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	07/31/2025

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 0689 Level of Harm - 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) Licensure Reference Number 175 NAC 12-006.09(I)(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. 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: -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. 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: -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. (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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. B. Record review of a facility policy entitled “Activities of Daily Living” revised 7/2015 revealed: 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. Transfer as defined by the facility’s policy is how a resident moves between surfaces – to/from: bed, chair, wheelchair, standing position. Procedures: 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 ias accessed in Point of Care (POC). Any changes noted in the resident’s performance or abilities will be reported to the licensed nurse. 7. The licensed nurse will evaluate the resident for changes in their ADL status and coordinate necessary services in conjunction with the IDT. 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. 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 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. 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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	placed. 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. 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. 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. 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. 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.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D). Based on interview and record review the facility failed to ensure resident's were free of significant medication errors for 1 (Resident 47) of 5 residents sampled. The facility census was 64. The findings are: Record review of Resident 47's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 07-12-2025 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].- had a subarachnoid hemorrhage (bleeding that occurs in the space between the brain and the surrounding membrane).-Brief Interview of Mental Status was scored at a 12. According to the MDS Manual a score of 8-12 indicates moderate cognitive impairment.-required total assistance with toileting-required moderate assistance with bed mobility, toilet transfers and lower body dressing.-required supervision with upper body dressing, and hygiene- was taking high risk medications including antipsychotics, antianxiety, antidepressants, anticoagulants, diuretics, and opioids. Record review of Resident 47's Medication Administration Record (MAR) for July 2025 revealed an order dated 04-08-2025 for Carvedilol 12.5 mg by mouth 2 times a day for high blood pressure and to hold the medication if systolic blood pressure (SBP: the top number of a blood pressure reading) is less than 110 or pulse less than 50. The MAR also revealed on 07-14-2025 at 8am Resident 47's systolic blood pressure was 99 and the carvedilol was administered. Record review of Resident 47's progress note dated 07-16-2025 revealed Resident 47 was at a doctor's appointment and (gender) blood pressure was low and was being sent to the emergency room (ER).Record review of Resident 47's progress note dated 07-17-2025 revealed Resident 47 had returned from the hospital after requiring overnight observation for a hypotensive (low blood pressure) episode at the doctor's office.Record review of Resident 47's MAR for July 2025 revealed an order dated 07-17-2025 revealed an order for Carvedilol 6.25mg by mouth 2 times a day for high blood pressure and to hold the medication if SBP 120 or less. The MAR also revealed the following: -07-17-2025 at 8 PM the SBP was 118 and Carvedilol was administered.-07-18-2025 at 8 the SBP was 117 and Carvedilol was administered.-07-19-2025 at 8 PM the SBP was 104 and Carvedilol was administered.-07-21-2025 at 8 AM the SBP was 120 and the Carvedilol was administered.-07-25-2025 at 8 AM the SBP was 106 and the Carvedilol was administered.-07-25-2025 at 8PM the SBP was 99 and the Carvedilol was administered.-07-27-2025 at 8 AM the SBP was 101 and the Carvedilol was administered. An interview conducted with Licensed Practical Nurse (LPN) D on 07-29-2025 at 10:30 AM confirmed the Carvedilol was given outside of the blood pressure parameters for Resident 47 and was a significant medication error considering the recent hospitalization for hypotension.Record review of the facility policy titled Medication Errors and Adverse Reactions dated 12-2019 revealed nursing service must immediately implement and follow the physician's orders.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Licensure Reference Number NAC 175 12-006.19(A)Based on observations and interviews, the facility failed to ensure an intact door seal was present on a refrigerator in the kitchen, resulting in the potential for inconsistent food temperatures. This had the ability to affect 62 of 64 residents who ate food produced by the kitchen.Findings are:An observation on 7/25/2025 revealed the middle refrigerator door in the kitchen had a broken seal and did not close completely.An observation on 7/30/2025 at 6:15AM with Dietary Aide C of the kitchen refrigerator confirmed the temperature reading on the portable temperature gauge behind the broken seal read 32 degrees.An observation on 7/30/2025 at 6:45AM with the Dietary Manager revealed the temperature reading on the portable temperature gauge behind the broken seal on the refrigerator door revealed the temperature was 41 degrees.An interview on 7/30/2025 at 6:15AM with Dietary Aide C confirmed the temperature gauge behind the broken refrigerator seal read 32 degrees.An interview on 7/30/2025 at 6:45AM with the DM confirmed the refrigerator temperature was not consistent behind the broken refrigerator temperature and could affect the safety of the food in the refrigerator.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05 (G) The facility failed to ensure residents were free from chemical restraints for 1 (Resident 47) of 5 sampled residents. The facility census was 64. The findings are:Record review of Resident 47's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 07-12-2025 revealed the following about the resident:-admitted to the facility on [DATE].- had a subarachnoid hemorrhage (bleeding that occurs in the space between the brain and the surrounding membrane).-Brief Interview of Mental Status was scored at a 12. According to the MDS Manual a score of 8-12 indicates moderate cognitive impairment.-required total assistance with toileting-required moderate assistance with bed mobility, toilet transfers and lower body dressing.-required supervision with upper body dressing, and hygiene-was taking high risk medications including antipsychotics, antianxiety, antidepressants, anticoagulants, diuretics, and opioids. Record review of Resident 47's Medication Administration Record (MAR) revealed the following orders:-antipsychotic medication (medications that alter brain chemistry to help reduce psychotic symptoms like hallucinations)Seroquel 12.5mg at 5 AM, Seroquel 50mg at 1 PM, and Seroquel 100mg at bedtime dated 07-07-2025 and haloperidol 1mg twice a day dated 07-07-2025.-antidepressant medication (medications used to treat depression)sertraline 50mg daily dated 07-08-2025, and trazadone 100 mg at bedtime for insomnia dated 07-08-2025 and an order for trazadone dated 07-08-2025 100mg as needed for insomnia without a stop date.-antianxiety medications (medications that calm the nervous system)buspirone HCL 5mg twice a day dated 07-08-2025 and clonazepam 0.5mg twice a day dated 07-08-2025.Furthermore, the MAR revealed no indication for use of sertraline, and no stop date or rationale to continue trazadone as needed beyond 14 days. Record review of Resident 47's Electronic Health Record revealed no rationale for the use of more than 1 antipsychotic medication and not rationale for the use of more than on antianxiety medication. Record review of Resident 47's Core LTC Pharmacy admission Medication Regimen Review (AMRR) dated 07-08-2025 revealed the Licensed Pharmacist noted the following:-the resident was receiving psychotropic medications, please ensure there is a proper diagnosis to support use along with behavior and side effect monitoring for clonazepam, buspirone HCL, haloperidol, trazadone, sertraline and Seroquel.-recommend Antipsychotic Monitoring Form or monitoring for tardive dyskinesia (a drug induced movement disorder characterized by involuntary, repetitive and sometimes sudden movements of the face, limbs and trunk.-resident is on an as needed psychotropic medication, trazadone if physician does not want to discontinue the medication in 14 days, please provide the rationale and duration of continued use.-duplicate therapy to treat specific disease states, please review antidepressants trazadone and sertraline and antipsychotics Seroquel and haloperidol-resident is currently on a medication for insomnia, consider a 3-day sleep study and complete a sleep assessment. An interview with the Director of Nursing on 076-30-2025 at 2:41 PM confirmed the AMRR was not acted upon by the facility staff. Record review of the facility policy titled Psychoactive Medication dated 11-2021 revealed the following:-it is the policy of this facility to maintain every resident's right to be free from use of psychoactive medication.-a physician's order is necessary for the use of psychoactive medication.-psychoactive medications are to be administered only when required to treat the resident's medical symptoms.-no psychoactive medications will be utilized without a diagnosed specific condition.-as needed psychotropic medications will have an initial 14-day duration. If the medication is to be extended the medical provider must explain the benefits versus risks, and reorder with another defined duration of use.

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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. 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 with sutures; and follow up with primary care provider for wound re-evaluation and suture removal in 10-14 days.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.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.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 her 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.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.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. Resident 32 further revealed that Resident 32 did not tell CMA-E that they transferred independently, and at the time of the injury CMA-E said, that's my fault and I'm so sorry. Resident 32 said CMA-E did not mean for the resident to get hurt.A follow up interview on 7/30/2025 at 11:53 AM with LPN-D confirmed Resident 32's transfer status as listed on the care plan was two-person assist at the time of the laceration and Resident 32 was transferred with only one staff member.An interview on 7/30/2025 at 12:13 PM with the Director of Nursing (DON) with the Administrator (ADM) present confirmed Resident 32's transfer status was listed on the care plan as two-assist at the time of the incident. The DON further confirmed that the laceration which required 911 services, and 11 stitches should have been reported and was not.

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Omaha Nursing and Rehabilitation Center	4835 South 49th Street Omaha, NE 68117

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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: Dr. [NAME] 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 with sutures; and follow up with primary care provider for wound re-evaluation and suture removal in 10-14 days.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.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.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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 her 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.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.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. Resident 32 further revealed that Resident 32 did not tell CMA-E that they transferred independently, and at the time of the injury CMA-E said, that's my fault and I'm so sorry. Resident 32 said CMA-E did not mean for the resident to get hurt.A follow up interview on 7/30/2025 at 11:53 AM with LPN-D confirmed Resident 32's transfer status as listed on the care plan was two-person assist at the time of the laceration and Resident 32 was transferred with only one staff member.An interview on 7/30/2025 at 12:13 PM with the Director of Nursing (DON) with the Administrator (ADM) present revealed the DON would complete an investigation when needed. The DON reported according to the documentation within the medical record, Resident 32's care plan was being followed. The DON confirmed that the investigation into Resident 32's laceration was incomplete.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 (c)(ii)Based on interview and record review, the facility failed to perform a significant change assessment for 1 (Resident 44) of 21 sampled residents. The facility staff identified a census of 64.Record review of the Centers for Medicare and (&) Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's (RAI) Manual dated October 2023 revealed: -A significant change is a major decline or improvement in a resident's status that: -1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; -2. Impacts more than one area of the resident's health status; and -3. Requires interdisciplinary review and/or revision of the care plan. -When a resident's status changes and it is not clear whether the resident meets the significant change in status assessment guidelines, the nursing home may take up to 14 days to determine whether the criteria are met.Record review of Resident 44's admission Record printed 7/29/2025 identified the facility admitted the resident on 2/5/2025 and included the following diagnoses: unspecified severe protein-calorie malnutrition; dehydration; hypokalemia; and dysphagia. Further review of the admission record revealed a new diagnosis of malignant neoplasm (cancerous tumor) of the esophagus dated 7/15/2025.Record review of Resident 44's Census List printed 7/29/2025 revealed the facility transferred the resident to the hospital on 7/8/2025. Further review of the Census List revealed the resident re-entered the facility on 7/15/2025.Record review of Resident 44's Order Summary Report printed 7/29/2025 revealed orders that the resident was to have nothing by mouth (NPO) and enteral tube feeding four times a day for Gastrostomy tube (g-tube).Record review of Resident 44'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 5/8/2025 identified Resident 44 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 10. According to the MDS manual, a score of 10 indicated the resident had moderate cognitive impairment.Record review of Resident 44's MDS records revealed an incomplete quarterly and 5-day assessment dated [DATE]. 7/29/2025 marked day 15 post significant change in status.An interview on 7/29/2025 at 1:40 PM with the MDS Coordinator (MDSC) confirmed Resident 44's MDS dated [DATE] should have been completed as a significant change in status assessment.An interview on 7/30/2025 at 6:32 AM with the Director of Nursing revealed the facility does not have a policy on MDS completion. Instead, the facility staff were to follow the RAI manual.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Licensure Reference Number 175 NAC 12-006.09(E)Licensure Reference Number 175 NAC 12-006.09(F)(iii)Based on observation, interview, and record review, the facility failed to develop a respiratory care plan including the use of a bilevel positive airway pressure (BiPAP, a technique that is used for relieving breathing problems (such as those associated with sleep apnea or congestive heart failure) by pumping a flow of air through the nose to prevent the narrowing or collapse of air passages or to help the lungs expand) non-invasive ventilator for 1 (Resident 65) of 1 sampled resident. The facility staff identified a census of 64.The findings are:Record review of a facility policy entitled Care Planning dated reviewed 5/2021 revealed: -It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan will be revised as needed, and interventions will be implemented. 3. The care plan will be revised as needed for resident changes in condition, and interventions will be implemented as appropriate.Record review of Resident 65's admission Record printed 7/29/2025 revealed the facility admitted the resident on 5/29/2025. Further review of the admission record identified Resident 65 had diagnoses which included atrial fibrillation (a-fib, very rapid uncoordinated contractions of the atria of the heart resulting in a lack of synchronism between heartbeat and pulse beat), anxiety an abnormal and overwhelming sense of apprehension and fear often marked by physical signs, by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it), heart failure, chronic obstructive pulmonary disease (COPD, pulmonary disease that is characterized by chronic typically irreversible airway obstruction resulting in a slowed rate of exhalation), and tobacco use.Record review of Resident 65's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 6/2/2025 identified the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 13. According to the MDS manual, a score of 13 indicated the resident was cognitively intact. Further review of the MDS revealed non-invasive ventilator was not selected on the assessment.Record review of Resident 65's Progress Notes dated 5/29/2025 revealed a statement that the resident wears a BiPAP at night on each of the following dates: 6/6/2025, 6/10/2025, 6/11/2025, 6/17/2025, 6/21/2025, 6/22/2025, 6/23/2025, and 7/1/2025.Record review of Resident 65's electronic health record (EHR) including physician's orders, medication administration records (MAR), treatment administration records (TAR), 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), and scanned documents lacked any entry regarding Resident 65's use of a BiPAP device.An observation on 7/28/2025 at 7:44 AM revealed a BiPAP machine, mask, and device tube sitting at Resident 65's bedside.An observation on 7/29/2025 at 11:18 AM revealed a BiPAP machine, mask, and device tube sitting on the bedside table.An interview on 7/29/2025 at 11:34 AM with Licensed Practical Nurse (LPN-D) confirmed the use of the BiPAP. LPN-D further confirmed the CCP did not identify the use of the BiPAP listed and should have.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Licensure Reference Number 12-006.09(H)(v)Based on observation, interview, and record review, the facility failed to implement interventions to prevent a potential decrease in range of motion for 1 (Resident 7) of 1 sampled resident. The facility staff identified a census of 64.The findings are:Record review of a facility policy entitled Adaptive Equipment dated revised 10/2023 revealed:It is the policy of this facility to evaluate and provide adaptive equipment for residents who have been identified for at risk for contractures, skin breakdown, etc.Procedures: 1. On admission the resident will be assessed for needs for adaptive devices. 2. Residents needing adaptive equipment will be screened by therapy or nursing and equipment will be supplied for respective resident. 3. Residents will be assessed quarterly for continued needs of the adaptive equipment.Record review of Resident 7's Census List printed 7/27/2025 revealed the facility admitted the resident on 1/24/2025.Record review of Resident 7's Medical Diagnoses printed 7/27/2025 identified the resident had diagnoses which included nontraumatic chronic subdural hemorrhage (a collection of blood that forms between the brain and its outer covering), traumatic brain injury and osteoarthritis.Record review of Resident 7's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 4/19/2025 identified the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 12. According to the MDS manual, a score of 12 indicated the resident had moderate cognitive impairment. The MDS further identified Resident 7 had a limitation in range of motion (ROM) to one upper extremity.Record review of Resident 7's Order Summary Report and Treatment Administration Record (TAR) printed 7/30/2025 revealed an order dated 5/19/2025 to apply left arm brace at night and remove in the morning every day to prevent contractures with documentation throughout the month of July that showed the splint was applied as ordered.Record review of Resident 7'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 an intervention dated 5/20/2025 that read please put on left arm brace at night, remove in morning when [gender] gets up.Record review of Resident 7's Occupational Therapy Outpatient Therapy Daily Treatment Note (OT Note) dated 5/19/2025 revealed the resident was fitted with a resting hand splint and Resident 7 was able to wear the splint all day without complaints of pain or discomfort. Further review of the OT Note revealed the therapist created an ADL communication form for CNAs and discussed the wearing schedule with the resident and the resident's family member. Parties verbalized understanding of the need to wear at night and off during the day to prevent contractures and maintain range of motion.Record review of Resident 7's Occupational Therapy Outpatient Discharge Summary dated 7/1/2025 revealed training was provided to the resident and primary caregivers in positioning/pressure relieving techniques, positioning maneuvers, functional maintenance program, compensatory strategies and splinting/orthotic schedule specifically, to decrease pain, contracture and increase ROM in left upper extremity (LUE) in order to preserve current level of function and prevent decline from current level of skill performance with 100% carryover demonstrated.Record review of Resident 7's Progress Notes dated 6/1/2025 through 7/30/2025 showed no notes regarding the brace, including whether it was refused or removed.An observation on 7/28/2025 at 2:18 PM revealed Resident 7 with contractures to the fourth and fifth digits on the left hand. The fourth and fifth digits were tucked close to the palm while the remaining digits remained freely moveable.An observation on 7/30/2025 at 5:14 AM revealed Resident 7 lying in bed without a splint applied to the left arm. The splint was observed lying on a table near the door and out of the resident's reach.An observation on 7/31/2025 at 6:04 AM revealed Resident 7 lying in bed without a splint applied to the left arm. The splint was observed lying on the table near the door and (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out of the resident's reach.During an interview on 7/28/2025 at 2:18 PM, Resident 7 reported that a splint was to be applied to the left arm. Resident 7 further reported that a brace has never been applied to her arm.An interview on 7/31/2025 at 6:07 AM with Nursing Assistant (NA-H) confirmed the brace was not in place. NA-H reported this being the first date a brace had been observed in the room.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Licensure Reference Number 175 NAC 12-006.09(H)(iv)(1). Based on observation, interview and record review, the facility failed to perform catheter care in a manner to prevent cross contamination for Resident 9; and the facility failed to assess an indwelling catheter for continued use for Resident 7. The facility census was 64. The findings are: A.Record review of Resident 9's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 06-16-2025 revealed the facility staff assessed the following about the resident: -Brief Interview of Mental Status (BIMS) was scored at 12. According to the MDS Manual a score of 8-12 indicates a person has moderate cognitive impairment. -required total assistance with hygiene, dressing, toileting, bathing, bed mobility and transfers. -had a urinary catheter. Record review of the Resident 9's Order Summary Report (OSR) printed on 07-30-2025 revealed an order dated 06-12-2025 for indwelling catheter care every shift. Observation on 07-30-2025 at 9:40 AM of Nursing Assistant (NA) J providing catheter care to Resident 9 revealed NA J used a disposable wipe and wiped around the catheter insertion site, then discarded the wipe in the trash. NA J obtained another disposable wipe and starting at the insertion site of the catheter, wiped down the tubing (down from the resident) and back (towards the resident) without folding or changing the wipe. Licensed Practical Nurse (LPN) D was present during the observation. An interview conducted with LPN D on 07-30-2025 at 10:00 AM confirmed NA J used a back-and-forth motion while providing catheter care and should not have. Record review of the facility policy titled Indwelling Catheter Care dated 06-22-2023 revealed it is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed for soiling. The purpose of the policy is to promote hygiene, comfort, and decrease the risk of infection for a resident with an indwelling catheter. Under the section Procedure using a disposable wipe, clean the catheter in a downward motion beginning at the insertion point and at least 4 inches down (from the resident toward the collection bag). Use a fresh disposable wipe for one cleansing motion. B. Record review of Resident 7's Census List printed 7/27/2025 revealed the facility admitted the resident on 1/24/2025. Record review of Resident 7's Medical Diagnoses printed 7/27/2025 identified the resident had diagnoses which included nontraumatic chronic subdural hemorrhage (a collection of blood that forms between the brain and its outer covering), traumatic brain injury and osteoarthritis. Record review of Resident 7's quarterly Minimum Data Set (MDS, a federally mandated (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 4/19/2025 identified the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 12. According to the MDS manual, a score of 12 indicated the resident had moderate cognitive impairment. The MDS further identified Resident 7 had an indwelling urinary catheter (flexible tubing inserted into the bladder used to drain urine). Record review of Resident 7's Order Summary Report and Treatment Administration Record (TAR) printed 7/30/2025 revealed an order dated 4/16/2025 that read Indwelling Catheter #16 French (Fr, size of catheter), 10 milliliter (mL) balloon to closed drainage system. The diagnosis to support the use of the catheter was left blank. Record review of Resident 7's Office Visit Form dated 5/8/2025 revealed Resident 7 was seen on 75/8/2025 by urology with orders to continue the indwelling urinary catheter, change catheter every four weeks, okay for PRN (as needed) changes if indicated with 30-50 mL sterile water flushes, and to return to urology PRN. The form lacked a diagnosis for the continued use of the catheter. An interview on 7/31/2025 at 7:48 AM with the Director of Nursing (DON) revealed the facility does not perform an assessment for continued use of indwelling urinary catheters. A follow up interview on 7/31/2025 at 8:30 AM with the DON revealed the facility does not have a policy regarding the assessment for continued use of indwelling urinary catheters.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(g)Based on observation, interview, and record review, the facility failed to obtain and implement physician's orders for the use of a continuous positive airway pressure (CPAP) non-invasive ventilator for 1 (Resident 65) of 1 sampled resident. The facility staff identified a census of 64.The findings are:Record review of Resident 65's admission Record printed 7/29/2025 revealed the facility admitted the resident on 5/29/2025. Further review of the admission record identified Resident 65 had diagnoses which included atrial fibrillation (a-fib, very rapid uncoordinated contractions of the atria of the heart resulting in a lack of synchronism between heartbeat and pulse beat), anxiety an abnormal and overwhelming sense of apprehension and fear often marked by physical signs, by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it), heart failure, chronic obstructive pulmonary disease (COPD, pulmonary disease that is characterized by chronic typically irreversible airway obstruction resulting in a slowed rate of exhalation), and tobacco use.Record review of Resident 65's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 6/2/2025 identified the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 13. According to the MDS manual, a score of 13 indicated the resident was cognitively intact. Further review of the MDS revealed non-invasive ventilator was not selected on the assessment.Record review of Resident 65's Progress Notes dated 5/29/2025 revealed a statement that the resident wears a BiPAP at night on each of the following dates: 6/6/2025, 6/10/2025, 6/11/2025, 6/17/2025, 6/21/2025, 6/22/2025, 6/23/2025, and 7/1/2025.Record review of Resident 65's electronic health record (EHR) including physician's orders, medication administration records (MAR), treatment administration records (TAR), 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), and scanned documents lacked any entry regarding Resident 65's use of a BiPAP device.An observation on 7/28/2025 at 7:44 AM revealed a BiPAP machine, mask, and tubing sitting at Resident 65's bedside. The BiPAP mask was observed laying directly on the bedside table with no barrier. The mask seal was shiny and oily, and debris was noted inside the facemask.An observation on 7/29/2025 at 11:18 AM revealed a BiPAP machine, mask, and tubing sitting on the bedside table. The mask had no barrier or bag to store it in. The mask seal was shiny and oily, and debris was noted inside the facemask.An interview on 7/29/2025 at 11:34 AM with Licensed Practical Nurse (LPN-D) revealed that the BiPAP mask should be in a bag when not in use and if the resident is able to remove the mask independently, the facility staff would have a bag for the resident to place the mask in once it was removed. LPN-D confirmed that there was no bag for the BiPAP mask available in the room. LPN-D confirmed that the mask and seal appeared dirty. LPN-D further confirmed that there were no orders for either the use of the BiPAP machine, or the cleaning of the BiPAP equipment.An interview on 7/29/2025 at 2:40 PM with the Director of Nursing (DON) confirmed the DONs expectation is that there were orders for the use and cleaning of the BiPAP machine.

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	285240	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Omaha Nursing and Rehabilitation Center	4835 South 49th Street Omaha, NE 68117

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 The facility failed to notify the practitioner of irregularities identified in the admission medication regimen review for 1 (Resident 47) of 1 resident's sampled. The facility census was 64. The findings are:Record review of Resident 47's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 07-12-2025 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].- had a subarachnoid hemorrhage (bleeding that occurs in the space between the brain and the surrounding membrane).-Brief Interview of Mental Status was scored at a 12. According to the MDS Manual a score of 8-12 indicates moderate cognitive impairment.-required total assistance with toileting-required moderate assistance with bed mobility, toilet transfers and lower body dressing.-required supervision with upper body dressing, and hygiene- was taking high risk medications including antipsychotics, antianxiety, antidepressants, anticoagulants, diuretics, and opioids. Record review of Resident 47's Medication Administration Record (MAR) revealed the following orders:-antipsychotic medication (medications that alter brain chemistry to help reduce psychotic symptoms like hallucinations)Seroquel 12.5mg at 5 AM, Seroquel 50mg at 1 PM, and Seroquel 100mg at bedtime dated 07-07-2025 and haloperidol 1mg twice a day dated 07-07-2025.-antidepressant medication (medications used to treat depression)sertraline 50mg daily dated 07-08-2025, and trazadone 100 mg at bedtime dated 07-08-2025 and an order for trazadone dated 07-08-2025 100mg as needed for insomnia without a stop date.-antianxiety medications (medications that calm the nervous system)buspirone HCL 5mg twice a day dated 07-08-2025 and clonazepam 0.5mg twice a day dated 07-08-2025. Record review of Resident 47's Core LTC Pharmacy admission Medication Regimen Review (AMRR) dated 07-08-2025 revealed the Licensed Pharmacist noted the following:-the resident was receiving psychotropic medications, please ensure there is a proper diagnosis to support use along with behavior and side effect monitoring for clonazepam, buspirone HCL, haloperidol, trazadone, sertraline and Seroquel.-recommend Antipsychotic Monitoring Form or monitoring for tardive dyskinesia (a drug induced movement disorder characterized by involuntary, repetitive and sometimes sudden movements of the face, limbs and trunk.-resident is on an as needed psychotropic medication, trazadone if physician does not want to discontinue the medication in 14 days please provide the rationale and duration of continued use.-duplicate therapy to treat specific disease states, please review antidepressants trazadone and sertraline and antipsychotics Seroquel and haloperidol-resident is currently on a medication for insomnia, consider a 3-day sleep study and complete a sleep assessment. Record review of Resident 47's Electronic Health Record (EHR) revealed no indication the AMRR recommendations were acted upon. An interview with the Director of Nursing on 07-30-2025 at 2:41 PM confirmed the AMRR was not acted upon by the facility staff. Record review of the facility policy Medication Regimen Review (MRR) dated 08-2017 revealed the following:-it is the policy of this facility that the drug regimen of each resident, which includes a review of the resident's medical chart; will be reviewed at least once a month by a licensed pharmacist. Irregularities will be documented on a separate written report and list the resident's name, the relevant drug, and the irregularity the pharmacist identified. These reports will be sent to the facility to be acted upon.-admission orders for residents of the facility will undergo an admission Medication Regimen Review by a the Licensed Pharmacist as part of the admission process.-the MRR includes identification of irregularities, medication-related errors, adverse consequences and use of unnecessary drugs.-An unnecessary drug is defined as medication ordered:-in excessive dosage (including duplicate drug therapy)-for excessive duration-without adequate monitoring-without adequate indications for its use-in the presence of adverse consequences which indicate the dose should be reduced or discontinued.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-005 (G) The facility failed to ensure residents were free of unnecessary medications for 1 (Resident 47) of 5 residents sampled. The facility census was 64. The findings are:Record review of Resident 47's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 07-12-2025 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].- had a subarachnoid hemorrhage (bleeding that occurs in the space between the brain and the surrounding membrane).-Brief Interview of Mental Status was scored at a 12. According to the MDS Manual a score of 8-12 indicates moderate cognitive impairment.-required total assistance with toileting-required moderate assistance with bed mobility, toilet transfers and lower body dressing.-required supervision with upper body dressing, and hygiene- was taking high risk medications including antipsychotics, antianxiety, antidepressants, anticoagulants, diuretics, and opioids. Record review of Resident 47's Core LTC Pharmacy admission Medication Regimen Review (AMRR) dated 07-08-2025 revealed routine blood pressure and pulse monitoring was recommended due to hypertension medication Carvedilol. Record review of Resident 47's MAR for July 2025 revealed an order dated 07-17-2025 revealed an order for Carvedilol 6.25mg by mouth 2 times a day for high blood pressure and to hold the medication if Systolic Blood Pressure (SBP: the top number of a blood pressure reading) was 120 or less. The MAR also revealed the following: -07-17-2025 at 8 PM the SBP was 118 and Carvedilol was administered.-07-18-2025 at 8 the SBP was 117 and Carvedilol was administered.-07-19-2025 at 8 PM the SBP was 104 and Carvedilol was administered.-07-21-2025 at 8 AM the SBP was 120 and the Carvedilol was administered.-07-25-2025 at 8 AM the SBP was 106 and the Carvedilol was administered.-07-25-2025 at 8PM the SBP was 99 and the Carvedilol was administered.-07-27-2025 at 8 AM the SBP was 101 and the Carvedilol was administered. An interview with the Director of Nursing (DON) on 07-28-2025 at 3:45 PM confirmed that Carvedilol was administered when the SBP was too low and should not have been. Furthermore, the DON confirmed the AMRR was not acted upon by the facility. Record review of the facility policy Medication Regimen Review (MRR) dated 08-2017 revealed the following:-it is the policy of this facility that the drug regimen of each resident, which includes a review of the resident's medical chart; will be reviewed at least once a month by a licensed pharmacist. Irregularities will be documented on a separate written report and list the residents name, the relevant drug, and the irregularity the pharmacist identified. These reports will be sent to the facility to be acted upon.-admission orders for residents of the facility will undergo an admission Medication Regimen Review by a Licensed Pharmacist as part of the admission process.-the MRR includes identification of irregularities, medication-related errors, adverse consequences and use of unnecessary drugs.-An unnecessary drug is defined as medication ordered:-in excessive dosage (including duplicate drug therapy)-for excessive duration-without adequate monitoring-without adequate indications for its use-in the presence of adverse consequences which indicate the dose should be reduced or discontinued.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Licensure Reference Number 175 NAC 12-006.17Based on record review and interview, the facility failed to maintain an accurate medical record for 1 (Resident 32) of 1 sampled resident. The facility staff identified a census of 64.The findings are: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 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 written by Registered Nurse (RN-G) 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.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.An interview on 7/30/25 at 10:21 with Licensed Practical Nurse (LPN-D) who was assigned responsibility for Resident 32 on 7/6/2025, revealed at the time of the incident Resident 32 was assisted by one staff member.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.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.An interview on 7/30/2025 at 12:13 PM with the Director of Nursing (DON), with the Administrator (ADM) present revealed RN-G was a weekend supervisor and RN-G assisted LPN-D with documentation of the resident's laceration.A follow up interview on 7/30/2025 at 12:24 PM with LPN-D confirmed that the progress note dated 7/6/2025 inaccurately stated that Resident 32 was assisted with two staff members.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 12-006.18B Based on observation, interview and record review, the facility staff failed to use Personal Protective Equipment (PPE (gowns, gloves, masks and face shields)), during cares for 2 (Resident 10 and Resident 16) of 2 sampled residents, which were both identified to require Enhanced Barrier Precautions (EBP (A form of infection control to minimize transmission of infectious disease). Findings are: A.An observation on 07/29/2025 at 10:25 AM revealed a sign on Resident 10's door that indicated the resident was in EBP and the required PPE that should be worn by staff. An observation on 07/29/2025 at 10:25 AM revealed Certified Nursing Assistant-A (CNA) and CNA- B entered Resident 10's room and donned (put gloves on) gloves without performing any hand hygiene. During this observation, CNA-B turned the resident and preformed standard perineal care. CNA-B doffed (removed gloves) gloves, and applied Alcohol Based Hand Rub (ABHR) before donning a new pair of gloves to complete the Perineal care. CNA-B then doffed the gloves and donned a new pair of gloves without hand hygiene and placed a clean incontinent product on resident 10. CNA-B then repositioned Resident 10's head, covered the resident up and lowered the bed without changing gloves or completing hand hygiene. CNA-B doffed gloves into the trash can, tied the trash bag and used ABHR before exiting the room with the trash bag. CNA-A and CNA-B both performed cares without a gown on, and they both verbalized awareness of Resident 10's EBP status. An observation on 07/29/2025 at 10:45 am revealed Resident 10's room had a 3-drawer stand next to the resident's armoire that had all the PPE in it.An interview on 07/29/2025 at 10:34 AM with CNA-A and CNA-B confirmed the CNAs should have had a gown on when performing cares for Resident 10. An observation on 07/30/2025 at 4:59 AM revealed CNA-C in Resident 10's room preforming incontinent care without a gown and only 1 assist. An interview with CNA-C on 07/30/2025 at 5:02 AM revealed CNA-C, admitted Resident 10 was to have EBP precautions with PPE worn with cares. CNA-C admitted no gown was worn during cares for Resident 10. B. An observation on 07/30/2025 at 5:04 AM revealed a sign on Resident 16's door indicating the resident was on EBP precautions. An observation on 07/30/2025 at 5:04 AM revealed Licensed Practical Nurse (LPN)-F entered Resident 16's room and marked the piston syringe without hand hygiene (HH), donned gloves, then continued the G-Tube feeding without a gown. An observation on 07/30/2025 at 6:00 AM revealed the Director of Nursing (DON) entered Resident 16's room and verified the PPE for the resident was under the sink area. An interview on 07/30/2025 at 6:00 AM with the DON revealed there was gowns, and gloves in Resident 16's PPE cart. An interview on 07/30/2025 at 6:00 AM with LPN-F revealed the LPN did not wear a gown or preform HH during the G-tube cares for Resident 16. The facility provided an Infection Control Policy dated 10/2022. The policy is to implement infection control measures to prevent the spread of communicable disease and conditions. The policy identified Enhanced Barrier Protections (EBP): expand the use of PPE and refer to the use of 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. PPE: The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply.