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	06/16/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview, the facility failed to report two allegations of potential misappropriation to the State Agency within the required timeframe for 1 (Resident 501) of 1 sampled resident. Facility staff identified a census of 83.Findings are:Record review of facility policy entitled Abuse, Neglect and Exploitation revised 01/2024 revealed: - 9. Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse should: - f. Contact the State Agency and the local Ombudsman office to report the alleged abuse. - 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 (sic)(including the State Survey Agency and adult protected services where state law provides jurisdiction in long-term care facilities) in accordance with State law. - 14. The Administrator should follow up with government agencies, during business hours, to confirm the report was received, and to report the results of the investigation when final, as required by state agencies.Record review of Resident 501's admission Record revealed the facility admitted the resident on 01/09/2026. Further review of the admission record identified Resident 501 had diagnoses of major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks and is accompanied by irritability, fatigue, poor concentration, sleep disturbances, weight gain or loss, feelings of worthlessness or guilt, and sometimes suicidal tendencies) and anxiety disorder (an abnormal and overwhelming sense of apprehension and fear often marked by physical signs, by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it).Record review of Resident 501'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 01/15/2026 identified Resident 501 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14. According to the MDS manual, a score of 14 indicated the resident had intact cognition.Record review of Resident 501's Progress Notes (PN) dated 03/09/2026 revealed an entry that Resident 501 alleged a facility nurse was wearing the resident's necklace. Resident 501 reported the facility nurse stole the necklace. Further review of the progress note identified the nurse had worked at the facility for approximately two years and the necklace was seen in all past photos taken in the facility.Record review of an e-mail dated 03/20/2026 from the Ombudsman (a state official who works with nursing home and assisted living residents who helps answer resident concerns and complaints and advocates for resident rights and their well-being) to the Social Services Director (SSD) identified Resident 501 had brought forth concern of a stolen (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	necklace to the Ombudsman and reported to the Ombudsman that they had filed a grievance directly with the facility.Record review of Resident 501's PN dated 04/22/2026 revealed an entry that Resident 501 reported another resident who resided on a different floor came to Resident 501's room and stole a phone charger. Further review of the progress note showed the resident from the other floor was interviewed and denied taking the charger and the charger was not located.During an interview on 06/16/2026 at 8:39 AM, the SSD reported they were unable to locate a grievance related to the concerns of stolen items dated 03/09/2026 and 04/22/2026. The SSD confirmed the PN entries dated 03/09/2026 and 04/22/2026 were allegations of potential misappropriation and further confirmed allegations of misappropriation should be reported to the State Agency. The SSD reported they were unaware of the allegation dated 04/22/2026.During an interview on 06/16/2026 at 10:52 AM, the facility Administrator (ADM) reported facility management were unaware of the allegation dated 04/22/2026. The ADM confirmed the facility did not have evidence that the allegation on 03/09/2026 and 04/22/2026 were reported to the State Agency.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview, the facility failed to complete an investigation and submit the investigation to the State Agency within 5 working days for two allegations of potential misappropriation for 1 (Resident 501) of 1 sampled resident. Facility staff identified a census of 83.Findings are:Record review of facility policy entitled Abuse, Neglect and Exploitation revised 01/2024 revealed: - 7. Investigation of Alleged Abuse, Neglect and Exploitation. - When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted. Once the resident is care for and initial reporting has occurred, an investigation should be conducted. Components of an investigation may include: -a. Interview the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses. -b. If there is no discernible response from the resident, or if the resident's response is incongruent with that of a reasonable person, interview the resident's family, responsible parties, or other individuals involved in the resident's life to gather how he/she believes the resident would react to the incident. -c. Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area, and visitors in the area. Obtain witness statements, according to appropriate policies. All statements should be signed and dated by the person making the statement. -d. Document the entire investigation chronologically. - 9. Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse should: - c. Initiate an investigation immediately. - i. Document actions taken in steps above in the medical record. - 13. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must: - b. Have evidence that all alleged violations are thoroughly investigated. - d. Report the results of all investigation to the administrator or his or her designated representative and to the other official in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. - 14. The Administrator should follow up with government agencies, during business hours, to confirm the report was received, and to report the results of the investigation when final, as required by state agencies.Record review of Resident 501's admission Record revealed the facility admitted the resident on 01/09/2026. Further review of the admission record identified Resident 501 had diagnoses of major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks and is accompanied by irritability, fatigue, poor concentration, sleep disturbances, weight gain or loss, feelings of worthlessness or guilt, and sometimes suicidal tendencies) and anxiety disorder (an abnormal and overwhelming sense of apprehension and fear often marked by physical signs, by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it).Record review of Resident 501'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 01/15/2026 identified Resident 501 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14. According to the MDS manual, a score of 14 indicated the resident had intact cognition.Record review of Resident 501's Progress Notes (PN) dated 03/09/2026 revealed an entry that Resident 501 alleged a facility nurse was wearing the resident's necklace. Resident 501 reported the facility nurse stole the necklace. Further review of the progress note identified the nurse had worked at the facility for approximately two years and the necklace was seen in all past photos taken in the facility.Record review of an e-mail dated 03/20/2026 from the Ombudsman (a state official who works with nursing home and assisted living residents who helps answer resident concerns and complaints and advocates for resident rights and their well-being) to the Social Services Director (SSD) identified Resident 501 had brought forth (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concern of a stolen necklace to the Ombudsman and reported to the Ombudsman that they had filed a grievance directly with the facility.Record review of Resident 501's PN dated 04/22/2026 revealed an entry that Resident 501 reported another resident who resided on a different floor came to Resident 501's room and stole a phone charger. Further review of the progress note showed the resident from the other floor was interviewed and denied taking the charger and the charger was not located.Record review of facility investigations dated March 2026 through May 2026 revealed no evidence of a completed investigation for the allegation dated 03/09/2026 and 04/22/2026.During an interview on 06/16/2026 at 10:52 AM, the Administrator (ADM) confirmed there was no evidence an investigation was completed regarding Resident 501's allegations of potential misappropriation dated 03/09/2026 and 04/22/2026.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Licensure Reference Number 175 NAC 12-006.09(F)(iii)Based on record review and interview, the facility failed to revise the care plan to reflect resident risk for leaving the facility without signing out, without a destination, and time of return, or of potential locations the resident could be located for 1 (Resident 501) of 3 residents sampled. Facility staff identified a census of 83.Findings are: Record review of facility policy entitled Care Plan Process revised 09/2019 revealed: -A care plan will: -a. Incorporate identified problem areas -i. Onset date -b. Incorporate risk factors associated with identified problems -i. 'Related to' factors (risk factors)- why the problem exists or may exist -ii. All risk factors must be care planned -iii. Build on the resident's strengths -iv. Reflect treatment goals and objectives -viii. In measurable outcomes, such as evidenced by -what does the resident do, or what issue to improve, or maintain what function, etc. Record review of Resident 501's admission Record revealed the facility admitted the resident on 01/09/2026. Further review of the admission record identified Resident 501 had diagnoses of absence of left and right legs below the knee. Record review of Resident 501's Progress Notes (PN) dated 01/17/2026 identified Resident 501 exited the facility without informing facility staff. Facility staff contacted Resident 501's emergency contact (EC) who reported the resident frequents a specific apartment complex in Omaha and did not have a cell phone. Record review of Resident 501'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) printed on 06/15/2026 revealed the facility did not identify the resident was at-risk for leaving the facility without informing staff, or interventions to be implemented when the resident did not return from an outing. During an interview on 06/15/2026 at 4:43 PM, the Director of Nursing (DON) reported the interdisciplinary team meets to discuss resident's departure from the facility. The DON confirmed the CCP should be updated to reflect the resident's risk for leaving the facility without communicating with staff their destination or expected return time to the facility. B. In an interview with the administrator on 6/16/26 at 9:00 AM it was confirmed the facility had not care planned Resident 501would leave the community at times without signing out and they should have.

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 perform treatment for pressure ulcers according to the practitioner's orders for Resident 509, failed to accurately complete and score the Braden Scale for Resident 4 and 509, and failed to evaluate, implement and monitor interventions to prevent pressure ulcer development and to promote wound healing for 4 (Resident 4, 502, 506, and 509) of 4 residents on sample. The facility census was 79.The findings are:Record review of the facility's policy titled Risk Assessment-Braden-Weekly Data Collection dated 01-2024 revealed the purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing skin issues, new pressure injuries or worsening of existing pressure injuries. The purpose of the skin risk assessment is to identify all risk factors and then determine which can be modified and which cannot, or which can be immediately addressed, and which will take time to modify. Risk factors that increase a resident's susceptibility to develop pressure injuries or to not heal pressure injuries include but are not limited to:-under nutrition, malnutrition, and hydration status;-impaired/decreased mobility and decreased functional ability;-the presence of previously healed pressure injuries;-the presence of an existing pressure injury;-exposure of skin to urinary and fecal incontinence or other source of moisture;-elevated body temperature;-altered skin status over pressure points;-impaired perfusion, oxygenation or circulation deficits, for example generalized atherosclerosis or lower extremity arterial insufficiency;-conditions such as end-stage renal disease (ESRD), thyroid disease or diabetes mellitus;-drugs such as steroids that may affect healing;-advanced age;-impaired sensory perception;-cognitive impairment; and-resident refusal to some aspects of care and treatment.The risk assessment should be conducted as soon as possible after admission, but no later than 8 hours after admission is completed. A comprehensive skin data collection will be completed on admission, readmission, weekly and with significant change in condition to obtain a risk assessment. Once the data collection is conducted and risk factors are identified and characterized, a resident-centered care plan can be created to address the modifiable risks for pressure injuries. Repeat the risk assessment (Braden) weekly for the first four weeks, if there is significant change in condition, or as often as is required based on the resident's condition. Record review of the facility's policy titled Prevention of Pressure dated 06-07-2024 revealed the purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific factors. Under the section titled Preparation revealed the facility staff were to review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Under the section titled Risk Assessment revealed the facility staff are to assess the resident on admission for existing pressure injury risk factors. Repeat the risk assessment (Braden) weekly and upon any changes in condition. Under the section titled Skin Assessment revealed the facility staff are to conduct a comprehensive skin assessment upon admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. During the skin assessment inspect: for the presence of redness, temperature of skin and soft tissue and edema. Inspect the skin daily when performing or assisting with personal care and:-Identify any signs of developing pressure injuries, such as non-blanching (reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device) redness. For darkly pigmented skin, inspect changes in skin tone, temperature and consistency.-Inspect pressure points to the sacrum, heels, buttocks, coccyx, elbows, etc.-Wash skin after any episodes of incontinence, using pH balanced skin cleanser.-Moisturize dry skin daily.-Reposition the resident as indicated on the care plan.-Keep the skin clean and hydrated.-Clean promptly after episodes of incontinence.-Avoid alkaline soaps and cleansers.-Use a barrier product to protect the skin from moisture.-Use incontinence products with high absorbency.-Do not rub or (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	otherwise cause friction on skin that is at risk of pressure injuries.-Use facility approved protective dressings for at risk individuals. Under the section titled Mobility/Repositioning revealed the facility staff are to reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary team. Choose a frequency for repositioning based on the resident's risk factors, in accordance with current clinical guidelines. Teach residents who can change positions independently the importance of repositioning, provide support devices and assistance as needed. Remind and encourage residents to change positions. Select appropriate support surfaces for pressure redistribution based on the resident's risk factors, in accordance with current clinical practice guidelines from the facility supply contracted company. Staff are to evaluate, report and document potential changes in the skin and review the interventions and strategies for effectiveness on an ongoing basis. Record review of the facility's Braden Scale evaluation revealed a score of less than 16 facility staff were to initiate skin integrity interventions. Further review of the Braden Scale showed a score of less than 9 indicated the resident was at severe risk for pressure ulcer development; a score of 10-12 indicated the resident was at high risk; a score of 13-14 indicate thee resident was at moderate risk; and a score of 15-18 indicate the resident was at mild risk. A. Record review of Resident 502's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) revealed the facility staff assessed the following about the resident:-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.-Had a diagnosis of dementia and adult failure to thrive. -Required moderate assistance with toileting, lower body dressing and hygiene.-Required touching assistance for transfers.-Was frequently incontinent of bladder.-Had an unplanned weight loss of 5% or more in 1 month or 10% or more in 6 months. -Was at risk of developing a pressure ulcer/injury. -Had moisture associated skin damage (MASD) such as incontinence-associated dermatitis, perspiration or drainage. Record review of Resident 502'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) dated 05-29-2024 revised on 03-06-2026 revealed Resident 502 had the potential for pressure ulcer development related to decreased mobility, weakness and incontinence, the goal was Resident 502's skin would remain intact, and the intervention listed was to provide pressure reducing/relieving device to the bed and wheelchair. Further review of the CCP revealed Resident had an actual impairment of skin integrity related to malnutrition, decreased mobility, weakness and incontinence and on 06-24-2026 Resident 502 had an unstageable deep tissue injury (DTI) dated 05-29-2024 revised on 06-30-2026. The goal was Resident 502 would have no complications related to the skin injury to the buttocks through the review date. Interventions dated 06-24-2026 were: air mattress, Enhanced Barrier Precautions (EBP) and provide the treatment to the buttocks DTI as ordered by the provider. Record review of Resident 502's Skin/Wound Weekly Observation (SWWO) dated 05-16-2026 revealed Resident 502 had a current skin issue. The SWWO did not identify the type, size or characteristics of the skin issue and under the section new interventions revealed a treatment was in place for the buttocks and was completed without difficulty. Record review of Resident 502's SWWO dated 05-23-2026 revealed Resident 502 had a current skin issue. The SWWO did not identify the type, size or characteristics of the skin issue and under the section new interventions revealed a treatment was in place for the buttocks and was completed without difficulty. Record review of Resident 502's SWWO dated 05-30-2026 revealed Resident 502 had a current skin issue. The SWWO did not identify the type, size or characteristics of the skin issue and under the section new interventions revealed a treatment was in place for the buttocks and was completed without difficulty, no drainage noted. Record review of Resident 502's Treatment Administration Record (TAR) for June 2026 revealed an order dated 11-06-2025 for Calmoseptine ointment (a moisture barrier used to soothe and protect the skin), wash wounds with normal saline, apply Calmoseptine and cover with a mepilex daily. Further review of the TAR for June 2026 revealed the Calmoseptine treatment had been discontinued on 06-16-2026. Record review of (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Resident 502's SWWO dated 06-06-2026 revealed Resident 502 had a current skin issue. The SWWO did not identify the type, size or characteristics of the skin issue and under the section new interventions revealed a treatment was in place for the buttocks and was completed without difficulty. There was no pain or discomfort voiced. Record review of Resident 502's Physician Round Form (PRF) dated 06-12-2026 revealed the facility staff requested to discontinue all orders for Calmoseptine as all areas are healed. Record review of Resident 502's SWWO dated 06-13-2026 revealed Resident 502 had a current skin issue. The SWWO did not identify the type, size or characteristics of the skin issue and under the section new interventions revealed a treatment was in place for the buttocks and was completed without difficulty, no pain or discomfort voiced. Record review of Resident 502's SWWO dated 06-20-2026 revealed Resident 502 had a current skin issue. The SWWO did not identify the type, size or characteristics of the skin issue and under the section new interventions revealed a treatment was in place for the buttocks and was completed. Record review of Resident 502's Skin/Wound New Observation (SWNO) dated 06-24-2026 revealed Resident 502 had a DTI to the right gluteal fold measuring 6 centimeters (cm) in length by 8 cm in width and the wound bed was completely covered with eschar (dead tissue that is hard or soft in texture and is usually black, brown or tan in color). Record review of Resident 502's SWWO dated 06-26-2026 revealed Resident 502 had an unstageable pressure injury to the right buttock measuring 3.97 cm in length by 4.29 cm in width and the left buttock had a stage 3 pressure ulcer measuring 4.05 cm in length by 4.62 cm in width. The SWWO dated 06-26-2026 also revealed the pressure ulcer to the left buttock was a new wound. Record review of Resident 502's Progress Notes (PN) dated 06-27-2026 revealed Resident 502's previously unstageable pressure ulcer was exhibiting purulent drainage, and the wound practitioner was notified and gave orders to send Resident 502 to the hospital for further evaluation and treatment of the pressure ulcer. Record review of Resident 502's Acute Care and Emergency General Surgery Hospital Note (ACEGHN) dated 06-27-2026 revealed Resident 502 was found to be in septic shock and had a large sacral wound with foul smelling brown purulent discharge. Record review of Resident 502's Surgical Procedure Note dated 06-27-2026 revealed Resident 502 had undergone an incision, drainage and debridement of the sacral wound of a stage 4 pressure ulcer. After debridement the wound cavity measured 6 cm in length by 5 cm in width by 4 cm in depth and the bone at the base of the wound. An interview conducted on 06-16-2026 at 9:00 AM with the Assistant Director of Nursing (ADON) A revealed (gender) had looked at Resident 502's skin to the buttocks and there was no skin issues before requesting to discontinue the Calmoseptine ointment on 06-12-2026 and confirmed that the SWWO's before and after 06-12-2026 had identified a skin issue to the buttocks and Resident 502 did not receive the treatment after 06-15-2026 until the DTI to the right gluteal fold was identified on 06-24-2026. B. Record review of Resident 4's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-BIMS was scored as an 11. According to the MDS Manual a score of 8 to 12 indicated moderate cognitive impairment. -Had a diagnosis of PVD, ESRD, and diabetes mellitus.-Was at risk of pressure ulcer development.-Had MASD.-Was receiving dialysis services. Record review of Resident 4's CCP dated 09-10-2024 revised 06-23-2026 revealed Resident 4 had an actual impairment of skin integrity to the left lower extremity related to PVD and diabetes. The goal was that the resident will have no complications related to skin injury through the review date. Interventions listed were:-Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short dated 09-10-2024.-Educate resident/family/caregivers of causative factors and measures to prevent skin injury dated 09-19-2024.-Keep skin clean and dry. Use lotion on dry skin dated 09-19-2024.-Use caution during transfers and bed mobility to prevent injury dated 09-10-2024.-Pressure reducing cushion to the wheelchair dated 12-29-2025.-Pressure reducing mattress in place dated 12-29-2025.-EBP dated 06-23-2026.-Needs protective garments-Prevalon Boots dated 06-23-2026. Record review of Resident 4's EMR under the section Census revealed Resident 4 went to the hospital on [DATE] and returned to the facility on [DATE]. Record review of Resident 4's PN dated (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	06-23-2026 revealed Resident 4 was being sent to the emergency room (ER) from the dialysis center for a blood pressure of 224/116 and nausea. Record review of Resident 4's PN dated 06-24-2026 revealed Resident 4 had returned from the hospital. Record review of Resident 4's readmission Progress Note (RPN) revealed Resident 4 was readmitted with no skin concerns. Record review of Resident 4's Braden Scale dated 06-25-2026 revealed under the question Is the Braden score 16 or below the box was checked no. Record review of Resident 4's TAR for June 2026 revealed an order to complete a skin check and document in the forms section every Wednesday and indicated the dates to be completed were: 06-03-2026, 06-10-2026, 06-17-2026 and 06-24-2026. Record review of Resident 4's SWWO dated 06-10-2026 revealed Resident 4 had no skin issues. Record review of Resident 4's SWWO dated 06-22-2026 revealed Resident 4 had a DTI to the right heel measuring 3 cm in length by 2.5 cm in width and was covered with eschar. The SWWO also revealed that the practitioner had been notified and ordered Skin Prep apply to the right heel daily, may leave open to air and Prevalon boots while in bed. Record review of Resident 4's EMR progress notes and forms section revealed no skin evaluations for any of the 12 days between 06-10-2026 and 06-22-2026. Record review of Resident 4's PN dated 07-02-2026 revealed Resident 4 did not have Prevalon boots in the room. An observation conducted on 07-13-2026 revealed Resident 4 was lying in bed and had a green heel protector that wrapped around Resident 4's right ankle. An observation conducted on 07-13-2026 at 1:50 PM revealed Resident 4 was in bed and had the same green heel protector on the right foot. An observation conducted on 07-14-2026 at 6:00 AM revealed Resident 4 was in bed and had the green heel protector to the right foot. An observation conducted on 07-15-2026 at 6:00 AM revealed Resident 4 was in bed and had no heel protector on the right foot. An observation conducted on 07-15-2026 at 8:35 AM revealed Resident 4 was in bed and had no heel protector on the right foot. An observation conducted on 07-15-2026 at 10:30 AM revealed Nursing Assistant (NA) E was in the room applying the green heel protector to the right foot. An interview was conducted on 07-15-2026 at 10:35 AM with NA E confirmed the green heel protector had not been on Resident 4's right foot and should have been. An observation conducted on 07-15-2026 at 10:45 of ADON A providing wound care to Resident 4's right heel revealed a DTI that was covered with black eschar measuring approximately 2.5 cm in length and 2 cm in width. During the interview, ADON A confirmed that the green heel protector was a Prevalon boot. An interview conducted on 07-15-2026 at 11:30 AM with the ADON A confirmed the green heel protector was not a Prevalon boot and the Nurse Practitioner (NP) was aware of the use of the green heel protector and was ok with it. An interview conducted on 07-15-2026 at 12:30PM with NP B who revealed the facility staff requested an order for Prevalon boots and NP B ordered what was requested and stated the little green heel protectors are fine with me. An interview was conducted on 07-16-2026 at 11:30 AM confirmed the Braden Scale conducted on 06-25-2026 should have been scored as a 12 and the box indicating the score was 16 or less should not have been checked no. An interview conducted on 07-20-2026 at 11:00 AM with ADON A confirmed a SWWO was not completed between 06-10-2026 and 06-22-2026 when the DTI was identified. C. Record review of Resident 506's Electronic Medical Record (EMR) under the section titled Census revealed Resident 506 went to the hospital on [DATE] and returned to the facility on [DATE]. Record review of 506's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-BIMS was scored as a 4. According to the MDS Manual a score of 0 to 7 indicated severe cognitive impairment.-Had a diagnosis of PVD and DM. -Required touching assistance with upper body dressing.-Required partial assistance with toileting, lower body dressing and hygiene.-Required substantial assistance with tub or shower transfers.-Required total assistance with bathing. -Was not at risk for pressure ulcer development. Record review of Resident 506's CCP dated 08-02-2024 revised 06-24-2026 revealed Resident 506 had an actual impairment of skin integrity related to wounds to the right lateral ankle and left foot. The goal was Resident 506 would have no complications related to skin injury through the review date. Interventions listed on the care plan dated 08-02-2024 were:-Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short.-Educate (continued on next page)

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	285058	A. Building B. Wing	06/16/2026

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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F 0686 Level of Harm - Actual harm Residents Affected - Some	resident/family/caregivers of causative factors and measures to prevent injury. -Pressure reducing cushion to the wheelchair.-Pressure reducing mattress.-Prevalon boot (a specialized medical boot used primarily for non-ambulatory patients to completely offload the heel) while in bed. -Use caution during transfers and bed mobility to prevent injury. Interventions listed after 08-02-2024 were:-EBP dated 06-11-2026.-Treatment in place to the right ankle and left foot per provider order. Record review of Resident 506's Braden Scale dated 06-24-2026 revealed a score of 13 which indicated moderate risk of pressure ulcer development. Record review of Resident 506's Nursing readmission Assessment under section Skin Conditions revealed on 06-24-2026 a 2.5 cm in length by 2 cm in width diabetic wound was noted to the left foot. Record review of Resident 506's Tissue Analytics Evaluation ([NAME]) dated 06-26-2026 revealed Resident 506 had a stage 2 pressure ulcer to the left heel measuring 0.85 cm in length by 1.28 cm in width and 0.1 cm in depth while in the hospital. Record review of Resident 506's TAR for June 2026 revealed an order for treatment of the pressure ulcer to the left foot dated 06-26-2026, 2 days after the wound was identified and 3 days after readmission. The TAR also revealed an order for a Prevalon boot to the right foot while in bed as needed that had not been administered during the month of June 2026. An observation conducted on 07-13-2026 at 11:10 AM revealed Resident 506 was in the wheelchair in the hallway outside of the room, observation of the room revealed a pressure relief mattress on the bed and the absence of a Prevalon boot in the room and closet. An observation conducted on 07-13-2026 at 12:45 PM revealed Resident 506 was lying in bed and had a positioning wedge under the left knee and the left heel was resting on the mattress and no prevalon boot on either foot. An observation conducted on 07-14-2026 at 10:05 AM resident was lying in bed with a wedge under the left leg. The left heel was still touching the mattress and no Prevalon boot to either foot. An observation conducted on 07-15-2026 at 1:50 PM revealed Resident 506 had a pressure ulcer to the left heel that was approximately 1 cm in length and 0.5 cm in width, the skin surrounding the wound was intact and dry. No drainage or odors were observed. An interview conducted on 07-16-2026 at 12:00 PM with ADON A confirmed Resident 506 had not been wearing a Prevalon boot and was uncertain whether the positioning wedge was to be used instead. An interview conducted on 07-16-2026 at 12:10 PM with ADON A confirmed the practitioner had not ordered the pressure relieving wedge and confirmed Prevalon boot was listed as an intervention on the care plan. D. Record review of Resident 509's Care Area Assessment Worksheet (CAAW) dated 01-19-2026 revealed Resident 509 had admitted to the facility with a stage 4 pressure ulcer to the left buttocks. Record review of Resident 509's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-Had a diagnosis of quadriplegia (the partial or total loss of motor and sensory function in all four limbs and the torso).-BIMS was scored as 14. According to the MDS Manual a score of 13 to 15 indicated a person is cognitively intact. -Required moderate assistance with oral hygiene.-Required maximal assistance with upper body dressing.-Required total assistance with toileting, bathing, lower body dressing, rolling right to left, and transfers. -Was not at risk of developing pressure ulcers. Record review of Resident 509's CCP dated 01-20-2026 revised on 07-06-2026 revealed Resident 509 had actual skin impairment of skin integrity related to weakness, impaired mobility, quadriplegia and history of pressure ulcer to the left buttock, and stage 2 pressure ulcers to the right and left plantar foot. The goal was Resident 509 would have no complications related to skin injuries. Interventions listed on the CCP were:-Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short dated 01-20-2026.-Educate resident/family/caregivers of causative factors and measures to prevent skin injury dated 01-20-2026. -Keep skin clean and dry. Use lotion on dry skin dated 01-20-2026. -Pressure reducing cushion in wheelchair dated 01-24-2026. -Pressure reducing mattress in place 01-20-2026. -Use caution during transfers and bed mobility to prevent injury dated 01-20-2026.-Enhanced Barrier Precautions (EBP) dated 06-12-2026.-Left plantar (bottom of the foot) foot: wound care treatment order in place dated 07-02-2026. -Right plantar foot: wound treatment order in place dated 07-02-2026. Record review of Resident 509's Braden Scale dated 04-21-2026 revealed a score of 11 which (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	06/16/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Some	indicated Resident 509 was at high risk of pressure ulcer development. Record review of Resident 509's Order Summary (OS) printed on 07-13-2026 revealed orders to complete a skin assessment and document findings on SWWO form located under the forms tab every Wednesday for monitoring and a treatment of the pressure ulcers to the plantar surface of the bilateral feet as follows: -Left plantar foot, wash area with wound cleanser, and pat dry, paint all around the wound with skin prep and allow to dry, apply a small amount of Silvadene to the wound bed only, apply a small piece of aquacel to the wound cut to fit the size and shape of the wound and cover with a mepilex change every Monday, Wednesday and Friday and as needed for soiling, saturation or accidental removal. Remove the dressings for showers or bathing. -Right plantar foot, wash area with wound cleanser, and pat dry, paint all around the wound with skin prep and allow to dry, apply a small amount of Silvadene to the wound bed only, apply a small piece of aquacel to the wound cut to fit the size and shape of the wound and cover with a mepilex change every Monday, Wednesday and Friday and as needed for soiling, saturation or accidental removal. Remove the dressings for showers or bathing. Record review of Resident 509's Braden Scale dated 07-15-2026 revealed Resident 509 had no sensory impairment and had scored a 17 which indicated a mild risk for pressure ulcer development. An observation conducted on 07-14-2026 at 6:00 AM revealed Resident 509 was lying in bed without pressure-relieving boots and the plantar surfaces of both feet were touching the mattress. An observation conducted on 07-15-2026 at 6:00 AM revealed Resident 509 was lying in bed without pressure-relieving boots and the plantar surface of both feet were touching the mattress. An observation conducted on 07-15-2026 at 10:05 AM of Licensed Practical Nurse (LPN) G and the Assistant Director of Nursing (ADON) B providing wound care to Resident 509 revealed both wounds were washed with wound cleanser and patted dry, silvadene cream was placed in the wound bed and Opticell AG dressing was cut to size and placed in the wound beds and then covered with a bordered gauze. During this observation Resident 509 did not want the Mepilex dressing used because it rolls and comes loose with muscle spasms and wanted the bordered gauze dressing used instead because it stays in place. An interview conducted on 07-16-2026 at 9:43 AM with ADON B confirmed the physician's order was not followed and confirmed the use of Opticell AG dressing for the wound care instead of Aquacel dressing that was ordered. An interview conducted on 07-16-2026 at 10:15 AM with ADON C confirmed upon review of Resident 509's Braden Scale Score of 17 dated 07-15-2026 indicating mild risk for pressure ulcer development was incorrect as it indicated the resident had no sensory impairment. ADON C further confirmed Resident 509 was quadriplegic and had sensory impairment and had developed pressure ulcers to both feet. The interview also revealed that ADON C was uncertain what interventions were put into place when the left plantar foot pressure ulcer was identified to prevent further pressure ulcer development before the right plantar foot pressure ulcer developed. An interview conducted on 7-16-2026 at 11:30 AM with Nurse Practitioner (NP) N confirmed the Opticell AG dressing and Aquacel dressing were not the same and were not interchangeable.

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	285058	A. Building B. Wing	06/16/2026

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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 record review and interview, the facility failed to have a comprehensive and consistent process to identify when alert and oriented residents would return to the facility after leave and steps to take if the resident failed to return for 2 (Resident 501 and 503) of 4 residents sampled. Facility staff identified a census of 83.Findings are: A. Record review of Resident 501's admission Record revealed the facility admitted the resident on 01/09/2026. Further review of the admission record identified Resident 501 had diagnoses of absence of left and right legs below the knee. Record review of Resident 501'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 01/15/2026 identified Resident 501 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14. According to the MDS manual, a score of 14 indicated the resident had intact cognition. Further review of the MDS revealed the resident required substantial assistance with transfers and was independently mobile in a manual wheelchair. Record review of Resident 501's Progress Notes (PN) revealed the following: -On 06/10/2026 at 5:14 AM, a note showed the resident was out of the facility throughout the night shift. At 3:42 PM, the emergency contact (EC) reported Resident 501 was at a friend's house and was doing fine and would plan to return the next day. -On 06/11/2026, the administrator (ADM) sent a text message to the EC at 11:10 am and 3:59 PM asking if they knew when the resident would return to the facility with no answer. A telephone call was made by the ADM to the EC at 2:49 PM with no answer. At 6:31 PM, the EC stated the resident would return on 6/12/2026. -In a note dated 06/12/2026, the Social Services Director (SSD) reported they attempted to contact Resident 501's EC on 06/11/2026 at 12:00 PM and 3:00 PM with no response. On 06/11/2026 at 3:30 PM the SSD responded to areas the resident frequented but did not locate the resident. On 06/11/2026 at 6:30 PM, the residents EC contacted the SSD and reported the resident would be back to the facility on [DATE]. -On 06/12/2026, the SSD responded to areas the resident frequented. The SSD located Resident 501. The resident agreed to come back to the facility and transportation was arranged. The resident later reported that they did not want to come back to the facility and signed discharge against medical advice paperwork. Record review of a Visitor/Resident Sign In/Out Sheet revealed Resident 501 signed themselves out on 06/09/2026 at 12:10 PM with destination of friends. There was no expected time of return, physical destination, or contact number left for the facility. During an interview on 06/15/2026 at 4:07 PM, Licensed Practical Nurse (LPN)-A reported they were assigned to Resident 501's care on 06/09/2026. LPN-A reported the resident left the facility around 11:00 AM and returned to the facility approximately 30 minutes later. LPN-A further reported Resident 501 left again on 06/09/2026. LPN-A reported they were unaware of the time the resident left. LPN-A further reported when a resident does not return to the facility when expected, or if the resident leaves without facility knowledge, LPN-A would call the contact number left on the sign out form. If the resident was unable to be reached using the contact number or if no number was left, LPN-A (continued on next page)

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	285058	A. Building B. Wing	06/16/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported they would inform facility management and follow management's instructions. LPN relayed facility staff became aware of a resident not being in the facility when medications and treatments are due. LPN-A reported steps taken would be documented in the resident's progress notes. During an interview on 06/15/2026 at 4:20 PM, the Director of Nursing (DON) reported there was no set time frame for when the facility staff should call and check on the resident. The DON further reported that facility staff would attempt to contact the resident when medications and treatments were due if the resident had not returned to the facility at an expected return time, if a return time was not listed, or if facility staff were unaware of the cognitive resident's departure from the facility. The DON relayed if facility staff were unable to contact the resident they would continue to try until contact is made and an updated plan for return was provided to the facility. The DON reported facility staff would also try the emergency contact number listed in the resident's chart. The DON communicated if facility staff was unable to contact anyone at all, they would report the resident's absence to the local police department and Adult Protective Services (APS). During an interview on 06/15/2026 at 5:08 PM, the facility administrator (ADM) reported the facility would report to APS and the local police department not over 24 hours from the time a resident was supposed to return to the facility. The administrator confirmed a delay in reporting to APS due to belief Resident 501's EC was at work. The administrator confirmed APS was not notified until approximately 6:15 PM on 06/11/2026. B. Review of a facility Document titled Staff education signing out created 6/12/2026 at 6:35PM revealed the following: All resident's must sign out of the facility at the nurse's station on the resident's floor. All residents who are not allowed to go outside without supervision will be noted in their Care Profile. When a resident signs out (not an Elopement) the resident will be asked the approximate time of return and will be educated that if they do not return at that time, the facility will do the following: 1. Attempt to call the resident. If not able to reach the resident, move onto the next step. 2. Notify the Administrator and/or Director of Nursing. 3. Notify the Emergency Contact/Family. 4. Document attempts. 5. Adult Protective Services will be notified by the Administrator and/or Director of Nursing. 6. Police will be notified. 7. Physician and/or Nurse Practitioner will be notified. In an interview with the Administrator on 6/16/26 at 10:25 AM, it was revealed that all staff were sent the above education on 6/16/26 though the electronic system the facility uses for payroll. Further interview confirmed that not all staff members had signed the education at this time. (continued on next page)

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	285058	A. Building B. Wing	06/16/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 503's Minimum Data Set(MDS, a federally mandated comprehensive assessment tool used to determine a residents functional capabilities and helps nursing home staff identify health problems) with an assessment reference date (ARD) of 4/1/26 revealed the a Brief Interview for Mental Status (BIMS, a tool used to screen and identify the cognitive status of residents in nursing facilities) of 13/15 which according to the MDS manual a score of 13-15 suggests intact cognition. Further review revealed Resident 503 they were independent in a motorized wheelchair(w/c) once seated in the w/c. Record review of facility form titled Release of responsibility for Leave of Absence reveled the following 'I, the undersigned, hereby accept complete responsibility for [Resident 503] while away from emerald Nursing and Rehab Mercy and absolve the management of said facility, it's personnel and the attending physician of responsibility for any deterioration in condition, or accident that may happen while the resident is away. I understand the bed will be reserved for the above-named resident when he returns on or before the appointed time. Authorization must be signed by the resident or by the nearest relative in case the resident is physically or mentally incompetent. We do ask that a cell phone number is provided with each Leave of Absence. By signing this the resident and/or representative is acknowledging that if the representative does not return at the expected time the facility staff will attempt to contact the resident and/or representative and obtain an updated anticipated return date/and time. If the facility staff are unable to reach the resident and/or representative the facility will Notify the Emergency Contact/Family, Document attempts, Adult Protective Services will be notified, Police will be notified and the Physician and/or Nurse Practitioner will be notified.' Further review of the document revealed Resident 503 signed out on 6/13/26 at 1:30 PM stating the resident was going to 'ex-wife' with nothing marked in approximate date/time of return. The sign in on the form was dated 6/15/26 at 11:15 AM. Record review of Resident 503's progress notes reveled and entry on 6/13/26 at 1:38 PM stating 'Resident signed out of facility'. Record review of Resident 503's Progress Note dated 6/14/26 at 6:05 AM revealed 'resident did not return to facility last night. Call placed to resident's cell phone and ex-wife, no answer from either'. Record review of Resident 503's Progress Note dated 6/14/26 at 4:00 PM revealed 'This nurse placed a call to the resident and the resident's ex-wife to inquire about the residents expected time of return to the facility. No answer was received from either party at this time. Voicemails were unable to be left. Facility will continue to attempt contact and monitor for residents return. Record review of resident 503's progress note dated 6/14/26 at 8:24 PM reveled At approximately 4:45 PM resident sent Director of Social Services (DSS) a text the [gender] was at [gender] ex-wife's and [gender] electric wheelchair (w/c) would not stay charged. Resident 503 stated they would wait for transportation to bring them back to the facility on 6/15/26. In an Interview with the Administrator on 6/16/26 at 8:55 AM The Administrator confirmed steps 1-4 of the process were completed when the facility was unable to reach Resident 503, but no evidence was provided of notification of APS the Police or Physician and/or Nurse Practitioner was contacted when Resident 503 did not return to the facility and the facility was unable to reach the resident or the Emergency Contact.

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F 0693 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(c)Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(a)Based on observation, interview, and record review, the facility failed to administer the correct amount of enteral nutrition (liquid formula containing nutrients) per the provider's order on 1 (Resident 103) of 3 sampled residents, ensure flush orders were obtained for 1 (Resident 102) of 3 sampled resident's percutaneous endoscopic gastrostomy (PEG, a tube inserted directly into the stomach to administer nutrients and medications) tube, and ensure 2 (Residents 103 and 101) of 3 sampled resident's enteral nutrients were refrigerated after opening the container per the manufacturer's recommendations. The facility census was 79.Findings are:A.A record review of the facility's Care and Treatment of Feeding Tubes with a revision date of 1-2024 revealed the staff would ensure that the administration of enteral nutrition followed the practitioner's orders.A record review of the facility's Competency Assessment Enteral Tube Feeding via Syringe (bolus: a large, concentrated dose over a short period of time) with a revised date of November 2018 revealed staff would verify there was a physician's order for the procedure and verify the type, amount, method, and rate of administration. The staff would administer only full-strength feeding tube formulas. Do not add water. The staff would attach a 60 milliliter (ml) syringe to the tube and fill the syringe with the prescribed amount of enteral feeding to be given. The staff was to follow the enteral feeding with the ordered flush of warm water. A record review of Resident 103's Clinical Census dated 07/15/2026 revealed the resident was admitted to the facility 03/05/2026.A record review of Resident 103's Medical Diagnosis dated 07/15/2026 revealed the resident had diagnoses of cerebral infarction (stroke), encephalopathy (damage or malfunction of the brain), type 2 diabetes mellitus (uncontrolled blood sugar), personal history of other infectious and parasitic diseases (history of bacterial, viruses, fungi, or parasitic infections), gastrostomy status (had a PEG tube).A record review of Resident 103's Minimum Data Set (MDS, a comprehensive assessment used to develop a resident's care plan) dated 06/19/2026 revealed the resident had a Brief Interview for Mental Status (BIMS, a score of a resident's cognitive abilities) of 00 which indicated the resident was cognitively impaired. The resident was dependent on staff for all activities of daily living, mobility, and transfers. The resident did not attempt eating. The resident had a feeding tube and received 51 percent (%) or more calories and 501 cubic centimeters (cc) per day of the fluid intake through the feeding tube. A record review of Resident 103's Care Plan Report with an admission date of 03/05/2026 revealed the resident required enteral feeding related to the resident's brain injury. The resident had weight loss since admission and had diarrhea (loose stools) with the tube feeding. An intervention was the resident was dependent with tube feeding and water flushes. See Doctor of Medicine (MD) orders for current feeding orders.A record review of Resident 103's Order Summary Report dated 07/15/2026 revealed the resident had an enteral feed order for the enteral nutrition Glucerna 1.5, bolus, 240 ml five times per day for a total of 1200 ml per 24 hours.An observation on 07/13/2026 at 2:02 PM with the Director of Nursing (DON) revealed Licensed Practical Nurse (LPN)-G entered Resident 103's room, performed hand hygiene, put a barrier towel on overbed table, got the enteral feeding supplies, measured water in a graduate (a container with measurements on it), and applied gloves. LPN-G put a towel under the resident's PEG tube. LPN-G removed gloves and regloved with no hand hygiene, got a stethoscope, and checked the PEG tube's residual (remaining amount of stomach contents), applied a 60 cc syringe, flushed the PEG tube with 35 mL water, opened a bottle of Glucerna 1.5 ready to hang nutrients and poured an unmeasured amount of Glucerna 1.5 into a Medline ribbed 9 ounce disposable plastic cup and poured the nutrients into syringe on the PEG tube. LPN-G administered 2 full 60 cc syringes of Glucerna 1.5, then topped off the syringe with approximately another 30 cc's because the syringe had not completely emptied, then topped off the syringe again with another unmeasured amount of Glucerna (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.5. LPN-G poured in the remaining 35 mL of water before the Glucerna 1.5 completely drained from the 60 cc syringe. LPN-G then closed the PEG tube port, removed the 60 cc syringe from the PEG tube, placed the cap back on Glucerna 1.5 and placed the container back on the dresser. When questioned on the amount administered, LPN-G filled the Medline 9 oz plastic cup with water to the line that LPN-G thought they filled the Glucerna 1.5 to and poured the water into a graduate. The amount was centered on the 200 ml mark of the graduate.In an interview on 07/13/2026 at 2:02 PM the DON confirmed the amount of water from the ribbed plastic cup that LPN-G poured into the graduate was 200 mL.In an interview on 07/13/2026 at 2:02 PM LPN-G confirmed LPN-G filled the plastic cup to a certain line on the plastic cup. LPN-G confirmed LPN-G filled the 60 cc syringe 3 or 4 times. LPN-G confirmed the fluid was 200 cc and that would have been the amount of Glucerna 1.5 that was given to Resident 103.In an interview on 07/14/2026 at 1:25 PM, the Director of Nursing (DON) confirmed LPN-G should have used a graduate to measure Resident 103's Glucerna 1.5 but did not.In an interview on 07/15/2026 at 7:45 AM, the facility's Regional Nurse Consultant (RNC) confirmed LPN-G used a plastic cup for Resident 103's enteral feeding. The RNC confirmed that was not LPN-G's regular practice for measuring enteral feeding, but the Assistant Director of Nursing (ADON) instructed LPN-G to use a ribbed plastic cup.B.A record review of the facility's Care and Treatment of Feeding Tubes with a created date of 11-17; 1-2024 revealed the facility would utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Feeding tubes would be utilized in accordance with physician's orders which typically include the frequency of flush. Direction for staff on how to provide the frequency of and volume used for flushing, including flushing for medication administration, and what to do when a prescriber's order does not specify.A record review of the undated National Library of Medicine's Chapter 17 Enteral Tube Management revealed to prevent enteral tubes from clogging, it is important to flush feeding tubes at a minimum of once per shift. https://www.ncbi.nlm.nih.gov/books/NBK593216/A record review of Resident 102's Clinical Census dated 07/14/2026 revealed the resident was admitted to the facility 08/18/2025.A record review of Resident 102's Medical Diagnosis dated 07/15/2026 revealed the resident had diagnoses of cerebral palsy (neurologic disorder affecting a person's ability to move, maintain balance, and hold posture), paraplegia (paralysis of the lower half of the body), hypokalemia (electrolyte imbalance), iron deficiency, unspecified severe protien-calorie malnutrition (body lacks sufficient calories and protein), and gastrostomy status.A record review of Resident 102's MDS dated 04/28/2026 revealed the resident had a BIMS of 13 which indicated the resident was cognitively aware. The resident required setup or clean-up assistance with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with upper body dressing and was dependent on staff for toileting hygiene, bathing, and personal hygiene. Ther resident needed substantial/maximal assistance with rolling in bed and was dependent on staff for positioning and transfers. The resident had a feeding tube and received 26-50 % or more calories and 501 cc per day of the fluid intake through the feeding tube. A record review of Resident 102's Care Plan Report with an admission date of 05/15/2025 revealed the resident required enteral feeding related to the resident resisted eating. The resident had weight loss since admission and had diarrhea with the tube feeding. An intervention was the resident was dependent with tube feeding and water flushes. See MD orders for current feeding orders.A record review of Resident 102's Order Summary Report dated 07/13/2026 revealed the resident had an enteral feed order of Nutren 1.5 three times per day, give 220 ml, flush with 200 ml of water. It did not reveal a separate order for PEG tube flushes.A record review of Resident 102's Clinical Physician Orders dated 07/13/2026 revealed the resident's enteral feed order of Nutren 1.5 three times per day, give 220 ml, flush with 200 ml of water was on hold with a last revision date of 05/17/2026. It did not reveal a separate order for the PEG tube flushes to be continued.A record review of Resident 102's Nutrition Follow Up Visit dated 06/09/2026 revealed the resident's Registered Dietician (RD) recommended the resident transition to 100% oral feedings but did not reveal a recommendation to (continued on next page)

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	285058	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continue to flush the PEG tube.A record review of Resident 102's Physician Round Form dated 07/01/2025 revealed the facility completed the form with a chief complaint of the resident's RD-P recommended the resident transition to 100% by mouth (PO) eating and the enteral feeding was on hold. The new orders were: No new order, continue to follow up closely with the facility RD dated 07/08/2026. There was no discussion that the resident's PEG tube flush orders were part of the enteral feeding order that was put on hold, and there was not a separate order to flush the resident's PEG tube.An observation of Resident 102's PEG tube cares on 07/13/2026 at 1:10 PM revealed LPN-J entered the room and cleaned and applied a new split sponge to the resident's peg tube site but that was all LPN-J had done. The PEG tube contained a dark brown, crusty substance inside the PEG tube.In an interview on 07/15/2026 at 11:30 AM, the facility's RD-Q confirmed Resident 102 seen RD-P at the resident's doctor's office and RD-P is no longer at the resident's doctor's office. RD-Q confirmed RD-Q is now the dietician seeing the resident. RD-Q confirmed that RD-Q was watching the resident's weight closely, if the resident continues to decline, they would have to put the resident back on an enteral feeding in the mornings, if the resident agreed. RD-Q was not aware that the resident's PEG tube was not being flushed because the flush orders were included in the enteral feeding order that was placed on hold.In a telephone interview on 07/15/2026 at 2:57 PM, Resident 102's physician's LPN-R confirmed that LPN-R and the resident's doctor were not aware that the resident's PEG tube flushes were not being completed because the flushes were included in the enteral feeding order that RD-P placed on hold. LPN-R confirmed the facility had not contacted the physician's office to request an order for PEG tube flushes. LPN-R confirmed the resident's physician would not have been OK with the resident's PEG tube not being flushed, and the physician still wanted the PEG tube to be flushed so that it did not get occluded (plugged). The physician did not have any plans to discontinue the PEG tube until they know the resident will be able to maintain the resident's weight.In an interview on 07/14/2026 at 1:25 PM, the DON confirmed that Resident 102's PEG tube should have been flushed per best practice but was not completed.C.A record review of the facility's Care and Treatment of Feeding Tubes with a revision date of 1-2024 revealed the staff would use infection control precautions and related techniques to minimize the risk of contamination. The facility would ensure that the selection and use of enteral nutrition was consistent with manufacturer's recommendations.A record review of [NAME] Laboratories' Glucerna 1.5kcal (kilocalorie) manufacturer's data sheet dated November 2019 with the DON revealed that once opened, unused product should be covered and stored in a refrigerator. https://www.abbottnutrition.ie/downloads/6-Glucerna-1_5kcal-datasheet-pending-GMS-[NAME]-Version-1-Nov record review of Resident 103's Order Summary Report dated 07/15/2026 revealed the resident had an enteral feed order for the enteral nutrition Glucerna 1.5, bolus, 240 ml five times per day for a total of 1200 ml per 24 hours.An observation on 07/13/2026 at 2:02 PM with the Director of Nursing (DON) revealed Licensed Practical Nurse (LPN)-G entered Resident 103's room, completed the resident's enteral feeding using an opened, partially used, 1000 ml container of Glucerna 1.5 ready to hang (RTH) bottle that was sitting on the dresser. LPN-G placed the cap back on Glucerna 1.5 and placed the container back on the dresser.An observation on 07/14/2026 at 7:14 AM revealed an opened, partially used, 1000 ml bottle of Glucerna 1.5 RTH sitting on the resident's dresser.In an interview on 07/16/2026 at 8:15 AM, LPN-L confirmed the staff does not refrigerate Resident 103's Glucerna 1.5 between tube feedings.In an interview on 07/16/2026 at 8:25 AM, the DON confirmed the staff leaves the opened bottles of enteral nutrients in the resident's rooms between enteral feedings. The DON confirmed the staff does not refrigerate the 1000 ml bottles of enteral nutrition after they have been opened. The DON confirmed the Osmolite 1.5 RTH and the Glucerna 1.5 RTH should have been refrigerated after opened per the manufacturer's data sheets.In an interview on 07/16/2026 at 9:50 AM, RD-Q confirmed the enteral feeding nutrients should have been refrigerated after opening.In an interview on 07/16/2026 at 11:22 AM, the facility's Nurse Practitioner (NP)-N confirmed the enteral feeding nutrients should have been refrigerated after opening.D.A record review of the facility's Care (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	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Treatment of Feeding Tubes with a created date of 11-17; 1-2024 revealed the staff would use infection control precautions and related techniques to minimize the risk of contamination. The facility would ensure that the selection and use of enteral nutrition was consistent with manufacturer's recommendations.A record review of [NAME] Laboratories' Osmolite 1.5kcal manufacturer's data sheet dated November 2018 with the DON revealed that once opened, unused product should be covered and stored in a refrigerator. https://www.proconnect.[NAME]/content/dam/an/hcpproconnect/uk/en/product-content/adult/Osmolite_1.5kcal record review of Resident 101's Order Summary Report dated 07/14/2026 revealed the resident had an enteral feed order for the enteral nutrition Osmolite 1.5, 350ml with 100ml Flush (Bolus) four times a day for caloric intake.An observation on 07/13/2026 at 11:56 AM revealed there was an opened and dated 1000 ml bottle of Osmolite 1.5 RTH on Resident 101's bedside table.An observation on 07/13/2026 at 12:25 PM revealed Registered Nurse (RN)-S took an opened, partially used, 1000 ml bottle of Osmolite 1.5 RTH off the bedside table and measured 350 ml of the Osmolite in a graduate and administered the nutrients to Resident 101.An observation on 07/16/2026 at 7:03 AM revealed an opened, partially used, warm to the touch, 1000 ml bottle of Glucerna 1.5 RTH sitting on the resident's bedside table. The bottle was dated 07/15/2026 at 9:30 PM.An observation on 07/16/2026 at 8:11 AM with LPN-M revealed an opened, partially used, warm to the touch, 1000 ml bottle of Glucerna 1.5 RTH sitting on the resident's bedside table. The bottle was dated 07/15/2026 at 9:30 PM.In an interview on 07/16/2026 at 8:11 AM, LPN-M confirmed there was an opened, partially used, warm to the touch, 1000 ml bottle of Glucerna 1.5 RTH sitting on the resident's bedside table. The bottle was dated 07/15/2026 at 9:30 PM.In an interview on 07/16/2026 at 8:15 AM, LPN-L confirmed the staff does not refrigerate 1000 ml bottles of enteral nutrients between tube feedings.In an interview on 07/16/2026 at 8:25 AM, the DON confirmed the staff leaves the opened bottles of enteral nutrients in the resident's rooms between enteral feedings. The DON confirmed the staff does not refrigerate the 1000 ml bottles of enteral nutrition after they have been opened. The DON confirmed the Osmolite 1.5 RTH and the Glucerna 1.5 RTH should have been refrigerated after opened per the manufacturer's data sheets.In an interview on 07/16/2026 at 9:50 AM, RD-Q confirmed the enteral feeding nutrients should have been refrigerated after opening.In an interview on 07/16/2026 at 11:22 AM, the facility's NP-N confirmed the enteral feeding nutrients should have been refrigerated after opening.

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	285058	A. Building B. Wing	06/16/2026

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Licensure Reference Number 175 NAC 12-006.04(B)(ii). Based on record review and interview the facility failed to ensure licensed nurse's received competency evaluations for enteral tube feedings, wound care and Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) for 3 of 3 nurses employed at the facility. The facility census was 79. The findings are:Record review of Licensed Practical Nurse (LPN) G's employee filed revealed LPN G was hired on 05-13-2020 and the absence of competency evaluations for enteral tube feedings, wound care (other than negative pressure wound therapy), or EBP. Record review of Assistant Director of Nursing (ADON) A' s employee file revealed ADON A was hired on 05-18-2026 and the absence of competency evaluations. Record review of ADON B's employee file revealed ADON B was hired on 03-26-2019 and the absence of competency evaluations. An interview conducted with the Administrator on 07-20-2026 at 10:30 AM revealed ADON A and B had transferred to the facility from another facility in the organization and was requesting competency evaluations for the other facility. An interview conducted with the Regional Nurse Consultant (RNC) on 07-20-2026 at 2:00 PM confirmed competency testing had not been completed for ADON A and ADON B.

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	285058	A. Building B. Wing	06/16/2026

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F 0835 Level of Harm - Actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Licensure Reference Number 175 NAC 12-006.01(A) Based on observations, record reviews, and interviews, the facility management failed to utilize its resources to attain or maintain the highest practicable physical and psychosocial well-being of each resident as identified by the deficient practices cited. The facility staff identified a census of 79. Findings are:A record review of the facility's Job Description And Performance Standards Administrator dated 04/22/2025 revealed the Administrator's position was responsible for establishing and maintaining systems in an effective and efficient manner and operate the facility in a manner to safely meet the needs of the residents in compliance with federal, state, and local requirements. The Administrator' job functions included ensuring staff identified and reviewed resident's incidents, accidents, complaints, concerns, and provision of resident care and service and take action to alleviate problems and prevent reoccurrence. The Administrator was responsible for the facility quality assurance performance improvement committee and to review, discuss, and implement recommendations on resident care. The Administrator would consult with the department supervisors regarding staffing, in-service attendance, and the overall effectiveness of each department. The Administrator would oversee the hiring, orientation, and training of nursing staff, communicate with physicians and families of residents regarding notable changes of the resident's status, and provide direction and monitoring for nurses and medication aides on an ongoing basis with input from the Director of Nursing (DON) and nurse managers. The Administrator was responsible for the review of nursing guidelines annually with input from the DON and Medical Director and implement changes accordingly. The Administrator would review therapeutic diets as ordered by the resident's physician. A record review of the facility's Job Description And Performance Standards Director of Nursing dated 04/22/2025 revealed the DON was responsible for the oversight, coordination, and facilitation of all nursing services to ensure that quality care of each resident was provided while maintaining compliance with all local, state, and federal regulations and facility policies and procedures. administering the nursing program in a long-term care facility to maintain standards of resident care. The DON was responsible to oversee all staff interactions and provide direction as needed to ensure staff issues do not effect quality of care for the residents. The DON was to regularly inspect facility and nursing practices for compliance with federal. State and local standards and regulations. The DON would review nursing procedures manual periodically and maintain working knowledge of current procedures. The DON would follow universal precautions and observe infection control policies, including personal protective equipment (PPE) and hand-washing. A record review of the facility's Job Description And Performance Standards Assistant Director of Nursing (ADON) dated 04/22/2025 revealed the ADONs' essential job duties were to assist the DON with all the functions of the nursing department. The ADONs were to ensure compliance with federal, state, and local laws and regulations governing the facility. The ADONs were to assure regulatory compliance on updated care plans as needed, identify areas for improvement based on audits results and work with the nursing staff to modify the processes and educate the staff, and to follow up on dietary recommendations. The ADONs were to provide education and coaching to the nursing staff as needed to improve residents' outcomes. A record review of the facility's undated Job Description And Performance Standards Medical Director revealed that the Medical Director was responsible for overseeing the clinical care provided to residents, guiding facility-wide health policies and protocols, and ensuring regulatory compliance. On the revisit survey with an exit date of 07/20/2026, the survey team identified the repeat deficiencies of F657, F693, F880, and F689 from the previous complaint surveys, and identified the additional deficiencies of F726, F835, and F867. F657: The facility failed to review and revise 1 (Resident 102) of 3 sampled resident's care plan related to all nutrition and hydration taken by mouth (PO) instead of enteral feeding (by tube inserted into the stomach) and failed to update the care plan for pressure ulcer (wound) prevention and treatment for 3 (Resident 4, 506, and 509) of 4 sampled residents. An observation conducted on (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	07-13-2026 at 11:12 AM revealed Resident 4 was in bed and there was no fall mat next to the bed. An observation conducted on 07-13-2026 revealed Resident 4 was lying in bed and had a green heel protector that wrapped around Resident 4's right ankle. An interview conducted on 07-15-2026 at 12:30PM with NP B who revealed the facility staff requested an order for Prevalon boots and Nurse Practitioner (NP) B ordered what was requested and stated the little green heel protectors are with me. An interview conducted on 07-16-2026 at 12:30 PM with the Regional Nurse Consultant (RNC) confirmed Resident 4's care plan for falls had not been revised and should have been and interventions on the care plan should reflect the correct type of pressure reducing device used for pressure ulcer prevention. An observation conducted on 07-13-2026 at 11:10 AM revealed Resident 506 was in the wheelchair in the hallway outside of the room, observation of the room revealed a pressure relief mattress on the bed and the absence of a Prevalon boot in the room and closet. An interview conducted on 07-16-2026 at 12:10 PM with ADON A confirmed the practitioner had not ordered the pressure relieving wedge and confirmed Prevalon boot was listed as an intervention on the care plan. A record review of Resident 102's Care Plan Report with an admission date of 05/15/2025 revealed the resident required enteral feeding related to the resident revisited eating. The resident had weight loss since admission and had diarrhea (loose stools) with the tube feeding. An intervention was the resident was dependent with tube feeding and water flushes. See Doctor of Medicine (MD) orders for current feeding orders. In an interview on 07/15/2026 at 7:14 AM, the DON confirmed that Resident 102's care plan had not been revised to reflect that Resident 102 was receiving all nutrition and hydration by mouth and not receiving enteral feedings or percutaneous endoscopic gastrostomy (PEG, a tube inserted directly into the stomach to administer nutrients and medications) tube flushes. The DON confirmed the DON called the ADON-A for the resident's floor, and the ADON confirmed the care plan was not revised to indicate the resident was 100% intakes by mouth instead of enteral feedings. An interview conducted on 07-16-2026 at 12:00 PM with ADON A confirmed Resident 506 had not been wearing a Prevalon boot and was uncertain whether the positioning wedge was to be used instead. An interview conducted on 07-16-2026 at 12:10 PM with ADON A confirmed the practitioner had not ordered the pressure relieving wedge and confirmed Prevalon boot was listed as an intervention on the care plan. F693: The facility failed to administer the correct amount of enteral nutrition (liquid formula containing nutrients) per the provider's order on 1 (Resident 103) of 3 sampled residents, ensure flush orders were obtained for 1 (Resident 102) of 3 sampled resident's PEG tube, and ensure 2 (Residents 103 and 101) of 3 sampled resident's enteral nutrients were refrigerated after opening the container per the manufacturer's recommendations. An observation on 07/13/2026 at 2:02 PM revealed Licensed Practical Nurse (LPN)-G did not administer the correct amount of enteral nutrition. In an interview on 07/14/2026 at 1:25 PM, the DON confirmed LPN-G should have used a graduate to measure Resident 103's Glucerna 1.5 but did not. An observation of Resident 102's PEG tube cares on 07/13/2026 at 1:10 PM revealed LPN-J entered the room and cleaned and applied a new split sponge to the resident's peg tube site but that was all LPN-J done. The PEG tube contained a dark brown, crusty substance inside the PEG tube. In an interview on 07/14/2026 at 1:25 PM, the DON confirmed that Resident 102's PEG tube should have been flushed per best practice but was not completed. An observation on 07/13/2026 at 2:02 PM with the DON revealed Licensed Practical Nurse (LPN)-G entered Resident 103's room, completed the resident's enteral feeding using an opened, partially used, 1000 milliliters (mL) container of Glucerna 1.5 ready to hang (RTH) bottle that was sitting on the dresser, placed the cap back on Glucerna 1.5 and placed the container back on dresser. In an interview on 07/16/2026 at 8:25 AM, the DON confirmed the staff leaves the opened bottles of enteral nutrients in the resident's rooms between enteral feedings. The DON confirmed the staff does not refrigerate the 1000 mL bottles of enteral nutrition after they have been opened. The DON confirmed the Osmolite 1.5 RTH and the Glucerna 1.5 RTH should have been refrigerated after opened per the manufacturer's data sheets. An observation on 07/16/2026 at 8:11 AM with LPN-M revealed an opened, partially used, warm to the touch, 1000 (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	mL bottle of Glucerna 1.5 RTH sitting on the resident's bedside table. The bottle was dated 07/15/2026 at 9:30 PM. In an interview on 07/16/2026 at 8:25 AM, the DON confirmed the staff leaves the opened bottles of enteral nutrients in the resident's rooms between enteral feedings. The DON confirmed the staff does not refrigerate the 1000 ml bottles of enteral nutrition after they have been opened. The DON confirmed the Osmolite 1.5 RTH and the Glucerna 1.5 RTH should have been refrigerated after opened per the manufacturer's data sheets.In an interview on 07/16/2026 at 11:22 AM, the facility's NP-N confirmed the enteral feeding nutrients should have been refrigerated after opening.F689 - the facility failed to perform treatment for pressure ulcers according to the practitioner's orders for Resident 509, failed to accurately complete and score the Braden Scale for Resident 4 and 509, and failed to evaluate, implement and monitor interventions to prevent pressure ulcer development and to promote wound healing for 4 (Resident 4, 502, 506, and 509) of 4 residents sampled.An observation conducted on 07-14-2026 at 6:00 AM revealed Resident 509 was lying in bed without pressure-relieving boots, and the plantar surfaces of both feet were touching the mattress.An observation conducted on 07-15-2026 at 10:05 AM of LPN G and the ADON B providing wound care to Resident 509 revealed both wounds were washed with wound cleanser and patted dry, silvadene cream was placed in the wound bed and Opticell AG dressing was cut to size and placed in the wound beds and then covered with a bordered gauze. During this observation Resident 509 did not want the Mepilex dressing used because it rolls and comes loose with muscle spasms and wanted the bordered gauze dressing used instead because it stays in place.An interview conducted on 07-16-2026 at 9:43 AM with ADON B confirmed the physician's order was not followed and confirmed the use of Opticell AG dressing for the wound care instead of Aquacel dressing that was ordered.An interview conducted on 07-16-2026 at 10:15 AM with ADON C confirmed upon review of Resident 509's Braden Scale Score of 17 dated 07-15-2026 indicating mild risk for pressure ulcer development was incorrect as it indicated the resident had no sensory impairment and Resident 509 was quadriplegic and had sensory impairment and had developed pressure ulcers to both feet. The interview also revealed that ADON C was uncertain what interventions were put into place when the left plantar foot pressure ulcer was identified to prevent further pressure ulcer development before the right plantar foot pressure ulcer developed.An interview conducted on 7-16-2026 at 11:30 AM with NP N confirmed the Opticell AG dressing and Aquacel dressing were not the same and were not interchangeable.F867 - The facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program identified and addressed concerns related to deficient practice identified on the survey and ensure correction for repeat deficient practice from previous surveys were maintained. This had the potential to affect all residents that resided in the facility. In an interview on 7/20/26 at 12:38 PM with the RNC when asked if the issues being cited should have been identified by the facility prior to the visit it was reported [they] would be remiss in saying they did everything perfectly and they should have caught it. Further interview revealed they were looking at specifics in the audits being completed and not the regulation as a whole, and they need to do better. F686 - The facility failed to treatment for pressure ulcers according to the practitioner's orders for Resident 509, failed to accurately complete and score the Braden Scale for Resident 4 and 509, and failed to evaluate, implement and monitor interventions to prevent pressure ulcer development and to promote wound healing for 4 (Resident 4, 502, 506, and 509) of 4 residents on sample. An interview conducted on 06-16-2026 at 9:00 AM with the ADON A revealed (gender) had looked at Resident 502's skin to the buttocks and there was no skin issues before requesting to discontinue the Calmoseptine Ointment on 06-12-2026 and confirmed that the Skin/Wound Weekly Observation (SWWO)'s before and after 06-12-2026 had identified a skin issue to the buttocks and Resident 502 did not receive the treatment after 06-15-2026 until the Deep Tissue Injury (DTI) to the right gluteal fold was identified on 06-24-2026. An observation conducted on 07-15-2026 at 10:45 of ADON A providing wound care to Resident 4's right heel revealed a DTI that was covered with black eschar measuring approximately 2.5 centimeters (cm) in length and 2 cm in width. During the interview, ADON A confirmed that the green heel protector was a Prevalon boot. An (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	interview conducted on 07-15-2026 at 11:30 AM with the ADON A confirmed the green heel protector was not a Prevalon boot and the Nurse Practitioner was aware of the use of the green heel protector and was ok with it. An interview was conducted on 07-16-2026 at 11:30 AM confirmed the Braden Scale conducted on 06-25-2026 should have been scored as a 12 and the box indicating the score was 16 or less should have not been checked no. An interview conducted on 07-20-2026 at 11:00 AM with ADON A confirmed a SWWO was not completed between 06-10-2026 and 06-22-2026 when the DTI was identified. An observation conducted on 07-14-2026 at 10:05 AM resident is lying in bed with wedge under the left leg and left heel is still touching the mattress and no Prevalon boot to either foot. In an interview conducted on 07-16-2026 at 12:00 PM with ADON A confirmed Resident 506 had not been wearing a Prevalon boot and was uncertain whether the positioning wedge was to be used instead. An interview conducted on 07-16-2026 at 12:10 PM with ADON A confirmed the practitioner had not ordered the pressure relieving wedge and confirmed Prevalon boot was listed as an intervention on the care plan. An interview conducted on 07-16-2026 at 9:43 AM with ADON B confirmed the physician's order was not followed and confirmed the use of Opticell AG dressing for the wound care instead of Aquacel dressing that was ordered. An interview conducted on 07-16-2026 at 10:15 AM with ADON C confirmed upon review of Resident 509's Braden Scale Score of 17 dated 07-15-2026 indicating mild risk for pressure ulcer development was incorrect as it indicated the resident had no sensory impairment and Resident 509 was quadriplegic and had sensory impairment and had developed pressure ulcers to both feet. The interview also revealed that ADON C was uncertain what interventions were put into place when the left plantar foot pressure ulcer was identified to prevent further pressure ulcer development before the right plantar foot pressure ulcer developed. An interview conducted on 7-16-2026 at 11:30 AM with NP N confirmed the Opticell AG dressing and Aquacel dressing were not the same and were not interchangeable. F726 - The facility failed to ensure licensed nurse's received competency evaluations for enteral tube feedings, wound care and Enhanced Barrier Precautions (EBP) for 3 of 3 nurses employed at the facility. Record review of LPN G's employee filed revealed LPN G was hired on 05-13-2020 and the absence of competency evaluations for enteral tube feedings, wound care (other than negative pressure wound therapy), or EBP. Record review of ADON A' s employee file revealed ADON A was hired on 05-18-2026 and the absence of competency evaluations. Record review of ADON B's employee file revealed ADON B was hired on 03-26-2019 and the absence of competency evaluations. An interview conducted with the RNC on 07-20-2026 at 2:00 PM confirmed competency testing had not been completed for ADON A and ADON B. In an interview on 7/20/26 at 12:38 PM, the RNC when asked if the issues being cited should have been identified by the facility prior to the visit it was reported [they] would be remiss in saying they did everything perfectly and they should have caught it. Further interview revealed they were looking at specifics in the audits being completed and not the regulation as a whole, and they need to do better.

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	06/16/2026

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 0867 Level of Harm - Actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Licensure Reference Number 175 NAC 12-006.07(C) Based on observation, interview, and record review, the facility failed to ensure the Quality Assurance and Performance (QAPI, . It is a data-driven, proactive program required by the Centers for Medicare and Medicaid Services for healthcare facilities like nursing homes to continuously track and elevate patient care safety and quality) program identified and addressed concerns related to deficient practice identified on the survey and ensure correction for repeat deficient practice from previous surveys were maintained. This had the potential to affect all residents that resided in the facility. The facility census was 79. Findings are:A record review of facility policy titled Quality Assurance and Performance Improvement (QAPI) Program-Governance and Leadership with a created date of 1-2024 revealed the following:Policy: The Quality Assurance and Performance Improvement Program is overseen and implemented by the QAPI committee, which reports its findings, actions, and results to the Administrator and governing body.Policy Interpretation and Implementation1. The Administrator, whether a member of the QAPI committee or not, is ultimately responsible for the QAPI program, and for interpreting its results and findings to the governing body.2. The governing body is responsible for ensuring that the QAPI program:a. Is implemented and maintained to address identified priorities;b. Is sustained through transitions of leadership and staffing;c. Is adequately resourced and funded, including the provision of money, time, equipment, training and staff coverage sufficient to conduct the activities of the program;d. Is based on data, resident and staff input, and other information that measures performance; and e. Focuses on problems and opportunities that reflect processes, functions and services provided to the residents. 11. Governance and leadership-a. The governing body and/or executive leadership is responsible and accountable for the QAPI program.b. Governing oversight responsibilities include, but are not limited to the following: i. Approving the QAPI plan annually and as needed. ii. Ensuring the program is ongoing, defined, implemented, maintained, and addresses identified priorities.iii. Ensuring the program is sustained during transitions in leadership and staffing.iv. Ensuring the program is adequately resourced, including ensuring the staff time, equipment, and technical training as needed.v. Ensuring the program identifies and prioritizes problems and opportunities that reflect organizational processes, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.vi. Ensuring that corrective actions address gaps in systems and are evaluated for effectiveness.vii. Setting clear expectations around safety, quality, rights, choice, and respect. During the recent survey with an exit date of 07/20/2026 the following deficiencies and repeat deficiencies were identified: F657 The facility failed to review and revise Resident 102's care plan related to 100 % PO (oral intake) instead of enteral intakes and failed to update the care plan for pressure ulcer prevention and treatment for Resident 4, 506 and 509.F686- The facility failed to provide treatment for pressure ulcers according to the practitioner's orders for Resident 509, failed to accurately complete and score a Braden's scale for Resident 4 and 509, and failed to evaluate, implement and monitor interventions to prevent pressure ulcer development and to promote wound healing for Resident 4, 502, 506, 509.F689 The facility failed to ensure fall interventions were in place according to the plan of care for Resident 4.F693 The facility failed to administer the correct amount of enteral nutrition per the provider's order for Resident 103, ensure flush orders were obtained for Resident 102's PEG tube, and ensure Resident 103 and 101's enteral nutrients were refrigerated within 1 hour of opening the container per manufacturer's recommendations. A record review of the facility's last standard survey results from the 03/20/2025 survey revealed the facility was cited for:F580-Notify of Changes (Injury/Decline/Room Change);F677-ADL Care Provided for Dependent Residents;F684-Quality of Care;F686-Treatment/Services to prevent/heal Pressure Ulcer-Repeat;F689-Free from Accident Hazards/Supervision/Devices -Repeat;F756-Drug Regimen Review;F758-Free from Unnecessary (continued on next page)

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	285058	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0867 Level of Harm - Actual harm Residents Affected - Some	Psychotropic Meds/PRN (as needed) use; andF812-Food Procurement, Store/Prepare/Serve-Sanitary. A Record review of the facility survey results from a revisit survey on 3/18/26 revealed the following were cited:F657-Care Plan Timing and Revision-Repeat; andF686-Treatment/Services to prevent/heal Pressure Ulcer-Repeat. A Record review of the facility survey results from a complaint survey on 3/24/26 revealed the facility was cited for:F689-Free from Accident Hazards/Supervision/Devices -Repeat. A record review of a facility survey from a complaint survey on 4/9/26 revealed the facility was cited for:F689-Free from Accident Hazards/Supervision/Devices -Repeat. A record review of a facility survey from a complaint survey on 5/7/26 revealed the facility was cited for:F689-Free from Accident Hazards/Supervision/Devices-Repeat; andF693-Tube Feeding Management/Restore Eating Skills- Repeat. A record review of a facility survey from a complaint survey on 6/16/26 revealed the facility was cited for:F657-Care Plan Timing and Revision -Repeat; andF689-Free from Accident Hazards/Supervision/Devices- Repeat In an interview on 7/20/26 at 12:38 PM with the Regional Nurse Consultant when asked if the issues being cited should have been identified by the facility prior to the visit it was reported [they] would be remiss in saying they did everything perfectly and they should have caught it. Further interview revealed they were looking at specifics in the audits being completed and not the regulation as a whole, and they need to do better.