STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285097	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Omaha	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18 Based on observation and interview, the facility failed to maintain ventilation covers, water systems, fixtures, ceilings, doors, outlet covers and call systems in clean, good and working condition in 11 (rooms 204, 301, 304, 305, 306, 310, 502, 505, 511, 512, 514) of 42 occupied resident rooms. The facility census was 64.Findings are: Observation on 01/20/26 between11:35 AM and 12:13 PM with the facility Maintenance Supervisor and the facility Administrator, during the environmental tour of the facility , revealed the following environmental concerns: - There was no call string attached to the wall in the bathroom of room [ROOM NUMBER]. - The water pressure was very light in the sink in rooms [ROOM NUMBERS]. - Cobwebs were present along the walls and ceiling in room [ROOM NUMBER]. - The ventilation system covers were coated with a grey fuzzy substance that resembled dust in rooms 301, 304, 305, 306, 316, 502, 505, 511, 512, 514. - The bathroom light was out (not functioning) in room [ROOM NUMBER]. - There were reddish brown stains on the ceiling and light cover and dark stains on the floor in the bathroom in room [ROOM NUMBER]. - There were scratches and a deep gouge in the bathroom door in room [ROOM NUMBER]. - The call light outlet was cracked and broken on the wall in room [ROOM NUMBER]. - The phone outlet cover was broken on the wall in room [ROOM NUMBER]. Interview on 01/20/2026 at 12:15 PM with the Maintenance Supervisor [MS] confirmed the issues observed during the environmental tour and confirmed that they needed to be cleaned and / or repaired. The MS confirmed that there were no active work orders for the concerns identified during the environmental tour and that staff were inconsistent with submitting work orders.

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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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(A) Based on interview and record review, the facility failed to ensure the state agency was notified of Resident 39's elopement on 01/10/2026 and Resident 1's fall with major injury. This affected 2 (Resident 39 and 1) of 4 sampled residents. The facility census was 62. Findings are: A record review of the facility's Abuse, Neglect, and Exploitation policy last dated 1/2024 revealed the facility staff should have reported all allegations of Abuse, Neglect, and Exploitation including injuries of unknown source within 2 hours for serious bodily injury and 24 hours if no injury. The report of the investigation results should have been sent to the State Survey Agency within 5 working days of the incident. A. A record review of the facility's Elopement / Exit Seeking policy dated 09/02/2019 revealed: Elopement is defined as a resident leaving the physical structure of the facility without the knowledge of the facility staff. A record review of Resident 39's Clinical Census dated 01/15/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 39's Medical Diagnosis dated 01/15/2026 revealed the resident had diagnoses of Personal History Of Traumatic Brain Injury (TBI), Unspecified Mood (effective) Disorder, and History Of Falling. A record review of Resident 39's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 10/21/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 13, which indicated the resident was cognitively aware. The resident required supervision/touching assistance with eating, oral hygiene, and footwear and required partial/moderate assistance with toileting, dressing, and personal hygiene. The resident required supervision or touching assistance with all mobility. The resident did have inattention, disorganized thinking, and was depressed. The resident did have verbal behavioral symptoms directed toward others that significantly interfered with resident care. And put others at significant risk for physical injury. The resident exhibited wandering behaviors (walking around aimlessly) and his behaviors were worse. The resident had not fallen. The resident was on antidepressant medications and anticonvulsants (medications used to treat convulsions), but hypnotics were not marked. A record review of Resident 39's Care Plan with an admission date of 10/15/2025 revealed the resident had a focus area of the resident was independent with activity participation and an intervention included the resident's preferred activities were walking outside. There was a focus area that the resident had a functional deficit (deficiency) with the current activities of daily living and there were interventions on the care plan of the resident would walk independently, was independent with a wheelchair, was very impulsive, not very redirectable, and does not like education, gets irritable when reminded of safety. The care plan did not reveal interventions related to the resident's wandering behaviors. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 39's Progress Notes dated 01/10/2026 revealed the resident left the facility 2 times on 01/10/2026 without signing out and letting staff know the resident was leaving. On 01/10/2026 at 10:07 AM the resident was educated on the use of the resident sign out book and if the resident wanted to leave the premises, the resident had to sign out and in. On 01/10/2026 at 1:37 PM the resident was trying to leave the facility without signing out and continued to exit seek. The police offered to take the resident to the hospital, but (gender) refused and 911 was called to take the resident to the emergency room. On 01/10/2026 at 7:35 PM it was documented the resident arrived back from the hospital at 6:25 PM by stretcher. A Nursing Assistant (NA) alerted the nurse that the resident's wheelchair was near the drive-up area and the resident did not notify staff or sign out the book of leaving the facility. The elopement drill was completed. The Administrator was notified at 6:41 PM, the resident's power of attorney (person designated to make decisions for a person) was notified at 6:55 PM, and 911 was notified at 7:03 PM. The surrounding area was searched, and the Omaha Police Department and staff were searching for the resident. On 01/10/2026 at 10:00 PM it was documented that the resident returned to the facility escorted by the police and the Administrator. The resident was assessed and sent to the hospital for evaluation of hypothermia (excessively low body temperature) and injuries from a fall. The resident had abrasions to the left side of the head, base of hand, knuckles, and complained of left shoulder pain. In an interview on 01/20/2026 at 8:18 AM, the Administrator confirmed the second time the resident left the facility without signing out on 01/10/2026, nobody knew where the resident was going. The Administrator confirmed the incident was not reported to the State Agency. B. Record review of Resident 1's Progress Note dated 1/2/2026 at 10:00 AM revealed Resident 1 had a ground level fall that resulted in a right facial laceration and required transport to the hospital. Record review of the Hospital Discharge summary dated [DATE] revealed that Resident 1 had a right upper eye lid laceration with sutures. Interview with Clinical Consultant A on 01/15/25 at 3:41 PM confirmed the facility did not report Resident 1's fall with the significant injury to the State Agency and should have.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide a bed hold information and a written reason for transfer at the time of hospitalization for Resident 1 on 5 occasions. The facility staff identified a census of 64.Findings are: A. A record review of a policy titled Bed Hold and Return to Facility Policy and Procedure created 5/17 and revised 1/2024 revealed the following information: Policy It is the policy of the facility that residents who are transferred to the hospital or go on a therapeutic leave are provided with written information about the State's bed hold duration and payment amount before and the transfer. Additionally, this facility permits residents to return to the facility after hospitalization or therapeutic leave if their needs can be met by the facility, they require the services provided by the facility and they are eligible for Medicaid or Medicare covered services or services covered by another payor. Residents and their representative will be provided with bed hold and return information at admission and before a hospital transfer or therapeutic leave. The facility will maintain in contact with the resident and representative while the resident is absent from the facility and arrange for their return if appropriate.Nursing and social work staff are educated. B. A record review of Resident 1's Clinical Census revealed Resident 1 was admitted to the facility on [DATE] and listed on a hospital leave 12/01/2025, 12/09/2025, 12/18/2025 and 01/02/2026. A record review of Resident 1's Progress Notes dated 11/30/25 at 2:12 AM revealed the doctors office was notified and Resident 1 was sent out to the Emergency Room. A Record review of Resident 1's medical records including progress notes and miscellaneous documents revealed no bed hold information or reason for transfer for Resident 1 for 11/30/25, 12/01/25, 12/09/25, 12/18/25, and on 01/02/26. An interview with Social Service Director on 1/20/2026 at 9:50 AM confirmed the facility had no bed hold forms or reason for transfer forms completed for Resident 1 and should have completed one with each transfer out to the hospital.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 12-006.09(H)(iii)Based on record review and interviews, the facility failed to provide surgical wound care as ordered by the physician for 1 (Resident 46) of 1 sampled resident. The facility staff identified a census of 64. Findings are:A record review of the facility's New/re-admission Process to be completed by the Licensed Nurse undated procedure revealed the following: 6. Licensed Nurse then to review admission orders. b. Wound orders to be inputted by the License Nurse (medication would be inputted by the Pharmacy, but the Licensed Nurse needs to input the order for the treatment. A record review Resident 46's Face Sheet revealed that the resident was admitted on [DATE] with a diagnosis of Encounter for surgical aftercare following surgery on the circulatory system. A record review of the hospitals after visit summary (AVS) for Resident 46 dated 12/19/2025 revealed the following: Wound care Location: Toe, fourth; Location orientation: Left; Wash area: soap and water, rinse and pat dry; Topicals (to wound bed): Povidone (Betadine) liquid/swabs; Primary dressing: Gauze square; Secondary dressing: Gauze, rolled; Wash foot with soap and water daily; rinse and pat dry with a clean towel. Betadine paintleft fourth toe and place gauze floss between each toe space and allow to dry completely before applying socks and/or Rooke boot (a vascular boot that provides redistribution of pressure to help treat and/or prevent skin breakdown). Ensure that dry gauze is in the crease of the 5th pinky toe. Frequency: twice a day. A record review of Resident 46's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated [DATE] revealed that the wound care order was not activated on the TAR until 12/23/2025. Wound care was not charted on the TAR from 12/19/2025 until 12/23/2025. In an interview on 01/15/2026 at 2:51 PM Interim Director of Nursing (IDON) confirmed that the facility staff should have utilized the wound care orders on the AVS. IDON confirmed that the wound care order was not initiated on 12/19/2025. In an interview on 01/21/2026 at 12:28 PM Director of Nursing (DON) confirmed that wound care was not completed from 12/19/2025 until 12/23/2025.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)Based on observation, interview and record review the facility failed to ensure that an air mattress was working and calibrated correctly for 1 resident (Resident 24). The facility reported a census of 64.A record review of Resident 24's undated care plan revealed Resident 24 had an admission date of 05/31/2025 and had the following diagnoses: Spastic Hemiplegia (brain damage disorder affecting one side of the body, causing stiffness, weakness and poor motor control in the affected arm and leg), quadriplegia (paralysis affecting all four limbs and the torso), cramps and spasms of muscle, amputation of left foot, amputation of right leg above the knee, and a history of wounds. A record review of Resident 24's Skin Observation Sheet, dated 1/13/2026 revealed Resident had a Stage III pressure ulcer (a deep crater where fat tissue is visible) to the sacrum (tailbone). Resident 24 also had a venous ulcer to the left lateral leg, a venous ulcer to the left anterior lower leg, a venous ulcer to the left lateral lower stump and a surgical wound to the right lower stump. A record review of Resident 24's undated care plan revealed a focus area for potential and actual impairment of skin integrity (possibility of/or actual skin damage) and an intervention dated 11/8/2023 for a low air loss mattress (an inflatable medical mattress designed to reduce pressure, enhance circulation and manage moisture). A record review of Resident 24's order summary did not reveal an order for an inflatable mattress or parameters for its use. A record review of Residents 24's weight summary note dated 11/5/2025 revealed the most recent recorded weight of 190.4lbs. A record review of the instruction manual for the Med Aire Plus 8 Alternating Pressure and Low Air Loss Mattress Replacement System revealed the following information:Operation: Mode Selection. It is recommended to always keep the control unit in the alternating pressure mode when the patient is in a lying position for more efficient pressure ulcer prevention and treatment.Weight setting selection.The pressure of the mattress can be adjusted by choosing the patients corresponding weight setting using the weight setting buttons (+) (-). Use the weight setting buttons to select the desired level. Pressure levels will range from 10-50 mmHg. An observation on 01/15/2026 at 10:00 AM, accompanied by Licensed Practical Nurse M (LPN), revealed Resident 24's inflatable mattress had a beeping (alarm) noise. An observation on 01/15/2026 at 2:10 PM revealed Resident 24's inflatable mattress had a beeping noise. An observation on 01/20/2026 at 8:16 AM revealed Resident 24's mattress was not beeping, and the mattress controls revealed the mattress was set at the highest setting [PHONE NUMBER]lbs. An interview on 01/15/2026 at 10:02 AM with LPN M confirmed Resident 24's inflatable air mattress was alarm beeping, which indicated it was not working correctly. LPN M confirmed they did not know how to correct it. LPN M revealed they had called the medical equipment people to fix it 2 weeks ago but was unable to provide evidence of the call. LPN M confirmed over or under inflation of an air mattress for a resident with pressure injuries could make the injuries worse or cause new skin issues. LPN M confirmed they were not familiar with the air mattress and did not know how to calibrate it or adjust it to the resident. An interview on 01/15/2026 at 10:05 AM with Resident 24 confirmed the mattress had been beeping for weeks and no one knew how to fix it. An interview on 01/15/2026 at 2:10 PM with Medication Aide I (MA) confirmed Resident 24's mattress had been beeping for several weeks. An interview on 01/15/2026 with the Interim Director of Nursing (IDON), confirmed they were unaware Resident 24's mattress had been beeping and had been beeping all day. The IDON confirmed they had not been notified of the malfunction. The IDON confirmed a malfunctioning air mattress could cause further injury to Resident 24's wounds. An interview on 01/15/2026 at 3:51 PM with the Maintenance Director (MD) confirmed they had not been informed of the issue with Resident 24's mattress until 1/15/2025. The MD revealed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 24 did not wish to change to another bed. The MD confirmed they would be able to attach a new motor to Resident 24's mattress and would not have to move the resident. The MD revealed the air mattress would be calibrated to the manufacturer's instructions. An interview on 01/15/2026 at 3:51 PM with the IDON confirmed they did not want to cause Resident 24 further discomfort by moving them and agreed attaching a replacement motor to the existing mattress would be a suitable repair. An interview on 01/20/2026 at 8:31 AM with the MD revealed they calibrated the air mattress by inflating it completely and then reducing air pressure until Resident 24 stated they were comfortable. An interview on 01/20/2026 at 9:23 AM with the IDON confirmed they did not know how to calibrate an air loss mattress. The IDON confirmed it was unknown how long the air mattress had been malfunctioning. The IDON confirmed they thought it was appropriate to inflate the bed according to the residents comfort level. The IDON reviewed Resident 24's last recorded weight of 190.4lbs. The IDON confirmed the mattress should have been calibrated according to Resident 24's weight as the resident has active wounds.

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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 observation, interview, and record review, the facility failed to implement interventions to prevent potential accidents or elopements on 1 (Resident 39) of 4 sampled residents. The facility census was 62. Findings are:A.A record review of the facility's Elopement / Exit Seeking policy dated 09/02/2019 revealed: Elopement is defined as a resident leaving the physical structure of the facility without the knowledge of the facility staff. It was the policy of the facility to provide a safe and secure environment and be proactive in preventing elopement. A record review of Resident 39's Clinical Census dated 01/15/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 39's Medical Diagnosis dated 01/15/2026 revealed the resident had diagnoses of Personal History Of Traumatic Brain Injury (TBI), Unspecified Mood (effective) Disorder, and History Of Falling. A record review of Resident 39's Care Plan with an admission date of 10/15/2025 revealed the resident had a focus area of the resident was independent with activity participation and an intervention included the resident's preferred activities were walking outside. There was a focus area that the resident had functional deficit (deficiency) with the current activities of daily living and there were interventions on the care plan of the resident would walk independently, was independent with a wheelchair, was very impulsive, not very redirectable, and does not like education, gets irritable when reminded of safety. The care plan did not reveal interventions related to the resident's wandering behaviors or elopement. A record review of Resident 39's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 10/21/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 13, which indicated the resident was cognitively aware. The resident required supervision/touching assistance with eating, oral hygiene, and footwear and required partial/moderate assistance with toileting, dressing, and personal hygiene. The resident required supervision or touching assistance with all mobility. The resident did have inattention, disorganized thinking, and was depressed. The resident did have verbal behavioral symptoms directed toward others that significantly interfered with resident care. And put others at significant risk for physical injury. The resident exhibited wandering behaviors (walking around aimlessly) and (gender) behaviors were worse. The resident had not fallen. The resident was on antidepressant medications and anticonvulsants (medications used to treat convulsions), but hypnotics were not marked. The resident had a wander/elopement alarm. A record review of the facility's Audit of Wanderguards did not reveal Resident had a Wanderguard. A record review of Resident 39's Progress Notes dated 01/02/2026 3:47 PM revealed an elopement risk assessment was completed and the resident showed no active elopement attempts, would continue current plan of care. At 8:08 PM, check wanderguard safety device to ensure device functioning was no longer applicable. A record review of Resident 39's Progress Notes dated 01/10/2026 revealed the resident left the facility 2 times on 01/10/2026 without signing out and letting staff know. On 01/10/2026 at 10:07 AM the resident was educated on the use of the resident sign out book and if the resident wanted to leave the premises, the resident had to sign out and in. On 01/10/2026 at 1:37 PM the resident was trying to leave the facility without signing out and continued to exit seek. The police offered to take the resident to the hospital, but (gender) refused and 911 was called to take the resident to the emergency room. On 01/10/2026 at 7:35 PM it was documented the resident arrived back from the hospital at 6:25 PM by stretcher. A Nursing Assistant (NA) alerted the nurse that the resident's wheelchair was near the drive-up area and the resident did not notify staff or sign out the book of leaving the facility. The elopement drill was completed. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator was notified at 6:41 PM, the resident's power of attorney (POA)(person designated to make decisions for a person) was notified at 6:55 PM, and 911 was notified at 7:03 PM. The surrounding area was searched, and the Omaha Police Department and staff were searching for the resident. On 01/10/2026 at 10:00 PM it was documented the resident returned to the facility escorted by the police and the Administrator. The resident was assessed and sent to the hospital for evaluation of hypothermia (excessively low body temperature) and injuries from a fall. The resident had abrasions to the left side of the head, base of hand, knuckles, and complained of left shoulder pain. A record review of the facility's 24-Hour Incident Report with an incorrect date of 01/10/2025 as per the events of the above progress note and an included interview dated 01/01/10/2026 revealed the summary of events were 10:00 AM resident educated on facility sign in and out procedures. At 12:09 PM the Administrator was called that the resident left the facility and refused to sign the sign out book. At 6:25 PM resident returned to the facility on a stretcher. At 6:30 a NA returned from break and observed Resident 39's wheelchair near the drive-up area, a facility-wide elopement drill was initiated and the administrator was notified at 6:41 PM, the resident's power of attorney was notified at 6:55 PM, and law enforcement was notified at 7:03 PM. At approximately 9:15 PM law enforcement arrived at the facility with the resident. The resident was assessed and sent to the Emergency Department. It included a written statement from NA-Q that the resident arrived to the facility after 3:00 PM and NA-Q seen the resident get off the stretcher. About 15 minutes later NA-Q confirmed about 15 minutes later NA-Q seen the resident on the phone at the front desk and that was the last time NA-Q seen the resident before another NA reported seeing the resident wheelchair outside at the end of the walkway. A written statement from NA-R confirmed NA-R never witnessed the resident in the building. A written statement from Medication Aide (MA)-S confirmed when MA-S returned from break MA-S witnessed the resident's wheelchair outside empty. NA-S informed the nurse and assisted in a search for the resident. A record review of the facility's Release of Responsibility for Therapeutic Visits and Visitor Sign In Logs dated 01/06/2026 - 01/11/2026 did not reveal Resident 39 signed out on 01/10/2026. A record review of Resident 39's Documentation Survey Report v2 for monitoring behavior symptoms dated 01/2026 did not reveal a task for 15 minute safety checks following the resident's return from the emergency room after the first incident on 01/10/2026. An observation on 01/14/2026 at 1:12 PM revealed the resident had abrasions by Resident 39's left eye and on the knuckles of the right hand. The observation did not reveal a wanderguard. An observation on 01/15/2026 at 12:06 PM revealed Resident 39 was sitting at the receptionist desk right by the front door and had abrasion by the left eye. The observation did not reveal a wanderguard. At first there were no staff present with the resident, but the staff did return shortly before anyone opened the front door. In an interview on 01/14/2026 at 7:54 AM, the Administrator confirmed Resident 39's wanderguard was removed 01/02/2026 because the resident had a cognitive level of 13 and the resident was the resident's own person and was able to leave the facility if the resident wanted to. An Elopement Risk Data Collection was completed after the resident's incident on 01/10/2026 was completed and still deemed not high risk. In an interview on 01/14/2026 at 10:20 AM the Clinical Consultant (CC)-A confirmed the resident had a wanderguard on admission, but should not have had because the resident was the resident's own person, the POA was not enacted, and the resident was cognitively aware. After the Elopement Risk Data Collection on 01/02/2026 indicated the resident was a low risk for elopement, the wanderguard was removed. The incidents on 01/10/2026 were out of character for the resident. There were no interventions put in place to protect the resident from eloping because the resident was their own person and a BIMS of 13 so the resident could come and go as they pleased. In an interview on 01/20/2026 at 8:18 AM, the (continued on next page)

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	285097	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Omaha	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator confirmed that after the first incident no interventions were put in place and there was nothing the facility could do because the resident was cognitively aware, made own decision, and could leave if the resident wanted to. The the second time the resident left the faciity on [DATE] the staff was unaware the resident left the facility. B.A record review of the facility's Falls Management policy with a last date revised of 1/2024 revealed the staff should have implemented goals and interventions with the resident/patient/family and communicate interventions to the staff. The staff should adjust or add interventions to the Care Plan. A record review of Resident 39's Progress Notes dated 10/5/2025 - 01/15/2026 revealed the resident had fallen 11/01/2025, 11/11/2025, two times on 12/24/2025, 12/31/2025, and an out of facility fall on 01/10/2026. A record review of Resident 39's Care Plan with an admission date of 10/15/2025 did not revealed fall interventions for the resident's falls in the facility for 11/1/2025, the two on 12/24/2025, or 12/31/2025, but did not reveal interventions that would prevent the falls from reoccurring. A record review of Resident 39's Fall Data Collection dated 11/01/2025 revealed the root cause and intervention for the fall was the resident had footwear on, pop was spilled on the floor. A record review of Resident 39's Fall (Witnessed) dated 12/24/2025 revealed the resident was given nighttime medications which makes the resident drowsy, but nothing to prevent it from happening again. A record review of Resident 39's Fall Data Collection dated 11/01/2025 revealed the root cause and intervention for the fall was assessment and called 911. No interventions for when the resident returned from the hospital. An observation on 01/14/2026 at 1:12 PM revealed paper towels scattered on the floor in the resident's room, boxes of pop to the right of the bedside table. Resident 39's urinal was hanging on the trash can by the door, not in reach of the resident. An observation on 01/20/2026 at 7:38 AM revealed Resident 39's room had paper towels on floor by bed, a bedside table on right side of bed with 6 packs of Dr. Pepper and 5 bottles of Ensure on floor to right of bedside table. The resident's urinal was hanging on trash can by door to the room and not in reach. No fall interventions observed. An observation on 01/20/2026 at 8:28 AM revealed Resident 39's two 6 packs of Dr. Pepper were now in the hall and now had a case Pepsi cans by the bedside table, a box of Buns, and 2 other boxes by the bedside table between the bed and the restroom. The resident's urinal was hanging on the trash can by the room entrance door. No other fall interventions were observed. In an interview on 01/15/2025 at 2:03 PM CC-A confirmed there were not interventions put in place following Resident 39's falls on 11/01/2025, 12/24/2025, or 12/31/2025 and there should have been.