STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285240	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Omaha Nursing and Rehabilitation Center	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)
F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Based on record review and interview, the facility failed to ensure a signed Advance Directive Code Status Form was completed to confirm resident's directives for Cardiopulmonary Resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) for 1 [Resident 1] of 6 sampled residents. The facility had a total census of 63 residents. Findings are: A record review of Resident 1's Admission Record revealed Resident 1 was admitted to the facility on [DATE]. Resident 1's Admission Record identified the following diagnoses: Type 2 Diabetes Mellitus, congestive heart failure [weakened heart muscle that cannot pump blood effectively], and chronic obstructive pulmonary disease [lung disease causing restricted airflow and breathing problems]. A record review of Resident 1'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 [DATE] revealed a Brief Interview of Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of ,d+[DATE], which indicated the resident had moderate cognitive impairment. A record review of Resident 1's care plan revealed a focus area dated [DATE] indicating Resident 1 was to be a full code [wants to receive all available measures to save life, including CPR]. Interventions listed for the focus area stated that code status was to be reviewed quarterly with care plan conference. A record review of Resident 1's Advanced Directives Code Status form signed by Resident 1's representative on [DATE] identified Resident 1 had a DNR [Do not resuscitate, no CPR]. A record review of Resident 1's Advanced Directives Code Status form signed by Resident 1 on [DATE] identified Resident 1 as a full code. A record review of Resident 1's hospital discharge orders dated [DATE] revealed a Do Not Resuscitate order. A record review of Resident 1's electronic health record revealed there was no indication a updated Advanced Directive Code Status from from Resident 1 or their responsible party of the DNR status. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of an Advanced Directives Code Status form revealed the following statement: this directive may be changed at any time by the resident or responsible party. It is the responsibility of the resident or responsible party to inform the facility of the decision to change this directive. A record review of an Order Audit Report revealed the following orders related to code status for Resident 1: -[DATE] Do Not Resuscitate order -[DATE] Do Not Resuscitate order discontinued -[DATE] Full Code order -[DATE] Do Not Resuscitate order A record review of Resident 1's Nurse Practitioner Notes for 60 day visits revealed the following: -[DATE] visit-Under Advance Directive section, it was noted Resident 1 is a full code -[DATE] visit- Under Advance Direction section, it was noted that a discussion was done with questions answered and explained to patient/POA/caregivers. Resident 1's code status was documented to be DNR. -[DATE] visit-Under Advance Directives section, it is noted that a advance directive discussion was done with patient/staff/POA and the decision was that patient was a DNR. Resident 1's code status was documented to be DNR. -[DATE] visit-Under Advance Directives section, it was noted that a discussion was done with questions answered and explained to patient/POA/caregivers. Resident 1's code status was documented to be a DNR. A review of Progress Note for Resident 1 dated [DATE] revealed nurse responded to Resident 1's room and Resident 1 was responding to nurse. Resident 1 was making gurgling noises and was blue in the face. Nurse was unable to get pulse, 911 was called, and Resident 1's code status was confirmed as DNR. Staff remained with Resident 1 until paramedics arrived with Resident 1 being declared deceased at 5:20 PM. In an interview on [DATE] at 10:46 AM, the Director of Admissions reported that a Code Status Form was completed on admission to the facility. The Director of Admission then notified the nurse of code status and the nurse inputs an order into the resident's medical record. The Director of Admission reported that the hospital code status was not used. Just recently, the Director of Admission had been starting to check code status on readmissions. In an interview on [DATE] at 12:04 PM, Social Service Director reported that code status are reviewed at care plan meetings. Social Service Director reported that Social Service Director would utilize the code status identified on the face sheet for the electronic medical record when talking with the resident or representative during a care plan. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 1's Care Plan Review dated [DATE] revealed the following statement: Code status to remain. In interviews on [DATE] at 12:30 PM and 1:01 PM, the Director of Nursing confirmed an expectation that nursing staff members check a resident code status on the dashboard/face sheet of the electronic medical record. The Director of Nursing confirmed that it was facility process to have the resident complete a signed DNR form at the facility. A review of facility policy dated ,d+[DATE] titled Resident Rights-Advanced Directives revealed the following: -When an Advance Directive is completed: a. Review the Advance Directive to validate the document reflects the resident choices and that the document is signed and dated by the resident or responsible agent. Further review of facility policy dated ,d+[DATE] titled Resident Rights-Advanced Directives revealed the following: -6. Obtain copy of the Advance Directive and conservatorship/guardianship documents and place in the resident health record. -a. It should be noted that a Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form is not an advance directive. -b. Once the advance directive or information regarding resident preferences regarding treatment options is received by the facility, it will be confirmed in the resident medical record and communicated to members of the care plan team. -c. The facility will also notify the attending physician of advance directives so that, if necessary, appropriate orders can be documented in the resident's medical record and plan of care. -i. A No CPR or DNR telephone order may be used once Advance Directive documents are received and in the health record. -ii. Transfer records shall include copies of the Advance Directives and signed No CPR orders. -7. The care plan team will periodically, at least quarterly, annually, and on a change of condition, review the advance directive and/or preferences regarding treatment options with the resident or his/her representative his/her advance directives to ensure that they are still the wishes of the resident. Such reviews will be made during the assessment process and recorded in the medical record. -8. The resident or surrogate decision-maker may modify or cancel the Advance Directive decision at any time. -a. Changes or revocations of a directive must b submitted to the facility, in writing. -b. The facility may require that the resident or resident representative create/execute new documents if changes are extensive. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-c. The care plan team, including the physician, will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment instrument (MDS), care plan, or elsewhere in the clinical record. -d. Immediate action must be taken to implement desired changes.