STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285092	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Columbus	2855 40th Avenue Columbus, NE 68601

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09Based on record reviews, observations and interviews, the facility failed to ensure that medications were administered as ordered by a health care provider for 1 of 3 sampled residents and failed to administer insulin injections per professional standards for 1 of 2 sampled residents The census at the time of the survey was 75. Findings are: ARecord review of the facility's policy titled Medication Administration dated 05/2017 revealed that the purpose of the policy is to ensure that residents are given the correct medication and dosage, at the scheduled time and by the right route (by mouth, injection, in eyes, nose, ears, etc.). Number 15 revealed that documentation of administration must be entered into the Medication Administration Record (MAR) as soon as medication is given and if the medication is not given, a reason for the omission must be documented. Record review of the facility's policy titled Medication Errors dated 11/17/2024 revealed that for each medication that are not administered document the rational as to why medication not administered.Record review of Resident 5's admission Record revealed that the resident was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes (a common form of diabetes that develops especially in adults and most often in obese individuals and that is characterized by high blood sugar resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production).Record review of Resident 5's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) revealed in Section C-Cognitive Patterns that Resident 5 has a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15 indicating the resident is cognitively intact.Record review of Resident 5's Order Summary (a summary of the resident's medication and treatment orders) dated 04/28/2026 revealed an order for Mounjaro injection (a GLP-1 medication used to treat type 2 diabetes) 15MG to be administered subcutaneously (beneath the skin) every 7 days with a start date of 11/13/2025.Record review of Resident 5's Electronic Medication Administration Record (EMAR, a record of the medication administered during a specified time period) with a print date of 04/28/2026 revealed that Mounjaro injections were not administered on 2 separate dates: 03/12/2026 and 04/02/2026. Interviews on 04/28/2026 at 10:50AM with Resident 5 confirmed that on at least 2 occasions Resident 5 did not receive the Mounjaro injections as ordered. Resident 5 voiced concerns regarding the missing doses as this medication was started after a different diabetes medication was discontinued. Resident 5 reports concerns about a possible increase in blood glucose levels (BGL). Resident 5 reports no confirmation on an increase of BGL as the resident has not been seen by a Primary Care Partitioner (PCP) since the 2 missed injections. Record review of Resident 5's progress notes dated 04/28/2026 revealed no progress notes related to the missed Mounjaro injections for 03/12/2026 and 04/02/2026. Record review of the facility's incident log revealed no medication errors were documented in the facility from 01/28/2026 to 04/28/2026. Interview with the Director of Nursing (DON) on 04/29/2026 at 11:26AM confirmed that Resident 5 did not receive the scheduled Mounjaro injections on 03/12/2026 and 04/02/2026, confirmed that there was no documentation in the resident's progress notes regarding the missed injections for either date, confirmed that the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's PCP was not notified of missed injections and confirmed that no incident report or medication error report was filed at the time of the incident. The DON revealed future plans for securing all GLP-1 medications as missing medications appear to be an issue. BRecord review of the facility's undated clinical performance check list titled Administer Insulin via Insulin Pen revealed the steps required to administer insulin to residents using an insulin pen (a pen that has been prefilled with insulin). Steps in the checklist revealed that after attaching a new needle onto the insulin pen, the pen is to be primed (a process of removing air bubbles from the needle prior to injection to ensure an accurate dose) by turning the dosage knob (knob used to dial up the correct units of insulin) to the 2 unit indicator. With the pen pointed up, push the knob down to dispense the 2 units. If no insulin is noted from the needle, repeat the primming process. Instructions on how to administer the injection into the resident revealed that after cleansing the injection site, insert the needle with a quick motion, slowly push the injection knob down and hold the pen at the site for 6-10 seconds and then pull the needle out. Observation on 04/28/2026 at 7:35 AM revealed the Licensed Practical Nurse (LPN) gathering the supplies needed to administer insulin to Resident 8. Record review of Resident 8's Order Summary dated 04/28/2026 revealed that Resident 8 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes and revealed orders for 13 units of long-acting insulin to be given every morning and 25 units of the long-acting insulin to be given at night. A short acting insulin is ordered to be given before meals and at bedtime. The order is written as sliding scale and is based on the resident's blood glucose level (BGL) prior to the injection. The LPN verified the number of units ordered for both the long-acting insulin and the short acting insulin based on the resident's BGL. The LPN cleaned the rubber stoper with an alcohol wipe prior to inserting the needle, dialed up the correct doses: 13 units for the long-acting insulin and 7 units for the short acting insulin. The LPN entered the resident's room, cleaned the injection site on the resident's right upper arm, injected the long-acting insulin, pulling the pen out immediately after pressing the plunger down. The LPN then repeated the process with the short acting insulin. The LPN did not prime either of the insulin pens prior to injecting them into the arm of Resident 5 and did not hold either of the insulin pens at the injection site for 6-10 seconds before removing them.Interview with the LPN on 04/28/2026 at 8:27 AM confirmed that neither of the insulin pens were primed prior to dialing up the ordered number of insulin units and confirmed that neither of the insulin pens were held at the injection site for 6-10 seconds after administration. Interview with the DON on 04/29/2026 at 11:26 AM confirmed that it is the facility's expectation that insulin pens be primed prior to use and that the pens are held in place for at least 10 seconds after the plunger injects the insulin to ensure an accurate dose is given.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review and interviews, the facility failed to ensure that the Daily Nurse Staff Posting was posted as required. This had the potential to affect all residents residing in the facility. The facility census was 75.Findings are:Record review of the facility policy titled Nurse Staff Posting and dated 1/2024 revealed the nurse staffing information will contain the following information:facility namethe current datefacilities current censusthe total number and actual hours workedThe facility will post the nurse staffing total at the beginning of each shift, and the posted information will be maintained for 18 months.An observation on 4/28/2026 at 9:37 AM during a facility walk through revealed no daily nursing staff posting in the facility.During an interview on 4/28/2026 at 9:37 the Director of Nursing (DON) confirmed the daily nurse posting was not posted anywhere and should have been. During an interview on 4/28/2026 at 9:40 DON confirmed that the facility census was 75 and there is 1 nurse on the floor scheduled for the dayshift and 1 nurse scheduled for the nightshift. During an interview 4/28/2026 at 12:48 PM Regional Nurse Consultant (RNC) confirmed the facility did not perform the required daily staff posting due to turnover in the scheduler position and that it had not been completed for the last 2 weeks.During an interview 4/29/2026 at 8:10 AM Scheduling Coordinator (SC) confirmed that (gender) started in the position on 4/8/2026 and was unaware the daily nurse staffing was to be completed or posted.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18Based on observation, record review and interviews, the facility failed to ensure Enhanced Barrier Precautions (EBP - an infection control strategy that focuses on prevention of the spread of Multidrug Resistant Organisms (MDRO's) in nursing homes) were followed when cares were provided to 1 out of 3 sampled residents, and the facility failed to ensure hand hygiene with glove changes for 2 out of 3 sampled residents, and the facility failed to clean and sanitize glucose monitor machine when used between 2 residents. The facility census was 75. Findings are:Record review of facility policy dated 1/2024 titled PPE Enhanced Barrier Precautions revealed EBP requires the use of gown and gloves for high-contact resident care activities.Record review of facility policy, titled Infection Control Standard Precautions - Handwashing, dated last revised 1/2024 revealed for staff to perform hand hygiene before and after contact with residents, and before applying gloves and after removal of gloves.A.An observation on 4/28/2026 at 11:03 AM of an EBP sign outside Resident 6's door instructed staff to wear gloves and gown for high contact resident care activities including when providing hygiene and changing briefs.An observation on 4/28/2026 at 11:04 AM Nursing Assistant (NA) - B removed a cylinder from under Resident 6's penis. The resident then rolled to the side and the NA removed the bedpan with gloves on. Peri cares were performed. NA - B did not wear a gown.An observation on 4/28/2026 at 11:05 AM revealed a 3 drawer tub inside Resident 6's room with gowns and gloves available.During an interview on 4/28/2026 at 11:05 AM NA - B revealed (gender) was unaware if it was needed to have on a gown or not when providing pericares for Resident 6.Record review of skin/wound assessment dated [DATE] for Resident 6 revealed Moisture Associated Skin Damage (MASD) to areas on the back of the resident's thighs.Review of Resident 6's Comprehensive Care Plan - (CCP- written instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care) date initiated 4/2/2024 revealed a history of Methicillin Resistant Staphylococcus aureus (MRSA) and MDRO infection.Record review of Resident 6's CCP revealed an intervention date initiated 7/2/2024 revealed staff to wear gowns and gloves during high-contact resident care activities.During an interview on 4/29/2026 at 9:47 AM Registered Nurse (RN) - A and Infection Preventionist (IP) nurse confirmed that staff do not have to wear gowns when doing peri cares for a resident with EBP for wounds.During an interview on 4/29/2026 at 10:57 AM NA -C confirmed that (gender) does consider peri cares as high contact care but did not think that oral cares would be considered high contact care.During an interview on 4/29/2026 at 10:59 AM NA - D confirmed that (gender) did not know which residents were on EBP or why.During an interview on 4/29/2026 at 11:08 AM RN IP - A confirmed that peri cares would be considered high contact care activities and that staff should wear gowns and gloves when performing peri cares for residents on EBP. During an interview on 4/29/2026 at 1:07 PM Resident 6 confirmed that staff do not wear a gown when they perform pericares, or when they transfer (gender) from the bed to the wheelchair.B.Record review of online facility staff education regarding hand washing and hand hygiene was dated 3/6/2025 and 2/26/2026. An observation on 4/28/2026 at 8:05 AM in the East Dining room revealed MA - E put on gloves and no hand hygiene was performed.During an interview on 4/28/2026 at 8:08 AM MA - E confirmed that (gender) should have washed (gender) hands before putting on gloves.An observation on 4/28/2026 at 8:18 AM MA - F put on gloves to give insulin and no hand hygiene was performed and then changed gloves and no hand hygiene was performed. During an interview on 4/28/2026 at 8:19 AM MA - F confirmed that (gender) should have performed hand hygiene before putting on gloves and when changing gloves.C.An observation on 4/28/2026 at 11:33 AM NA - G and MA - H transferred Resident 7 to toilet and peri cares were performed and the resident's brief was changed. No hand hygiene was performed before putting on gloves or when changing gloves.During an interview on 4/28/2026 at 11:34 AM NA - G confirmed there is not hand sanitizer in the resident's rooms and (gender) did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have any.D.An observation on 4/28/2026 11:42 AM of MA - H put gloves on to perform an accucheck for Resident 7. No hand hygiene was performed.During an interview on 4/28/2026 at 11:44 AM MA - H confirmed that (gender) should have washed (gender) hands before putting gloves on.During an interview on 4/29/2026 at 9:53 AM Administrator (Adm) confirmed there are no EBP or hand washing audits completed with staff.During an interview on 4/29/2026 at 1:29 PM RN Infection Preventionist - A confirmed that it is the facility's expectation for all staff to complete hand hygiene before and after all resident cares, before and after gloving and with glove changing and that hand washing should be completed for at least 20 seconds.E.Record review of the facility's policy titled Blood Sampling-Capillary (Finger Sticks) Level 111 with a revised date of 08/2011 revealed the steps to be taken while obtaining a sample of the resident's blood to be used to measure the resident's blood glucose level (BGL, the amount of sugar in the blood). Steps in the Procedure number 6 revealed Following the manufacturer's instructions, clean and disinfect the glucose monitoring device (glucometer, a small handheld machine used to measure BGL) after each use with 10% bleach preparation. Record review of the facility's policy titled Glucometer Disinfection dated 05/2019 revealed the steps required to properly clean and disinfect a glucometer including using a disinfectant wipe to cleanse the glucometer and allowing at least 5 minutes for the disinfectant to dry. The policy revealed that the purpose of the procedure guide is to prevent the transmission of bloodborne diseases to the residents and the employees.Observations on 04/28/2026 at 7:75AM revealed the Licensed Practical Nurse (LPN) preparing to administer morning medications to Resident 8. The LPN proceeded to obtain Resident 8's BGL after administering the oral medications. The LPN applied gloves, inserted a BG test strip into the glucose monitor, placed a lancet (a small disposable needle used to poke a tiny hole in the skin) to Resident 8's finger and drew blood. The LPN then applied the drop of blood to the test strip. After obtaining Resident 8's BGL, the LPN placed the glucose monitor on top of the medication cart located in the hall and administered the required insulin to Resident 8. The LPN did not clean or disinfect the blood glucose monitor after use with Resident 8. The LPN then proceeded to gather medication for Resident 11, including the dirty, un-sanitized blood glucose monitor. The LPN repeated the steps used with Resident 8 to obtain a BGL for Resident 11, at no time cleaning or disinfecting the monitor between residents as required. After obtaining the BGL, the LPN placed the un-sanitized glucometer in the top drawer of the medication cart. Interview with the LPN on 04/28/2026 at 8:27 AM confirmed that at no time was the glucometer cleaned or disinfected and should have been. Interview with the Director of Nursing (DON) on 04/29/2026 at 11:26 AM revealed that it is the facility's expectation that the glucometers are cleaned and disinfected between each resident use to help prevent the spread of bloodborne illnesses.