

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2024
NAME OF PROVIDER OR SUPPLIER  Emerald Nursing & Rehab Omaha		STREET ADDRESS, CITY, STATE, ZIP CODE  5505 Grover Street Omaha, NE 68106	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 04577</p> <p>Licensure Reference Number: 175 NAC 12-006.04C3a(6).</p> <p>Based on record review and interview, the facility failed to notify the medical provider of blood sugars that were outside of parameters and holding insulin based on blood sugars for 1 [Resident 1] of 4 residents. The facility had a total census of 62 residents.</p> <p>Findings are:</p> <p>A record review of Resident 1's admission record revealed Resident 1 was admitted to facility on 3/11/24 with a diagnosis of hyperglycemia [high blood sugar].</p> <p>A record review of Resident 1's active orders revealed an order dated 3/11/24 to notify the provider of blood sugars of greater than 400 or less than 70.</p> <p>A review of Resident 1's 3/2024 MAR [Medication Administration Record] revealed an order dated 3/11/25 for Lispro [a medication to treat high blood sugars] insulin inject per sliding scale 4 times per day as follows based on blood sugar level:</p> <ul style="list-style-type: none"> <li>-blood sugar level of 180-250 administer 3 units of Lispro Insulin</li> <li>-blood sugar level of 251-300 administer 6 units of Lispro Insulin</li> <li>-blood sugar level of 301-350 administer 9 units of Lispro Insulin</li> <li>-blood sugar level of 351-400 administer 12 units of Lispro Insulin</li> <li>-blood sugar level greater than 400 administer 15 units of Lispro Insulin</li> </ul> <p>A review of Resident 1's 3/2024 MAR revealed the following orders for Humulin N [Intermediate acting insulin]:</p> <p>-start 3/11/24- discontinue 3/13/24 Humulin N inject 15 units subcutaneously every 8 hours scheduled at 6 AM, 2 PM, and 10 PM</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-start 3/13/24-discontinue 3/14/24 Humulin N inject 20 units subcutaneously every 8 hours scheduled at 6 AM 2 PM, and 10 PM</p> <p>-start 3/14/24-discontinue 3/16/24 Humulin N inject 20 units every 8 hours scheduled at 12:00 AM, 8 AM, 4 PM</p> <p>-start 3/16/24-discontinue 3/21/24 Humulin N inject 25 units subcutaneously every 8 hours scheduled at 6 AM 2 PM, and 10 PM</p> <p>-start 3/21/24 Humulin N inject 25 units subcutaneously every 8 hours scheduled at 12:00 AM, 8 AM, and 4 PM</p> <p>A record review of Resident 1's 3/2024 MAR revealed blood sugars greater than 400 or less than 70 on the following dates and times:</p> <p>-3/11/24 at 4:30 PM the blood sugar was 403</p> <p>-3/11/24 at 10 PM the blood sugar was 535</p> <p>-3/12/24 at 11 AM the blood sugar was 519</p> <p>-3/13/24 at 4:30 PM the blood sugar was 460</p> <p>-3/13/24 at 10 PM the blood sugar was 500</p> <p>-3/14/24 at 4:30 PM the blood sugar was 515</p> <p>-3/19/24 at 11 AM the blood sugar was 415</p> <p>-3/19/24 at 2 PM the blood sugar was 415</p> <p>-3/19/24 at 10 PM the blood sugar was 516</p> <p>-3/20/24 at 4:30 PM the blood sugar was 404</p> <p>-3/24/24 at 7 AM the blood sugar was 481</p> <p>-3/24/24 at 10 PM the blood sugar was 62</p> <p>-3/25/24 at 7 AM the blood sugar was 404</p> <p>-3/25/24 at 4:30 PM the blood sugar was 421</p> <p>A review of Resident 1's Progress Notes revealed the following notes documenting notification of Resident 1's provider of blood sugar levels:</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-3/14/24 at 3:27 AM New orders received at 1:00 AM to recheck resident blood sugar in 2 hours due hyperglycemia reading of 552 and to give 25 Units of insulin Lispro NOW. Blood sugar at 0300 measured at 235. No new orders.</p> <p>-3/12/24 1:26 PM At 1250 contacted [name] APRN [Advanced Practice Registered Nurse] concerning elevated blood sugars. Informed of tube feeding orders and insulin orders. Orders rec'd [received] to increase Humulin N insulin to 20 units every 8 hours and to continue with the sliding scale of Lispro.</p> <p>A review of Resident 1's 3/2024 MAR revealed Humulin N 25 Units scheduled for 12:00 AM was not administered for the following dates and times with the reasons as follows:</p> <p>-3/22/24 12 AM other/see nurses notes</p> <p>-3/23/24 12 AM other/see nurses notes</p> <p>-3/25/24 12 AM hold/see nurses notes</p> <p>-3/26/24 12 AM blood sugar 100, other/see nurses notes</p> <p>3/27/24 12 AM blood sugar 92, hold/see nurses notes</p> <p>A review of Resident 1's Progress Notes revealed the following notes that corresponded to the documentation on the MAR related to not administering Resident 1's Humulin N 25 Units scheduled for 12 AM:</p> <p>-3/22/24 12:47 AM Blood sugar 128 at 2330 with only 110 supplemental feeding administered</p> <p>-3/23/24 12:08 AM Blood sugar monitoring. Insulin's held during the night due to low glucose levels</p> <p>-3/25/24 12:08 AM BS [Blood Sugar] 112. Pt [patient] has been known to drop fast. Will recheck at a later time.</p> <p>-3/26/24 12:30 AM Blood sugar 100. TF fed [tubefeeding] was 33</p> <p>-3/27/24 12:47 AM Insulin held d/t [due to] pt [patient history of bs [blood sugar] dropping.</p> <p>A review of the Provider Communication Form for Resident 1 dated 3/25/24 revealed the following:</p> <p>-Midnight Humulin N is being held due to lower blood sugars (not less than 100). This is an every 8 hour insulin. Changed from 6, 2, and 10 to 8, 4 and midnoc [midnight] due to was holding 6 am dose. Then due to was holding 6 am dose. Then Blood sugars @ 0700/0730 is elevated. No Blood Sugar is to be done with Humulin N yet they are. An order was received for Resident 1 on 3/25/24 to do blood sugars with Humulin N insulin.</p> <p>In an interview on 3/27/24 at 10:21 AM, LPN A [Licensed Practical Nurse] reported facility policy is to notify APRN of blood sugars less than 60 or greater than 400 and document notification in the progress notes. LPN A reported Resident 1's Humulin N administration times were changed to be more compatible with meal and feeding times.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 3/27/24 at 11:46 AM, the DON [Director of Nursing] confirmed that there is no documentation that Resident 1's provider was notified of high and low blood sugars other than the two times documented in the Progress Notes on 3/12/24 and 3/14/24. The DON reported that the night nurse had held Resident 1's 12 AM insulin based on nursing judgement and did not notify the provider of the insulin being held. The DON reported plans to provide education to nursing staff and to implement a Progress Improvement Plan.</p> <p>A review of facility policy titled Notification of Condition Change: Physician Policy revised 12/17/18 revealed the following:</p> <ul style="list-style-type: none"> <li>-Charge nurses are responsible to provide timely and complete communication to physicians when there is a change in a resident's condition.</li> <li>-Type of conditions that may require notification of the physician: .16. Extremes in blood levels concerns.</li> </ul> <p>A review of facility policy titled Administering Medications revised April 2019 revealed the following:</p> <ul style="list-style-type: none"> <li>-If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical director to discuss the concerns.</li> </ul>		