STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285173	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Florence Home	7915 North 30th Street Omaha, NE 68112

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure residents were protected from potential abuse by allowing an employee who was accused of abuse by Resident 5, to finish their shift. This had the potential to affect Residents in rooms 201-205 and 219-220 on the 200 hall. The facility had a census of 80. Findings are:An interview on 9/24/25 at 1:00pm with the Director of Nursing (DON) revealed the following:On 7/13/2025 the resident (Resident 5) made a statement that they did not want the Nurse Aide (NA-C) to change the resident because the NA throws the resident against the wall. Licensed Practical Nurse D (LPN) assigned another employee to care for the resident for the rest of the evening. The DON confirmed they were not aware of the incident until 7/14/1025 when they read Resident 5's progress notes from the evening before. The DON confirmed they contacted LPN D who wrote the progress note and received a verbal report from LPN D about the incident on 7/14/2025.The DON confirmed LPN-D should have contacted the DON immediately after the incident and LPN-D had not done so.The DON confirmed that LPN-D did not send NA-C home after LPN-D was informed of the incident and should have done so. The DON confirmed they had educated LPN-D verbally about informing management immediately of any accusations of abuse, but the DON had not documented the verbal education. An interview on 9/25/25 at 3:27 PM with the DON revealed NA - C worked on the 200 hall from 6-10 PM covering rooms 201-205 and covering rooms 201-204 and 219-220 from 2-6 PM. The DON confirmed NA-C would have had the potential to affect the residents in these rooms on 7/13/2025.A record review of a progress noted dated 7/13/2025 by LPN D revealed the following:Resident (5) refuses care from their assigned NA - C because they throw me against the wall, nurse educated resident that NA-C will be in the room to help spot the replacement NA since the resident requires 2 people during transfers. LPN-D witnessed brief change and NA-C did not overexert any strength during the brief change.A record review of the facility's Abuse Policy dated 1/28/2025 revealed the following: The policy stated the residents' rights to be free from verbal, physical and mental abuse, corporal punishment, and involuntary seclusion. The administration and employees of the Organization recognize its residents, regardless of cognitive ability, to be vulnerable and will take action to protect and prevent mistreatment, abuse, neglect, and misappropriation of resident property within the facility by:intervening in the situationReporting the situation to the proper authoritiesInvestigating the allegationPreventing abuse, neglect, and misappropriation while the investigation is in process.Document evidence that the Organization intervened, reported, prevented abuse/neglect/misappropriation, and investigated.Not employing individuals who have been:Found guilty of abusing or mistreating individuals by a court of law.Entered into the State Nurse Aide Registry concerning abuse, neglect, and mistreatment of residents or misappropriation of their property.Reporting any knowledge, it has of actions by a court of law against an employee for service as a Nurse Aide to the State Nurse Aide Registry of Licensing Authorities.The facility procedure consists of Pre-hire screening, Volunteer screening, employee and volunteer training, prevention, identification, reporting, immediate intervention, and investigation.

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	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 report an allegation of abuse against Resident 5 within the required timeframe. The facility had a census of 80. Findings are:An interview on 9/24/25 at 1:00 PM with the Director of Nursing (DON) revealed the following:On 7/13/2025 the resident (Resident 5) made a statement that they did not want the Nurse Aide (NA-C) to change the resident because the NA throws the resident against the wall. Licensed Practical Nurse D (LPN) assigned another employee to care for the resident for the rest of the evening. The DON confirmed they were not aware of the incident until 7/14/1025 when they read Resident 5's progress notes from the evening before. The DON confirmed they contacted LPN D who wrote the progress note and received a verbal report from LPN D about the incident on 7/14/2025.The DON confirmed LPN-D should have contacted the DON immediately after the incident and LPN-D had not done so.The DON confirmed that LPN-D did not send NA-C home after LPN-D was informed of the incident and should have done so. The DON confirmed they had educated LPN-D verbally about informing management immediately of any accusations of abuse, but the DON had not documented the verbal education. An interview on 9/25/25 at 3:27 PM with the DON revealed NA - C worked on the 200 hall from 6-10 PM covering rooms 201-205 and covering rooms 201-204 and 219-220 from 2-6 PM. The DON confirmed NA-C would have had the potential to affect the residents in these rooms on 7/13/2025.A record review of a progress noted dated 7/13/2025 by LPN D revealed the following:Resident (5) refuses care from their assigned NA - C because they throw me against the wall, nurse educated resident that NA-C will be in the room to help spot the replacement NA since the resident requires 2 people during transfers. LPN-D witnessed brief change and NA-C did not overexert any strength during the brief change.A record review of the facility's Abuse Policy dated 1/28/2025 revealed the following: The policy stated the residents' rights to be free from verbal, physical and mental abuse, corporal punishment, and involuntary seclusion. The administration and employees of the Organization recognize its residents, regardless of cognitive ability, to be vulnerable and will take action to protect and prevent mistreatment, abuse, neglect, and misappropriation of resident property within the facility by:intervening in the situationReporting the situation to the proper authoritiesInvestigating the allegationPreventing abuse, neglect, and misappropriation while the investigation is in process.Document evidence that the Organization intervened, reported, prevented abuse/neglect/misappropriation, and investigated.Not employing individuals who have been:Found guilty of abusing or mistreating individuals by a court of law.Entered into the State Nurse Aide Registry concerning abuse, neglect, and mistreatment of residents or misappropriation of their property.Reporting any knowledge, it has of actions by a court of law against an employee for service as a Nurse Aide to the State Nurse Aide Registry of Licensing Authorities.The facility procedure consists of Pre-hire screening, Volunteer screening, employee and volunteer training, prevention, identification, reporting, immediate intervention, and investigation.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Licensure Reference Number 175 NAC 12-006.09 (H). Based on record review and interview the facility failed to hold a blood pressure medication according to the prescribed blood pressure parameters for 1 (Resident 19) of 6 resident's sampled. The facility census was 80. The findings are:Record review of Resident 19's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 06-25-2025 revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored at a 15. According to the MDS Manual a score of 13-15 indicates a person cognitively intact. - required extensive assistance with hygiene, and bed mobility.-required total assistance with dressing, toileting, bathing and transfers.-had a pressure ulcer. Record review of Resident 19's Medication Administration Record (MAR) for August 2025 revealed an order for Midodrine 5 milligram (mg) tablet take 1 tablet 3 times a day, hold if Systolic Blood Pressure (SBP: the top number of a blood pressure reading) was above 120. The following entries revealed a SBP of above 120.-08-15-2025 at 8:00 AM Blood Pressure (BP) was 127/79 and documented as administered.-08-25-2025 at 8:00 AM BP was 125/84 and documented as administered. Record review of Resident 19's MAR for September 2025 revealed an order for Midodrine 5 mg take 1 tablet 3 times a day, hold if SBP was above 120. The following entries revealed a SBP of above 120.-09-18-2025 at 8:00 AM BP was 133/82 and documented as administered.-09-21-2025 at 8:00AM BP was 122/69 and documented as administered.-09-12-2025 at 12:00 PM BP was 121/75 and documented as administered.-09-22-2025 at 12:00 PM BP was 127/72 and documented as administered-09-18-2025 at 5:00 PM BP was 133/82 and documented as administered.-09-22-2025 at 5:00 PM BP was 132/79 and documented as administered. An interview conducted on 09-25-2025 at 1:40 PM with Director of Nursing confirmed that Midodrine 5mg should have been held for the dates identified in August and September. Record review of the facility policy titled Following Physician's Orders dated 08-2025 revealed the purpose of this policy is to provide guidelines for following physician's and non-physician provider orders. If a physician order is present and is failed to be administered according to specific orders, it may result in a medication discrepancy.