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	04/09/2026

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 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 Number 175 NAC 12-006.04(F)(i)(5). Based on interview and record review the facility failed to update the resident's representative of changes in condition for 1(Resident 3) of 3 residents sampled. The facility census was 117. The findings are:A.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. The resident and/or resident representative will be educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. 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. Requirements for notification of resident, the resident representative, and their physician:-an accident involving the resident, which results in injuiry and has the potential for requiring physician intervention.-a significant change in the resident's physical, mental or psychosocial status in either life-threatening conditions or clinical complications.-a need to alter treatment significantly such as a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. Notification is provided to residents and/or resident representatives to promote the resident's right to make choices about care and treatment and to keep them informed of the resident's current health status. B.Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-had diagnosis of Diabetes Mellitus type 2. -Brief Interview of Mental Status (BIMS) was scored as a 6. According to the MDS Manual a score of 0-7 indicates severe cognitive impairment.- required substantial assistance with upper body dressing, and bed mobility.-required total assistance with toileting, bathing, lower body dressing and transfers.Record review of Resident 3's Progress Notes (PN) dated 12-13-2025 revealed Resident 3 had fallen at 6:15 AM and 7:20 AM and had been sent to the hospital for evaluation. The progress note did not indicate Resident 3's representative had been notified of the falls or being sent to the hospital. Record review of Resident 3's Dietary Progress Notes (DPN) dated 03-11-2026 revealed Resident 3 had lost 68 lbs which was a 28% weight loss in 30 days which was a significant weight loss. The progress notes did not indicate Resident 3's representative had been notified of the significant weight loss. An interview conducted with the Assistant Director of Nursing (ADON) on 04-08-2026 at 10:30 AM confirmed Resident 3's representative had not been notified of the 2 falls on 12-13-2025 with transfer to the hospital or the significant weight loss identified on 03-11-2026 and should have been.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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)(i)(1). Based on interview and record review the facility failed to implement interventions to prevent a significant injury for 1 (Resident 6) of 3 residents sampled and failed to investigate and implement interventions for falls for 1(Resident 3) of 3 residents sampled. The facility census was 117. The findings are:A.Record review of the facility's policy titled Accidents and Incidents reveals the facility strives to ensure that residents/patients, visitors, and/or volunteers will not experience undue discomfort and/or have their health and safety placed in jeopardy due to an unusual occurrence (accident/incident). The facility defines an accident/incident as an event, occurrence, or happening that may produce an actual or potential undesirable outcome. Should an accident occur facility strives to prevent such an occurrence from happening again. A thorough investigation and follow-up will be completed within 5 working days. B. Record review of Resident 6's admission Notification E-mail (ANE) dated 03-25-2026 revealed Resident 6 was admitted to the facility on [DATE] and Resident 6 had a diagnosis of dementia and required moderate to maximum assistance of 2 for function and mobility. Record review of a After Visit summary with a date of 3/25/2026 revealed the under the section identified as Activity Instructions revealed the instructions as follows:-Activity as tolerated.-Up with assistance, gait belt, walker and 2 people assisting. Record review of Resident 6's Nursing admission Data Collection (NADC) dated 03-25-2026 revealed the following about the resident:-admitted to the facility on [DATE].-Was alert and oriented to self only. -Had limited range of motion and weakness in all four extremities.-Had poor muscle control and balance. -Was dependent on 2 assistants for transfers. -Had a recent change in cognitive status within the last 90 days.-Vision was severely impaired. Record review of Resident 6's Baseline Care Plan (BCP) dated 03-26-2026 printed 04-06-2026 revealed Resident 6 had a functional deficit with current Activities of Daily Living (ADL) and the goal was Resident 6 would maintain current level of ADL function. The interventions listed included assistance with ambulation, bed mobility, wheelchair mobility and transfers but did not indicate how much assistance was to be provided. The BCP revealed Resident 6 was at risk for falls and the goal was Resident 6 would not sustain a serious injury. The interventions listed were Physical Therapy (PT) and Occupational Therapy (OT) to evaluate and treat if indicated and Resident 6's safety insight was poor at this time and staff are to conduct routine visual rounding to determine additional safety queuing.Record review of Resident 6's Visual/Bedside Kardex printed on 04-06-2026 revealed no instruction on how much assistance Resident 6 required with ambulation, bed mobility, wheelchair mobility, or transfers. Record review of Resident 6's Progress Notes (PN) dated 04-05-2026 revealed Resident 6's left foot was extremely swollen, discolored and painful and the left knee was rotated inward and Resident 6 was sent to the hospital emergency room for evaluation. Record review of Resident 6's Hospital Orthopedic Physician Consult Note (HOPCN) dated 04-05-2026 revealed Resident 6 had a left total hip dislocation. An interview conducted on 04-06-2026 at 2:40 PM with Nursing Assistant (NA) E revealed Resident 6 was a pivot transfer and it helps if you have a second person. An interview conducted on 04-07-2026 at 5:45 AM with NA D revealed NA D had worked with Resident 6 on the shift prior to being sent to the hospital on [DATE] and NA D had transferred Resident 6 that morning alone. An interview conducted on 04-07-2026 at 11:50 AM with NA C revealed NA C always transferred Resident 6 with the assistance of 2 staff, one day it took 2 to 3 of us to transfer Resident 6. An interview conducted on 04-07-2026 at 12:00 PM with the Director of Nursing (DON) revealed the staff refer to the Visual Bedside Kardex for information on how residents are to be transferred. An interview conducted on 04-07-2026 at 12:50 AM with the Assistant Director of Nursing (ADON) revealed if a resident transfer status was maximum assistance of 1 and the resident had a diagnosis of dementia the expectation is that staff transfer with 2 assist.An interview conducted on 04-09-2026 at 7:15 AM with the DON (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	confirmed Resident 6 was a maximum assist of 2-3 people for transfers, the visual/bedside Kardex had not been completed and Resident 6's transfer status had not been identified on the Kardex prior to 04-05-2026 when Resident 6 was found to have a dislocated left hip and should have.C. Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-had diagnosis of Diabetes Mellitus type 2. -Brief Interview of Mental Status (BIMS) was scored as a 6. According to the MDS Manual a score of 0-7 indicates severe cognitive impairment.-required substantial assistance with upper body dressing, and bed mobility.-required total assistance with toileting, bathing, lower body dressing and transfers.Record review of Resident 3's Comprehensive Care Plan (CCP) dated 12-12-2025 revealed Resident 3 was at risk for falls related to weakness, impaired mobility, diabetes and psychotropic medications, the goal was Resident 3 would not sustain serious injury through the review date. Interventions listed were Physical and Occupational therapy to evaluate and treat and resident's safety insight is poor, and staff will conduct routine visual rounding to determine additional safety queuing. Record review of Resident 3's Progress Notes (PN) dated 12-13-2025 revealed Resident 3 had fallen at 6:15 AM and 7:20 AM and had been sent to the hospital for evaluation.Record review of Resident 3's CCP revealed no additional fall interventions were implemented after the falls on 12-13-2026.Record review of Resident 3's Electronic Health Record (EHR) including forms, evaluations and progress notes revealed no fall evaluation dated 12-13-2025 and no new intervention to prevent further falls. An interview conducted with the ADON on 04-08-2026 at 10:30 AM confirmed Resident 3's falls on 12-13-2025 were not investigated, and new interventions were not implemented and should have been.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 12-006.09(J)(i)(1). Based on observation, interview and record review the facility failed to accurately record meal intakes, implement interventions to prevent a significant weight loss, and failed to implement practitioner orders to ensure adequate nutrition after a bariatric surgery for 1 (Resident 3) of 1 residents sampled. The facility census was 117. The findings are: A. Record review of the facility policy titled Weight Monitoring dated 10-06-2025 revealed based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this not possible or resident preferences indicate otherwise. Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. Weight analysis will be completed by the Registered Dietician or designee. A significant change in weight is defined as: 5% change in weight in 1 month, 7.5 % change in weight in 3 months, and 10% change in weight in 6 months. The interdisciplinary team including the Registered Dietician, Dietary Manager, Activities, Social Work and Nursing meets weekly for a Nutrition meeting. The Registered Dietician or Dietary Manager should assist with interventions, and actions are to be recorded in the nutrition progress notes. The Interdisciplinary plan of care communicates care instructions to the staff. B. Record review of maintenance logs for the facility scales revealed the fourth-floor scale needed a new battery on 02-23-2026, that was replaced and revealed the fourth-floor scale had been calibrated for accuracy by the facility staff on 02-28-2026 and 03-31-2026 and an outside company calibrated the scale on the fourth floor on 04-02-2026.C. Record review of Resident 6's Nutrition admission Data Collection (NADC) dated 12-22-2025 revealed Resident 6 had a gastric bypass in June of 2025 and the Registered Dietician (RD) recommended adding ensure nutritional supplement 3 times a day as Resident 6 had been taking that prior to admission to the facility. Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-had diagnosis of Bipolar Disorder and Anxiety Disorder -Brief Interview of Mental Status (BIMS) was scored as a 6. According to the MDS Manual a score of 0-7 indicates severe cognitive impairment.-required substantial assistance with upper body dressing, and bed mobility.-required total assistance with toileting, bathing, lower body dressing and transfers. -weight was 240 pounds (lb). Record review of Resident 3's Comprehensive Care Plan (CCP) dated 12-22-2025 revised 03-11-2026 revealed Resident 3 had a nutritional problem or potential nutritional problem related to having had a gastric bypass and decreased appetite. The goal was Resident 3 would maintain adequate nutritional and hydration status. Interventions listed were to provide a regular diet, supplements per practitioner orders and to monitor weights and meal intakes dated 12-22-2025. Record review of Resident 3's Electronic Health Record (EHR) under the section Weights and Vitals revealed Resident 3 weighed 240 lbs on 02-01-2026 and weighed 188.0 lbs on 02-24-2026 indicating a loss of 52 lbs or 21.6% weight loss. Record review of Resident 3's Dietary Progress Notes (DPN) dated 03-01-2026 revealed Resident 3's weight was down 58 lbs., Resident 3 ate 50-100% of meals, and Resident 3 had an order for ensure nutritional supplement 3 times a day but does not always take the supplement. No new interventions were identified to prevent further weight loss. Record review of Resident 6's CCP revealed no additional nutritional interventions. Record review of Resident 6's DPN dated 03-11-2026 revealed the RD had reviewed Resident 6's weight and changed the nutritional supplement from ensure to boost breeze related to indicators of loose stools. Record review of Resident 6's CCP revealed an intervention dated 03-14-2026 to change ensure supplement to boost breeze 3 times a day. Record review of Resident 3's Office Visit Notes (OVN) dated 03-17-2026 revealed an order to (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resume bariatric vitamins (specialized high potency nutritional supplement designed for individuals who have undergone weight loss surgery). Record review of Resident 3's Order Summary (OS) printed on 04-06-2026 revealed the bariatric vitamins were not identified. Record review of Resident 3's Medication Administration Records (MAR) for March 2026 and April 2026 revealed the bariatric vitamins were not administered. Record review of Resident 3's DPN dated 03-22-2026 revealed Resident 3's practitioner had not replied to the RD's update on weight loss and the RD would update the practitioner again and request weekly weights. Record review of Resident 3's DPN dated 03-25-2026 revealed the RD followed up with a second update on weight loss for Resident 3's practitioner. Record review of Resident 3's DPN dated 04-01-2026 revealed Resident 3's practitioner ordered weekly weights for closer monitoring. Record review of Resident 3's EHR under section Weights and Vitals revealed no weekly weight was obtained on 04-08-2026. An observation conducted on 04-08-2026 at 8:15 AM revealed the facility staff had delivered breakfast to Resident 3, consisting of scrambled eggs, 2 slices of bacon, a banana and a large orange juice. Resident 3 was in bed with eyes closed and the breakfast tray was left on the bedside table. An observation conducted on 04-08-2026 at 9:00 AM revealed Nursing Assistant (NA) H entered Resident 3's room to pick up the breakfast room tray and saw that Resident 3 was asleep and walked back out of the room without attempting to encourage or assist the resident with breakfast. A continuous observation conducted on 04-08-2026 from 9:20 to 10:00 AM revealed the staff had not come into to encourage or monitor Resident 3's breakfast intake. An observation conducted on 04-08-2026 at 10:00 AM revealed Licensed Practical Nurse (LPN) A had entered Resident 3's room to perform a treatment and asked the resident if Resident 3 was done eating and Resident 3 stated yes, all I want is the banana. LPN A then placed the banana on the bedside table and took the room tray out of the room. LPN A did not encourage Resident 3 to eat or offer to provide a substitute. An interview conducted with the Maintenance Director (MD) on 04-09-2026 revealed the scale on the fourth floor has been functioning properly since 02-24-2026. An interview conducted with LPN A on 04-09-2026 at 11:55 AM confirmed Resident 3 did not eat anything for breakfast on 04-08-2026, and confirmed LPN A had not offered Resident 3 a substitute on 04-08-2026 and should have. Record review of Resident 3's EHR under tasks revealed the intake for breakfast on 04-08-2026 was 75-100% of the meal was consumed. An interview conducted with the Director of Nursing (DON) on 04-09-2026 at 12:00 confirmed the documentation in Resident 3's EHR for breakfast on 04-08-2026 was 75-100% and confirmed that documentation was not accurate. An interview conducted with the Assistant Director of Nursing (ADON) at 2:45 AM confirmed the orders received on 03-17-2026 for bariatric vitamins had not been implemented and should have. The ADON further confirmed that if the meal intakes in the EHR are incorrect the RD would not be able to assess Resident 3's nutrition accurately.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H). Based on observation, interview and record review the facility failed to evaluate, monitor and implement interventions for severe pain and failed to ensure pain medications were available for use for 1(Resident 3) of 3 residents sampled. The facility census was 117. The findings are:Record review of the facility's policy titled Pain Management dated 01-2024 revealed the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The facility utilizes a systematic approach for recognition, assessment, treatment and monitoring of pain. Evaluate the resident for pain upon admission, during periodic scheduled assessments, and with change in condition or status. Behavioral signs and symptoms that may suggest the presence of pain include but are not limited to:-change is gait-loss of function-decline in activity level-resisting care, striking out-bracing, guarding, or rubbing-fidgeting, increased or recurring restlessness-facial expressions: grimacing, frowning, fear, grinding teeth.-change in behavior: depressed mood, decreased participation in usual daily living.-loss of appetite-sleeping poorly-sighing, groaning, crying, breathing heavily.If the resident's pain is not controlled by the current treatment regimen, the practitioner should be notified. Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-had diagnosis of Diabetes Mellitus type 2. -Brief Interview of Mental Status (BIMS) was scored as a 6. According to the MDS Manual a score of 0-7 indicates severe cognitive impairment.-required substantial assistance with upper body dressing, and bed mobility.-required total assistance with toileting, bathing, lower body dressing and transfers. -had pain almost constantly.-had pain that frequently effected sleep.-had pain that almost constantly interfered with therapy. Record review of Resident 3's Comprehensive Care Plan (CCP) dated 12-22-2025 revealed Resident 3 had the potential for pain related to diabetic neuropathy in bilateral feet and lower back pain. The goal was Resident 3 would verbalize adequate relief of pain or ability to cope with incompletely relieved pain. Interventions listed to achieve the goal were:-The resident is able to: call for assistance when in pain, reposition self, ask for medication, and tell you how much pain is experienced, and what increases or alleviates the pain.-the resident prefers to have pain controlled by medication.-provide non-pharmacological interventions to assist with pain management: redirection, distraction, and repositioning. Record review of Resident 3's Order Summary printed on 04-06-2026 revealed Resident 3 had the following orders for pain:-Aspercreme with 4% lidocaine, apply topically to feet twice a day for neuropathic pain -Diclofenac gel 1% apply to each knee 3 times a day.-Lidocaine pain patch 4% apply 1 patch to the right thigh and 1 patch to the back daily-12 hours on and 12 hours off. -pregabalin 150 milligram (mg) capsule, take one capsule twice daily. -acetaminophen 500 mg tablet take 1 tablet by mouth every 6 hours as needed for pain. Record review of Resident 3's Treatment Administration Record (TAR) for April 2026 revealed the aspercreme with lidocaine 4% was not available and not administered to Resident 3 and acetaminophen 500 mg give 1 tablet as needed every 6 hours for pain had not been administered for the month of April 2026. Further review of the TAR revealed the lidocaine patch 4% was to be applied at 8:00 AM and removed at 8:00 PM. Record review of Resident 3's Progress Notes (PN) revealed the following about aspercreme with lidocaine 4%:-04-05-2026 reordered medication-04-06-2026 medication on order from pharmacy-04-07-2026 on order from pharmacy-04-07-2026 medication reordered awaiting pharmacy to deliver.-04-08-2026 called pharmacy they will deliver the medication tonight-04-08-2026 medication on order, awaiting delivery.-04-09-2026 called pharmacy again they stated the medication would be delivered tonight. An observation conducted on 04-08-2026 at 10:00 AM revealed Licensed Practical Nurse (LPN) A had entered Resident 3's room to administer Diclofenac cream to Resident 3's knees, LPN A asked (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3 to rate the pain and Resident 3 responded 10 and its throbbing, LPN A applied cream to bilateral knees revealing there was no lidocaine patch on the right leg, and left the room. An interview conducted on 04-08-2026 at 10:05 AM with Resident 3 revealed Resident 3 had not had the lidocaine 4% patch applied to the right thigh and back that was due at 8:00AM. An interview conducted on 04-08-2026 at 11:25 AM with Resident 3 revealed Resident 3 had not received the Lidocaine 4% patch to the right thigh and back. An interview conducted on 04-08-2026 at 11:30 AM with LPN A revealed LPN A confirmed that Resident 3 had not received the lidocaine pain patch. An interview conducted on 04-08-2026 at 11:35 AM with MA B confirmed Resident 3 had not yet received the Lidocaine 4% patch to the right thigh and back and confirmed that even though the patch would be applied late the next shift would remove the patch at the assigned time. An observation conducted on 04-08-2026 at 12:45 PM revealed Resident 3 was lying in bed and Resident 3 had a lidocaine patch on the right thigh dated 04-08-2026. An interview conducted on 04-08-2026 at 12:50 PM with MA B confirmed Resident 3's lidocaine patch 4% to the right thigh and back had been applied at 12:45 PM. An interview conducted with the Assistant Director of Nursing on 04-09-2026 at 11:35 AM confirmed Resident 3 would not receive the full dose of the lidocaine patch because it was applied late. An observation on 04-09-2026 at 2:15 PM revealed Resident 3 was in bed and LPN A asked if the Diclofenac cream was effective for Resident 3's knee pain. Resident 3 replied it brought the pain to a 3 which was acceptable but my feet are a 10. An interview conducted on 04-09-2026 at 2:20 PM with Resident 3 revealed Resident 3 had not received aspercreme with lidocaine cream to bilateral feet. An interview conducted on 04-09-2026 at 2:25 PM with LPN A confirmed Resident 3's pain was a 10 on 04-08-2026 at 10:00 AM and confirmed LPN A did not offer non-pharmacological pain interventions, did not return and re-evaluate Resident 3's pain, did not administer any as needed pain medications and did not contact Resident 3's practitioner and should have. LPN A also confirmed Resident 3 had not received aspercreme with lidocaine to the bilateral feet yet this week because it was unavailable.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09. Based on observation, interview and record review the facility failed to monitor daily fluid intake, and failed to ensure medications and treatments were coordinated with the provision of dialysis services for 1 (Resident 5) of 1 residents sampled. The facility census was 117. The findings are:A.Record review of the facility policy titled Special Needs-Dialysis Policy dated 01-2024 revealed the policy is to outline care and services for dialysis residents in order to reduce the risk of infections, complications, and to provide for ongoing monitoring and interventions. An assessment of the resident will be performed on admission and quarterly and will include the location of the dialysis shunt, when dialysis is performed and where, and what to monitor. This information will be included as part of the resident's plan of care. The facility will ensure medications and meals are provided as ordered. Physician referral may be needed in order to adjust medication times or obtain an order to hold medications on dialysis day. B.Record review of Resident 5's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 03-22-2026 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 a 14. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required supervision and set up with eating and oral hygiene.-required partial assistance with upper body dressing, bed mobility and transfers.-required substantial assistance with toileting and lower body dressing.-had a diagnosis of End Stage Renal Disease (ESRD), Diabetes and Glaucoma.-was receiving dialysis.-was legally blind. Record review of Resident 5's Comprehensive Care Plan dated 03-17-2026 revealed Resident 5 had ESRD and receives dialysis, the goal was Resident 5 would not experience any unavoidable complications from dialysis through the review date. Interventions listed were:-if bleeding from the vascular access is not controlled, apply direct pressure, call the dialysis team/nephrologist to determine the need for the resident to be transported emergently to the emergency room (ER).-Resident has dialysis, the location of services, the days of the week and time of services were not on the CCP.-monitor/document/report any signs or symptoms of infection to the access site such as redness, swelling and warmth.-monitor/document/report any signs or symptoms of renal insufficiency such as changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Record review of Resident 5's Order Summary (OS) printed on 04-07-2026 revealed Resident 5 had an order for dialysis treatments 3 times a week on Monday, Wednesday, and Friday at Dialysis Omaha at 5:45 AM. Record review of Resident 5's Medication Administration Record (MAR) for March 2025 revealed the following medications were not given because Resident 5 was out of the facility for dialysis:-March 18th 2026 at 8:00 AM- hydralazine 25 milligram (mg) tablet,-carvedilol 25mg tablet-nifedipine 30 mg Extended Release tablet, -losartan potassium 100 mg tablet,-simvastatin 40 mg tablet, -venlafaxine 150 mg Extended Release tablet, -Xarelto 20 mg tablet, -Gabapentin 300 mg tablet-Insulin Glargine 100 units per milliliter (ml) inject 35 units, -atropine sulfate 1% eye drops 1 drop in the right eye,-brimonidine 0.2% eye drops instill 1 drop in the right eye, -dorzol/timol 2-0.5% eye drops instill 1 drop in the right eye, -prednisolone 1% eye drops instill 2 drops into the right eye. March 20, 2026 at 8:00AM--losartan potassium 100 mg tablet, -simvastatin 40 mg tablet, -venlafaxine 150 mg extended-release tablet, -Xarelto 20 mg tablet, -Gabapentin 300 mg tablet-Ferrous sulfate 325 mg tablet-Insulin Glargine 100 units per milliliter (ml) inject 35 units, -atropine sulfate 1% eye drops 1 drop in the right eye,-brimonidine 0.2% eye drops instill 1 drop in the right eye, -dorzol/timol 2-0.5% eye drops instill 1 drop in the right eye, -prednisolone 1% eye drops instill 2 drops into the right eye. -Nepro nutritional supplement -blood sugar check Record review of Resident 5's Electronic Health Record under the section Census revealed Resident 5 was at the hospital from [DATE] to 04-03-2026. Record review of Resident 5's Hospital Discharge Orders (HDO) dated 04-03-2026 revealed an order to limit fluids to 1500 ml per day. Record review of (continued on next page)

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	04/09/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 5's MAR for April 2026 revealed the following medications were not given due to resident being out of the facility for dialysis:-April 6, 2026 between 6:00 and 10:00 AM-losartan potassium 100 mg tablet, -carvedilol 25 mg tablet-venlafaxine 150 mg extended-release tablet, -Eliquis 5 mg tablet, -Gabapentin 300 mg tablet-Ferrous sulfate 325 mg tablet-atropine sulfate 1% eye drops 1 drop in the right eye,-brimonidine 0.2% eye drops instill 1 drop in the right eye, -dorzol/timol 2-0.5% eye drops instill 1 drop in the right eye, -prednisolone 1% eye drops instill 2 drops into the right eye. -Nepro nutritional supplement -treatment to the right abdominal fold- cleanse wound and apply triad paste and cover with a dressing -treatment to the right and left buttock-cleanse area and apply triad paste to wound beds. Record review of Resident 5's MAR for April 2026 did not have the order to limit fluids to 1500 ml a day. Record review of Resident 5's Progress Notes (PN) from 04-03-2026 revealed no record of fluid monitoring and no documentation that Resident 5 had a fluid restriction of 1500 ml per day. An interview conducted on 04-09-2026 at 8:30 AM with Resident 5 revealed Resident 5 did not know about the 1500 ml fluid limit per day. An interview conducted with the Assistant Director of Nursing (ADON) on 04-09-2026 at 1:05 PM confirmed Resident 5's medications and treatments should be scheduled around dialysis treatments and not be omitted and confirmed the 1500 ml fluid limit per day was not implemented and should have been.

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	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehabilitation Mercy	7410 Mercy Road Omaha, NE 68124

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(1). Based on interview and record review the facility failed to develop and implement interventions and arrange services for behavioral management for 1 (Resident 3) of 3 residents sampled. The facility census was 117. The findings are:A.Record review of the facility policy titled Mood and Behavior Policy and Procedure dated 01-2024 revealed it is the policy of the facility that each resident must receive and the facility must provide the necessary behavioral health care and services and medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. B.Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-had diagnosis of Bipolar Disorder and Anxiety Disorder -Brief Interview of Mental Status (BIMS) was scored as a 6. According to the MDS Manual a score of 0-7 indicates severe cognitive impairment.- required substantial assistance with upper body dressing, and bed mobility.-required total assistance with toileting, bathing, lower body dressing and transfers. Record review of Resident 3's Comprehensive Care Plan (CCP) dated 12-17-2026 revealed Resident 3 had a positive level 2 PASRR screen related to anxiety and bipolar disorder. The goal was Resident 3 would have psychological needs met through the review date. The interventions listed were to arrange mental health services. An interview conducted with Resident 3 on 04-09-2026 at 9:00 AM revealed Resident 3 used to see a counselor at Immanuel because of the bipolar disorder and has not seen a mental health practitioner since admission. An interview conducted with the Social Services Director (SSD) on 04-09-2026 at 11:30 am confirmed Resident 3 had not been referred for mental health services and should have.

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	04/09/2026

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 0760 Level of Harm - Minimal harm or potential for 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 Number 175 NAC 12-006.10(D). Based on interview and record review the facility failed to ensure residents were free from significant medication errors for 1(Resident 5) of 5 residents sampled. The facility census was 117. The findings are:A.Record review of Medication Errors in Nursing Homes Fact Sheet from the Long-Term Care Community Coalition dated 01-2023 revealed a medication error means an observed or identified preparation or administration of medications which is not in accordance with the prescriber's order, the manufacturer's specifications, or accepted professional standards or principles. A significant medication error is an error which causes the resident discomfort or jeopardizes their health and safety. Common medication errors include taking medication dose late, omitted dose, dispensing the wrong medication, giving the medication through the wrong route, and a wrong or extra dose of medication. B. Record review of Resident 5's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 03-22-2026 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 a 14. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required supervision and set up with eating and oral hygiene.-required partial assistance with upper body dressing, bed mobility and transfers.-required substantial assistance with toileting and lower body dressing.-had a diagnosis of End Stage Renal Disease (ESRD), Diabetes and Glaucoma.-was receiving dialysis.-was legally blind. Record review of Resident 5's Order Summary (OS) printed on 04-07-2026 revealed Resident 5 had an order for dialysis treatments 3 times a week on Monday, Wednesday, and Friday at Dialysis Omaha at 5:45 AM. Record review of Resident 5's Medication Administration Record (MAR) for March 2026 revealed Resident 5 did not receive the following medications due to being out of the facility for dialysis:-March 18, 2026 -Xarelto 20 mg tablet, Gabapentin 300 mg tablet, Insulin Glargine 100 units per milliliter (ml) inject 35 units, atropine sulfate 1% eye drops 1 drop in the right eye, brimonidine 0.2% eye drops instill 1 drop in the right eye, dorzol/timol 2-0.5% eye drops instill 1 drop in the right eye, prednisolone 1% eye drops instill 2 drops into the right eye. -March 20, 2026--Xarelto 20 mg tablet, Gabapentin 300 mg tablet, Insulin Glargine 100 units per milliliter (ml) inject 35 units, atropine sulfate 1% eye drops 1 drop in the right eye, brimonidine 0.2% eye drops instill 1 drop in the right eye, dorzol/timol 2-0.5% eye drops instill 1 drop in the right eye, prednisolone 1% eye drops instill 2 drops into the right eye. Record review of Resident 5's MAR for April 2026 revealed Resident 5 did not receive the following medications due to being out of the facility for dialysis:-April 6, 2026 Eliquis 5 mg tablet, Gabapentin 300 mg tablet, atropine sulfate 1% eye drops 1 drop in the right eye, brimonidine 0.2% eye drops instill 1 drop in the right eye, dorzol/timol 2-0.5% eye drops instill 1 drop in the right eye, prednisolone 1% eye drops instill 2 drops into the right eye. An interview conducted with Resident 5 on 04-09-2026 at 8:30 AM revealed Resident 5 had not been receiving the eye drops ordered for glaucoma on dialysis days and in the past Resident 5 took brimonidine eye drops to dialysis to be administered right before dialysis because the dialysis treatment would cause eye swelling and pain. Furthermore, Resident 5 experienced mild eye pain this week at dialysis. An interview conducted with the Assistant Director of Nursing (ADON) on 04-09-2026 at 10:30 AM confirmed Resident 5 had not received medications and eye drops on dialysis days and should have had the medications scheduled around dialysis and are errors of omission.