

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 04/27/2026
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18Based on observations, record reviews and interviews: the facility failed to utilize hand washing and gloving techniques and failed to implement A record review of the Enhanced Barrier Precautions (EBP, an infection control strategy designed to prevent the spread of multi-drug-resistant organisms) for 2 (Residents 1 and 3) of 3 sampled residents. The facility had a census of 62. Findings are: A. A record review of Resident 3's Electronic Clinical Resident Profile sheet revealed Resident 3 was admitted to the facility on [DATE].A record review of Resident 3's Minimum Data Set ((MDS - a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents functional, medical, psychosocial and cognitive status) dated 2/26/2026 revealed Resident 3 had a Brief Interview for Mental Status (BIMS - a standardized assessment used in nursing homes to assess cognitive function, specifically memory and orientation) of 14 indicating Resident 3 was cognitively intact.A record review of Resident 3's Care Plan (CP - a personalized, actionable document that outlines a patient's health needs, goals and specific interventions to manage their care) with the following diagnoses: Type 2 Diabetes Mellitus (a chronic condition where the body cannot effectively use insulin leading to high blood sugar levels) Chronic venous insufficiency (a condition where leg veins cannot efficiently return blood to the heart, causing blood to pool in the legs), localized edema (swelling confined to a specific body part) and Cellulitis (a common, potentially serious bacterial skin infection affecting deep dermis (thick layer of skin located between the epidermis - outermost skin layer and subcutaneous tissue - the deepest layer of skin) and subcutaneous tissues) of right lower limb.A record review of Resident 3's progress note dated 4/21/2026 by Licensed Practical Nurse (LPN) A revealed the following: New area noted to Lt (left) LE (lower extremity - leg) today during cares. Advanced Practice Registered Nurse (APRN)-wound care provider was updated. New orders for x-ray to rule out fluid at wound site and tx (treatment) orders until visit on Friday. Resident updated.A record review of Resident 3's order summary revealed the following order dated 4/21/2026: Wound care: Cleanse with facility cleanser or soap and water. Rinse and pat dry. Apply xeroform (a sterile, non-stick, fine mesh gauze dressing) cut to fit bed of wound, then cover with bordered gauze wound dressing (a sterile adhesive bandage with a central nonstick absorbent pad surrounded by a breathable, adhesive border) every day and as needed if dislodged or soiled. An observation on 4/22/26 at 12:25 PM by of wound care provided by Registered Nurse (RN) B to Resident 3 revealed the following: RN B washed their hands and dried them with paper towels. RN B turned off the faucet with their bare hands. and approached Resident 3.RN B had placed wound supplies on a towel on the bedside table for Resident 3's wound care. RN B donned gloves and removed Resident 3's shoe and edema wear from Resident 3's leg and repositioned the leg on the wheelchair pedal to provide access to the wound. RN B removed their gloves, used hand sanitizer, and donned clean gloves. RN B removed the old dressing from the wound and discarded it along with their gloves. RN B performed hand hygiene and donned clean gloves. RN B sprayed wound cleaner on a 4x4 gauze pad and cleaned the wound, starting at the center and moving outward, using a clean gauze pad with each wipe. RN B changed gloves using hand sanitizer in between and rinsed the wound with a gauze pad wet with normal saline. RN B changed gloves and used hand sanitizer. RN B (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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RN B confirmed they had used their contaminated left hand to touch the dressing that was then applied directly to the wound. B. A record review of Resident 1's Clinical Resident Profile sheet revealed they were admitted to the facility on [DATE]. A record review of Resident 1's MDS dated [DATE] revealed Resident 1 had a BIMS of 14, indicating Resident 1 was cognitively intact. A record review of Resident 1's undated CP revealed Resident 1 has the following diagnoses: Quadriplegia (a paralysis caused by cervical spinal cord injury or illness, resulting in partial or total loss of function in all 4 limbs and the torso, Neuralgia (intense, sharp pain caused by damaged, irritated or compressed nerves) and Neuritis (inflammation of a nerve or group of nerves resulting in pain, numbness, muscle weakness and loss of reflexes), Extended spectrum Beta Lactamase resistance infection (infection caused by bacteria resistant to many common antibiotics), Acquired absence (amputation) of left foot, Acquired absence (amputation) of right leg above the knee, Cervicalgia (pain in the neck region), Sepsis (a life-threatening medical emergency caused by the body's extreme, overactive response to an infection). A record review of Resident 1's Skin/Wound Weekly observation, dated 4/14/2026 revealed they had the following wounds: venous (shallow, slow-healing open area) wound on left lower leg, surgical wound to right knee from an amputation, abrasion (superficial skin wound) to the left hand, palm, back of the hand and fingers, a Stage II Pressure Ulcer (a shallow, open ulcer with a pink/red wound bed or an intact/ruptured serum-filled blister) to the sacrum (wound to the skin over the tailbone), venous wound to the left arm and a skin tear (traumatic wound caused by friction) to left scapula (shoulder blade). A record review of Resident 1's wound care orders revealed the following order dated 4/6/2026: Wound Care: Left Hand Wash with soap and water, rinse, and pat dry. Apply Betadine pt entire left hand and leave it open to air. Daily every day shift A record review of Resident 1's Order Summary revealed the following order dated 2/26/2026: EBP: Staff to use enhanced barrier precautions (gloves/gown) during high contact activities d/t wounds. An observation on 4/27/26 at 9:30 AM of wound care provided by Licensed Practical nurse (LPN) C for Resident 1 revealed the following: LPN C entered Resident 1's room and asked Resident 1 if they could do the wound care to the wound care to Resident 1's left hand. Resident 1 agreed to having the treatment completed. LPN C washed their hands and donned gloves and did not gown. Resident 1's arms were both contracted (a permanent physical shortening of muscle, tendon, or scar tissue, resulting in joints becoming fixed in a bent position) with the left fingers pressed firmly together and left thumb tucked beneath the fingers. Visible portions of Resident 1's left hand had dark purplish/red scab tissue with gray edges. LPN C placed a clean chux pad underneath Resident 1's left arm. LPN C soaked several 4x4 gauze pads in a wound cleaning solution of soap and water and used separate pads to wash Resident 1's left hand, using one pad for each pass over the scabbed area until the hand was clean. Large pieces of scab tissue separated from Resident 1's hand, leaving pink intact skin beneath. LPN C removed their gloves, used hand sanitizer and donned clean gloves, then patted Resident 1's left hand dry with clean gauze. LPN C removed the chux from underneath Resident 1's arm and disposed of it in the trash. LPN C removed their gloves, using hand sanitizer, donned clean gloves and placed a clean chux pad under Resident 1's left hand. LPN C removed their gloves, used hand sanitizer, and donned clean gloves. LPN C used gauze pads and a clear cup of water to rinse Resident 1's left hand. LPN C changed their gloves, using hand sanitizer in between and patted Resident 1's hand dry with clean gauze. LPN C changed gloves, using hand sanitizer in between and (continued on next page)</p>		

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