STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285275	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Lancaster LLC	1001 South Street Lincoln, NE 68502

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45613 Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2) Based on interview and record review; the facility failed to follow the medical practitioner's orders regarding wound care and failed to ensure wound treatment was completed for 1 (Resident 1) of 4 sampled residents. The facility census was 177. Findings are: Record review of facility's Skin and Wound Management Policy, last revised 1/2024, revealed the nursing staff and the medical practitioner: -Will assess and document regarding all current wound care treatments, -will identify type and characteristics of a pressure sore, -will identify and define complications of healing regarding pressure sores, -the practitioner will order wound treatments and identify medical interventions related to wound management. Record review of the undated facility admission record revealed that Resident 1's most recent admission to the facility was on 6/28/24 with a diagnosis of Chronic Obstructive Pulmonary Disease and Type 2 Diabetes. Record review of Resident 1's Minimum Data Set (MDS - a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 9/27/24 revealed: -The resident's cognitive assessment indicated no cognitive impairment, -the resident received substantial assistance with transfers (moving from one surface to another), bed mobility, dressing, and toileting hygiene, -the resident used a wheelchair for mobility, (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 0686 Level of Harm - Actual harm Residents Affected - Few	-the resident had a Stage 2 (partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed) pressure ulcer, -the resident did not participate in Restorative Nursing (type of nursing care designed to assist residents of nursing homes to maintain or improve their functional abilities). Record review of Resident 1's Comprehensive Care Plan (CCP- written instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care) date initiated 6/28/24 the resident was at risk for skin breakdown and has an open area on coccyx. Record review of Resident 1's Order Summary Report printed on 10/29/24 revealed no orders for wound care. Record review of Resident 1's weekly skin observation dated 8/30/24 revealed a pressure issue noted to coccyx with measurements of 2 centimeters (cm) long by 2 cm wide and .1 cm in depth. Record review of Resident 1's weekly skin observation dated 10/01/24 revealed a Stage 2 pressure issue, to coccyx with measurements of 7 cm long, by 6 cm wide and .25 cm in depth. Record review of the Tissue Analytics wound evaluation assessment dated [DATE] revealed the following visits from the Advanced Practice Registered Nurse (APRN): -On 9/18/24 Resident 1 was seen for a stage 2 linear wound on the coccyx down the crease of buttocks and the plan was to wash with facility cleanser, pat dry. Apply a thick layer of Triad cream to the wound area change or re-apply dailiy and as needed. Apply facility barrier cream as needed after bathing, changing, and in between treatments after soiling. Check and change every 2 hours. turn every 2-3 hours to relieve pressure. Resident needs to be on an air mattress and needs a Roho cushion (a pressure relieving cushion) for the wheelchar. -On 9/25/24 Resident 1 was seen and the document noted that the wound is larger, the resident still needs an air mattress, and to be propped off [gender]'s bottom. The plan is to continue current treatment. -On 10/2/24 the wound was staged at a Stage 3 (a wound that involves full thickness skin loss, exposing fat tissue but not muscle, tendon, or bone) pressure ulcer. Notes revealed to wash the wound with facility cleanser, pat dry. Apply a thick layer of Triad cream to the wound area. Cover the entire area with a sacral mepilex dressing or 2 4 x 4's large enough to cover the entire wound area. Change or re-apply daily and as needed. Check and change every 2 hours and change the dressing if it is soiled or wet. Turn resident every 2-3 hours to relieve pressure. Obtain an air mattress and a Roho cushion for Resident 1's chair. Record review of Resident 1's Treatment Administration Record (TAR) from 8/1/24 through 10/4/24 revealed no wound care treatments were ordered or completed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/29/24 at 1:38 PM Licensed Practical Nurse (LPN) - A confirmed that Resident 1 did have a wound to [gender]'s coccyx. It was also confirmed there were no documented treatment orders on the TAR, or documentation that any wound care had been done from when wound was found on 8/30/24 until the resident discharged out to the hospital on 10/4/24. LPN-A further revealed there was a treatment but could not confirm what the treatment was or if the treatment was completed for the wound. Interview on 10/29/24 at 2:47 PM the Director of Nursing confirmed that Resident 1 did not have any wound treatment orders on the TAR. It was also confirmed that the wound had been getting bigger. DON further confirmed that there was no documentation that the wound treatment had ever been completed while the resident was at the facility.