revealed Resident 3 had an actual impairment of skin integrity related to fragile skin, impaired mobility, incontinence and malnutrition. The goal was Resident 3 would maintain intact skin. The interventions listed were:-avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short.-Educate resident, family and caregivers of causative factors and measures to prevent skin injury,-keep skin clean and dry. Use lotion on dry skin,-pressure reducing cushion to wheelchair,-pressure reducing mattress in place,-use caution during transfers and bed mobility to prevent injury. Record review of Resident 3's SWWO dated 01-30-2026 revealed Resident 3 had a DTI to the right heel measuring 3.9 cm in length and 4.2 cm in width and a DTI to the left heel measuring 4.4 cm in length by 3.9 cm in width. A new intervention that was listed was a new treatment order for skin prep to both heels. Record review of Resident 3's CCP dated 01-19-2026 revealed no new interventions on or after 01-30-2026 for Resident 3's pressure ulcers to the bilateral heels. Record review of Resident 3's Treatment Administration Record (TAR) for January 2026 revealed no new treatment initiated for the pressure ulcers to the bilateral heels. Record review of Resident 3's TAR for February 2026 revealed the following order dated 02-02-2026 for Resident 3's pressure ulcers to the bilateral heels:-wash with facility cleanser and pat dry,-paint entire heel with skin prep and allow to dry,-may leave open to air,-protect heels at all times with Prevalon boots (a specialized medical device designed to prevent heel pressure ulcers by floating the heel, providing total offloading and maintaining a neutral 90-degree foot position), offloading or floating. Record review of Resident 3's SWWO dated 03-12-2026 revealed Resident 3 had a new unstageable pressure ulcer to the right bottom foot measuring 1.8 cm in length and 2.1 cm in width that was 100% covered with eschar (dead skin). Record review of Resident 3's CCP printed on 03-16-2026 revealed no new interventions on or after 03-12-2026 for the pressure area to the bottom of the right foot. Record review of Resident 3's OS printed on 03-16-2026 revealed the absence of an order for treatment of the right bottom foot. Record review of Resident 3's TAR for March 2026 revealed the absence of treatment for the right bottom foot. Observation on 03-16-2026 at 11:00 AM revealed Resident 3 was lying in bed on an air mattress set at 8 which equals 315 lbs. and wearing green heel protectors (a heel boot that pads the heel and ankle and does not float the heel). Observation on 03-17-2026 at 6:00 AM revealed Resident 3 was lying on the back in bed on an air mattress set at 8 with green heel protectors on bilateral feet. Observation on 03-17-2026 at 8:05 AM revealed Resident 3 was in bed with the Head of Bed (HOB) elevated on an air mattress set at 8 and green heel protectors to bilateral feet. Observation on 03-17-2026 at 9:30 AM with Licensed Practical Nurse (LPN) C providing wound care revealed Resident 3 had the following pressure ulcers:-left heel measuring 4 cm in length and 5.5 cm in width that was black in color.-right heel measuring 7 cm in length and 7 cm in width that was black in color.-right medial bottom foot (continued on next page)</p>		

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F 0686  Level of Harm - Actual harm  Residents Affected - Few	measuring 3 cm in length and 3 cm in width that was black in color.-right lateral foot was a non-blanchable dark pink/purple area measuring 3 cm in length and 2 cm in width. An interview conducted with LPN C on 03-17-2026 at 10:00 AM confirmed the green heel protectors did not provide protection for the entire foot and the heel protector to the left foot had moved up the foot and was not relieving pressure to the wound to the left heel. An interview conducted with the WIN on 03-17-2026 at 11:00 AM confirmed Resident 3 was to be wearing Prevalon boots to both feet, not the green heel protectors. An interview conducted with LPN C on 03-17-2026 at 11:30 AM confirmed a setting of 8 would be correct for a patient weighing 315 lbs and could cause more pressure for Resident 3 who weighed 145 lbs. An interview with ADON A on 03-18-2026 at 10:30 AM confirmed the air mattress had not been set up correctly for Resident 3. ADON A confirmed that the correct air mattress setting for Resident 3 should be a 3. ADON A further confirmed that Resident 3 was not receiving treatment to the right bottom foot as ordered. An interview with the WIN on 03-18-2026 at 2:20 PM confirmed the treatment order for Resident 3's right bottom foot was not transcribed onto the TAR to ensure the treatment was performed.		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure reference: 12-006.12(D)(i)Based on observation, interview and record review, the facility failed to ensure medication was stored securely in accordance with facility policy for 2 [Resident 2 and 3] of 6 residents. The facility had a total census of 115 residents. Findings are:A.</p> <p>A review of facility policy revised 8/2024 and titled Centralized medication storage in the long-term care facility revealed the following policy:</p> <p>-Medications are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier, and in accordance with federal and state laws and regulations. The medication supply is accessible only to authorized personnel.</p> <p>B.</p> <p>Observations on 3/17/26 at 8:14 AM revealed a container of Gavilyte-G solution [laxative] with pharmacy label for Resident 3 located on the bathroom sink in Resident 3's bathroom. The container had approximately 1 inch of solution in the bottom.</p> <p>In an interview on 3/16/26 at 10:47 AM, Wound and Infection Nurse confirmed that the Gavilyte-G container should not be stored on Resident 3's bathroom sink.</p> <p>C.</p> <p>Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 01-04-2026 revealed the facility staff assessed the following about the resident:</p> <p>-admitted to the facility on [DATE].</p> <p>-Brief Interview of Mental Status (BIMS) was scored as 13. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact.</p> <p>-required extensive assistance with toileting, bathing, dressing, hygiene, bed mobility, and transfers.</p> <p>-was at risk of developing a pressure ulcer.</p> <p>-had 2 venous ulcers.</p> <p>An observation conducted on 03-16-2026 revealed a clear plastic bag containing medications including furosemide, pantoprazole, carvedilol, Entresto, aspirin, and a lantus insulin pen and the dresser in Resident 2's room.</p> <p>An interview conducted on 03-16-2026 with Licensed Practical Nurse (LPN) D confirmed the medications were sitting on the dresser in Resident 2's room and confirmed the medications are to be kept locked up.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Licensure reference: 12-006.11(E)Based on observations, interviews, and record review, the facility failed to ensure temperatures of food on the steam table were hot enough to protect from potential food borne illness. This has the potential to affect 40 of 41 residents residing on the second floor of the facility. Findings are:Observations on second floor at 3/16/26 between 11:58 AM-12:02 PM revealed the lunch food arrived on the floor at 11:58 AM inside a heated cart. The BBQ pork was taken from the cart and placed in the steam table and the temperature was measured as 125 F [Fahrenheit] by [NAME] F.A review of second floor Daily Food Temperature log for lunch 3/16/26 revealed meat entree temperature was recorded as 125 F.In an interview on 3/16/26 at 12:02 PM, Food Service Director reported pork had been cooked and BBQ sauce added. The Food Service Director reported that the sauce had been cold when added to the cooked pork. The Food Service Director reported that the initial cooked pork temperature on the steam table should be 165 F.Observations at 3/16/26 at 12:17 PM revealed temperature of BBQ pork was measured by Food Service Director using a different thermometer and was measured at 133 F.Observations on 3/16/26 at 12:39 PM of [NAME] F taking temperatures, end of meal service, revealed the BBQ pork was 137.3 F and the pork without sauce was 119 F. In an interview on 3/17/26 at 6:14 AM, the Food Service Director reported steam table wells had been cleaned last evening to try to improve the temperature in the heating wells.A review of undated Daily Food Temperature Form revealed the following Standard Operation Procedures:- The temperatures of food items will be taken and properly recorded at the beginning and end of each meal. The steam table is utilized as a holding/serving unit and not a warming or cooking unit. Food can be placed in the steam table no longer than 15 minutes prior to serving. Temperatures for hot food must be above 135 degrees F. If any food should drop below this temperature it must be brought back up to 165 degrees F. for a minimum of 15 seconds prior to serving. Review of the 2022 U.S. Food and Drug Administration Food Code revealed food shall be held at 135 degrees F or above except during preparation, cooking, or cooling.</p>		

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  03/18/2026
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.18(B) Based on observation, interview and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP) during wound care for 1 (Resident 2) of 2 residents sampled. The facility census was 115. The findings are:A.Record review of the facility policy titled Enhanced Barrier Precautions (EBP) dated 01-2024 revealed EBP are infection control interventions designed to reduce the transmission of resistant organisms that employs targeted gown and glove use during high contact activities. EBP may be indicated for residents with any of the following: -wounds, or indwelling medical devices regardless of Multi-Drug Resistant Organism (MDRO) colonization status, -residents known to be infected or colonized with an MDRO;will be placed on EBP and signage on the door placed. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident activities:-dressing-bathing/showering-providing hygiene-changing linens-changing briefs or assisting with toileting-device care or use such as a central line, urinary catheter, or feeding tube-wound care: any opening requiring a dressing. B.Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 01-04-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-Brief Interview of Mental Status (BIMS) was scored as 13. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required extensive assistance with toileting, bathing, dressing, hygiene, bed mobility, and transfers. -was at risk of developing a pressure ulcer.-had 2 venous ulcers. Record review of Resident 2's Electronic Health Record (EHR) under the section census revealed Resident 2 was at the hospital from [DATE] to 03-04-2026. Record review of Resident 2's Transition Orders and Information for the Continuation of Patient Care (TOIPC) dated 03-04-2026 revealed Resident 2 had two open wounds on both the right and left buttocks, an incision to the left below the knee amputation (BKA) site, unstageable pressure ulcers to the right lateral ankle, the right lateral foot, the right lateral 5th toe, and the right heel, had a Peripherally Inserted Central Line (PICC) to the right upper arm, and had an active Methicillin Resistant Staph Aureus (MRSA: an MDRO) infection. An observation conducted on 03-16-2026 at 2:00 PM revealed Resident 2 was in (gender) room and there was no EBP sign on the door to the room and there were no gowns inside or outside of the room for the staff to use. An observation conducted on 03-17-2026 at 2:15 PM of Licensed Practical Nurse (LPN) D providing wound care to Resident 2 revealed the use of gloves and the lack of use of a gown. An interview conducted with LPN D on 03-17-2026 at 3:10 PM confirmed EBP was not utilized during wound care and should have been.</p>		