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	04/01/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Licensure Reference Number 175 NAC 12-006.09(I)(i)(1). Based on observation, interview and record review, the facility failed to ensure fall interventions were implemented for 1(Resident 2) of 4 residents sampled. The facility census was 57. The findings are: Record review of the facility policy titled Incidents and Accidents dated 12-2023 revealed it is the policy of the facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. The purpose of incident reporting can include:-assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. -meeting regulatory requirements for analysis and reporting of incidents and accidents. Licensed staff will utilize Risk Management to report incidents/accidents and assist with completion of any investigative information to identify root causes. Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored as a 2. According to the MDS Manual a score of 0-7 indicates severe cognitive impairment. -required total assistance with bed mobility, toileting, dressing, personal hygiene, transfers and bathing. Record review of the facility incident log printed on 03-31-2026 revealed Resident 2 had fallen on 11-09-2025 and 03-15-2026.Record review of Resident 2's Comprehensive Care Plan (CCP) printed on 03-31-2026 revealed Resident 2 was at risk for falls related to incontinence, weakness, osteoarthritis to bilateral hips, and history of falls at home. The goal was Resident 2 would not sustain serious injury through the review date. Interventions listed to achieve the goal were as follows:-03-01-2024 Keep call light in reach, ensure resident is wearing proper footwear when ambulating or in the wheelchair, therapy evaluation and treatment per physician orders, and keep needed items in reach. -06-10-2025 Bolster mattress-06-19-2025 Stop sign on bathroom door-08-10-2025 Fall mat at bedside.-9-24-2025 Staff will attempt to engage resident in activities in commons area between meals if not lying down. -11-09-2025 Dycem (a non-slip material used to stabilize objects) to the wheelchair cushion. -03-15-2026 Resident purse to be secured to the wheelchair-03-24-2026 Resident is allowed to use a seat belt in the wheelchair. Resident is able to unbuckle seatbelt independently. An observation conducted on 04-01-2026 at 5:50 AM revealed Resident 2 was in bed and the absence of Dycem on or underneath the wheelchair cushion. An observation conducted on 04-01-2026 at 11:15 AM revealed Resident 2 was in the therapy gym working with therapy and Resident 2's wheelchair did not have Dycem in place on or underneath the wheelchair cushion. An interview conducted on 04-01-2026 at 1:40 PM with the Assistant Director of Nursing (ADON) A confirmed there was no Dycem in place to Resident 2's wheelchair cushion and ADON A had placed a new Dycem in the wheelchair.

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