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	03/12/2026

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 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. Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview, the facility failed to report an allegation of potential neglect to the State Agency (SA) within the required timeframe for 1 (Resident 1) of 1 sampled resident. The facility staff identified a census of 71.Findings are:Record review of a facility policy entitled Abuse, Neglect and Exploitation dated revised 1/2024 revealed: - 6. Identification of Abuse, Neglect, and Exploitation - The facility will consider factors indicating possible abuse, neglect, and/or exploitation of residents, including, but not limited to, the following possible indicators: -a. Resident, staff, or family report of abuse. - h. Failure to provide care needs such as feeding, bathing, dressing, turning & positioning. - 7. Investigation of Alleged Abuse, Neglect and Exploitation - When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conducted. Components of an investigation may include: -a. Interview the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses. - c. Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area, and visitors in the area. Obtain witness statements, according to appropriate policies. All statements should be signed and dated by the person making the statement. -d. Document the entire investigation chronologically. - 13. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must: -a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the advents (sic) that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other official (including the State Survey Agency and adult protected services where state law provides for jurisdiction in long-term care facilities) in accordance with state law. -b. Have evidence that all alleged violations are thoroughly investigated. -c. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in process. -d. Report the results of all investigations to the administrator or his or her designated representative and to the other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriation corrective action must be taken. - 14. The Administrator should follow up with government agencies, during business hours, to confirm the report was received, and to report the results of the investigation when final, as required by state agencies.Record review of a facility policy entitled Grievance Policy dated revised 1/2024 revealed: - G. Response: Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority. If a complaint cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility Grievance Official.Upon receipt of a grievance or concern, the Grievance Official will review the grievance, determine immediately if the grievance meets a reportable complaint. Consistent with the facility's Abuse (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevention Policy the facility Administrator and Grievance Official will immediately report all alleged violations involving resident neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law. The Grievance Official will initiate the appropriate notification and investigation processes per individual circumstance and facility policies. The investigation will consists of at least the following: a review of the completed complaint report; an interview with the person or persons reporting the incident if applicable; interviews with any witnesses to the incident or concern; a review of the resident medical record if indicated; a search of resident room (with resident permission); an interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident; interviews with the resident's roommate, family members, and visitors; and a root-cause analysis of all circumstances surrounding the incident.Record review of Resident 1's admission Record showed the facility admitted the resident on 02/24/2026. Further review of the admission record revealed Resident 1 had diagnoses that included hemiplegia (complete or severe loss of movement on one side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) following a nontraumatic intracerebral hemorrhage (stroke).Record review of Resident 1'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 03/02/2026 revealed Resident 1 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 13. According to the MDS manual, a score of 13-15 indicated the resident had intact cognition. Further review of the MDS identified Resident 1 was frequently incontinent of bladder and was not on a toileting program.Record review of a Grievance Form dated 02/27/2026 involving Resident 1 revealed a grievance was heard by the facility social worker. The grievance was filed by Resident 1's Family Member (FM-1) who reported Resident 1 stayed wet for over 4 hours today. When I asked for assistance, I was ignored and had to find different staff to assist my [family member].Record review of a facility provided Reportable Incident Log from 01/21/2026 to 03/11/2026 revealed no reportable incident that involved Resident 1.An interview on 03/11/2026 at 12:57 with Resident 1 revealed Resident 1 at times had been incontinent in an incontinence brief due to waiting for help to use the restroom after Resident 1 had activated the call light. Resident 1 reported the longest they have waited for help to the bathroom was approximately 45 minutes. Resident 1 reported [gender] was frustrated when this happened because it was an extra mess that would need to be cleaned up.An interview on 03/11/2026 at 1:01 PM with Resident 1's Family Member (FM-2) in the resident's room revealed an instance of waiting up to four hours for the call light to be answered once activated. FM-2 was unsure of the date of occurrence.An interview on 03/12/2026 at 8:26 AM with the Director of Nursing revealed an investigation into the grievance was conducted but was not documented. The DON confirmed the grievance dated 02/27/2026 related to Resident 1 was an allegation of potential neglect. The DON further confirmed allegations of potential neglect were to be reported to the State Agency within required timeframes and confirmed this allegation of potential neglect was not reported.An interview on 03/12/2026 at 11:52 AM with the Facility Administrator (ADM) revealed the allegation of potential neglect was not reported because the ADM understood if there was no resident outcome, the allegation did not require a report.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(i) Based on observation, interview, and record review, the facility failed to ensure activities of daily living (ADLs) and voiding patterns (habits, behaviors, and physical processes of how a person empties their bladder) completed per the Care Plan on 1 (Resident 3) of 3 sampled residents. The facility census was 71. Findings are:A record review of Resident 3's Resident Census dated 03/12/2026 revealed the resident was admitted on [DATE] and sent to the hospital on [DATE]. The resident returned to the facility 02/24/2026. A record review of Resident 3's Medical Diagnosis dated 03/11/2026 revealed the resident had diagnoses of Metabolic Encephalopathy (brain dysfunction), Repeated Falls, and Muscle Weakness. A record review of Resident 3's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 03/02/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 9 which indicated the resident was moderately cognitively impaired (difficulty thinking and comprehending). The resident required setup or clean-up assistance with eating and upper body dressing, supervision with oral hygiene (cleaning), and partial/moderate assistance with bathing, lower body dressing, footwear, and toileting and personal hygiene. The resident was partial/moderate assistance with all bed mobility and transfers. The resident had no falls in the lookback period. The resident was occasionally incontinent (lack of control) of bladder and frequently incontinent of bowels. The resident was not on a toileting program. A record review of Resident 3's Care Plan Report with an admission date of 02/06/2026 revealed a focus area of the resident had functional deficit (loss) with current ADLs and interventions included the resident 1 staff assist with ambulating with a walker. 1 staff assist partial with bed mobility, 1 staff assist partial with transfers, 1 staff assist partial with toileting hygiene, 1 assist supervisions with toilet transfers. The resident had a focus area of bladder incontinence related to impaired mobility and ambulation and interventions included establish voiding patterns and the resident used disposable briefs, change as needed (PRN). The resident was on a diuretic (medication that increased urine production to remove excess fluids from the body). A record review of Resident 3's Electronic Medical Record did not reveal a voiding patterns assessment had been completed. A record review of Resident 3's Progress Notes dated 02/09/2026 revealed the resident had an unwitnessed fall at 9:15 PM and resident said they were trying to get out of bed. A record review of Resident 3's Progress Notes dated 02/10/2026 at 12:46 AM revealed the resident had a witnessed fall and the staff seen the resident sliding out of bed. A record review of Resident 3's Progress Notes dated 02/10/2026 revealed the resident had an unwitnessed fall at 5:30 AM and the resident was found laying on the floor next to the bed. A record review of Resident 3's Progress Notes dated 02/10/2026 at 22:03 revealed the resident had an unwitnessed fall and the resident was found on the floor next to the bed. An observation on 03/12/2026 at 4:30 AM - 8:55 AM revealed staff did not enter Resident 3's room to check and change the resident except at 8:32 AM Nursing Assistant (NA)-H entered the room, placed the resident breakfast tray on the resident's bedside table, and exited the resident's room without checking the resident or asking the resident if the resident needed anything. An observation on 03/12/2026 at 8:56 AM revealed Licensed Practical Nurse (LPN)-C entered Resident 3's room to deliver the resident's medications, the resident was sleeping. At 8:59 AM an observation revealed the resident sat up on the side of the bed, stood up, grabbed the walker, and walked the resident's self to the restroom, and closed the door. LPN-C was standing in the doorway to the room at the med cart with LPN-C back to the resident. LPN-C heard the resident's walker move and LPN-C looked back and watched the resident get up and transfer self to the restroom without assistance. LPN-C did not ask the resident if the resident needed assistance or supervise the resident transfer on and off the toilet or offer toileting hygiene. At 9:04 AM Resident 3 exited the resident and transferred self to the recliner. An observation on 03/12/20226 at 9:30 AM revealed Resident 3 was picking at the breakfast tray and the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's spouse was changing the resident bed and picking up the room. In an interview on 03/12/2026 at 9:30 AM, Resident 3's spouse confirmed the spouse was picking up the room and changing the bed because the staff don't do anything and there was dried blood on the bedding because (gender) picks at (gender). The spouse was only aware that the resident had fallen twice before being sent to the hospital. In an interview on 03/12/2026 at 9:26 AM, NA-H confirmed NA-H had not checked on Resident 3 until NA-H delivered the breakfast tray, then just left the tray. NA-H confirmed residents were supposed to be checked and changed every 2 hours and they had not. In an interview on 03/12/2026 at 9:53 AM, the facility's Director of Nursing (DON) confirmed staff should check residents every 2 hours. The DON confirmed they did not complete a voiding patterns assessment on Resident 3. The DON confirmed that staff should have assisted a resident with transfers that was listed on the MDS as needing partial/moderate assistance and on the Care Plan as 1 assist partial with transfers. The DON confirmed LPN-C or staff should have supervised Resident 3 with toilet transfers.

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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 observation, interview and record review facility failed to follow provider orders during wound care to promote healing of incisions/wounds and failed to ensure wound care was completed as ordered on 2 (Resident 2 and 4) of 3 sampled residents. The facility census was 71. Findings are: A. A record review of Resident 4's admission Record dated 3/11/2026 revealed the following diagnosis: Chronic Venous Hypertension (Idiopathic) with Ulcer of Right Lower Extremity (the blood pressure inside the blood vessels in the leg is too high), Venous Insufficiency (Chronic) (Peripheral) (difficulty in blood moving back to the heart resulting in blood staying in the lower legs) and Peripheral Vascular Disease (narrowing of the blood vessels resulting in difficulty for blood to flow back to the heart). A record review of Resident 4's Skin assessment dated [DATE] revealed that the resident had a venous ulcer (a slow-healing, shallow sore) on the right ankle. A record review of Resident 4's Treatment Administration Record (TAR) dated 3/2026 revealed the following orders: Wound Care: RT (right) lateral Ankle: Wash area foam soap and water, rinse and pat dry, apply Xeroform (a petroleum-jelly-soaked mesh cloth that does not stick to the wound, making dressing changes much less painful) gauze to wound bed, cover with ABD (abdominal) pad and secure with kerlix (a soft, absorbent, and stretchy bandage used to wrap and protect wounds). Change daily and as needed for excess drainage. every day shift for wound care An observation on 3/12/2026 between 6:58 AM and 8:10 AM revealed that there is a red open area on Resident 4's right lateral ankle. An observation on 3/12/2026 between 6:58 AM and 8:10 AM revealed Licensed Practical Nurse (LPN)-E cleansed the wound on the right lateral ankle, applied the xeroform gauze to the wound bed, wrapped the wound with kerlix and secured the kerlix with paper tape. In an interview on 3/12/2026 between 6:58 AM and 8:10 AM LPN-E confirmed that ABD pad was not placed while completing wound care to the right lateral ankle and should have been. LPN-E confirmed that the dressing completed on the right lateral ankle was ordered to be completed for Resident 4's right toes. B. A record review of the facility's undated How To Guide Wound VAC (vacuum)(Negative Pressure Wound Therapy revealed the staff would confirm Wound VAC orders and always follow the physician orders and facility policy. A record review of Resident 2's Resident Census dated 03/11/2026 revealed the resident was admitted on [DATE]. A record review of Resident 2's Medical Diagnosis dated 03/11/2026 revealed the resident had (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses of Type 2 Diabetes Mellitus Without Complications (uncontrolled blood sugars), Peripheral Vascular Disease (poor blood flow in the arms or legs), Encounter For Orthopedic Aftercare Following Surgical Amputation (care following removal of a body part), and Acquired Absence Of Other Left Toe (S). A record review of Resident 2's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 02/16/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 14 which indicated the resident was cognitively aware (able to think and comprehend). The resident required setup or clean-up assistance with eating and upper body dressing, supervision with oral hygiene (cleaning), and partial/moderate assistance with bathing, lower body dressing, footwear, and toileting and personal hygiene. The resident was supervision or touching assistance with all mobility and transfers. The resident had a recent major orthopedic surgery and had surgical wounds and wound care. A record review of Resident 2's Care Plan Report with an admission date of 02/10/2026 revealed a focus area of the resident had impairment (damage or harm) of the skin integrity and was admitted with a surgical amputation to the 3rd toe of the left foot. Interventions included wound vac to left foot as ordered and back up wet to dry dressings as ordered in case would vac malfunctioned. The Care Plan Report did not reveal impairment to the left lower leg. - A record review of Resident 2's Clinical Physician Orders dated 03/11/2026 revealed the resident had orders for: - Wound vac dressing to the left 3rd toe changed every 3 days and as needed that had a start date of 02/13/2026 and an end date of 02/13/2026. - Wound vac dressing to the left 3rd toe changed every 3 days and as needed that had a start date of 02/16/2026 and an end date of 02/26/2026. - Wound vac to left foot 3rd toe at 100mmhg (millimeters of mercury, a unit of pressure) with constant suction. Check for function and change canister as needed (PRN) with a start date of 02/11/2026 and an end date of 02/26/2026. - Wound care: OK to apply wet to dry dressings if unable to apply wound vac or wound vac malfunctions with a start date of 02/17/2026 and an end date of 02/26/2026. -Wound care left foot, 1st and 2nd toes, wash area with soap and water, rinse, pat dry, paint with betadine (an antiseptic used to treat infections) 2 times per day (BID) and PRN with a start date of 02/11/2026 and an end date of 03/08/2026. -Wound care left 3rd toe amputation site: cleanse with cleanser, pat dry, lightly pack with betadine moistened gauze, then cover with rolled gauze. Change daily and PRN with a start date of 02/26/2026 and an end date of 3/3/2026. -Wound care left leg, wash area with soap and water, rinse, and pat dry. Secure with gauze, then edemawear (stockings to reduce swelling from excess fluid). Keep left leg incision clean and dry every day (QD) and PRN with a start date of 02/11/2026 and an end date of 02/27/2026. -Wound care: Paint left thigh and calf incisions with betadine and cover with bordered gauze daily and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PRN with a start date of 02/26/2026 and an end date of 03/08/2026. A record review of Resident 2's Progress Note dated 02/10/2026 revealed that the resident was to have a wound vac placed on the left foot on 02/11/2026. A record review of Resident 2's Progress Note dated 02/12/2026 at 12:37 AM revealed that the resident's wound vac was not running, the battery appeared to be dead without a charger. The resident reported that the charger possibly went with the resident to Dialysis (treatment for Kidney Failure) on 02/11/2026. The staff would pass onto the day shift nurse to call the Dialysis Center. The Progress Note did not reveal how long the wound vac had gone without suction if or if the staff done anything for the wound dressing. A record review of Resident 2's Progress Note dated 02/16/2026 at 7:51 PM revealed that the resident returned from Dialysis with the machine off and no charge. The facility was unable to find the cord. The Progress Note did not reveal how long the wound vac went without suction. The staff removed the wound vac and applied the wet to dry dressing. The 02/16/2026 progress notes did reveal a Skilled Note entry at 6:12 PM and an abdominal (stomach assessment was completed at 6:18 PM. A record review of Resident 2's Progress Note dated 02/17/2026 revealed that the resident had a wet to dry dressing and the staff were waiting for the wound care nurse to do the wound vac. A record review of Resident 2's Progress Note dated 02/18/2026 revealed that the resident's wound vac was removed at an appointment 02/17/2026 and it was never re-applied. Wet to dry CDI (clean, dry, and intact). A record review of Resident 2's Progress Note dated 02/23/2026 revealed that the resident told the nurse the resident did not want the wound vac dressing changed because the resident was more comfortable with the dressing being completed by someone who had done it successfully in the past. A record review of Resident 2's Medication Administration Record and Treatment Administration Record (MAR & TAR) dated February 2026 revealed: Indent Wound vac dressing to the left 3rd toe changed every 3 days and as needed that had a start date of 02/13/2026 and an end date of 02/13/2026 was not completed. Wound vac dressing to the left 3rd toe changed every 3 days and as needed that had a start date of 02/16/2026 and an end date of 02/26/2026 was entered to change every Monday, Wednesday, and Friday, not every 3 days. It was marked refused 02/23/2026. Wound vac to left foot 3rd toe at 100mmhg (millimeters of mercury, a unit of pressure) with constant suction. Check for function and change canister as needed (PRN) with a start date of 02/11/2026 and an end date of 02/26/2026 was not marked as completed on 02/13/2026 on the day shift or the 2:00 PM – 10:00 PM shift or the 02/17/2026 day shift. It was marked n or no 23 of 45 shifts. Wound care: OK to apply wet to dry dressings if unable to apply wound vac or wound vac malfunctions with a start date of 02/17/2026 and an end date of 02/26/2026 was not marked as being completed. Wound care left leg, wash area with soap and water, rinse, and pat dry. Secure with gauze, then (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	edemawear (stockings to reduce swelling from excess fluid). Keep left leg incision clean and dry every day (QD) and PRN with a start date of 02/11/2026 and an end date of 02/27/2026 was not marked as completed 02/11/2026 or 02/13/2026. Wound care: Paint left thigh and calf incisions with betadine and cover with bordered gauze daily and PRN with a start date of 02/26/2026 and an end date of 03/08/2026 was not marked completed 03/03/2026 air 03/04/2026. A record review of the facility's Reason For Visit form dated 02/26/2026 revealed the resident's provider documented that Resident 2's left 3rd toe amputation site was macerated (softened or broken-down skin) with a large amount of slough (dead tissue). The resident reported that the wound vac had only been changed weekly instead of 3 times per week which was completely inappropriate and unsafe. New skin breakdown on the bottom of the foot because of that. The provider discontinued (stopped) the wound vac and just ordered betadine fluffed gauge to left 3rd toe amputation site, cover with rolled gauze and it MUST BE CHANGED DAILY. In a telephone interview on 03/11/2026 at 1:17 PM, Resident 2 confirmed the facility only had a couple of people the knew how to work with a wound vac or change a dressing on an amputated toe. The resident confirmed the resident's doctor was med and took off the wound vac because it was not being managed right and was doing more harm than good. Resident 2 confirmed there were 3, six day stretches where the staff did not change the wound dressing at all. Sometimes the staff could not get the wound vac dressing to seal, one time, there were 3 different nurses in the room, and they had to change it 3 times before they could get it to seal. In a telephone interview on 03/11/2026 at 3:23 PM, Licensed Practical Nurse (LPN)-B confirmed that LPN-B was working on 2/13/2026 and did not know why the order for wound vac dressing to the left 3rd toe changed every 3 days and as needed that had a start date of 02/13/2026 and an end date of 02/13/2026 did not get completed. LPN-B confirmed the only reason LPN-B could think of that it did not get completed was that LPN-B got pulled to do admissions. LPN-B confirmed one day, but LPN-B could not remember the date, the resident returned from Dialysis without the wound vac cord, but LPN-B found it at the bottom of a bag attached to Resident 2's wheelchair. LPN-B could not confirm how long the wound vac had not worked before she found it. LPN-B confirmed LPN-B changed the wound vac dressing on 02/16/2026 and had problems getting the dressing to seal because the pressure readings were not consistent, so LPN-B had another nurse look at it, so the resident refused to let LPN-B change the wound vac dressing on 02/23/2026 because of the problems before. In a telephone interview on 03/12/2026 at 11:04 AM, LPN-B confirmed LPN-B was an agency nurse and the facility did not do a formal competency (education and skills evaluation) on wound vacs or wound vac dressing changes. One time there was another nurse in the room with (gender) when LPN-B completed the wound vac dressing change, but no formal education or evaluation. In an interview on 03/12/2026 at 11:33 AM, the facility's Director of Nursing (DON) confirmed the facility did not have a policy or competencies on wound vacs, just the How To Guide. In an interview on 03/12/2026 at 11:55 AM, the DON confirmed Resident 2's wound care orders were not completed as ordered by the physician and should have been.

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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 ensure causal factors (reason the event happened) were completed on 1 (Resident 3) of 3 sampled residents, interventions (what was put in place to prevent it from happening again) were implemented for falls on 2 (Residents 2 and 4) of 3 sampled residents, and post fall assessments to include neurological assessments (neuro checks)(focused assessments to monitor a resident's brain and nervous system function), when indicated, were completed on 2 (Residents 1 and 3) of 3 sampled residents. The facility census was 71. Findings are:A record review of the facility's Falls Management policy dated 04/2015 revealed that in the event a resident had fallen and /or was found on the ground, a complete head-to-toe assessment must be performed prior to moving the resident. The nurse would palpate (feel) and examine all areas for breaks in the skin or other abnormal findings, obtain vital signs including blood pressure pulse, and respirations. The staff would obtain neuro checks for any unwitnessed fall or any fall with evidence of an injury to the head. The nurse would complete an incident report and the resident fall would be noted on the 24 hour report for 3 days for post fall monitoring, including vitals every 8 hours. Fall Injury Prevention – Post Fall included assess the resident an immediately implement appropriate measure to prevent injury, initiate and complete the Accident/Incident Protocol, review the Plan of Care, and adjust or add interventions on the Plan of Care. A. A record review of Resident 3's Resident Census dated 03/12/2026 revealed the resident was admitted on [DATE] and sent to the hospital on [DATE]. The resident returned to the facility 02/24/2026. A record review of Resident 3's Medical Diagnosis dated 03/11/2026 revealed the resident had diagnoses of Metabolic Encephalopathy (brain dysfunction), Repeated Falls, and Muscle Weakness. A record review of Resident 3's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 03/02/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 9 which indicated the resident was moderately cognitively impaired (difficulty thinking and comprehending). The resident required setup or clean-up assistance with eating and upper body dressing, supervision with oral hygiene (cleaning), and partial/moderate assistance with bathing, lower body dressing, footwear, and toileting and personal hygiene. The resident was partial/moderate assistance with all bed mobility and transfers. The resident had no falls in the lookback period. A record review of Resident 3's Care Plan Report with an admission date of 02/06/2026 revealed a focus area of the resident had functional deficit (loss) with current ADLs and interventions included the resident 1 staff assist with ambulating with a walker. 1 staff assist partial with bed mobility, 1 staff assist partial with transfers, 1 staff assist partial with toileting hygiene, 1 assist supervisions with toilet transfers. The resident had a focus area of bladder incontinence related to impaired mobility and ambulation and interventions included establish voiding patterns and the resident used disposable briefs, change as needed (PRN). The resident was on a diuretic (medication that increased urine production to remove excess fluids from the body). The resident had a focus area of the resident was at risk for falls related to weakness, limited mobility due to recent infection, new environment, (continued on next page)

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	285097	A. Building B. Wing	03/12/2026

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Emerald Nursing & Rehab Omaha	5505 Grover Street Omaha, NE 68106

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use of medications that have the potential for adverse drug reactions, and confusion. The interventions were Physical Therapy (PT)/Occupational Therapy (OT) to evaluate and treat if indicated with a date initiated of 02/06/2026, and the resident had poor safety insight at that time and staff would conduct routine visual rounding with a date initiated of 03/05/2026. A record review of Resident 3's Progress Notes dated 02/09/2026 revealed at 9:15 PM the resident was found on the floor by the Nursing Assistant (NA) and resident said the resident was trying to get out of bed to go home. The resident denied hitting head. Assessment was done that included vitals. No noted or reported injury or pain. For education, the resident was advised to use the call light if the resident wanted to get out of bed. The Progress Note did not reveal neuro checks were started or causal factors for the fall. A record review of Resident 3's Progress Notes dated 02/10/2026 at 12:46 AM revealed the resident was seen by staff sliding out of bed onto the floor. Resident did not hit the resident's head. No injury was seen and denied pain or discomfort. Assessment included range of motion (ROM) and vital signs. The staff would continue to monitor, and the resident was encouraged to use call light if needed anything. The Progress Note did not reveal causal factors of the fall or a new intervention to prevent the fall from happening again. A record review of Resident 3's Progress Notes dated 02/10/2026 at 5:52 AM revealed the resident was found lying on the floor next to the bed on top of blankets and a pillow under the resident's head. The resident denied hitting the resident's head. ROM and vital signs were assessed, and neuro checks were started. The resident had spilled urine on the floor and it was not known what the resident was attempting to do. The resident was confused and unable to be re-orientated. The staff would continue to monitor, and the resident was encouraged to use call light if needed assistance but does not use it. The Progress Note did not include causal factors of the fall or a new intervention to prevent the resident from falling again. A record review of Resident 3's Progress Notes dated 02/10/2026 at 2:18 AM revealed the Physician Assistant (PA) seen the resident for the recent falls and confusion. The PA ordered Melatonin (a dietary supplement used to treat insomnia) and a urinalysis (urine test for infection). A record review of Resident 3's Progress Notes dated 02/10/2026 at 22:03 revealed the resident was found on the floor next to the bed. The resident refused the assessment, and the resident was sent to the Emergency Department. The Progress Note did not contain causal factors of the fall. A record review of the facility's State Report dated 02/16/2026 revealed the facility notified the State of Nebraska of the fall Resident 3 had on 02/10/2026 that led to the transfer to the Emergency Department and noted the multiple falls since admission. The State Report included interventions that were in place at the time of the fall but did not include the causal factors of the falls. The State Report revealed the interventions that were put in place to prevent the falls from re-occurring were on 02/09/2026 at 9:15 PM they educated the resident to use the call light and final one, the resident was sent to the Emergency Department, but it did not reveal new interventions for the 02/10/2026 at 12:30 AM or 02/10/2026 at 5:30 AM falls. A record review of the facility's Omaha Operations LLC pages the facility provided with a locked date of 02/25/2026 revealed they were 1 page of the Fall (Un-witnessed) on 02/09/2026 at 9:15 PM, Fall (Witnessed) on 02/10/2026 at 12:30 AM, Fall (Un-witnessed) on 02/10/2026 at 5:30 AM, and the Fall (Un-witnessed) on 02/10/2026 at 9:30 PM incidents that included the Incident Description and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediate Action Taken, but not the entire document. The bottom of each page revealed Privileged and Confidential – Not part of the Medical Record – Do not Copy. They did not reveal causal falls or what interventions were put in place to prevent the resident from falling again other than the 02/10/2026 at 9:30 PM Fall (Un-witnessed) when they sent Resident 3 to the Emergency Room. The only incident that documented neuro checks were started was on the Incident on 02/10/2026 at 5:30 AM. A record review of Resident 3's Neurological Evaluation Flow Sheet – V2 dated 02/10/2026 at 5:56 AM revealed neuro checks were started on the resident 02/10/2026 at 5:30 AM. They did not reveal neuro checks were started for the unwitnessed fall on 02/09/2026 at 9:15 PM. An observation on 03/12/2026 at 4:30 AM – 8:55 AM revealed staff did not enter Resident 3's room to check and change the resident except at 8:32 AM Nursing Assistant (NA)-H entered the room, placed the resident breakfast tray on the resident's bedside table, and exited the resident's room without checking the resident or asking the resident if the resident needed anything. An observation on 03/12/2026 at 8:56 AM revealed Licensed Practical Nurse (LPN)-C entered Resident 3's room to deliver the resident's medications, the resident was sleeping. At 8:59 AM an observation revealed the resident sat up on the side of the bed, stood up, grabbed the walker, and walked the resident's self to the restroom, and closed the door. LPN-C was standing in the doorway to the room at the med cart with LPN-C back to the resident. LPN-C heard the resident's walker move and LPN-C looked back and watched the resident get up and transfer self to the restroom without assistance. LPN-C did not ask the resident if the resident needed assistance or supervise the resident transfer on and off the toilet or offer toileting hygiene. At 9:04 AM Resident 3 exited the resident and transferred self to the recliner. In an interview on 03/12/2026 at 9:26 AM, NA-H confirmed NA-H had not checked on Resident 3 until NA-H delivered the breakfast tray, then just left the tray. NA-H confirmed residents were supposed to be checked and changed every 2 hours and they had not. In an interview on 03/12/2026 at 9:53 AM, the facility's Director of Nursing (DON) confirmed staff should check residents every 2 hours. The DON confirmed that staff should have assisted a resident with transfers that was listed on the MDS as needing partial/moderate assistance and on the Care Plan as 1 assist partial with transfers. The DON confirmed LPN-C or staff should have supervised Resident 3 with toilet transfers. In an interview on 03/12/2026 at 12:45 PM, the DON confirmed the Care Plan did not include interventions for the falls the resident had. The DON confirmed the facility did have an internal fall document, but it was not part of the medical record, so they could not provide that document to review. The DON confirmed the resident's medical record should have included the causal factors for the falls and interventions that were put in place to prevent the falls from happening again except the final fall went the resident was sent to the hospital. The DON confirmed it because the falls happened back-to-back and the facility did not have enough time in between the falls to come up with interventions. The DON confirmed neuro checks were not started after the 02/09/2026 at 9:15 PM fall and should have been. B. A record review of the facility's Falls Management policy dated 4/2015 revealed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fall Injury Prevention – Post Fall 1. Assess the resident/patient and immediately implement appropriate measures to prevent injury. a. EX. Wipe up spills, improve lightening, call light in reach, appropriate footwear. b. Document in medical record 2. Initiate and complete the Accident/Incident Protocol 3. Review Fall Risk Assessment for any changes in fall risk, reassess post fall. 4. Review the Plan of Care – Fall Risk Reduction 5. Discuss findings and interventions with the resident/patient/family for inclusion in the Interdisciplinary Plan of Care (IPOC). 6. Adjust/add interventions on the Plan of Care- Fall Risk Reduction. 7. Present resident/patient at the next scheduled IPOCC meeting: a. Review current assessment and reports. b. Compare data from previous assessments. c. Discuss identified trends or potential new risk factors. 8. Review and revise Interdisciplinary Plan of Care. 9. Update and communicate interventions. 10. Provide appropriate training for caregivers, noting any changes implemented. 11. Educate resident /patient/family, as appropriate. 12. Verify completion of the Accident/Incident Process. 13. Verify referral to therapy for screen. A record review of the facility's Fall Data Collection dated 1/14/2026 revealed that the root cause of the fall was the air mattress. The initial intervention that was implemented to prevent reoccurrence was to request the air mattress changed to a regular mattress. A record review of Resident 4's undated Care Plan Report revealed the following: 1/14/26 new fall with right femur fracture (a break in the long, strong bone between your hip and knee) and surgical aftercare. The intervention listed was working with therapy post-surgery on right femur with an initiation date of 1/22/2026. A record review of Resident 4's Minimum Data Set (MDS, a federally mandated comprehensive (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 1/1/2026 revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14/15 indicating the resident is cognitively intact (the ability to make ones own decisions and think for oneself). An observation on 3/11/2026 at 12:23 PM revealed Resident 4 lying in bed on an air mattress. An observation on 3/12/2026 at 6:58 AM revealed Resident 4 lying in bed on an air mattress. In an interview on 3/11/2026 at 12:41 PM Physical therapy Assistant (PTA)-G confirmed that the order for Occupational Therapy (OT) was placed on 3/4/2026 and Resident 4 was evaluated on 3/5/2026. PTA-G confirmed that OT has been working with the resident twice a week since 3/5/2026. The order for Physical Therapy (PT) was also placed on 3/4/2026 and Resident 4 was scheduled to be evaluated by PT on 3/12/2026. In an interview on 3/11/2026 at 12:59 PM Director of Nursing (DON) confirmed that the Fall investigation in the charting system said the air mattress was the reason for the fall and the resident was switched to a regular mattress. The DON said that no other intervention was seen besides the therapy evaluation. In an interview on 3/11/2026 at 1:10 PM Medication Aide (MA)-F confirmed that Resident 4 is on an air mattress. In an interview on 3/11/2026 at 1:24 PM DON confirmed that the PT evaluation was to assess for change due to the resident being in the hospital. The DON confirmed that the air mattress was changed to a regular mattress, and then Resident 4 stated that Resident 4 could not sleep on the regular mattress, so it was changed back to the air mattress per resident request. In an interview on 3/12/2026 at 11:29 AM DON confirmed that the air mattress was switched to a regular mattress on 3/4/2026. The DON confirmed that there was no additional evidence of any other interventions regarding the fall besides therapy. C. Record review of Resident 1's admission Record showed the facility admitted the resident on 02/24/2026. Further review of the admission record revealed Resident 1 had diagnoses that included hemiplegia (complete or severe loss of movement on one side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) following a nontraumatic intracerebral hemorrhage (stroke). Record review of Resident 1'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 03/02/2026 revealed Resident 1 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 13. According to the MDS manual, a score of 13-15 indicated the resident had intact cognition. Further review of the MDS identified Resident 1 had one non-injury fall since admission to the facility. Record review of Resident 1's Fall Data Collection dated 02/27/2026 revealed the resident sustained a witnessed fall when Resident 1 slipped and fell during a self-transfer in the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 1's Progress Notes (PN) revealed a PN dated 02/27/2026 at the time of the fall, and a follow-up note dated 02/28/2026 at 12:52 PM. Record review of Resident 1's Electronic Health Record (EHR) including progress notes, skilled services documentation, and scanned documents revealed no further evidence of post-fall injury monitoring and documentation. Interview on 03/11/2026 at 3:51 PM with RN-A confirmed a resident should be monitored for post-fall injury for 72 hours after a fall, and a progress note should be entered. Interview on 03/12/2026 at 5:43 AM with LPN-I confirmed a resident should be monitored for post-fall injury for 72 hours after a fall, and a progress note should be entered. Interview on 03/12/2026 at 8:26 AM with the DON confirmed a post-fall evaluation should be completed on a resident to include vital signs every shift for 72 hours. The DON further confirmed there was additional evidence an assessment was completed for the 72 hours after Resident 1's fall.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Licensure Reference Number 175 NAC 12-006.09(H)(iv)(2)Based on observations, interviews, and record reviews, the facility failed to establish voiding patterns to develop a toileting program for 1 (Resident 1) of 3 sampled residents. The facility staff identified a census of 71.Findings are:Record review of Resident 1's admission Record showed the facility admitted the resident on 02/24/2026. Further review of the admission record revealed Resident 1 had diagnoses that included hemiplegia (complete or severe loss of movement on one side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) following a nontraumatic intracerebral hemorrhage (stroke).Record review of Resident 1'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 03/02/2026 revealed Resident 1 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 13. According to the MDS manual, a score of 13-15 indicated the resident had intact cognition. Further review of the MDS identified Resident 1 was frequently incontinent of bladder and was not on a toileting program.Record review of Resident 1'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 the following interventions related to toileting: -Resident 1 required partial assistance of one staff for toilet transfers dated revised 03/06/2026; -Resident 1 required substantial assistance of one staff for toileting hygiene dated revised 03/06/2026; -Establish voiding patterns dated revised 03/06/2026. -Incontinent: Routine check and change on rounds and as required for incontinence dated revised 03/06/2026.Record review of Resident 1's Nursing admission Data Collection - V 2 Section 6. Bladder dated 02/24/2026 revealed the facility assessed Resident 1 to have functional urinary. Further review of the bladder evaluation showed Resident 1's treatment program included routine check and change and prompted voiding. Review of Resident 1's Electronic Health Record which included scanned documents, progress notes, and forms revealed no evidence of Resident 1's voiding patterns.Observation on 03/12/2026 at 7:06 AM revealed Nurse Aide (NA)-H assisted Resident 1 out of bed, to get dressed, and to the toilet. There was a bed pad with a yellow wet area, and Resident 1's brief was noted to be wet.Interview on 03/11/2026 at 12:57 PM with Resident 1 revealed Resident 1 was aware of the urge to use the restroom. Resident 1 reported they must turn on the call light and wait for toileting assistance. Resident 1 reported they would like to be on a toileting program to restore continence but it had not been offered.Interview on 03/12/2026 at 7:12 AM with NA-H confirmed Resident 1's brief and bed pad were wet with urine. NA-H reported Resident 1 was not on a toileting program and further reported Resident 1 is toileted when [gender] calls for help.Interview on 03/12/2026 at 8:26 AM with the Director of Nursing revealed there was no bladder diary or established voiding patterns to aid in the development of an effective toileting program for Resident 1. The DON confirmed the established voiding patterns should have been completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 12-006.18 Based on observations, interviews and record review the facility staff failed to follow infection control practice to prevent the potential for cross contamination on 1 (Resident 4) of 3 sample residents. The facility census was 71. Findings are:A.A record review of the facility's Infection Control Standard Precautions- Handwashing with a revision date of 1/2024 revealed the following: 7. Use an alcohol-based hand rub containing at least 62 percent alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. before and after direct contact with residents; h. Before moving from a contaminated body site to a clean body site during residents care; i. After contact with residents intact skin; j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; m. After removing gloves. Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand turning the glove inside out. 4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. An observation on 3/11/2026 at 2:52 PM revealed Licensed Practical Nurse (LPN)-D, completed hand hygiene with soap and water, grabbed gloves out of the box, put the gloves on and removed the wound dressing. LPN-D removed gloves, pulled gloves out of the pocket on LPN-D scrub top, put the gloves on and cleansed the wound. LPN-D removed the gloves, pulled gloves out of the pocket on the scrub top, put the gloves on and placed the xeroform (a petroleum-jelly-soaked mesh cloth that does not stick to the wound, making dressing changes much less painful) over the wound and wrapped the wound with kerlix (a soft, absorbent, and stretchy bandage used to wrap and protect wounds). LPN-D removed the gloves, got new gloves out of the box, put them on and cleansed Resident 4's toes. In an interview on 3/11/2026 at 2:52 PM LPN-D confirmed that LPN-D should have completed hand hygiene between glove changes and did not. LPN-D confirmed that LPN-D should not have utilized the gloves from LPN-D's pocket and should have gotten clean gloves out of the box of gloves. B.A record review of the facility's MDRO (Multidrug-Resistant Organisms) PPE (Personal Protective Equipment)-Enhanced Barrier Precautions with a revision date of 1/2024 revealed the following: Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs target gown and glove use during high contact resident care activities. EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling (inside the body) medical devices, regardless of MDRO colonization (carrying the germ) status Residents known to be infected or colonized with an MDRO (that is CDC (Center for Disease Control) MDRO targeted); will be placed on EBP and signage on door placed. A record review of the facility's Enhanced Barrier Precaution signage revealed the following: Everyone Must: Clean their hands, including before entering and when leaving the residents room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities. Dressing Bathing/Showering Transferring Changing linens Providing Hygiene Changing briefs or assisting with toileting Device care or use: Central line, urinary catheter, feeding tube tracheostomy Wound Care: any skin opening requiring a dressing Do not wear the same gown and gloves for care of more than one person. A record review of Resident 4's admission Record dated 3/11/2026 revealed the following diagnosis:Extended Spectrum Beta Lactamase (ESBL) Resistance and Personal History of Methicillin Resistant Staphylococcus Aureus Infection (Germs that are difficult to treat). An observation on 3/12/2026 at 5:36 AM of Resident 4's room door frame revealed that there is an EBP magnet on the top left side. An observation on 3/12/2026 between 6:58 AM and 8:10 AM revealed LPN-E entered Resident 4's room with the treatment cart (a mobile storage that contains supplies for treatments of skin issues and/or wounds). LPN-E did not put on a gown. LPN-E removed wound care supplies from the treatment cart and placed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the supplies on the residents' uncleaned bedside table without disenfecting the table or putting a protective barrier down. There were scissors on the bedside table upon entering Resident 4's room. LPN-E used the scissors to cut the xeroform gauze to size and did not disenfect the scissors prior to using them on the wound care supplies. In an interview on 3/12/2026 between 6:58 AM and 8:10 AM LPN-E confirmed that the treatment cart should not have entered the room and did. LPN-E confirmed that LPN-E should have had EBP on while doing the dressing change and did not. LPN-E confirmed that the table should have been disinfected prior to placing wound care supplies on table and was not. LPN-E confirmed that the scissors should have been disinfected prior to cutting the wound care supplies and they were not. In an interview on 3/12/2026 at 11:55AM DON confirmed that the process in the EBP signage is the expectation for all staff to follow while providing high contact cares for anyone on EBP, including the residents with the EBP magnets in the top of the door frames.