| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285059 | A. Building<br>B. Wing | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rose Blumkin Jewish Home | 323 South 132nd Street<br>Omaha, NE 68154 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Licensure Reference Number 175 NAC 12-006.18 (B & D)Licensure Reference Number 175 NAC 1-005.06(D)Based on observation, interview, and record review, the facility failed to ensure staff followed hand washing and gloving practices following cares for 2 (Resident 2 and 3) of 2 sampled residents; failed to ensure staff donned (applied) and doffed (removed) required personal protective equipment (PPE) while working with a resident in contact isolation for 1 (Resident 2) of 1 sampled residents; failed to ensure staff did not allow potentially contaminated surfaces to contact staff clothing; and failed to sanitize potentially contaminated resident care equipment after use. This had the potential to affect all 24 residents who resided on the secured unit.Findings are:Record review of facility policy entitled Hand Hygiene & Gloving dated modified July 2023 revealed: -Hand hygiene may be performed using soap and water or by using an alcohol-based hand rub (ABHR). ABHR can not be used if hands are visibly soiled or when in contact with Clostridioides difficile [C. diff}, norovirus or other spore producing infections. -Wash hands vigorously for approximately 20 seconds, being careful to cover every area. -Gloves will be worn when contact with body fluids, mucous membranes and non-intact skin is anticipated and hand hygiene will be performed prior to and after the removal of gloves.<br><br>Record review of facility policy entitled Infection Prevention and Control Program modified December 2025 revealed: -Environmental Controls: Multiple resident use equipment that has the potential for contamination with blood and other body fluids will be cleaned with approved cleaning wipes after each Resident use. These devices include but are not limited to the nurse's personal stethoscope.<br><br>Record review of facility education entitled C. diff dated 03/2026 revealed: -Wash your hands with soap and water only, no hand sanitizer can be used. -Bleach wipes to clean/sanitize. No purple lid wipes, they do not kill the bacteria.<br><br>A. Record review of Resident 2's Diagnosis Report revealed the resident had diagnosis of enterocolitis due to clostridium difficile.<br><br>Record review of Resident 2'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) revealed staff were to wash hands with soap and water, use gown and gloves when caring for the resident dated 03/26/2026.<br><br>Observation on 04/14/2026 from 11:52 AM to 12:08 PM revealed Registered Nurse (RN)-B administered Resident 2's tube feeding. RN-B and Nurse Aid (NA)-E were both utilizing gown and gloves. NA-E was in the room, finished cares with Resident 2, doffed gloves and removed the trash liner for the receptacle. RN-B asked NA-E for assistance with getting Resident 2 to the bathroom so Resident 2 could brush teeth. With bare hands, NA-E used the left hand to move the gown out of the way and used the right hand to dispense hand sanitizer with the right hand meeting the hip area of<br>(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 |
|---|---|---|---|
| | 285059 | A. Building<br>B. Wing | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rose Blumkin Jewish Home | 323 South 132nd Street<br>Omaha, NE 68154 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | NA-E's uniform. NA-E donned gloves and assisted Resident 2 and RN-B into the restroom. NA-E remained in the room to finish oral care with the resident.<br><br>RN-B doffed gown and gloves exited the room, and applied alcohol-based hand rubbed. RN-B proceeded to the medication cart where they documented the care that was performed.<br><br>Interview on 04/14/2026 at 12:09 PM with RN-B confirmed ABHR was used for hand hygiene. RN-B further confirmed they should have washed hands with soap and water.<br><br>Interview on 04/14/2026 at 1:25 PM with NA-E confirmed use of ABHR before donning new gloves in Resident 2's room. NA-E reported they were unaware soap and water must be used when working with residents who have a C. diff infection.<br><br>Interview on 04/14/2026 at 1:36 PM with the Infection Preventionist (IP) confirmed soap and water must be used for hand hygiene when working with residents who were infected with C. diff. The IP confirmed the failure to wash hands with soap and water had the potential for cross contamination.<br><br>B. Observation on 04/15/2025 at 5:48 AM with Licensed Practical Nurse (LPN)-A revealed LPN-A donned gown, gloves, and goggles and entered Resident 2's room to disconnect the tube feeding at the ordered time. LPN-A reported to the surveyor they needed the medication/treatment cart before continuing. LPN-A doffed gown and gloves, exited the room without performing hand hygiene with soap and water, and retrieved the cart. LPN-A returned to the room, washed hands with soap and water for 21 seconds, donned PPE and disconnected the tube feeding. LPN-A, utilizing a personal stethoscope placed the bell of the stethoscope on Resident 2's abdomen to check for placement of the feeding tube. LPN-A completed tasks, doffed gloves, washed hands for 22 seconds and donned new gloves. LPN-A touched the sink, a graduate, and a new syringe package that was previously removed from the cabinet in the restroom. LPN-A moved their gown, and with gloved hands, used the right hand to reach into the pocket to retrieve a marker. LPN-A labeled supplies in the room and replaced the marker in the right pocket. LPN-A doffed all PPE, washed hands with soap and water for 20 seconds and exited the room. In the hallway, LPN-A used a purple-top wipe (sanitizing cloth) and cleansed the personal stethoscope.<br><br>Interview on 04/15/2026 at 6:12 AM with LPN-A confirmed they did not wash hands with soap and water when they left the room to retrieve the cart. LPN-A further confirmed a purple-top disinfecting wipe was used to cleanse the personal stethoscope and that the gloved right hand came in contact with objects in the resident's room before retrieving a marker out of the right pocket. LPN-A reported they had received training from the facility regarding C. diff but could not recall when or in what method the training was delivered.<br><br>Interview on 04/15/2026 at 6:16 AM with the Director of Nursing confirmed bleach wipes must be used for equipment and further confirmed purple-top wipes would not kill C. diff spores. The DON confirmed LPN-A should have used soap and water to wash hands when leaving the room and confirmed the potential for cross contamination when LPN-A placed the gloved hand in the uniform pocket.<br><br>C.<br><br>A record review of the United States (US) Centers for Disease Control and Prevention's (CDC) C. diff (Clostridioides difficile) Facts for Clinicians) dated 03/05/2024 revealed C. diff sheds in feces and<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285059 | A. Building<br>B. Wing | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rose Blumkin Jewish Home | 323 South 132nd Street<br>Omaha, NE 68154 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | any surface, device or material that becomes contaminated with feces could serve as a reservoir (a source where an infectious agent lives, grows, and multiplies) for the C. diff spores (a cell that certain fungi, plants, and bacteria produce). If C. diff is suspected or confirmed the resident should be isolated (physical separation of individuals who have a contagious disease from those who are health to prevent the spread of the infection) and placed in contact precautions (a type of transmission-based infection control designed to prevent the spread of infections transmitted by direct or indirect contact with a patient's body fluids or contaminated environment). https://www.cdc.gov/c-diff/hcp/clinical-overview/index.html#:~:text=Treatment%20and%20recovery,including%<br><br>A record review of two undated signs located by the door to Resident 2's room revealed a sign that indicated the resident was in contact precautions and everyone must clean their hands before entering and when leaving the room and providers and staff must also put on gowns and gloves before entering and before leaving the resident's room. The other sign was a sign that indicated the resident was in Enhanced Barrier Precautions (EBP) and everyone must clean their hands before entering and when leaving the room and providers and staff must also put on gowns and gloves when performing high-contact Resident Care Activities that included transferring.<br><br>A record review of Resident 2's Care Plan Report with a print date 04/15/2026 revealed a problem area of the resident was at risk of infection and had C. diff, a gastrostomy tube (a tube inserted into the stomach for direct access to nutrients, hydration, and medication delivery) and a nephrostomy tube (a tube inserted into the kidney to drain urine into an external bag. The report had interventions of EBP and C diff – wash hands with soap and water, use precautions of gown/gloving when caring for the resident.<br><br>An observation on 04/14/2026 at 1:33 PM – 150 PM revealed Resident 2 was in sitting in a wheelchair in the middle the main hallway of the Southwest unit (resident rooms 401 – 421). The resident was speaking with the resident's nurse practitioner, Occupational Therapist (OT)-C, and Physical Therapy Assistant (PTA)-D. At 1:38 PM, PTA-D assisted the resident from the wheelchair to a standing position, and the resident walked down the main hallway with a walker and PTA-D beside the resident holding the resident gait belt and touching the resident nephrostomy tube drain bag with PTA-D's right hand. PTA-D had gloves on, but neither the resident nor PTA-D had a gown on. OT-C followed the resident with the resident's wheelchair with gloved hands, no gown. Resident 2, PTA-D, and OT-C walked all the way down the main hall and to the resident's room with PTA-D's and OT-C's clothing and PTA-D's bare left arm touching the resident, the resident's clothing, and/or the resident's wheelchair. When they got to the resident's room, PTA-D assisted the resident into the resident's wheelchair and removed the gait belt. OT-C entered the resident's restroom without donning (putting on) a gown, removed OT-C's gloves, washed hands, exited the resident's room and donned new gloves. PTA-D entered the resident's room without a gown, got the footrests for the resident's wheelchair, exited the room, and put the footrests on the wheelchair. PTA-D then touched Resident 2's thighs and lower legs to correctly position onto the footrests. OT-C and PTA-D then entered the resident's room while assisting the resident and made the resident comfortable while touching the curtain, bed, call light, and overbed table all without gowns on. OT-C removed gloves and washed OT-C's hands for greater than 20 seconds before exiting the room. PTA-D removed gloves, exited the room, and used hand sanitizer before walking back into the unit.<br><br>In an interview on 04/14/2026 at 1:50 PM OT-C, confirmed OT-C was the Therapy Director and the staff should only have to wear a gown if they were coming in contact with the resident's diarrhea. They would not have taken the resident out of the room if the resident was incontinent (unable to control bowels). OT-C confirmed that PTA-D should have washed hands with soap and water instead (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285059 | A. Building<br>B. Wing | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rose Blumkin Jewish Home | 323 South 132nd Street<br>Omaha, NE 68154 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | of using hand sanitizer since the resident had C. diff.<br><br>In an interview on 04/15/2026 at 6:55 AM, the DON confirmed OT-C and PTA-D should have worn gowns when working with Resident 2 and when entering Resident 2's room. The DON confirmed PTA-D should have washed hands with soap and water instead of using hand sanitizer after working with Resident 2.<br><br>D.<br><br>A record review of Resident 3's Care Plan Report with a print date of 04/14/2026 revealed the resident had a PEG (percutaneous endoscopic gastrostomy) tube (a tube inserted into the stomach to deliver nutrients, hydration, and medications) and the resident was on EBP. The resident had orders for enteral feeding (delivery of nutrients directly to the stomach), PEG tube flushes, and medication delivery through the PEG tube.<br><br>In an observation on 04/15/2026 at 4:54 AM – 5:26 AM revealed LPN-A applied gloves after performing handwashing with soap and water for 7 seconds before adjusting the resident's room to prepare for cares, starting cares on the resident. Removed gloves and applied new gloves after handwashing with soap and water for 5 seconds before preparing PEG tube flush water. Removed gloves and applied new gloves after handwashing with soap and water for 8 seconds before starting the PEG tube flush and medication administration through the PEG tube. Removed gloves and applied new gloves after performing handwashing with soap and water after PEG tube cares and before removing trash and cleaning supplies.<br><br>In an interview on 04/15/2026 at 5:26 AM, LPN-A confirmed LPN-A should have washed hands with soap and water for at least 20 seconds each time and did not.<br><br>In an interview on 04/15/2026 at 7:06 AM, the DON confirmed LPN-A should have washed hands with soap and water for at least 20 seconds. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285059 | A. Building<br>B. Wing | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rose Blumkin Jewish Home | 323 South 132nd Street<br>Omaha, NE 68154 |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Licensure Reference Number 175 NAC 12-006.09(F)(iii)Based on record review and interview, the facility failed to update the care plan with new interventions to prevent the potential for accidents for 1 (Resident 23) of 2 sampled residents. Facility staff identified a census of 95.Findings are:Record review of facility policy entitled Minimum Data Set (MDS) and Comprehensive Care Plan dated modified October 2023 revealed: - The comprehensive care plan is designed to meet the Resident's medical, nursing, mental and psychosocial needs as identified in the MDS [a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems] and as assessed by the Interdisciplinary Team (IDT). - The Comprehensive Care Plan may include the following areas, if appropriate, but not limited to, services to attain and maintain residents highest level of functioning: - Risks for: elopement, falls, skin breakdown, incontinency, dehydration, weight loss. - The care plan will be updated by floor staff as changes occur with a resident when the change occurs. - The Care Plan is to be modified as the Resident's condition warrants. All members of the team are responsible for updating the Care Plan.Record review of Resident 23's Progress Notes (PN) dated 02/22/2026 revealed Resident 23 reported they sustained an unwitnessed fall earlier in the day. Resident 23 reported they fell asleep in the wheelchair and slid out of the seat and onto the floor. Resident 23 further reported they got themselves up off the floor and back into the wheelchair independently. Facility staff notified the Advanced Practice Registered Nurse (APRN) and orders were received to complete an x-ray of the left shoulder for complaints of pain and difficulty moving left arm. Record review of Resident 23's PNs dated 02/23/2026 revealed the facility was notified of a fracture to Resident 23's left clavicle (collarbone).Record review of facility investigation dated 02/26/2026 revealed the following safety measures were implemented: bed alarms remained in use, increased monitoring implemented, therapy continued to evaluate mobility and seating options, staff were instructed to assist Resident 23 to bed if sleepy, and ongoing communication maintained with resident and spouse.Record review of Resident 23'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 04/15/2026 revealed no new interventions added to the care plan after the fall.Interview on 04/15/2026 at 10:54 AM with the Director of Nursing (DON) confirmed implemented interventions from the fall on 02/22/2026 were not listed on the care plan and should have been. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285059 | A. Building<br>B. Wing | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rose Blumkin Jewish Home | 323 South 132nd Street<br>Omaha, NE 68154 |

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 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)Based on record review, observation, and interview, the facility failed to obtain an order for tube feeding that included the formula type and strength and failed to record the amount of tube feeding administered for 1 (Resident 2) of 2 sampled residents. Facility staff identified a census of 95.Findings are:Record review of facility policy entitled Gastrostomy Tube/Jejunostomy Tube (G-Tube, a tube placed in the stomach to deliver nutrition, hydration, and/or medications. J-Tube a tube placed directly in the small intestine to deliver nutrition, hydration, and/or medications) modified August 2022 revealed: -The physician must prescribe the formula type, strength and rate. -Tube feeding pumps must be cleared each shift and intake total recorded each shift when receiving continuous feedings.Record review of Resident 2's Census List showed the facility readmitted the resident on 02/26/2026.Record review of Resident 2's Diagnosis Report showed Resident 2 had diagnoses that included dysphagia (difficulty swallowing).Record review of Resident 2's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 03/05/2026 identified Resident 2 had weight loss and was not on physician-prescribed weight-loss regimen. Further review of the MDS identified Resident 2 had a feeding tube and received 51 percent (%) or more of total calories and 501 milliliters (mL) of fluid intake per tube. Record review of Resident 2's Order Summary Report revealed an Enteral Feed Order every shift for nutrition to administer 73 ml per hour for 18 hours from 12:00 PM to 6:00 AM and off 6 hours (6:00 AM to 12:00 PM). The order did not include the formula type or strength.Record review of Resident 2's Medication Administration Record for April 2026 revealed there was no area to document the amount of tube feeding administration.Record review of Resident 2's Electronic Health Record (EHR) including scanned documents and progress notes did not identify any progress notes regarding the amount of tube feeding administered, nor any notes regarding any significant amount of time the feeding tube pump was not running during administration times.Observation on 04/14/2026 from 11:52 AM to 12:08 PM revealed Registered Nurse (RN)-B began the infusion of Nutren 1.5 and set the pump to a flow rate of 73 mL per hour.Observation on 04/15/2026 from 5:48 AM to 6:10 AM revealed Licensed Practical Nurse (LPN)-A disconnected Resident 2's tube feeding and flushed the tube. The tube feeding pump read 1070 mL's were administered.Interview on 04/15/2026 at 6:10 AM with LPN-A confirmed the tube feeding pump read 1070 mL's were administered. LPN-A reported they clear the pump totals when the administration is completed.Interview on 04/15/2026 at 7:47 AM with RN-F revealed there was no place in the medical record to their knowledge to record the amount of tube feeding administered to a resident.During an interview on 04/15/2026 at 9:49 AM, the Director of Nursing (DON) confirmed the total amount of tube feeding to be administered of 18 hours was 1,314 mL. The DON reported the facility was not recording tube feeding amounts and were relying on if there was a significant amount of time the tube feeding was held, the nurse would make a progress note. The DON confirmed there were no progress notes from 04/14/2026 to 04/15/2026 that showed the tube feeding was held. The DON reported they were unable to confirm Resident 2 received the full tube feeding amount because the feeding pump may have been cleared at any point in the night.Phone interview on 04/16/2026 at 10:53 AM with the DON confirmed the tube feeding formula type and strength were not listed in the order on the MAR and should have been. The DON further confirmed facility staff would rely on the order listed in the MAR to know what type and strength of tube feeding formula that should be administered. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285059 | A. Building<br>B. Wing | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rose Blumkin Jewish Home | 323 South 132nd Street<br>Omaha, NE 68154 |

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 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that the resident and his/her doctor meet face-to-face at all required visits.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the initial comprehensive and alternating regulatory visits for 2 (Residents 2 and 3) of 2 sampled residents were completed by a physician. The facility census was 95. Findings are:A record review of the facility's Physician Visit policy with a revised date of January 2018 revealed a nurse practitioner (APRN), clinical nurse specialist (CNS), or physician assistant (PA) may make every other required visit after the initial physician visit while the resident is Skilled Medicare A. For residents who are not admitted under a Skilled Medicare A stay, after the initial physician visit, the APRN, CNS, or PA may conduct all follow up visits.<br><br>A.<br><br>A record review of Resident 3's Clinical Census dated 04/14/2026 revealed that the resident was admitted to the facility 11/11/2025 as private pay (not Skilled Medicare A). The resident was sent to the hospital on [DATE] and returned to the facility as a Skilled Medicare A resident on 01/07/2026.<br><br>A record review or Resident 3's Client Uploaded Files dated 04/15/2026 revealed the APRN completed the:<br><br>- 11/12/2025 initial comprehensive visit.<br><br>- 12/12/2025 a 30-day certification visit.<br><br>- 01/12/2026 a 60-day certification visit instead of the physician completing a new initial comprehensive visit since the resident was re-admitted as a Skilled Medicare A resident on 01/07/2026.<br><br>- 2/12/2026 a 90-day certification visit, but it should have been a 30-day visit, but the physician still had not completed the initial comprehensive visit.<br><br>- 03/18/2026, 03/19/2026, and 03/21/2026 visits were completed but not labeled as a certification visit.<br><br>- 04/09/2026 a 60-day certification visit was completed but should have been the 90-day certification visit from the 01/07/2026 re-admission.<br><br>- It did not reveal that a physician visit had been completed.<br><br>A record review of Resident 3's Progress Notes dated 11/11/2026 – 04/14/2026 did not reveal an initial comprehensive visit was completed by a physician. The Progress notes did reveal the APRN completed a visits with the resident on 11/12/2025, did a chart review on the resident 12/2/2025, did not reveal a visit was done 12/12/2025, completed a visit on the resident 01/08/2026, did not reveal a visit was completed 01/12/2026 but the resident was sent to the emergency room that day to related to a fall, saw the resident 02/02/2026, 02/06/2026, 02/12/2026, 02/17/2026, 02/23/2026, and 03/19/2026.<br><br>In an interview on 04/15/2026 at 7:06 AM, the Director of Nursing (DON) confirmed that Resident 3's doctor was the facility's Medical Director (MD) and MD has not seen the resident at the facility, just (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285059 | A. Building<br>B. Wing | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rose Blumkin Jewish Home | 323 South 132nd Street<br>Omaha, NE 68154 |

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 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the APRN.<br><br>In an interview on 04/15/2026 at 9:50 AM, the DON confirmed the only visit Resident 3 had on admissions was the ones that were done by the APRN. The provider visits the resident had, would be in the miscellaneous tab in the computer. The resident did not have a follow-up visit by MD.<br><br>In an interview on 04/15/2026 at 11:08 AM, MD confirmed MD had not seen Resident 3 and MD delegated all the visit tasks to the APRN.<br><br>B. Record review of Resident 2's Census List revealed the facility admitted the resident on 01/27/2026. Further review of the census list showed the resident discharged on 01/28/2026 and was readmitted on [DATE].<br><br>Record review of Resident 2's admission and Medicare 5-day Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) revealed Resident 2 was readmitted on [DATE] on a Medicare Part A stay.<br><br>Record review of visit note created by the APRN dated 02/27/2026 revealed the reason for the visit was for admission history and physical.<br><br>Record review of Resident 2's Electronic Health Record (EHR) which included scanned documents and progress notes revealed no documentation that Resident 2 was seen by a medical doctor for the initial comprehensive visit.<br><br>Interview on 04/15/2026 at 6:54 AM with the DON confirmed there were no records of the medical doctor completing a visit with Resident 2. The DON reported the medical doctor had delegated visits to the APRN.<br><br>Interview on 04/15/2026 at 11:08 AM, the MD confirmed they had not seen Resident 2 and delegated visit tasks to the APRN. |