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	06/03/2026

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. Based on interview and record review, the facility failed to ensure significant injury was reported to Adult Protective Services within 2 hours for 1 [Resident 5] of 15 sampled residents. The facility had a total census of 65 residents. Findings are:A review of facility Abuse/Neglect Report dated 5/26/26 revealed Resident 5 was found on the floor on 5/18/26. A x-ray was ordered on 5/18/26 and the results were obtained on 5/20/26 which identified that Resident 5 had a distal fibula and medial malleolus fracture with minimal displacement. A further review of Abuse/Neglect Report dated 5/26/26 revealed a report was called to Adult Protective Services regarding Resident 5's fracture on 5/22/26 at 5 PM. In an interview on 6/2/26 at 5:16 PM, the Administrator confirmed that Resident 5's injury was not reported within the required 2 hours. A review of facility policy titled Abuse, Neglect and Exploitation dated 1/2024 revealed the following:- Serious bodily Injury-2 Hour Limit: If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion (unless the State has a shorter reporting time.)

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 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: 175 NAC 12-006.09(H); 175 NAC 12-006.09(H) (iii) Based on record review and interview, the facility failed to ensure assessment was completed after a fall, failed to ensure X-ray results were obtained, failed to ensure a orthopedic appointment was scheduled for 1 [Resident 5] of 3 residents sampled for medical care and failed to ensure weekly skin observations were complete for 2 [Resident 6 and 7] of 3 sampled residents. The total survey sample was 15. The facility had a total census of 65 residents. Findings are: A. A review of Resident 5's admission record revealed Resident 5 was admitted to the facility on [DATE] with a diagnosis of hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side [stroke]. A review of Resident 5's quarterly MDS [Minimum Data Set; a comprehensive assessment tool used for care planning] dated 2/26/26 revealed the following: -Brief Interview for Mental Status score of 15. A review of MDS manual revealed a score of 13-15 means cognitively intact A review of Resident 5's Care Plan revealed a focus area related to having a functional deficit with activities of daily living related to cerebrovascular accident, weakness, seizure disorder, and frequent falls with the following interventions: -CAM boot [Controlled Ankle Motion boot] tall related to left foot fracture on at all times until seen by orthopedics initiated 5/29/26 -Non weight bearing order until seen by orthopedics initiated 5/29/26 In an interview on 6/1/26 at 11:22 AM, Resident 5 reported that Resident 5 is non-weight bearing and has been staying in bed since the fall due to needing to use a Hoyer lift to get out of bed. A review of Fall Data Collection from dated 5/18/26 revealed Resident 5 found sitting with back to the bed legs extended out with wheelchair in front of Resident 5. The Fall Data Collection form revealed Resident 5 was slid out of bed and Resident 5 reported pain in left ankle. Resident 5 was assisted back to bed with help of 2 staff members and bed placed in low position. Resident 5's personal items and call light were within reach. A review of Resident 5's Progress Notes did not reveal any additional assessment of Resident 5 for injuries on 5/18/26 or 5/19/26. A review of physician order for Resident 5 dated 5/18/26 revealed an order for lateral left ankle x-ray, 3 views. A review of Resident 5's Radiology Report dated 5/19/26 at 9:10 Am revealed Resident 5 had a fracture to left involving the distal fibula and medial malleolus [ankle] with tissue swelling. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 5's Progress Note dated 5/20/26 at 12:43 PM revealed Nurse contacted portable x-ray company for results of x-ray results and results were called to practitioner. A review of Resident 5's Order Summary revealed an order dated 5/20/26 to wrap and keep wrapped affected ankle to remind Resident 5 of non-weight bearing status. A review of Resident 5's Order Summary revealed an order dated 5/23/26 for Cam boot tall related to left foot fracture on at all times until seen by orthopedics. A review of Resident 5's Progress Note dated 5/23/26 at 3:47 PM revealed CAM boot was delivered and fitted to Resident 5's left foot. In an interview on 6/2/26 at 4:16 PM, LPN Unit Director A confirmed there should have been a follow-up assessment note within 24 hours of Resident 5's fall. In interviews on 6/2/26 at 8:48 AM and 3:55 PM, Medical Records Clerk confirmed that no appointment had yet been made for Resident 5 to be seen by Orthopedics. Medical Records Clerk report orthopedics had been contacted on 6/2/26 and requested copies of the x-rays for their review before setting up an appointment with Resident 5. In an interview on 6/2/26 at 4:16 PM, LPN Unit Director A confirmed that an orthopedic appointment should have been made as soon as possible for Resident 5. In an interview on 6/2/26 at 5:06 PM, the Director of Nursing confirmed that the facility should have contacted the portable x-ray company to get the results of the x-ray on 5/19/26 and should have contacted orthopedics within a couple of days for an appointment. A review of facility policy titled Falls Management policy last revised 1/2024 revealed the following: -Resident fall will be documented for 24 hours for post fall monitoring. B. Record review of Resident 6's Quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 3/18/26 identified the facility admitted the resident on 12/10/25 with diagnosis of cerebral palsy(CP) a neurological disorder that affects movement, muscle tone, balance, and posture), cellulitis(a bacterial infection of the skin and underlying deep tissue) of right and left lower limb, and venous insufficiency. Further review of Resident 6's MDS revealed they required set up/clean up for upper body dressing, lower body dressing and putting on and taking off footwear, partial/moderate assist for shower/bathing, substantial/max assist for toileting hygiene, and was dependent for sit to stand and chair to bed transfers, who is frequently incontinent of urine and always incontinent of bowel. Record review of Resident 6's Electronic Medical Record (EMR) the section identified as Clinical Assessments revealed no Skin/Wound weekly observation was completed between 4/24/26 and 5/22/26. A four-week timeframe. C. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 7's Quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 3/29/26 identified the facility admitted the resident on 3/23/26 with diagnosis of end stage renal disease receiving dialysis, type II diabetes, coronary artery disease, and hypertension. Further review of Resident 7's MDS revealed they required set up/clean up assistance for eating, oral hygiene, upper body dressing, lower body dressing, and putting on/taking off footwear, partial assistance for toileting assistance, sit to stand and chair to bed transfers, and substantial/maximal assist for bathing, who was occasionally incontinent of urine. Record review of Resident 7's EMR the section identified as Clinical Assessments revealed no Skin/Wound weekly observation was completed between 4/24/26 an 5/11/26 a two-week time frame and between 5/11/26-5/30/26 a two and a half week time frame. Interview with LPN A on 6/1/26 at 2:10 PM revealed that skin assessments should be completed weekly. An interview with the Regional Nurse Consultant on 6/3/26 at 7:17 AM revealed the facility policy is to do Skin Assessments weekly and Braden Risk Assessments are completed on admission, weekly x 4 weeks and then quarterly. Record review of a facility policy entitled Skin and Wound Management-Prevention of Pressure with a revised date of 6/4/26 revealed the following: Prevention of Pressure Injuries Purpose The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Risk Assessment 1. Assess the resident on admission (within 8 hours) for existing pressure injury risk factors. Repeat the risk assessment weekly x 4 weeks and upon any changes in condition. (Risk Assessment Braden) Skin Assessment Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1) & 12-006.09(H)(iii)(2)Based on observation, interview and record review the facility failed to implement preventative measures to prevent a pressure ulcer, failed to provide treatment as ordered to promote healing of a pressure ulcer and failed to ensure weekly skin evaluations were completed for 1 (Resident 13) of 2 sampled residents. The facility identified a census of 65.Findings are:Record review of a facility policy entitled Skin and wound management-Prevention of Pressure with a revised date of 6/4/26 revealed the following: Prevention of Pressure InjuriesPurpose The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors.Risk Assessment1. Assess the resident on admission (within 8 hours) for existing pressure injury risk factors. Repeat the risk assessment weekly x 4 weeks and upon any changes in condition. (Risk Assessment Braden) Skin Assessment Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. Record review of Resident 13's Significant Change Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 3/24/26 identified the facility readmitted the resident on 3/18/26 from the hospital with diagnosis of right hip fracture, diabetes mellites, liver transplant status, congestive heart failure (CHF), peripheral vascular disease, and chronic obstructive pulmonary disease (COPD) who required substantial/max assist to roll right to left, sit to lying, sit to stand, chair to bed transfers and was dependent for toileting hygiene, lower body dressing and putting on and taking off footwear. Further review of the MDS revealed a brief interview for mental status (BIM's) of 13/15, according to the MDS manual 13-15 indicates a person is cognitively intact.Record review of clinical document entitled Braden Scale (a clinical assessment tool used to predict a patient's risk of developing pressure injuries dated 3/18/26 revealed a score of 15 indicating mild risk according to the Braden Scale form. According to the Braden Scale form if score is less than 16, initiate skin integrity interventions and document on the baseline care plan. Review of Resident 13's record revealed no interventions were implemented to prevent pressure ulcer/injury to Resident 13's heels.Review of Resident 13's comprehensive care plan copied on 6/1/26 revealed there was no focus (problem) area to identify the resident was at risk for pressure ulcer/injuries.Record review of Resident 13's Electronic Medical Record section identified as Clinical Assessments revealed no Skin/Wound weekly observation was completed between 3/18/26 and 4/3/26, a two-week time frame.Record review of a progress note for Resident 13 dated 4/7/26 revealed facility staff observed a 4 x 3 (centimeter) cm open blister to the right heel.Record review of a document from Tissue Analytics Advanced Practice Registered Nurse (APRN) for Resident 13 dated 4/10/26 revealed a right heel pressure ulcer-Stage III (a deep full thickness skin loss) with measurements length 4.05-centimeter (cm) x width 3.06 cm x depth 0.10 cm. Further review of note by the APRN revealed ?New wound. [gender] has an open, stage III to [gender] heel. There is some slough (dead skin) in the wound. Will use Alginate Ag alone for now. Plan: Wash with facility cleanser, pat dry, paint the periwound with skin prep and let dry, cover the wound with alginate ag, cut to fit size and shape, cover with Mepilex 9generic equivalent) or non-stick dressing and wrap with gauze. Change daily and PRN for soiling, saturation or accidental removal.Record review of a document from Tissue Analytics dated 5/15/26 revealed ?The periwound is very macerated (when the skin around a wound is exposed to too much moisture for too long). The skin prep needs to be applied all around the wound for protection. Medihoney was added last week (5/8/26), but it does not appear the order was updated in Point Click Care (PCC, electronic medical record). Please make sure orders are updated to reflect the latest orders.Record review of the Order Summary Report revealed an order dated 5/22/26 for wound care as follows: right heel wash with facility cleanser, pat dry, paint the peri wound with skin prep, let dry, cover the wound with Alginate Ag(an absorbent antimicrobial wound dressing) , cut (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Alginate to fit size and shape apply medihoney (a medical grade, sterilized honey used in wound care) to the wound bed (ok to apply directly to alginate and then apply to wound) cover with mepilex (an absorbent silicone foam pad) (generic equivalent) or non-stick dressing and wrap with gauze, change daily and PRN for soiling, saturation or accidental removal as needed.Observation on 6/1/26 at 11:10 AM of Resident 13's wound care revealed Licensed Practical Nurse (LPN) B entered Resident 13's room, placed supplies on bedside table, performed hand hygiene, donned gloves, LPN B did not don a gown, a barrier was placed under Resident 13's right heel, sock were removed to reveal a saturated dressing dated 5/30/26. LPN B removed the soiled dressing, removed gloves, performed hand hygiene, donned new gloves, donned a gown, cleansed the wound to right heel with facility wound cleanser and gauze. Resident 13's right heel wound had a gray/yellow base, wound edges were macerated. LPN B removed gloves, performed hand hygiene, donned gloves, cut alginate to fit the wound base, applied medihoney to the alginate and placed it on the wound, covered the wound with bordered gauze. LPN B placed the sock back on resident 13's foot and applied the prevalon boot.In an interview with LPN B on 6/1/26 at 11:20 AM it was confirmed the dressing removed from Resident 13 was dated 5/30/26 indicating the treatment was not completed as ordered on 5/31/26. LPN further confirmed they did not paint the peri wound with skin prep and did not wrap the heel with gauze and should have.In an interview with LPN A on 6/2/26 at 3:21 PM it was confirmed Resident 13's Braden on 3/18/26 indicated they were at risk and there was no evidence interventions were put in place.In an interview with the Director of Nursing (DON) on 6/2/26 at 5:00 PM confirmed Resident 13's Braden on 3/18/26 indicated they were at risk and there was no evidence interventions were put in place.An interview with the Regional Nurse Consultant on 6/3/26 at 7:17 AM revealed the facility policy is to do Skin Assessments weekly and Braden Risk Assessments are completed on admission, weekly x 4 weeks and then quarterly.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D)Based on record review and interview, the facility failed to ensure 1 (Resident 6) of 6 sampled was free from significant medication errors. The facility identified a census of 65.Findings are:Record review of Resident 6's Quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 3/18/26 identified the facility admitted the resident on 12/10/25 with diagnosis of cerebral palsy(CP) a neurological disorder that affects movement, muscle tone, balance, and posture), cellulitis(a bacterial infection of the skin and underlying deep tissue) of right and left lower limb, and venous insufficiency. Further review of Resident 6's MDS revealed they required set up/clean-up for upper body dressing, lower body dressing and putting on and taking off footwear, partial/moderate assist for shower/bathing, substantial/max assist for toileting hygiene, and was dependent for sit to stand and chair to bed transfers, who is frequently incontinent of urine and always incontinent of bowel.Record review of Resident 6's electronic medical record (EMR) document by an Advanced Practice Registered Nurse (APRN) with a date of service of 5/26/26 revealed the following: -Chief Complaint-acute visit-bilateral lower extremity (BLE) pain and erythema (redness). History of present illness-Patient expresses concern about their right lower extremity and cellulitis (skin infection). (Gender) reports they have had cellulitis in the past and that this felt similar. Skin-Bilateral lower extremities have several small bandages covering venous ulcers. Plan-Doxycycline hyclate (an antibiotic used to treat bacterial infections) 100 milligrams (mg) take one capsule by mouth twice daily for 7 days for right lower extremity cellulitis'.Record review of Resident 6's electronic medical record Electronic Medication Administration Record (EMAR) revealed the first dose of the Doxycycline was given on 5/28/26 at 9:00 PM, 2 days after it was ordered. Record review of Resident 6's Tissue Analytics (TA) Wound Notes dated 5-29-2026 revealed the APRN assessed Resident 6 with extensive erythema, swelling to the right lower leg was showing significant signs of cellulitis. Further review of the Resident 6's TA note dated 5-29-2026 revealed the APRN identified Resident 6 was supposed to start on a oral antibiotic 4 days ago, however, the antibiotic was not delivered. Resident 6's TA note dated 5-29-2026 further identified the resident remained [NAME] oral antibiotic with the resident physician planning on starting the resident in an intravenous (IV) antibiotic. Record review of the order summary report revealed an order on 5/29/26 for Zosyn (an antibiotic used to treat moderate to severe bacterial infections) solution 3-.0375 Grams infuse 3.375 grams IV every 6 hours for 7 days for cellulitis.Record review of an Emergency Department (ED) Provider note by Medical Doctor (MD) with an encounter date of 6/1/26 revealed Resident 6 was seen for pain in right leg. Further review of note revealed the patient had extensive cellulitis of the right lower leg. Vitals are within normal limits but white blood count (which measures immune system cells) is 31 (according to the Mayo Clinic normal is 3.4-9.6, an elevation is indicative of the body fighting an infection) and C-Reactive protein (a test to detect, diagnose and monitor conditions like infections) is 149 (according to the Mayo Clinic a CRP level greater than 50 is considered severe elevation) and lactate (which measures your lactic acid level in the blood) 3.4 (according to the Mayo Clinic normal is 0.5-2.2, an elevated levels can be indicative of sepsis) concerning for systemic inflammatory response (SIRS criteria)/ meeting sepsis criteria. Deep Vein Thrombosis (DVT) study was negative. IV Vancomycin (antibiotic), cefepime (antibiotic) and Flagyl (antibiotic) were ordered and the patient was admitted given failure of outpatient antibiotics. An interview was conducted with Licensed Practical Nurse (LPN) A on 6-02-2026 at 9:30 AM. During the interview LPN A reported confirmed the antibiotic medication was not administered as ordered. LPN A further reported the facility Director of Nursing and reported to the residents practitioner on 5/29/2026 the antibiotic that had been ordered on 5-26-2026 was not started until 5/28/2026. LPN A further reported staff had not followed up on 5-27-2026 on that status (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	of administering the antibiotic and should have. In an follow up interview with LPN A on 6/2/26 at 4:20 PM it was confirmed not giving the antibiotic for 2 days after it was ordered would be considered a significant medication error.In an interview with the Director of Nursing on 6/2/26 at 5:00 PM it was confirmed that not giving the antibiotic for 2 days after it was ordered would be considered a medication error.

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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 observation, record review and interview, the facility failed to perform wound care in a manner to prevent potential cross contamination for 2 (Resident 6 and Resident 13) of 3 residents sampled. The facility identified a census of 65.Findings are:A.Record review of Resident 6's Quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 3/18/26 identified the facility admitted the resident on 12/10/25 with diagnosis of cerebral palsy(CP) a neurological disorder that affects movement, muscle tone, balance, and posture), cellulitis(a bacterial infection of the skin and underlying deep tissue) of right and left lower limb, and venous insufficiency. Further review of Resident 6's MDS revealed they required set up/clean up for upper body dressing, lower body dressing and putting on and taking off footwear, partial/moderate assist for shower/bathing, substantial/max assist for toileting hygiene, and was dependent for sit to stand and chair to bed transfers, who is frequently incontinent of urine and always incontinent of bowel.Observation of wound care for Resident 6 on 6/1/26 at 9:11 AM revealed Resident 6 lying on the bed. The right lower extremity was noted to have drying blood on back of leg and foot, the fitted sheet on the bed under the leg was noted to have a large dry brown spot and fresh red spot. LPN B donned gloves, and gown, and without placing a barrier between the right lower leg and the soiled sheet completed the treatment to the lower leg allowing an open wound on the posterior lower leg and dressing once applied to touch the soiled sheet. In an interview with LPN B on 6/1/26 at 9:36 AM it was confirmed she should have placed a barrier between Resident 6's leg and the soiled sheet to prevent cross contamination. B.Record review of Resident 13's Significant Change Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 3/24/26 identified the facility readmitted the resident on 3/18/26 from the hospital with diagnosis of right hip fracture, diabetes mellites, liver transplant status, congestive heart failure (CHF), peripheral vascular disease, and chronic obstructive pulmonary disease (COPD) who required substantial/max assist to roll right to left, sit to lying, sit to stand, chair to bed transfers and was dependent for toileting hygiene, lower body dressing and putting on and taking off footwear. Further review of the MDS revealed a brief interview for mental status (BIM's) of 13/15, according to the MDS manual 13-15 indicates cognitively intact.Observation on 6/1/26 at 11:10 AM of Resident 13's wound care revealed Licensed Practical Nurse (LPN) B entered room, placed supplies on bedside table, performed hand hygiene, donned gloves, did not don a gown. LPN B removed the soiled dressing, removed gloves, performed hand hygiene, donned new gloves, donned a gown and completed wound care to Resident 13's right heel.Record review of Resident 13's order summary revealed and order dated 5/19/26 for the following: Enhanced Barrier Precautions (EBP) Staff to use enhanced barrier precautions (gloves and gowns) during high contact activities due to wounds every shift.In an interview with LPN B on 6/1/26 at 11:20 AM it was confirmed the gown should have been donned before starting wound care.