STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285137	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Omaha	6032 Ville DE Sante Drive Omaha, NE 68104

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1) and 12-006.09 (H)(iii)(2). Based on observation, interview and record review, the facility failed to implement treatment and interventions to promote healing and prevent new pressure ulcers for 1 (Resident 3) of 1 residents sampled. The facility census was 94. The findings are:Record review of the facility policy titled Skin Integrity and Pressure Ulcer Prevention dated 06-11-2025 revealed the purpose of the policy was to provide staff and licensed nurses with procedures to manage skin integrity, prevent pressure ulcers, complete wound assessments and provide treatment and care of skin and wounds utilizing professional standards of the National Pressure Injury Advisory Panel and Wound, Ostomy, Continent Nurses Society. Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact.-required limited assistance with upper body dressing. -required extensive assistance with bathing, bed mobility and lower body dressing.-required total assistance with transfers and toileting.-had a pressure ulcer. Record review of Resident 3's Admission/readmission Collection Tool (ARCT) dated 10-17-2025 revealed Resident 3 had been hospitalized for a urinary tract infection. Under the skin section of the assessment the facility staff noted an open wound to the coccyx measuring 7 by 5. The ARCT did not indicate what unit of measurement was used. Record review of Resident 3's Progress Note (PN) dated 10-17-2025 revealed Resident 3 returned from the hospital, a skin assessment had been completed, and a note was left for the Nurse Practitioner (NP) to update on the wound to the coccyx area (tailbone). Record review of Resident 3's Wound Observation Tool (WOT) dated 10-22-25 revealed Resident 3 had a stage 2 pressure ulcer (a shallow open wound involving the top 2 layers of skin) to the sacrum measuring 2.5 centimeters (cm) in length by 2.7 cm in width by 0.1 cm in depth. The WOT also revealed that the treatment plan for the wound to sacrum was to cleanse the wound with wound cleanser, rinse and pat dry and apply Hydrofera Blue (an antimicrobial wound dressing) with water resistant mepilex (a wound dressing that does not stick to the wound) change daily and as needed for soiling. Record review of Resident 3's Order Summary (OS) printed on 11-17-2025 revealed no order for treatment of the sacral wound dated on or before 10-22-2025.Record review of Resident 3's Treatment Administration Record (TAR) for October 2025 revealed an order dated 10-22-2025 to cleanse, rinse and pat dry coccyx, then apply triad paste and cover with a mepilex dressing every evening shift. Further review of the TAR revealed no orders for treatment to the coccyx before 10-22-2025.Record review of Resident 3's Nutrition: Assessment/Nutritional Data Collection dated 10-22-25 revealed the facility Registered Dietician (RD) had recommended Resident 3 to receive Prosource 30 milliliters (mls) twice a day for wound healing and to notify the RD of any significant changes or concerns. Record review of Resident 3's OS printed on 11-17-2025 revealed no order for Prosource.Record review of Resident 3's Medication Administration Record (MAR) for October 2025 revealed no order for Prosource 30 mls twice a day. Record review of Resident 3's WOT dated 10-28-2025 revealed the stage 2 pressure ulcer to the coccyx measured 7.25 cm in length by 7.66 cm in width by 0.0 depth and staged as a 2. The WOT also indicated the wound was declining and the treatment plan was to cleanse the wound with wound cleanser, rinse and pat dry and apply Hydrofera Blue with water resistant Mepilex change daily and as needed for soiling.Record review of Resident 3's Progress Notes (PN) dated 10-31-2025 revealed there was a decline in wounds to coccyx/sacral region and the wound nurse assessed the wounds and new treatment orders were obtained.Record review of Resident 3's Electronic Health Record (EHR) revealed no wound assessment on 10-31-2025.Record review of Resident 3's TAR for October 2025 revealed no new treatment orders for the wounds to the coccyx/sacral region.Record review of Resident 3's OS printed on 11-17-2025 revealed an order dated 11-04-2025 to Cleanse with wound cleanser, rinse, pat dry, and apply Hydrofera Blue, cut to fit wounds and cover with Duoderm (a wound dressing that provides a moist protective environment to promote wound healing) every other day for wound care.Record review of Resident 3's TAR for November 2025 revealed an order dated 11-01-2025 to cleanse with wound cleanser, rinse, pat dry and apply Hydrofera Blue, cut to fit wounds and cover with a water resistant Mepilex. Change daily and as needed for soiling.Record review of Resident 3's Tissue Analytics Wound Assessment ([NAME]) dated 11-11-2024 revealed the wound to the sacral/coccyx was staged as a 3 (a deep wound that has full thickness skin loss) and measured 2.86 cm in length and 2.90 cm in width and 0

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3) and 12-006.09(J).Based on observation, interview and record review the facility failed to ensure a tube feeding was running continuously for 1 (Resident 2) of 3 residents sampled and failed to provide treatment to a feeding tube insertion site according to the practitioner's orders for 1 (Resident 7) of 3 residents sampled. The facility census was 94. The findings are:Record review of the facility policy titled Enteral Nutrition Therapy (Continuous) dated 09-05-2025 revealed the facility will provide continuous enteral nutrition therapy in accordance with physician's orders and professional standards of practice. Record review of the facility policy titled Treatment Orders dated 06-12-2025 revealed treatment orders are written per physician's orders. The physician orders are followed as are the manufacturer's instructions for use for each product ordered.A.Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tools used for care planning) revealed the facility staff assessed the following about the resident:-could rarely or never make themselves understood-required total assistance for eating, dressing, grooming, toileting, bathing, bed mobility and transfers.-had a feeding tube. Record review of Resident 2's Order Summary printed on 11-17-2025 revealed an order for Jevity 1.5 (a tube feeding formula) per feeding tube at 40 milliliters (ml) per hour for 24 hours a day. An observation conducted on 11-19-2025 at 2:32 PM revealed Resident 3 was lying in bed and the tube feeding pump was not administering the tube feeding. The pump was beeping and the screen on the pump said the pump had been idle for 10 minutes. An observation conducted on 11-19-2025 at 3:25 PM revealed Resident 3 was lying in bed, the feeding pump was beeping and not administering the tube feeding and screen on the pump said the pump had been idle for 10 minutes. An interview conducted on 11-19-2025 at 3:30 PM with Licensed Practical Nurse (LPN) B revealed (gender) was the nurse for Resident 2 and confirmed the tube feeding was not running and should have been running at 40 ml per hour and confirmed LPN B had not restarted the tube feeding pump in the last hour. B.Record review of Resident 7's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored as 12. According to the MDS Manual a score of 8 to 12 indicates moderate cognitive impairment. -required total assistance with dressing, grooming, dressing, toileting, bathing, bed mobility and transfers.-had a feeding tube. Record review of Resident 7's Treatment Administration Record (TAR) for November 2025 revealed an order dated 05-19-2025 for feeding tube site care as follows:Cleanse site, apply Vaseline gauze follow by a split gauze two times a day for healing of the site. An observation on 11-18-2025 at 8:10 AM-8:30 AM of LPN C providing feeding tube site care for Resident 7 revealed when the old dressing was removed from the feeding tube site, Resident 7 grimaced. The observation also revealed the absence of Vaseline gauze on the old dressing and the presence of bright red blood around the feeding tube insertion site. An interview conducted with LPN C at 8:25 AM confirmed the absence of Vaseline gauze on the old dressing and confirmed Vaseline gauze should have been applied to the tube feeding site, and confirmed the old dressing had stuck to Resident 7's skin causing discomfort.