| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285058 | A. Building<br>B. Wing | 05/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Emerald Nursing & Rehabilitation Mercy | 7410 Mercy Road<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Licensure Reference Number 175 NAC 12-006.04(F)(i)(5)Based on record review and interview, the facility failed to notify the medical practitioner of omitted body weight measurements for 2 (Residents 101 and 102) of 3 sampled residents. The facility staff identified a census of 103.Findings are:A. Record review of Resident 101's admission Record (AR) revealed the facility admitted the resident on 01/22/2024. Further review of the AR revealed Resident 101 had diagnoses of dysphagia (difficulty swallowing) and presence of a gastrostomy tube (g-tube, tube inserted through the abdomen into the stomach to receive nutrition and hydration).Record review of Resident 101's Annual 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 02/13/2026 revealed the resident had a feeding tube while a resident at the facility.Record review of Resident 101's Order Summary Report (OSR) revealed an order for weekly weights every Wednesday on day shift for weight loss dated 01/10/2026.Record review of Resident 101's Weights revealed the last recorded weight was dated 04/1/2026.Record review of Resident 101's Electronic Treatment Administration Record (eTAR) revealed the following: -04/08/2026 no weight was recorded; -04/15/2026 no weight was recorded; -04/22/2026 no weight was recorded; and -04/29/2026 no weight was recorded.Record review of Resident 101's Electronic Health Record (EHR) including progress notes, eTAR, and scanned documents revealed no evidence that Resident 101's medical practitioner was notified of the facility's inability to capture the resident's weight.During an interview on 05/07/2026 at 12:29 PM the Director of Nursing (DON) confirmed there was no evidence of the provider being notified of the omitted weight measurements and further confirmed facility staff should have notified the provider.B. Record review of Resident 102's AR revealed the facility admitted the resident on 10/19/2021. Further review of the AR revealed Resident 102 had diagnoses of severe protein-calorie malnutrition and presence of a g-tube.Record review of Resident 102's OSR revealed an order for weekly weights every Friday related to nutritional deficiency dated 08/05/2025.Record review of Resident 102's weights revealed no record of weight from 03/20/2026 until 05/06/2026.Record review of Resident 102's eTAR dated March, April, and May 2026 revealed the following: -03/06/2026 resident refused weight measurement. -03/27/2026 there was no documentation on the eTAR. -04/03/2026 resident refused weight measurement. -04/10/2026 there was no documentation on the eTAR. -04/17/2026 resident refused weight measurement. -04/24/2026 resident refused weight measurement. -05/01/2026 there was no documentation on the eTAR.Record review of Resident 102's Progress Notes dated 03/01/2026 to 05/06/2026 revealed a note dated 03/06/2026 that Resident 102 would allow staff to weigh [gender] on 03/07/2026. There was no evidence the facility staff followed up on 03/07/2026 to attempt to obtain a weight measurement.Record review of Resident 102's EHR including progress notes, eTAR, and scanned documents revealed lack of evidence Resident 102's medical practitioner was notified of refusal of weights and omission of weights.During an interview on 05/07/2026 at 12:29 PM with the DON confirmed there was no evidence of the provider's notification of the omitted or refused weight measurements and further confirmed the facility staff should have notified the provider. |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview, the facility failed to report an allegation of potential neglect within the required timeframes for Resident 100. The facility staff identified a census of 103.Findings are:Record review of facility policy entitled Abuse, Neglect and Exploitation dated revised 01/2024 revealed: - 13. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must: -a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation or [sic] resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the advents [sic] that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other official (including the State Survey Agency and adult protected services where state law provides for jurisdiction in long-term care facilities) in accordance with State law.Record review of Resident 100's Comprehensive Care Plan (CCP) with an intervention dated 4/16/2026 revealed Resident 100 was depended for transfers , need the use of a Hoyer (mechanical) lift and 2 staff assisting with the transfer. Record review of an Abuse, Neglect, Misappropriation investigation with an incident date of 4/12/2026 revealed Nurse Aide (NA)-A transferred Resident 100 with a mechanical lift from the wheelchair to the bed without any assistance on 04/09/2026. NA-A reported after lifting the resident from the wheelchair and turning to the bed, [gender] attempted to turn the mechanical lift and one of the wheels got stuck. NA-A attempted to free the wheel which caused the mechanical lift to tilt and Resident 100 fell to the floor.Further review of the investigation revealed NA-A left the room and informed Medication Aide (MA)-B and Licensed Practical Nurse (LPN)-C of the incident and all three staff members returned to Resident 100's room. LPN-C reported [gender] asked Resident 100 about pain, but performed no further assessment and NA-A, MA-B, and LPN-C assisted Resident 100 into bed.Record review of Resident 100's Electronic Health Record (EHR) including progress notes, scanned documents, and forms showed there was no evidence of a post-fall evaluation regarding Resident 100's fall on 04/09/2026.Record review of Abuse and Neglect Policy Acknowledgement forms revealed the following: -NA-A acknowledged the facility policy on 12/18/2025. -MA-B acknowledged the facility policy on 01/28/2026. -LPN-C acknowledged the facility policy on 11/06/2025.Record review of a sign-in sheet entitled Resident's Rights & Abuse dated 02/13/2026 revealed LPN-C's signature.Interview on 05/07/2026 from 10:56 AM to 11:24 AM with the Director of Nursing (DON) confirmed the events within the investigation dated 04/12/2026. The DON further confirmed there was no documentation to support a post-fall evaluation was completed at the time of the incident. The DON confirmed NA-A, MA-B, and LPN-C were all previously trained on abuse, neglect, and misappropriation reporting procedures. The DON reported LPN-C's failure to complete a post-fall evaluation was considered potential neglect and should have been reported to facility management and the State Survey Agency at the time of occurrence. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Licensure Reference Number 175 NAC 12-006.09(H)Based on record review and interview, the facility failed to follow the plan of care for transfers resulting in significant injury and failed to complete a post-fall evaluation for 1 (Resident 100) of 3 sampled residents. The facility staff identified a census of 103.Findings are:Record review of facility policy entitled Falls Management dated revised 01/2024 revealed the facility would implement goals and interventions with the resident and family for inclusion in the comprehensive care plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) and communicate interventions to the care giving teams. Further review of the policy revealed in the event of a fall, the licensed nurse should complete a head-to-toe assessment to check for breaks in the skin and other abnormal findings. The policy further revealed vital signs to include blood pressure, pulse, pulse oximetry (device used to measure the percentage of oxygen in the blood), and respirations.Record review of Resident 100's 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 04/12/2026 revealed Resident 100's transfer status was dependent.Record review of Resident 100's CCP revealed Resident 100 required a mechanical lift and two staff assistance for transfers with an initiated date of 08/15/2024 and revised 04/16/2026.A. Record review of an Abuse, Neglect, Misappropriation investigation with an incident date of 4/12/2026 revealed Nurse Aide (NA)-A attempted to transfer Resident 100 with a mechanical lift from the wheelchair to the bed without any assistance on 04/09/2026. NA-A reported after lifting the resident from the wheelchair and turning to the bed, [gender] attempted to turn the mechanical lift and one of the wheels got stuck. NA-A attempted to free the wheel which caused the mechanical lift to tilt and Resident 100 fell to the floor. NA-A acknowledged a mechanical lift transfer required two staff members.Further review of the investigation revealed NA-A left the room and informed Medication Aide (MA)-B and Licensed Practical Nurse (LPN)-C of the incident and all three staff members returned to Resident 100's room. LPN-C reported [gender] asked Resident 100 about pain, but performed no further assessment and NA-A, MA-B, and LPN-C assisted Resident 100 into bed. Resident 100 had verbalized no complaints on 04/10/2026. On 04/11/2026, Resident 100 had complaints of pain to the right knee and facility staff observed swelling. Facility staff notified Resident 100's medical practitioner on 04/11/2026 and the facility received an order to perform an x-ray of the right knee. The facility was notified on 04/12/2026 of the x-ray results which showed an acute appearing right femur fracture. Resident 100 was subsequently sent to the hospital for evaluation and treatment. The facility investigation concluded the root cause of the incident was failure to follow established care plan interventions requiring the use of a mechanical lift with 2 staff assist for resident transfer. Staff involved did not adhere to the resident's documented status per care plan, resulting in an unsafe transfer process and subsequent resident injury.Record review of Resident 100's Electronic Health Record (EHR) including progress notes, forms, and scanned documents lacked evidence a post-fall evaluation to include absence of recorded vital signs and absence of a head-to-toe assessment.Interview on 05/07/2026 at 10:03 AM with the Director of Nursing (DON) confirmed at the time of Resident 100's fall, the care planned transfer status was dependent with mechanical lift and two staff members. The DON reported Resident 100 was transferred by mechanical lift and one staff member, and Resident 100 sustained a fall with a fracture.In a follow-up interview on 05/07/2026 at 10:56 AM, the DON confirmed a post-fall evaluation was not completed by the licensed nurse. The DON reported a post-fall evaluation should have completed at the time of the fall. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(a)Based on record review, observation, and interview, the facility failed to have complete tube feeding orders, failed to date and time tube feeding equipment, and failed to account for amount of infused tube feeding for 2 (Residents 101 and 102) of 3 sampled residents. The facility staff identified a census of 103.Findings are:Record review of facility policy entitled Care and Treatment of Feeding Tubes dated Revised 01/2024 revealed: -It was the facility's policy to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. -7. Direction for staff on how to provide the following care would be provided: -e. Frequency of and volume for flushing, including flushing for medication administration, and what to do when a prescriber's order does not specify.A. Record review of Resident 102's admission Record (AR) revealed the facility admitted the resident on 10/19/2021. Further review of the AR identified Resident 102 had diagnoses of severe protein-calorie malnutrition and unspecified nutritional deficiency.Record review of Resident 102's (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 01/28/2026 identified Resident 102 received 26-50 percent (%) of calories and 501 cubic centimeters (cc) or more through the feeding tube daily.Record review of Resident 102's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) identified Resident 102 required assistance with tube feeding and water flushes and to refer to MD (Medical Doctor) orders.Record review of Resident 102's Order Summary Report revealed the following orders: -200cc water flush three times a day dated 06/03/2025. -Nutren 1.5 Full Strength to be delivered via gastrostomy (g-tube, tube inserted through the abdomen into the stomach to deliver food, hydration, and medications) via pump at a rate of 55 milliliters (mL) per (/) hour (hr) for 12 hours nightly plus packet of liquacel (protein supplement). Goal rate of 55mL/hr. Add 200 cc water flush TID dated 06/10/2025.Observation on 05/06/2026 at 7:10 AM revealed Nutren 1.5 was running at 55mL/hr with a 30mL/hr water flush. Observation on 05/07/2026 at 8:10 AM with Registered Nurse (RN)-E revealed the tube feeding pump was running and instilling Nutren 1.5 at 55mL/hr with a 30 mL/hr water flush.Interview on 05/06/2026 at 9:10 AM with Licensed Practical Nurse (LPN)-D confirmed Nutren was running at 55 mL/hr and a water flush of 30mL/hr. LPN-D reported the tube feeding rate and the flush rate are determined by physician's orders. LPN-D was unable to locate an order for the 30 mL/hr water flush and was further unable to report what to do if a physician's order did not specify flush amounts.Interview on 05/06/2026 at 9:37 AM and 12:52 PM with the Director of Nursing (DON) confirmed there was no order for 30 mL/hr water flush. The DON revealed the facility followed the standards of practice related to feeding tubes.Interview on 05/07/2026 at 8:10 and 8:20 AM with RN-E confirmed the tube feeding pump was set to administer 55 mL/hr of tube feeding and 30 mL/hr of water. RN-E reported if there was no flush order during the continuous tube feed they would notify the APRN. RN-E confirmed there was no flush order for the continuous tube feeding. Follow up interview on 05/07/2026 at 8:44 AM with the DON revealed the facility had no written standards of practice related to feeding tubes available for review.B. Record review of Resident 102's April 2026 Electronic Treatment Administration Record (eTAR) revealed a total tube feeding administered recorded on 04/02/2026, 04/03/2026, 04/04/2026, and 04/05/2026. The rest of the dates were marked off or on and did not record the amount of tube feeding or water flush administered.Record review of Resident 102's May 2026 eTAR revealed total tube feeding administered was recorded on 05/02/2026 and 05/03/2026. Off was written for 05/01/2026, 05/04/2026, and 05/05/2026 and did not record the amount of tube feeding or water flush administered.Interview on 05/06/2026 at 9:37 AM with the DON<br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | revealed staff should verify on the pump the ordered amount of tube feeding and water flush was administered but did not need to be recorded.Interview on 05/06/2026 at 12:52 PM with the DON revealed the facility did not have a tube feeding competency available to review and reported the facility follows standards of practice.Interview on 05/07/2026 at 8:20 AM with RN-E reported without clearing the pump and recording the amount, there was no way to confirm the resident received the required nutrition and hydration.Follow up interview on 05/07/2026 at 8:44 AM with the DON revealed the facility had no written standards of practice related to tube feeding administration available for review.C. Observation on 05/06/2026 at 8:10 AM with LPN-D in Resident 102's room revealed Nutren 1.5 was being administered continuously. The tube feeding bag and water bag were not labeled with the date and time of first use.Observation on 05/07/2026 at 8:10 AM with RN-E in Resident 102's room revealed Nutren 1.5 was being administered continuously. The tube feeding bag and water bag were not labeled with the date and time of first use.Interview on 05/06/2026 at 8:11 AM with LPN-D confirmed the tube feeding supplies were not labeled with date and time of first use and should have been.Interview on 05/07/2026 at 8:20 AM with RN-E confirmed the tube feeding supplies were not labeled with date and time of first use and should have been.D. Record review of Resident 101's AR revealed the facility admitted the resident on 01/22/2024. Further review of the admission record identified Resident 101 had diagnoses of anoxic brain injury (lack of oxygen to the brain) and dysphagia.Record review of Resident 101's MDS dated [DATE] identified Resident 101 utilized a feeding tube and received 51 percent (%) or more of total nutrition and 501 milliliter (mL) or greater of hydration through the feeding tube daily.Record review of Resident 101's Order Summary Report revealed: -Enteral feed order every hour Osmolite 1.5, 60 mL/hr continuous feed with 100 mL/hr water flush dated 02/18/2026.Observation on 05/05/2026 at 12:54 PM revealed the ordered tube feeding and flush was administered at the ordered rate. The tube feeding bag and the water flush bag were not labeled with the date and time of first use.Interview on 05/07/2026 at 10:56 AM with the Director of Nursing confirmed the tube feeding was not labeled with date and time of first use and further confirmed should have been done. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Licensure Reference Number 175 NAC 12-006.04(F)(i)(6)Licensure Reference Number 175 NAC 12-006.17(A)(v)Based on record review and interview, the facility staff failed to document a post-fall evaluation for 1 (Resident 100) of 3 sampled residents. Facility staff identified a census of 103.Findings are:Record review of facility policy entitled Falls Management dated revised 01/2024 revealed: - 6. Upon arrival of the nurse, a quick head-to-toe scan will be performed without unnecessary movement, palpating and examining all areas for breaks in the skin and/or other abnormal findings. -7. Obtain vital signs: blood pressure, pulse, pulse oximetry, and respirations. -8. Obtain neurological checks (neuro-checks)per policy for any unwitnessed fall or any fall with evidence of injury to head. -9. If no obvious injury move resident to a comfortable position. If injury, severe pain or abnormal assessments observed, call 9-1-1 for transfer. -10. The nurse will complete documentation, to include vital signs.Record review of an Abuse, Neglect, Misappropriation investigation with report date 04/15/2026 identified Resident 100 sustained a fall while being transferred with one-staff member and mechanical lift on 04/09/2026. The investigation identified the medical record lacked evidence of an evaluation of Resident 100 at the time of the fall.Record review of Resident 100's Electronic Health Record (EHR) which included progress notes, forms, and scanned documents lacked evidence of an evaluation of Resident 100 at the time of the fall.Interview on 05/07/2026 at 10:56 AM with the Director of Nursing (DON) confirmed there was no post-fall evaluation noted in Resident 100's EHR. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Licensure Reference Number 175 NAC 12-006.18(B)Based on record review, observation, and interview, the facility failed to change a tube feeding pump set at the required intervals to prevent the potential for cross contamination for 1 (Resident 101) of 3 sampled residents. The facility staff identified a census of 103.Findings are:Record review of facility policy entitled Care and Treatment of Feeding Tubes dated revised 01/2024 revealed: - 7. Direction for staff on how to provide the following care will be provided. - d. Use of infection control precautions and related techniques to minimize the risk of contamination.Record review of Kangaroo ePump Enteral Feed and Flush Pump with Pole Clamp, Programmable dated Revised 04/2020 revealed: - The pump set usage warning indicator will blink on the running screen if a pump set has been used for 24 or more hours (hours actually running). It is recommended to replace pump sets after this length of usage.Observation on 05/05/2026 at 12:54 PM revealed Resident 101's Kangaroo ePump was running at the ordered rate. The machine display blinked Set Use > (greater than) 24 hrs (hours).Observation on 05/06/2026 at 6:26 AM revealed Resident 101's Kangaroo ePump was running at the ordered rate. The machine display blinked Set Use > 24 hrs.Interview on 05/06/2026 at 11:27 AM with Registered Nurse (RN)-E confirmed the Kangaroo ePump displayed set use greater than 24 hours. RN-E reported the pump set should be changed each time the tube feeding bag was replaced.Interview on 05/07/2026 at 12:50 PM with the Assistant Director of Nursing confirmed potential for cross contamination if the tube feeding pump set is not changed every 24 hours. |