

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 07/31/2025
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)
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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Licensure Reference Number 175 NAC 12-006.02(H)The facility failed to report a transfer which resulted in significant injury to the State Agency for 1 (Resident 32) of 1 resident sampled. The facility staff identified a census of 64.The findings are:Record review of a facility policy entitled Abuse: Prevention of and Prohibition Against dated revised 10/2022 revealed:The facility will provide oversight and monitoring to ensure that its staff, who are agents of the facility, deliver care and services in a way that promotes and respects the rights of the residents to be from [sic] abuse, neglect, misappropriation of resident property, and exploitation.This policy applies to all facility staff including, but not limited to, employees, consultants, contractors, volunteers, students, and other caregivers who provide care and services to residents on behalf of the facility. Definition:Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. 2. Because some cases of abuse are not directly observed, understanding resident outcomes of abuse can assist in identifying whether abuse is occurring or has occurred. Possible indicators of abuse include, but are not limited to: -Bruises, skin tears and injuries of unknown source; -Extensive injuries; -Injuries in an unusual location; H. Reporting/Response1. All allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator.2. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.Record review of Resident 32's Clinical Census printed 7/27/2025 identified the facility admitted the resident on 4/21/2025.Record review of Resident 32's Medical Diagnoses printed 7/27/2025 revealed the following: cirrhosis of the liver (widespread disruption of normal liver structure by fibrosis and the formation of regenerative nodules that is caused by any of various chronic progressive conditions affecting the liver [such as long-term alcohol abuse or hepatitis]), muscle weakness, generalized edema, and type 2 diabetes mellitus (a common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production).Record review of Resident 32's admission 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 5/11/2025 revealed Resident 32 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15. According to the MDS manual, a score of 15 indicated the resident was cognitively intact. Further review of the MDS revealed Resident 32 was dependent upon staff for assistance to transfer from bed to wheelchair.Record review of Resident 32's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed as of 5/19/2025, the resident was to be transferred with two staff members using a slide board to get out of bed and wheelchair, or use Hoyer lift with two staff.Record review of Resident 32's Progress Notes dated 7/6/2025 revealed: -Resident was being transferred from bed to wheelchair with two assist, bumped left lower leg on leg of wheelchair where pedals attach resulting in a laceration measuring approximately 4.5 by (x) 6 x 3. Large amount of bleeding, pressure dressing applied after PRN Oxycodone given as per order, 911 notified, here at 7:05 PM to transport resident to hospital. DON notified, note left to update APRN. Resident awake and alert leaving with paramedics per stretcher. assessment of wound. VSS, alert and oriented. -Resident return from ER via ambulance at approximately 9:30 PM with new order of bacitracin 500 unit/gram ointment to be applied 2 times a day. Patient to F/U (follow up) with PCP in 10-14 days for wound re-eval and suture removal.Record review of a Skin Alteration document dated 7/6/2025 revealed: -Incident Description: Resident was being transferred from bed to wheelchair with two assist, bumped left lower leg on leg of wheelchair where pedals attach resulting in a laceration measuring approximately 4.5 x 6 x 3. Large amount of bleeding, pressure dressing applied after assessment of wound. VSS, alert and oriented. -Immediate action taken: PRN (as needed) Oxycodone given as per order, 911 notified, here at 7:05 PM to transport resident for sutures. DON notified, note left to update APRN. -Agencies/People Notified: MD 7/6/2025.Record review of Resident 32's Medication and Treatment Administration Records dated July 2025 revealed the following orders dated 7/6/2025: bacitracin (antibiotic ointment) to be applied to Resident 32's left lower leg laceration twice daily; change of condition monitoring related to laceration to left lower extremity</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview, the facility failed to investigate a resident transfer which resulted in significant injury for 1 (Resident 32) of 1 resident sampled. The facility staff identified a census of 64.The findings are:Record review of a facility policy entitled Abuse: Prevention of and Prohibition Against dated revised 10/2022 revealed:The facility will provide oversight and monitoring to ensure that its staff, who are agents of the facility, deliver care and services in a way that promotes and respects the rights of the residents to be from [sic] abuse, neglect, misappropriation of resident property, and exploitation.This policy applies to all facility staff including, but not limited to, employees, consultants, contractors, volunteers, students, and other caregivers who provide care and services to residents on behalf of the facility.Definitions:Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.E. Identification:1. Facility staff with knowledge of an actual or potential violation of this policy must report the violation to his or her supervisor or the facility administrator immediately. The facility will assist staff in identifying abuse, neglect, and exploitation of residents, and misappropriation of resident property. This includes identifying the different types of abuse-mental/verbal, sexual, physical, and the deprivation by an individual of goods or services.2. Because some cases of abuse are not directly observed, understanding resident outcomes of abuse can assist in identifying whether abuse is occurring or has occurred. Possible indicators of abuse include, but are not limited to: -Bruises, skin tears and injuries of unknown source; -Extensive injuries; -Injuries in an unusual location; -Occurrences, patterns, and trends that may constitute abuse; -Episodes of resident to resident altercation, willful or accidental, with or without injury; -Sudden or unexplained changes in behaviors or activities (e.g., fear of a person or place, feelings of guilt or shame, etc.).F. Investigation1. All identified events are reported to the Administrator immediately.2. After receiving the allegation, and during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm.3. A licensed nurse will immediately examine the resident upon receiving reports of alleged physical or sexual abuse. The findings of the examination shall be recorded in the resident's medical record.4. All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee.5. The investigation will include the following: -An interview with the person(s) reporting the incident; -An interview with the resident(s); -Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; -A review of the resident's medical record; -An interview of with staff members (on all shifts) who may have information regarding the alleged incident; -An interview with staff members (on all shifts) having contact with the accused employee; and -A review of all circumstances surrounding the incident.6. To the extent there is evidence that could be used in a criminal investigation, staff will immediately notify the Administrator or his/her designee. Staff are not to tamper with or destroy any such evidence at any time.7. At the conclusion of the investigation, the facility will attempt to determine if abuse, neglect, misappropriation of resident property, or exploitation occurred.8. The investigation, and the results of the investigation, will be documented.9. All phases of the investigation will be kept confidential in accordance with the Facility's policies governing the confidentiality of medical records and privilege of quality assurance/quality improvement programs. 6. At the conclusion of the investigation, the facility will take action, as necessary, in light of the information gathered, which may include but is not limited to: -If the allegation is substantiated, analyzing the occurrence to determine why abuse, neglect, misappropriation of resident property, or exploitation occurred, and determining what changes are needed to prevent further occurrences; -Defining how care provision will be changed and/or improved to protect residents receiving services, if appropriate; -Training staff on changes made and demonstration of staff competency after training is implemented; -Identifying staff responsible for the implementation of corrective action; -The expected date for implementation; and -Identifying staff responsible for monitoring the implementation of the plan.Record review of Resident 32's Clinical Census printed 7/27/2025 identified the facility admitted the resident on 4/21/2025.Record review of Resident 32's Medical Diagnoses printed 7/27/2025included cirrhosis of the liver (widespread disruption of normal liver structure by fibrosis and the formation of regenerative nodules that is caused by any of various chronic progressive conditions affecting the liver [such as long-term alcohol abuse or hepatitis]) muscle weakness, generalized edema, and type 2</p>		

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<p>F 0689</p> <p>Level of Harm - 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>Licensure Reference Number 175 NAC 12-006.09(l) Licensure Reference Number 175 NAC 12-006.09(l)(i)(1)Based on observation, interview, and record review, the facility failed to transfer a resident according to the plan of care resulting in a significant injury for 1 (Resident 32) of 1 resident sampled for transfers; and the facility failed to implement call interventions identified on the plan of care for 1 (Resident 68) of 3 residents sampled for falls. The facility staff identified a census of 64.The findings are:A.</p> <p>Record review of Resident 68's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 06-23-2025 revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status (BIMS) was scored at a 9. According to the MDS Manual a score of 8-12 indicates a person has moderate cognitive impairment. -required supervision and hands on assistance with transfers, toileting, hygiene and dressing. -had repeated falls. <p>Record review of Resident 68's Comprehensive Care Plan (CCP) dated 03-10-2025 revealed Resident 68 had an actual fall with no injury due to poor balance, poor communication/ comprehension and unsteady gait. Interventions listed on the care plan were:</p> <ul style="list-style-type: none"> -03-10-2025 offer to assist resident to the bathroom at 2 AM. -03-14-2025 top blankets clipped to fitted sheet on the bed to prevent them from getting wrapped around the resident's feet. -03-24-2025 offer to assist the resident to the bathroom at 5 AM. -04-10-2025 staff to ensure the resident has nonskid socks on while in bed. -06-15-2025 nursing staff will not leave resident sitting on the side of the bed unsupervised following an acute change of condition. -06-16-2025 resident is not to be left unattended in the therapy gym. -06-18-2025 Monthly lab work to assess creatinine. <p>An observation on 07-29-2025 at 11:00 AM of Resident 68 lying in bed and the top covers are not pinned to the bottom sheet.</p> <p>An observation on 07-30-2025 at 5:10 AM of Resident 68 sitting on the side of the bed and top covers are not pinned to the bottom sheet.</p> <p>(continued on next page)</p>

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>An observation on 07-30-2025 at 1:15 PM of Resident 68 with Nursing Assistant (NA) I confirmed the top covers were not pinned to the bottom sheet.</p> <p>An interview with NA I on 07-30-2025 at 1:20 PM revealed NA I was not aware the top covers needed to be pinned to the bottom sheet.</p> <p>An interview with Licensed Practical Nurse (LPN) D on 07-31-2025 at 9:35 AM confirmed Resident 68's top covers were not pinned to the bottom sheet and should have been.</p> <p>Record review of the facility policy dated 12-2023 revealed it is the policy of this facility to provide an environment that remains as free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. On admission a fall risk evaluation will be completed to determine the resident risk for sustaining a fall. Resident with high risk factors identified on the fall risk evaluation will have an individualized care plan developed with interventions to prevent falls by addressing the risk factors and the particular elements of the evaluation that put the resident at risk.</p> <p>B.</p> <p>Record review of a facility policy entitled "Activities of Daily Living" revised 7/2015 revealed:</p> <p>A resident's abilities in ADL's do not diminish unless circumstance on the individuals' clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to: bathe, dress, groom, transfer, ambulate, toilet, eat, and use speech, language, or other functional communication systems.</p> <p>Transfer as defined by the facility's policy is how a resident moves between surfaces &ndash; to/from: bed, chair, wheelchair, standing position.</p> <p>Procedures:</p> <ol style="list-style-type: none"> 1. The facility interdisciplinary team (IDT, in conjunction with the resident, resident's family, surrogate, or representative, as appropriate) will develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. The plan of care will be developed in the electronic health record (EHR). 3. Plans of care will include a focus (area of impairment to include what the impairment is related to), measurable and objective goals, and interventions unique to the resident's needs and strengths. 4. The interventions will be provided by staff in accordance with professional standards of quality and clinical practices. <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>6. Nursing assistants will provide assistance with ADLs based on the resident's individualized plan of care. These interventions will be on the Kardex, which is accessed in Point of Care (POC). Any changes noted in the resident's performance or abilities will be reported to the licensed nurse.</p> <p>7. The licensed nurse will evaluate the resident for changes in their ADL status and coordinate necessary services in conjunction with the IDT.</p> <p>10. If a resident chooses to decline an intervention in the plan of care, the licensed nurse and social services will be notified. The IDT will review the plan of care with the resident in an effort to find alternative means to address the need.</p> <p>Record review of Resident 32's "Clinical Census" printed 7/27/2025 identified the facility admitted the resident on 4/21/2025.</p> <p>Record review of Resident 32's "Medical Diagnoses" printed 7/27/2025 included cirrhosis of the liver (widespread disruption of normal liver structure by fibrosis and the formation of regenerative nodules that is caused by any of various chronic progressive conditions affecting the liver [such as long-term alcohol abuse or hepatitis]), muscle weakness, generalized edema, and type 2 diabetes mellitus (a common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production).</p> <p>Record review of Resident 32's admission 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 5/11/2025 revealed Resident 32 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15. According to the MDS manual, a score of 15 indicated the resident was cognitively intact. Further review of the MDS revealed Resident 32 was dependent upon staff for assistance to transfer from bed to wheelchair.</p> <p>Record review of Resident 32's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed as of 5/19/2025, the resident was to be transferred with two staff members using a slide board to get out of bed and wheelchair, or use Hoyer lift with two staff.</p> <p>Record review of Resident 32's "Progress Notes" dated 7/6/2025 revealed: -Resident was being transferred from bed to wheelchair with two assist, bumped left lower leg on leg of wheelchair where pedals attach resulting in a laceration measuring approximately 4.5 by (x) 6 x 3. Large amount of bleeding, pressure dressing applied after PRN Oxycodone given as per order, 911 notified, here at 7:05 PM to transport resident to hospital. DON notified, note left to update APRN. Resident awake and alert leaving with paramedics per stretcher. assessment of wound. VSS, alert and oriented. -Resident return from ER via ambulance at approximately 9:30 PM with new order of bacitracin 500 unit/gram ointment to be applied 2 times a day. Patient to F/U (follow up) with PCP in 10-14 days for wound re-eval and suture removal.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 7/28/25 at 8:44 AM with Resident 32 revealed the resident sustained a laceration to the left lower leg during a transfer which required transport to the hospital for 11 stitches to be placed.</p> <p>An interview on 7/30/25 at 10:21 with Licensed Practical Nurse (LPN-D) revealed at the time of the incident, Resident 32 was assisted by one staff member.</p> <p>An interview on 7/30/2025 at 10:33 AM with Certified Medication Aide (CMA-E) revealed the only parties involved in the resident transfer were CMA-E and the resident. CMA-E reported after assisting Resident 32 with personal cares in bed, CMA-E turned around to get a blanket to place in the bottom of the wheelchair and when [gender] turned back around, Resident 32 was sitting at the edge of the bed. CMA-E reported that Resident 32 stated that the resident transfers independently without a slide board and instructed CMA-E how to arrange the chair. CMA-E placed the chair as the resident instructed and removed the arm rest from the wheelchair. Resident 32 proceeded to transfer, and CMA-E placed (gender) hand on the small of Resident 32's back to provide support and guidance. CMA-E revealed that a gait belt was not used because Resident 32 stated that [gender] transferred independently. CMA-E stated that blood was noticed to the left lower leg immediately after Resident 32 was seated in the wheelchair. CMA-E stated it appeared Resident 32 had hit the left lower leg on the wheelchair pedal bracket which are permanently affixed to the wheelchair.</p> <p>A follow up interview on 7/30/2025 at 11:13 AM with CMA-E revealed a resident's transfer status is determined by the plan of care. CMA-E further revealed other Nursing Assistants had informed [gender] that Resident 32 transferred independently.</p> <p>A follow up interview on 7/30/2025 at 11:22 AM with Resident 32 revealed the only staff member present during the transfer was CMA-E.</p> <p>A follow up interview on 7/30/2025 at 11:53 AM with LPN-D revealed Resident 32's transfer status was two-person assist at the time of the laceration and further confirmed Resident 32 was transferred with only one staff member.</p>		