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	03/24/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H) Based on record review and interview, the facility failed to include enough information to ensure a thorough investigation had been completed into an injury for 1 (Resident 1) of 3 reviewed with an injury. The facility census was 115. Findings are:A. Record review of a facility policy entitled Accidents and Incidents dated 1/2024 revealed the following information: Incident report, investigation and follow-up protocol:1. The facility strives to ensure residents will not experience undue discomfort and / or have their health and safety placed in jeopardy due to an unusual occurrence (accident / incident).2. The facility defines an accident / incident as an event, occurrence or happening that may produce an actual or potential undesirable outcome.3. The event may be an accident or a situation that could result in an accident. Accidents may include, but are not limited to, the following:- Falls / suspected falls- Injuries of unknown origin4. Should an accident / injury occur, the facility strives to prevent such an occurrence from happening again.5. A thorough investigation and follow-up will be completed within 5 working days. A summary of the accident / incident will be documented. B. Record review of a facility policy entitled Abuse, Neglect, Misappropriation dated 1/2024 revealed the following information: Definition: Serious Bodily injury means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of function of a bodily member, organ or mental faculty; requiring medical intervention such a surgery, hospitalization or physical rehabilitation. 7. Investigation of alleged abuse, neglect and exploitation: When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect and exploitation occur, an investigation is immediately warranted. Once the resident is cared for and the initial reporting has occurred, an investigation should be conducted. Components of an investigation may include: a. Interview the residents involved if possible and document the responses. c. Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area and visitors in the area. Obtain witness statements, all should be signed and dated by the person making the statement. D. Document the investigation chronologically. 13. In response to allegations of abuse, neglect, exploitation, or mistreatment; the facility must:b. Have evidence that alleged violations are thoroughly investigated. C. Record review of a facility investigation report dated 3/12/26 for Resident 1 revealed the facility reported an injury to the required state agencies. The following information was not included in the facility investigation report to ensure a thorough investigation had been completed into Resident 1's injury:- No interview statements from Resident 1 or facility staff.- No care planned interventions related to falls with injury.- No progress notes related to the residents falls while at the facility.- No fall data collection reports related to the residents falls while at the facility.- No hospital records related to Resident 1's condition prior to admission to the facility.- No hospital records related to resident 1's condition after admission to the hospital on 3/6/26. - No interventions that were in place prior to Resident 1's falls in the facility or planned interventions to prevent further falls or injury. D. Record review of Resident 1's admission Face Sheet dated 3/23/26 revealed Resident 1 was admitted on [DATE] with diagnoses that included: Orthopedic aftercare, Parkinsonism, fall on same level, fracture of lumbar [lower back] vertebra, spinal stenosis, Spondylosis [degeneration of the vertebral column], lumbar region fusion of (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the spine, Dorsalgia [mid-section back pain], anxiety disorder, and repeated falls. Record review of Resident 1's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 2/24/26 revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 13 [a score of 13-15 indicated intact cognition]. The MDS identified that Resident 1 was independent with self-care, mobility and stairs prior to admission to the facility. The MDS identified, after admission to the facility, Resident 1 required partial to moderate assist with upper and lower body dressing, putting on and taking off footwear, sit to stand transfers, chair to bed transfers, toilet transfers and walking 10 - 50 feet. The MDS identified that Resident 1 had falls prior to admission, had a fracture related to a fall in the 6 months prior to admission, and had 2 or more falls since admission, 1 with injury (not major), and none with major injury. Record review of a Hospital Consultation report dated 2/10/26 for Resident 1, prior to admission to the facility, revealed that Resident 1 had a L1 vertebral body fracture [spine] with subsequent spinal fusion [surgery that joins 2 or more vertebrae] completed on 2/10/26. Record review of Resident 1's Progress Notes revealed that Resident 1 was sent to the hospital on 3/6/26 for evaluation and returned to the facility on 3/10/26. Record review of Resident 1's hospital History and Physical dated 3/6/26 revealed a new L3 compression fracture. This was confirmed with a Computed Axial Tomography Scan [CT, a medical imaging scan used to obtain detailed internal images of the body] of the spine on 3/6/26 which revealed the following: 1. Acute fracture of the L3 vertebral body involving the anterior cortex, superior endplate, posterior cortex, bilateral pedicles, and left base of transverse process. Fractures extend along the course of both pedicle screws. Mild associated compression and mild retropulsion into the spinal canal. At least moderate spinal canal narrowing at L2-L3, metal artifact makes evaluation difficult. 2. Subacute nondisplaced fracture of the right transverse process of the L1 vertebral body similar to prior. Record review of Resident 1's Fall Data Collection reports revealed that Resident 1 had falls while in the facility on 2/19/26, 2/20/26, 2/24/26 and 3/12/26. Record review of the fall Data Collection reports for falls that had occurred on 2/20/26, 2/24/26 revealed that no injury had occurred with these falls that required hospitalization. The fall on 2/19/26 resulted in a raised area on the middle lower back and Resident 1 was sent to the hospital for evaluation. The fall on 3/12/26 resulted in Resident 1's request to be sent to the emergency room for evaluation after complaints of back pain. Interview on 3/23/26 at 2:29 PM with the Director of Nursing [DON] revealed the injury for Resident 1 was reported because it wasn't clear if the fracture happened at the facility or before admission. The DON confirmed that a Abuse, Neglect and Misappropriation Report had been completed and sent to the required State Agencies for Resident 1's injury. The DON confirmed that no other resident records were sent as a part of the facility investigation. The DON confirmed [gender] did not send any hospital records, progress notes related to Resident 1's falls, Resident 1's care plan or any other items. The DON confirmed that interviews were completed with staff, but these were not documented so were not sent as a part of the facility investigation information. The DON confirmed that the hospital records were not sent as a part of the facility investigation. The DON confirmed that the investigation was not thorough and other supporting documentation should have been a part of the investigation and sent in with the facility self-report. The DON confirmed that this was not done and should have been to ensure the investigation was thorough.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I) Based on observations, interviews and record reviews, the facility failed to ensure interventions (what was put in place to prevent it from happening again) were implemented for falls on 2 (Resident 3 and 4) of 3 sampled residents. The facility census was 115. Findings are:A record review of the facility's Falls Management policy with a revision date of 1/2024 revealed the following: Fall Injury Prevention - Post Fall 1. Assess the resident/patient and immediately implement appropriate measures to prevent injury. a. EX. Wipe up spills, improve lightening [sp], call light in reach, appropriate footwear. b. Document in medical record 2. Initiate and complete the Incident Event documentation including pertinent witness statements 3. Review Fall Risk Assessment for any changes in fall risk, reassess post fall. 4. Review and Revise Pain Assessment. 5. Discuss findings and interventions with the resident/patient/family for inclusion in the Interdisciplinary Plan of Care (IPOC). 6. Adjust/add interventions on the Plan of Care- Fall Risk Reduction. 7. Present resident/patient at the next scheduled IPOCC meeting: a. Review current assessment and reports. b. Compare data from previous assessments. c. Discuss identified trends or potential new risk factors. 8. Update and communicate interventions. 9. Provide appropriate training for caregivers, noting any changes implemented. 10. Educate resident /patient/family, as appropriate. 11. Verify completion of the Accident/Incident Documentation Process. 12. Verify referral to therapy for screen. A. A record review of Resident 3's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's capabilities and helps nursing home staff identify health problems) dated 1/20/26 identified the facility admitted the resident on 1/14/26 with diagnosis of Aphasia (a neurological disorder caused by brain damage commonly from a stroke or injury that impairs a persons ability to process, understand and speak, read or write language), Cerebrovascular Accident (a medical emergency caused by a sudden interruption of blood flow to the brain or a ruptured blood vessel), Non-Alzheimer's Dementia (a neurodegenerative or vascular condition causing cognitive decline), Hemiplegia of left non-dominant side(a form of paralysis affecting one side of the body), Anxiety Disorder, Depression, and Bipolar Disorder with a Brief Interview for Mental Status (BIM's, used to measure cognitive impairment I nursing home residents, categorized as 0-7 as severely impaired, 8-12 as moderately impaired and 13-15 as cognitively intact) of 14 requiring partial to moderate assistance for sitting to standing and chair to bed to chair transfers. A record review of Resident 3's Nursing admission Data Collection V-2 section 8. Fall Risk Letter K dated 1/14/26 identified Resident 3 at risk for falls. A record review of a form identified as the Fall Data Collection revealed Resident 3 had a non-injury fall on 1/15/26 at 9:50 AM with the initial intervention that was implemented to prevent reoccurrence Staff reminded on precautions when using assistive devices. A record review of a form identified as the Fall Data Collection revealed Resident 3 had a non-injury fall on 1/17/26 at 2:20 PM with the initial intervention that was implemented to prevent reoccurrence Educated to use call light for assistance. A record review of a facility self reported accident dated 1/30/26 revealed Resident 3 had a fall resulting in a Left Humerus Fracture with fall interventions listed as 1/15/26- Education provided to resident to use call light when assistance is needed, 1/17/26 -Call, Don't fall sign placed in room. Intervention noted for 1/27/26 fall noted as Educated staff on anticipating needs ahead of time. A record review of a form identified as the Fall Data Collection revealed Resident 3 had a non-injury fall on 2/7/26 at 7:10 PM with the initial intervention that was implemented to prevent reoccurrence was use of dysem (dycem-a nonslip product specially designed to address stabilization and gripping problems found around the home, in care homes and in hospitals) in wheelchair to prevent slipping A record review of the EMR revealed Resident 3 had a non-injury fall noted on 3/8/26 initial intervention that was implemented to prevent reoccurrence as N/A (not applicable) A record review of the Care Plan Report (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiated 1/14/26 revealed a Focus of The resident is at risk for falls related to weakness, impaired mobility, hemiplegia or hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non dominant side, history of falls prior to admission and a goal of The resident will not sustain serious injury through the review date of 4/14/26. Interventions/Tasks listed were1/15/26 Education provided to use call light when assistance is needed.1/17/26 Call, Don't fall sign placed1/27/26 Education provided to staff on anticipating needs of resident ahead of time.2/8/26 Dycem pad placed in wheelchairPT (Physical Therapy)/OT (Occupational Therapy) to eval and treat if indicatedThe residents' safety insight is poor at this time, staff will conduct routine visual rounding per routine care task to determine additional safety queuing. A record review of the Visual/Bedside Kardex Report with an As of date of 3/24/26 with a section listed *Safety revealed *2/8/26: Dycem pad placed in wheelchair. An observation of Resident 3's on 3/24/26 at 8:08 AM revealed no residents were present in the room, and there was not a Call, Don't Fall sign in bedroom or bathroom. An observation of Resident 3 on 3/24/26 at 9:30 AM revealed the resident lying in bed with call light within reach. Dycem pad noted under cushion in w/c. There was no sign present in bedroom or bathroom stating Call, Don't Fall. An interview with Nurse Aide (NA) C on 3/24/26 at 10:20 AM revealed they had a pocket report sheet with the residents in their care listed and had received a verbal report from the previous shift but was unaware of any specific fall interventions for Resident 3. An interview with Licensed Practical Nurse (LPN) A on 3/24/26 at 10:25 AM confirmed there was not a Call, Don't Fall sign present in Resident 3's bedroom or bathroom. B. A record review of resident 4's Quarterly MDS dated [DATE] identified the facility readmitted the resident on 12/23/25 with diagnosis of End Stage Renal Disease(ESRD), Cerebrovascular Accident (CVA), acquired absence of left leg below the knee with a BIM's of 11 indicating moderate cognitive impairment. A record review of Point of Care documentation ADL (Activities of Daily Living)-transferring dated 2/23/26 to 3/24/26 revealed Resident 4 usually required substantial/maximal assistance or was dependent on staff to complete all of the effort to complete the activity. A record review A record review of a form identified as the Fall Data Collection revealed Resident 4 had a non-injury fall on 3/12/26 at 10:10 PM with the initial intervention that was implemented to prevent reoccurrence as Encouraged resident to call and ask for help when items are out of reach or too low for her to obtain A record review A record review of a form identified as the Fall Data Collection revealed Resident 4 had a non-injury fall on 3/13/26 at 3:20 AM with the initial intervention that was implemented to prevent reoccurrence as Lowered bed all the way to the floor-will discuss with Assistant Director of Nursing (ADON) about fall mat A record review A record review of a form identified as the Fall Data Collection revealed Resident 4 had a non-injury fall on 3/17/26 at 10:00 PM with the initial intervention that was implemented to prevent reoccurrence as Rubber amt to place under resident to prevent slipping A record review of the Care Plan Report initiated 9/10/24 revealed a Focus of The resident is at risk for falls related to generalized weakness, impaired mobility, Encephalopathy, Left Below Knee Amputation (BKA) ESRD, Anemia, CVA, takes psychotropic medication and a goal of The resident will not sustain serious injury through the review date of 6/18/26. Interventions/Tasks listed were12/10/24: Dycem placed in wheelchair-initiated 12/11/2024Ensure bed is at appropriate height-initiated 3/28/2025Floor matt placed next to bed-initiated 10/22/2025PT/OT to eval and treat if indicatedThe residents' safety insight is poor at this time; staff will conduct routine visual rounding per routine care task to determine additional safety queuing. A record review of the Visual/Bedside Kardex Report with an As of date of 3/24/26 with a section listed *Safety revealed*12/10/24: Dycem placed in wheelchair* Ensure bed is at appropriate height*floor mat placed on floor next to bed An observation of Resident 4 on 3/24/26 at 8:05 AM revealed Resident 4 was in bed sleeping, a blue mat was propped against the wall next to the dresser. An observation of Resident 4 on 3/24/26 at 9:15 AM revealed Resident sitting up in bed, a blue mat was propped against the wall next to the dresser. An interview with NA B on 3/24/26 at 9:18 AM revealed that NA B was unsure of Resident 4's fall interventions and would need to ask the ADON. An interview with NA B on 3/24/26 at 9:41 AM confirmed the fall mat had not been on the floor next to the bed.