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| 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 06/13/2024 |
| 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50683</p> <p>Licensure Reference Number 175 NAC 12-006.18B3</p> <p>Licensure Reference Number 175 NAC 12-006.18A(1)</p> <p>Based on observation and interview, the facility failed to maintain walls, floors, resident equipment, fixtures, air conditioning and ventilation covers in a clean, safe and functional manner in 9 rooms (Rooms 231, 232, 234, 235, 236, 237, 238, 239, 240), which had the potential to affect 14 of 14 residents that utilized those rooms. The total number of occupied resident rooms on the second-floor north hallway, rooms 231 thru 240, was 9. The facility census was 58.</p> <p>Findings are:</p> <p>Observations on 06/10/24 from 7:54 AM through 9:00 AM revealed the following:</p> <ul style="list-style-type: none"> -Multiple dark brown smeared substance, resembling bowel movement, noted on toilet riser and toilet seat in room [ROOM NUMBER]. -Floor radiator cover was open and exposed in room [ROOM NUMBER]. The opening was approximately 8 inches by 2 inches exposing air conditioner conduit. -One missing drawer in a 6-drawer built in dresser near the sink in room [ROOM NUMBER]. -Multiple scratches in the 6-drawer wood dresser under the sink in room [ROOM NUMBER] which revealed an exposed edge, approximately 16 inches in length that was rough and sharp to touch. -Floor tile square near the entrance of room [ROOM NUMBER] was gouged (deep scratch below the surface) and had 3 missing one-inch pieces making an uneven, uncleanable surface. -Fitted sheet on bed in room [ROOM NUMBER] revealed a frayed (unraveled fabric) area of 16 x 4 inches. -Metal frame of floor vent cover in room [ROOM NUMBER] protruded (sticking out) 4 inches from the wall below the air conditioning unit which left a sharp edge. Large crack (opening) 10 inches x 0.5 inches through the drywall noted from the windowsill to the air conditioner unit. <p>(continued on next page)</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-6-drawer wood dresser under the sink in room [ROOM NUMBER] was missing a drawer knob.</p> <p>-A shared toilet in room [ROOM NUMBER] and 234 continuously ran, making the sound of continuous swirling water.</p> <p>-A 4x3 inch hole noted in drywall of the wall in room [ROOM NUMBER].</p> <p>- Several scratches that had removed the painted surface which left dark marks on a wall in room [ROOM NUMBER].</p> <p>-The ventilation cover in resident bathroom in room [ROOM NUMBER] was covered with gray fuzzy substance resembling dust.</p> <p>-The bathroom vent was not working in room [ROOM NUMBER].</p> <p>-Multiple scrapes left dark mark on the wall 10 x 1 feet in room [ROOM NUMBER] with a 2.5 x 2-inch hole through the drywall.</p> <p>-Wardrobe in room [ROOM NUMBER] was missing the right-side door which resulted in exposed resident clothing and personal items.</p> <p>-The bottom drawer face plate of a 3-drawer wood dresser by the sink in room [ROOM NUMBER] was off and laying on the floor.</p> <p>-A privacy curtain in room [ROOM NUMBER] was waded together and was placed on the over bed light fixture within 8 inches of the sprinkler head.</p> <p>-Floor tile broken near bed in room [ROOM NUMBER]. One half of the tile piece was missing which left an indentation and possible tripping hazard.</p> <p>-Floor tile by the bathroom in room [ROOM NUMBER] was cracked and was missing a 1.5 x 2-inch irregular shaped piece.</p> <p>-Baseboard near the bottom of the air conditioning unit was cracked, broken and protruded approximately 2 inches in room [ROOM NUMBER].</p> <p>-Opening through the dry wall near the foot of the bed in room [ROOM NUMBER] measuring approximately 12 x 1.5 inches above the baseboard.</p> <p>An environmental tour was conducted on 06/12/2024 at 1:15 PM with the Maintenance Director and Administrator with the above environmental concerns identified. During the environmental tour on 06/12/2024 at 1:15 PM the Maintenance and Administrator confirmed the issued identified above.</p> | | |

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| <p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49164</p> <p>Licensure Reference Number 175 NAC 12.006.09D1b</p> <p>Based on record review and interview; the facility staff failed to to maintain functional ambulation for 1 (Resident 19), failed to follow up a audiology appointment for 1 (Resident 1) of a total sample of 4. The facility staff identified a census of 59.</p> <p>Findings are:</p> <p>A. Record Review of Resident 19's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 02-02-2024 revealed a Brief Interview of Mental Status (BIMS, an assessment that aids in detecting cognitive impairment. A score of 0-7 equals severe impairment, 8-12 indicates moderate impairment and 13-15 indicates cognitively intact) score of 15 indicating cognitively intact. The MDS also indicated Resident 19 had diagnosis of High Blood Pressure, Peripheral Vascular Disease with toe amputation, End Stage Renal Disease currently on dialysis, Diabetes Mellitus Type 2 and Heart Failure. The MDS also indicated Resident 19's vision was severely impaired and Resident 19 needed partial/moderate assistance from staff with transfers from bed to chair and was dependent on staff assistance for ambulation.</p> <p>An interview with Resident 19 on 06-11-2024 at 8:00 AM revealed Resident 19 had a surgery earlier this year that resulted in amputation of toes on the left foot. Resident 19 indicated (gender) was not receiving therapy and could not walk as far as before the surgery. Resident 19 reported Resident 19 could feel they getting weaker.</p> <p>Record Review of Therapy Notes in Resident 19's Electronic Health Record (EHR, is a digital version of a patient's paper chart) revealed the last day of Physical and Occupational Therapy was 02-15-2024.</p> <p>Record Review of Resident 19's MDS dated [DATE] revealed Resident 19 required partial/moderate assistance from staff with transfers from bed and was not ambulating.</p> <p>An interview with the Director of Rehabilitation (DR) on 06-13-2024 at 11:50 AM revealed Resident 19 had not received therapy services since 02-15-2024 and confirmed Resident 19 had not been placed on a functional mobility program after therapy had discharged Resident 19. The DR confirmed Resident 19 had declined in the ability to ambulate.</p> <p>B. Record Review of Resident 1's MDS dated [DATE] revealed Resident 1 had the diagnosis of Diabetes Mellitus, Parkinson's Disease, Heart Failure, and High Blood Pressure. The MDS also revealed Resident 1 had a BIMS score of 13 which indicated Resident 1 was cognitively intact.</p> <p>An interview with Resident 1 conducted on 06-12-2024 at 9:57 AM revealed Resident 1 was supposed to have a hearing aid. Resident 1 reported not know if a hearing aid had been ordered.</p> <p>(continued on next page)</p> | | |

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| <p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record Review of Resident 1's EHR revealed Resident 1 had an appointment with audiology on 03-23-2023 and after that appointment, Resident 1 was to be fitted for hearing aids in 1-3 months. Further review of Resident 1's EHR revealed there was no other record of audiology appointments after 03-23-2023.</p> <p>An interview with the Director of Nursing (DON) on 06-13-2024 at 8:10 AM confirmed Resident 1 had not been seen by audiology since 03-23-2023 and the facility did not follow through on assisting Resident 1 obtain hearing aids.</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50683</p> <p>Licensure Reference Number 175 NAC 12-006.090</p> <p>Based on observation, record review and interviews, the facility failed to ensure a resident received a complete dose of seizure medication as ordered for 1 (Resident 34) of 5 residents observed during medication administration. The facility census was 58.</p> <p>Findings are:</p> <p>Record review of Resident 34's Comprehensive Care Plan (CCP, a document that details goals, action steps and appropriate timelines to address a resident's medical, behavioral health and social services needs) initiated on 12/10/2021 revealed Resident 34 admitted to the facility on [DATE] with the following diagnoses: Cerebral Infarction (stroke- occurs as a result of disrupted blood flow to the brain), Hydrocephalus (is a buildup of fluid in ventricles of the brain), Alcohol dependence (a chronic disease in which a person craves drinks that contain alcohol and is unable to control drinking), Traumatic Subarachnoid hemorrhage (pathologic presence of blood with the subarachnoid spaces in the brain, bleeding in the space between the brain and the membrane that covers it) with loss of consciousness of unspecified duration (pathologic presence of blood with the subarachnoid spaces in the brain, bleeding in the space between your brain and the membrane that covers it), Post traumatic seizures (seizures that occur after head trauma), Muscle weakness with muscle wasting and atrophy (a decrease in the size of an organ or tissue), Need for assistance with personal cares, Type 2 Diabetes Mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine. with diabetic neuropathy, Hypertension (high blood pressure), Swallowing problem related to dysphagia (difficulty swallowing), Aphasia (brain disorder where a person has trouble speaking or understanding other people speaking).</p> <p>Record review of Residents 34's CCP initiated on 12/10/2021 revealed Resident 34 was dependent on staff for all activities of daily living related bed mobility, transfers, dressing, grooming, bathing, incontinence care, toilet use, and personal hygiene. Further review of Resident 34's CCP revealed Resident 34 had severe cognitive impairment due to head injury. Resident 34 received all nutrition and medications through a gastric tube (a tube inserted through the wall of the abdomen directly into the stomach and was not able to have anything by mouth).</p> <p>Record review of Resident 34's current physician orders revealed an order was received on 03/28/2024 for Dilantin (a anticonvulsant medication) 100 mg (milligram) every 8 hours per g-tube (gastric tube, a gastric tube is a tube inserted through the abdominal wall directly into the stomach to deliver nutrition and/or medications).</p> <p>An observation on 06/12/2024 at 2:37 PM revealed that LPN (Licensed Practical Nurse) H obtained the Dilantin 100 mg and placed the medication into a medication cup and crushed the medication.</p> <p>(continued on next page)</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>LPN H entered Resident 34's room on 06/12/2024 at 2:41 PM, washed the over bed tray table with an antiseptic wipe and laid a clean paper towel on the over bed tray table. LPN H paused the tube feeding and the water that was flowing into Resident 34's stomach via a feeding machine. LPN H placed the crushed medication into a small plastic clear cup that was filled with approximately . 100 cc of water and stirred it. LPN H verified Resident 34's gastric tube was in the correct position by auscultation (hearing/listening for) with a stethoscope of a bolus of air pushed into the stomach via a syringe.</p> <p>An observation on 06/12/2024 at 2:50 PM revealed LPN H attached a feeding syringe without the plunger and poured the crushed Dilantin and water mixture into the empty syringe and allowed to flow into the g-tube via gravity (flowing naturally without force). Visible, unmeasurable remnants of crushed Dilantin remained in the clear plastic medication cup. LPN H flushed the g-tube with 80 milliliters of water, closed and capped the g-tube, and threw the clear plastic cup with Dilantin remnants into the trash.</p> <p>Record review of facility's Policy and Procedure for Medication Administration via Feeding Tube dated 01/2022 revealed the following:</p> <p>-# 6. Tablets are crushed and capsules are opened to facilitate mixing and administration. Tablets should be crushed to a fine consistency. Powder from the crushed tablets or capsule contents should be dispersed well in water or other prescribed diluents. All the particles must be in solution prior to administering the medication.</p> <p>Interview with DON on 06/13/2024 at 10:07 AM confirmed that Resident 34 did not receive the complete dose of Dilantin on 06/12/2024 at 2:50 PM which resulted in a significant medication error.</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47733</p> <p>Licensure Reference Number 175 NAC 12.006.17B</p> <p>Based on observation, interview, and record review, the facility failed to follow the Enhanced Barrier Precautions (EBP) while performing cares for Resident's 34,53 and 215 and failed to ensure an oxygen nasal cannula did not come in contact with the floor for Resident 3. The total sample size was 11 resident reviewed for infection control practices. The facility census was 58.</p> <p>Findings are:</p> <p>A. Record review of the facility (Enhanced Barrier Protection policy) EBP dated 2/2024 revealed catheter care is considered a high-contact resident care activity. According to the facility EHB policy dated 2/2024, catheter care/ toileting/ brief changes require a gown and gloves for barriers.</p> <p>B. An observation on 6/12/24 at 8:35 AM revealed (Nursing Assistant) NA-D and NA-E completed handwashing and set up of supplies upon entering the room. It is noted that Resident 215 had a (Enhanced Barrier Protection) EBP sign on the door. Further observation revealed NA-D and NA_E completed hand hygiene and gloves were placed on the hand and no gowns were worn during cares. NA-E performed catheter cares per protocol for wearing gloves and no gown</p> <p>An interview on 6/12/24 at 8:50 AM with NA-E was complete. During the interview NA E reported being aware of the EBP and the sign that is on the Resident's 215's door. NA-E confirmed a gown should have been worn.</p> <p>An interview on 6/12/24 at 8:50 AM (Director of Nursing) DON confirmed Resident 215 was on in EBP. DON confirmed the NA-D and NA-E should have been wearing gowns during cares for Resident 215. The DON further confirmed NA-E and NA-D were in the Resident's room without gowns on.</p> <p>49164</p> <p>C. Record Review of Resident 53's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 03-15-2024 revealed Resident 53 had diagnosis of Heart Failure, Diabetes Mellitus, Aphasia (the loss of ability to understand or express speech) and Hemiplegia (one sided muscle weakness) following a Cerebral Infarction (a cerebral infarction occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). The MDS dated [DATE] also revealed Resident 53 had a feeding tube (feeding tubes are tubes mainly inserted into the gastrointestinal tract to provide a route to give liquid nutrition.</p> <p>Record Review of Resident 53's care plan dated 05-06-2024 revealed Resident 53 had a high risk for infection related to having a gastrointestinal feeding tube and a multidrug resistant organism (MDRO). The goal of care was to mitigate any risk of transmission of a pathogen and Resident 53 was placed on Enhanced Barrier Precautions (EBP) during the provision of close contact care.</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>An observation on 06-13-2024 at 10:11 AM of Registered Nurse (RN) F flushing Resident 53's feeding tube revealed a sign on Resident 53's door stating Enhanced Barrier Precautions, wear a gown and gloves when performing high contact resident care activities. Examples of high contact resident activities included device care or use: central line, urinary catheter, feeding tube or tracheostomy. RN F had gathered equipment and had gloves on. RN F did not put on a gown before proceeding to flush Resident 53's feeding tube.</p> <p>Record Review of Facility Policy Standard and Transmission Based Precautions revised on 3-2024 revealed under section Enhanced Barrier Protection- the use of a gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident to resident. Examples of high-contact resident care activities that require a gown and glove use for EBP include: device care or use of a feeding tube.</p> <p>An interview with RN F on 06-13-2024 at 10:20 AM confirmed Resident 53 was on EBP and RN F should have worn a gown during feeding tube flush.</p> <p>50683</p> <p>D. An observation on 06/10/24 at 08:02 AM revealed an oxygen concentrator (piece of equipment that delivers oxygen) was on and running at 2.5 liters per minute in room [ROOM NUMBER]. Oxygen tubing with a nasal cannula was laying on the floor with the nasal cannula resting directly on the floor. No resident was in the room.</p> <p>An observation on 06/10/24 at 12:36 PM revealed an oxygen tubing and nasal cannula was on the floor in room [ROOM NUMBER] and oxygen concentrator was running at 2.5 liters per minute. NA C Resident 3 brought back to their room picked up the oxygen tubing and nasal cannula that was on the floor and placed the nasal cannula into the nose of Resident 3.</p> <p>Record review of the facility policy and procedure for Oxygen Tanks,Connectors and Concentrators dated 02/2019 revealed:</p> <p>1. Oxygen Tanks, Connectors and Concentrators</p> <p>-A. Equipment Guidelines:</p> <p>-1. Tubing should be replaced every week.</p> <p>-2. O2 (oxygen) masks should be replaced every week.</p> <p>-3. Cannulas should be replaced every week.</p> <p>-4. Oxygen concentrator filters will be cleaned according to manufactures recommendations.</p> <p>-B. Oxygen masks, nasal cannulas, and tubing will be used for one resident only. When used continuously or intermittently, tubing will be routinely changed to prevent the build up of respiratory secretions, mucous, and bacterial growth.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-C. When licensed staff remove treatment tubing will be covered and stored in bag.</p> <p>An interview with NA C on 06/13/24 at 10:05 AM confirmed they did apply the oxygen nasal cannula to Resident 3 and should have been cleaned or the charge nurse notified. NA C confirmed the nasal cannula had been in direct contact with the floor that was resting on the floor should have been cleaned.</p> <p>An interview with DON on 06/13/2024 at 10:07 AM confirmed any oxygen nasal cannula that has touched the floor should have been replaced with a new nasal cannula.</p> <p>E. An observation on 06/12/24 at 2:37 PM revealed (Licensed Practical Nurse) LPN H was in Resident 34's room. A sign posted on Resident 34's door indicated Resident 34 had EBP in place. LPN H placed the bell of a stethoscope directly on Resident's 34 stomach while performing an overall evaluation of Resident 34. LPN H completed the evaluation removed the double gloves LPN H was wearing and placed them in a trash can in the room. LPN H removed the gown with bare hands, rolled up the gown and placed it the trash can and washed hands with soap and water greater than 20 seconds and left the room. The un-sanitized stethoscope that was used directly on Resident 34 remained around LPN H's neck as LPN H walked down the hall to the main dining room.</p> <p>An interview with DON on 06/12/24 at 3:15 PM confirmed that LPN H should have cleaned the stethoscope that was used on a resident with enhanced barrier precautions before leaving that room.</p> |