Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285137	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure discharge planning was completed for 1 resident (Resident 1) of 4 residents surveyed. The facility claimed a census of 44.A record review of the Facility Discharge Planning Process dated 5/6/2019 and revised 8/18/2022, revealed the following:The discharge planning process will address each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan.ProcedureIdentify the resident's needs and goals regarding discharge upon or as soon as practicable after admission.The discharge plan is incorporated into the interdisciplinary care plan. It originates on the baseline care plan and will be included on the resident's comprehensive care plan, once developed.Address the resident's goals and treatment preferences in the plan.Document the date and any updated information in the discharge plan.The discharge plan will identify the discharge destination, and ensure it meets the residents' health and safety needs as well as preferences.A record review of Resident 1's Clinical Resident Profile sheet revealed Resident 1 was admitted to the facility on [DATE] and discharged from the facility on 2/10/2026.A record review of Resident 1's Discharge Minimum Data Set (MDS - a federally mandated assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a resident's functional, medical, psychosocial and cognitive status) dated 2/10/2026 revealed Resident 1 had a Brief Interview for Mental Status (BIMS - a mandatory tool used to assess the cognitive status of residents) score of 15, indicating Resident 1 was cognitively intact.A record review of Resident 1's Care plan revealed the following diagnoses: Generalized muscle weakness, difficulty in walking, cognitive communication deficit (a communication issue caused by disruptions in cognitive processes such as memory, attention and organization), Type 2 diabetes, Morbid obesity, high blood pressure and congestive heart failure (a chronic, progressive condition where the heart muscle is too weak to pump blood efficiently).A record review of Resident 1's undated care plan does not reveal a discharge plan was initiated.A record review of a rental application form for an independent living apartment revealed Resident 1 filled out and signed the form on 1/24/26.A record review of a Care Plan Conference Record Sheet, dated 0127/26 revealed Resident 1 had no discharge plans and did not attend the Care Plan Conference.A record review of an e-mail dated 2/5/2026 from the MDS Licensed Practical Nurse (LPN A) to the Social Services Director, Administrator, Director of Nursing and the Business Office Manager confirmed MDS LPN received confirmation Resident 1 was approved for independent living with a caregiver at the accepting facility and was working with the Office on Aging to set up caregiver services.A record review of a progress note by the Social Services Director (SSD) dated 2/10/2026 revealed Resident 1 discharged to an independent living facility and refused assistance from the SSD. SSD was unable to confirm transition to independent living.An interview on 3/10/2026 at 10:30 AM with LPN B confirmed Resident 1 was able to make their needs known and was cognitively intact.An interview on 3/10/2026 at 11:00 AM with NA C confirmed Resident 1 was able to make their needs known and was cognitively intact.An interview on 3/10/26 at 11:40 AM with SSD confirmed Resident (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 did not have an established discharge plan. Resident 1 contacted an independent living facility and set up their own discharge with Aged and Disabled waivers (A&D Waivers are Medicaid programs that allow individuals aged 65 or older or with disabilities to receive long-term care in their homes or communities rather than in nursing facilities). SSD confirmed they did not know about Resident 1's discharge plans until the day Resident 1 left the facility. SSD confirmed Resident 1 would not reveal who their caregivers were going to be to the SSD. SSD revealed the part-time Social Services assistant had been collaborating with Resident 1 in relation to their discharge. SSD was unable to provide documentation of a discharge plan for Resident 1and confirmed they could not prove the documentation had been completed.