

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  11/21/2024
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>49164</p> <p>Licensure Reference Number 175 NAC 12.006.10(D)</p> <p>Based on record review and interview the facility failed to ensure residents were free of significant medication errors for 1 (Resident 1) of 5 sampled residents. The facility census was 65.</p> <p>Findings are::</p> <p>Record review of Resident 1's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 09-23-2024 revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> <li>-Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS manual a score of 13 to 15 indicate a person is cognitively intact.</li> <li>-Diagnosis of End Stage Renal Disease (ESRD) currently receiving dialysis.</li> <li>-had a heart transplant in the past.</li> <li>-recently had a blood clot in the veins in the left upper extremity.</li> <li>-required moderate assistance with toileting, bathing, dressing, and transfers.</li> <li>-currently taking an anticoagulant medication.</li> </ul> <p>Record review of Resident 1's progress notes revealed on 09-24-2024 Resident 1 was to have a PT/INR (a lab test that measures how long it takes the blood to clot) on 09-26-2024.</p> <p>An interview with the Unit Director (UD) on 11-21-2024 at 2:00 PM revealed the PT/INR was to be done at the doctor's office during Resident 1's appointment on 09-26-2024. Furthermore, the facility contacted the Coumadin clinic and received orders for Warfarin (generic name for Coumadin) 3.5 milligrams (mg) on 09-26-2024 and then to hold Warfarin for the next 3 days.</p> <p>Record review of Resident 1's Medication Administration Record (MAR) for September of 2024 printed on 11-21-2024 revealed on 09-27-2024, 9-28-2024, and 09-29-2024 it was documented that the staff administered 0.5 mg of Warfarin.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident 1's progress notes dated 09-30-2024 revealed the facility received a call from the hospital with an update that Resident 1's procedure had to be rescheduled for 10-03-2024. Furthermore, the facility received orders to hold Warfarin for Resident 1 until post procedure.</p> <p>Record review of Resident 1's MAR for October of 2024 printed on 11-21-2024 revealed on October 2 the staff documented administering 3 mg of Warfarin to Resident 1.</p> <p>An interview with the UD on 11-21-2024 at 2:30 PM confirmed that according to the MARs for September and October. Resident 1 received the incorrect dose of Warfarin on 09-27-2024, 09-28-2024, 09-29-2024, and 10-02-2024.</p> <p>An interview with the Director of Nursing (DON) on 11-21-2024 at 3:00 PM confirmed Warfarin had not been given according to orders and a medication error involving Warfarin would be a significant medication error.</p>