

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/31/2024
NAME OF PROVIDER OR SUPPLIER  Omaha Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4835 South 49th Street Omaha, NE 68117	

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 0606</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Not hire anyone with a finding of abuse, neglect, exploitation, or theft.</p> <p>21492</p> <p>Licensure Reference Number 175 NAC 12-006.04(A)(iii)</p> <p>Based on record review and interview; the facility staff failed to complete background and registry checks for 2 of 5 employee file reviewed. The facility staff identified a census of 63.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of Housekeeping Staff A's employee file revealed a hire date of 8-27-2024. Further review of Housekeeping A's employee file revealed there was no indications a Nurse Aid registry check had been completed.</p> <p>B.</p> <p>Record review of Housekeeping Staff B's employee file revealed a hire date of 8-14-2024. Further review of Housekeeping B's employee file revealed a Adult/Child Protection Services background checks had been completed.</p> <p>On 10-31-2024 at 10:07 AM an interview was conducted with the facility Administrator. During the interview, the facility Administrator confirmed the required background checks had not been completed for Housekeeping Staff A and B.</p> <p>Record review of the facility policy titled Abuse:Prevention of and Prohibition against revised on 10-2022 revealed the following information:</p> <p>-Screening:</p> <p>-Prior to hire, the facility will screen potential employees for history of abuse, neglect, exploitation, or misappropriation . The screening will include but not limited to, Documentation of status and any disciplinary actions from licensing or registration boards and other registries.</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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21492</p> <p>Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1)</p> <p>Based on observations, record review, and interview; the facility staff failed to implement interventions to prevent the development of pressure ulcers for 1 (Resident 2 and 4) of 3 sampled residents. The facility staff identified a census of 63.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of Resident 2's Order Summary Report (OSR) printed on 10-30-2024 revealed Resident 2 admitted to the facility on [DATE] with a diagnoses of: Hyperlipidemia (fat particles in the blood system) Hypokalemia (low potassium level) Muscle weakness, Dysphagia (difficulty swallowing), Disorder of Plasma-protein Metabolism, Unspecified Protein Calorie Malnutrition. Further review of OSR printed on 10-30-24 revealed Resident 2's practitioner ordered Resident 2 to have a Prevalon boot (device used to help with preventing pressure ulcers to heels) to the left foot while in bed.</p> <p>Record review of Resident 2's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 9-25-2024 revealed Resident 2 was assessed with a Brief Interview of mental Status (BIMs, a score from the BIMs assessment that indicates a person's cognitive function) of a 12. According to the MDS [NAME] a score of 8 to 12 indicates a person has moderately impaired cognition. Required substantial to maximum assistance with rolling left and right and sitting and laying.</p> <p>Record review of Resident 2's Comprehensive Care Plan (CCP) dated 3-06-2024 revealed Resident 2 had the potential for pressure ulcer development. The goal for Resident 2 was to have intact skin. Interventions to meet this goal were as follows:</p> <ul style="list-style-type: none"> <li>-Call light within reach.</li> <li>-Encourage fluid intake and assist to keep skin hydrated.</li> <li>-Ensure Resident has prevalon boot to the affected stroke side while in bed.</li> <li>-Monitor Nutritional status.</li> </ul> <p>Observation on 10-30-2024 at 2:05 PM revealed Resident 2 was in bed and did not have the Prevalon boot on the left foot. Further observation revealed the Prevalon boots were setting on the resident chest of drawers that was next to the resident bed.</p> <p>Observation on 10-31-2024 at 4:58 AM revealed Resident 2 was in bed with feet uncovered and did not have the Prevalon boot on the left foot.</p> <p>On 10-31-2024 at 5:07 AM an interview was conducted with Nursing Assistant (NA) C. During the interview NA C confirmed Resident 2 did not have the Prevalon boot on to the left foot.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>B.</p> <p>Record review of Resident 4's OSR printed on 10-30-2024 revealed Resident 4 readmitted to the facility on [DATE] with the diagnoses of Schizoaffective disorder, Depression, Obesity, and need for assistance with personal Cares. Further review of Resident 4's OSR printed on 10-30-2024 revealed the residents' practitioner order Resident 4's heels to be elevated while in bed for skin breakdown.</p> <p>Record review of Resident 4's MDS dated [DATE] revealed Resident 4 had a BIMS of a 15. According to the MDS [NAME] a BIMS of 13 to 15 indicates a person is cognitively intact. Further review of Resident 4's MDS dated [DATE] revealed Resident 4 was dependent on staff for transfers, required substantial assistance to maximal assistance with rolling left to right and sitting to laying and laying to sitting.</p> <p>Record review of Resident 4's CCP with a initiation date of 8-23-2024 revealed Resident 4 was at risk for pressure ulcer development. The goal identified for Resident 4 was to have intact skin, free of redness, blisters or discoloration. Interventions identified on Resident 4's CCP to meet this goal were as follows:</p> <ul style="list-style-type: none"> <li>-Encourage fluid intake and assist in keeping skin hydrated.</li> <li>-Encourage to turn and reposition, provide assistance as necessary.</li> <li>-Monitor nutritional status. Serve diet as ordered.</li> <li>-Weekly head to toe skin at risk assessments.</li> </ul> <p>Observation on 10-30-2024 at 10:25 AM revealed Resident 4 was in bed and their feet were not elevated.</p> <p>Observation on 10-30-2024 at 11:28 AM revealed Resident 4 was in bed and did not have their feet elevated.</p> <p>Observation on 10-30-2024 at 12:39 PM revealed Resident 4 was in bed and Resident 4's heels were not elevated and heel boots were on top of the residents dresser.</p> <p>On 10-30-2024 at 13:39 PM an interview was conducted with Resident 4. During the interview Resident 4 reported staff do not elevate their feet. Resident 4 reported there were heel protection boots on the top of dresser that are to be used and staff do not use the.</p> <p>Observation on 10-31-2024 at 5:02 AM revealed Resident 4 was in bed and their feet were not elevated.</p> <p>On 10-31-2024 at 5:02 AM an interview was conducted with NA D. During the interview NA D confirmed Resident 4's feet were not elevated.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21492</p> <p>Licensure Reference Number 175 NAC 12-006.09(I)</p> <p>Based on record review and interview; the facility staff failed to implement additional interventions to prevent falls for 1 (Resident 4) of 4 sampled residents. The facility staff identified a census of 63.</p> <p>Findings are:</p> <p>Record review of Resident 4's Order Summary Report (OSR) printed on 10-30-2024 revealed Resident 4 readmitted to the facility on [DATE] with the diagnoses of Schizoaffective disorder, Depression, Obesity, and need for assistance with personal Cares.</p> <p>Record review of Resident 4's Minimum Data Set (MDS, a standardized assessment tool used to evaluate the health status of residents in long-term care (LTC) nursing facilities) dated 10-02-2024 revealed Resident 4 had a Brief Interview for Mental Status (BIMS, a score from the BIMS assessment that indicates a person's cognitive function) of a 15. According to the MDS [NAME] a BIMS of 13 to 15 indicates a person is cognitively intact. Further review of Resident 4's MDS dated [DATE] revealed Resident 4 was dependent on staff for transfers, required substantial assistance to maximal assistance with rolling left to right and sitting to laying and laying to sitting.</p> <p>Record review of Resident 4's Comprehensive Care Plan (CCP) dated 8-23-2023 revealed Resident 4' was at risk for falls. The goal identified for Resident 4 was Resident 4 would not sustain serious injury. Interventions to meet this goal were:</p> <ul style="list-style-type: none"> <li>-Bed in lowest position.</li> <li>-Ensure resident is wearing appropriate footwear when ambulating or wheeling in the wheelchair.</li> <li>-Bed mobility requires 2 staff participation to reposition and turn in bed.</li> </ul> <p>Record review of a Fall report dated 8-05-2024 revealed Resident 4 reveal a nursing assistant was providing care. During the provision of care, staff had instructed the resident to turn on their side resulting in the resident legs hanging over the bed and resulting being lowered to the floor. According to the Fall report dated 8-05-2024, the intervention was to ensure the resident was in the middle of the bed.</p> <p>Record review of a Fall report dated 8-27-2024 revealed Resident 4 had slid off the bed during cares. According to the Fall report dated 8-27-2024 the new intervention was to have 2 staff assisting with bed mobility.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 10-31-2024 at 1:12 PM an interview was conducted with the Director of Nursing (DON). During the interview review of Resident 4's care plan and the fall reports dated 8-05-2024 and 8-27-2024 were reviewed with the DON. The DON confirmed 2 staff should have been assisting Resident 4 when Resident 4 had falls on 8-05-2024 and 8-27-2024. The DON confirmed Resident 4 should have been position in the middle of the bed prior to the falls and further confirmed there was no new interventions for the falls on 8-05-2024 and 8-27-2024.		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21492</p> <p>Licensure Reference Number 175 NAC 12-006.09(J)(i)(1)</p> <p>Based on observation, record review, and interview; the facility staff failed to evaluate and implement interventions to prevent significant weight loss for 1 (Resident 2) of 3 sampled residents. The facility staff identified a census of 63.</p> <p>Findings are:</p> <p>Record review of Resident 2's Order Summary Report (OSR) printed on 10-30-2024 revealed Resident 2 admitted to the facility on [DATE] with a diagnoses of: Hyperlipidemia (fat particles in the blood system) Hypokalemia (low potassium level) Muscle weakness, Dysphagia (difficulty swallowing), Disorder of Plasma-protein Metabolism, Unspecified Protein Calorie Malnutrition. According to the OSR printed on 10-30-2024 Resident 2's diet was a general regular diet.</p> <p>Record review of Resident 2's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 9-25-2024 revealed Resident 2 was assessed with a Brief Interview of mental Status (BIMs, a score from the BIMs assessment that indicates a person's cognitive function) of a 12. According to the MDS [NAME] a score of 8 to 12 indicates a person has moderately impaired cognition. Required set up for meals and Resident 2's weight was 179.0 pound.</p> <p>Record review of Resident 2's Comprehensive Care Plan (CCP) dated 2-08-2024 revealed Resident 2 had the potential for nutritional problems related to diet restriction. The goal identified for Resident 2 was Resident 2 would eat 50-75% of most meals . The interventions identified on Resident 2's CCP were to provide the diet as ordered, Register Dietician (RD) was to evaluate and make diet change recommendation as needed. An undated portion of Resident 2's CCP dated 6-28-2024 revealed Resident 2 was a Lacto-ovo-vegetarin (some one who does not eat meat or seafood, but eats dairy and eggs).</p> <p>Record review of Resident 2's weight in their Electronic Medical Record ( EMR) revealed the following:</p> <p>-8-12-2024, 183.6 pounds (lbs).</p> <p>-9-25-2024, 178.8 lbs,a loss of 4.8 lbs or a loss of 2.61%.</p> <p>-10-09-2024, 163.2 lbs, a loss of 15.6 lbs or a loss of 8.72% within 30 days.</p> <p>-According to Resident 2's weight record in Resident 2's EMR revealed from 8-12-2024 to 10-09-2024 Resident 2 lost 20.4 lbs or a loss of 11.11% with in 90 day.</p> <p>Record review of Resident 2's Nutrition -Quarterly Evaluation sheet dated as completed on 9-27-2024 revealed the facility RD identified Resident 2 diet was regular , the consistency was regular had religious/ethnic/cultural food habits, weight was 178.8 as of 9-25-2024 and had a usual weight of 170-180 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident 2's Progress Note (PN) dated 10-10-2024 revealed the facility RD requested a re-weigh of Resident 2.</p> <p>Review review of Resident 2's EMR that included RD notes, practitioner order, Resident 2's CCP and Resident 2's PN from 8-12-2024 through 10-30-2024 revealed there was no follow up to the the re-weight the facility RD request and further revealed there was no assessment of Resident 2's significant weight loss within 30 days or 90 time frames. In addition there was no information related to how the facility staff were to meet Resident 2's nutritional needs based upon Resident 2's vegetarian diet or what Resident 2's food preference were.</p> <p>Record review of Resident 2's dietary information sheet dated 10-30-2024 for breakfast revealed the following:</p> <ul style="list-style-type: none"> <li>-Diet and texture was regular.</li> <li>-Diet other was identified as Vegetarian.</li> <li>-Hot cereal, toast, 2 juice, no biscuit gravy. Likes fish.</li> </ul> <p>According to Resident 2 dietary information sheet dated 10-30-2024 Resident 2 was to receive the following for the lunch meal:</p> <ul style="list-style-type: none"> <li>-Beef stroganoff over noodles was marked off the list.</li> <li>-Resident 2 was to receive a 4 ounce (oz) portion of crumb topped Cauliflower, a portion of blue berry Cobbler and a 8 oz beverage.</li> </ul> <p>Observation on 10-30-2024 at 12:14 Revealed Resident 2 was in the dinning room and was served a large mix of salad greens for lunch, there was no protein or salad dressing served with the mixture of salad greens, a small 4 ounce drink and a portion of a apple filling type of desert with a portion of whip cream on top.</p> <p>Observation on 10-30-2024 at 1:15 PM revealed Resident 2 remained in the dinning room and had taken a few bites of the salad mixture, had drank all of the drink and a bite of desert.</p> <p>On 10-30-2024 at 1:15 PM an interview was conducted with Resident 2. During the interview Resident 2 reported not wanting just salad and nothing else.</p> <p>On 10-30-2024 at 12:23 PM an interview was conducted with the Dietary Supervisor (DS). During the interview the DS reported not being aware of what to give Resident 2 due to the vegetarian diet. The DS further reported not being aware of Resident 2's significant weight loss.</p> <p>On 10-30-2024 at 1:01 PM an interview was conducted with the facility RD via phone. During the interview the RD reported there was a list of food items Resident 2 could have and reported not being aware of what the plan was to meet the resident needs.</p> <p>On 10-30-2024 at 3:14 PM the DS reported there was no evaluation of Resident 2's food preferences .</p> <p>(continued on next page)</p>		

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F 0692  Level of Harm - Actual harm  Residents Affected - Few	On 10-31-2024 at 12:58 PM an interview was conducted with the Director of Nursing (DON). During the interview the DON reported the facility RD had made the request for a re-weigh on 10-10-2024 and this had not been completed. The DON reported the expectation was the re-weigh should have been obtained within the week. The DON confirmed during the interview Resident 2 had significant weight loss as of 10-09-2024 and Resident 2's significant weight loss had not been evaluated and no new interventions had been implemented for Resident 2.		