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	06/24/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12.006.09(I) Based on observation, interview, and record review, the facility failed to implement interventions to prevent potential accidents for 1 (Resident 1) of 3 sampled residents. The facility census was 174. Findings are: A record review of Resident 1's Clinical Census dated 02/14/2025 - 06/24/2025 revealed the resident was admitted to the facility 02/14/2025. A record review of Resident 1's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 05/21/2025 revealed the resident was admitted to the facility on [DATE]. The resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 11, which indicated the resident was moderately cognitively impaired (somewhat confused). The resident had limited range of motion on one side of the lower extremities (shoulder to hand or hip to toe). The resident was independent for most activities of daily living and mobility. A record review Resident 1's Care Plan with and admission date of 02/14/2024 revealed the resident had an invoked Power of Attorney (POA)(a person to make financial and/or medical decisions for a resident) for healthcare. The resident used a manual wheelchair for mobility. A record review of Resident 1's Order Summary Report dated 06/24/2025 revealed the resident had diagnoses of Chronic Kidney Disease, Personal History Transient Ischemic Attack (disruption of blood flow to the brain) And Cerebral Infarction (stroke) Without Residual Deficits, Insomnia (difficulty falling and staying asleep), Acquired Absence Of Right Leg Above Knee, Other Diabetes Mellitus With Other Circulatory Complications (uncontrolled blood sugar levels with blood flow problems), Chronic Obstructive Pulmonary Disease, Chronic Systolic (Congestive) Heart Failure (CHF), Depression, Atherosclerotic Heart Disease (hardening of the arteries) and Tobacco Use. A record review of Resident 1's Nebraska Power of Attorney For Health Care dated by Resident 1 on 03/26/2021 revealed I direct that my attorney-in-fact comply with the following instructions or limitations: Medical decisions will be made by the POA. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 1's Order Summary Report dated 06/24/2025 revealed the resident had an order of: May have alcoholic beverages on holidays/special events. It did not reveal the provider order from 06/12/2025 to send the resident to the emergency room (ER) for toxicology screen (tests used to detect the presence and amount of drugs, alcohol, and other potentially harmful substances in the body) and well check due to being taken out of the facility by unknown person. A record review of Resident 1's admission History and Physical (H&P) dated 01/30/2024 revealed that Resident 1 had a history of methamphetamines (meth)(an illegal drug) use, smoked cigarettes every day, used marijuana, and used alcohol socially. A record review of the facility's Emerald Rehabilitation Fax dated 06/12/2025 revealed Resident 1 had a provider order to send the resident to the ER for toxicology screen and well check due to being taken out of the facility by unknown person. A record review of Resident 1's Drug Screen, Drugs of Abuse, Urine dated 06/12/2025 revealed the results of the drug screen was negative. It did not reveal an alcohol toxicology test had been completed. A record review of Resident 1's Progress Notes dated 06/12/2025 at 9:00 PM revealed Social Services (SS) was notified that the resident was in the resident's room intoxicated. The SS staff member spoke with the resident and the resident gave the SS worker the bottle of alcohol to throw away. The SS worker and unit manager put orders on the board for Physical Therapy (PT)/Occupational Therapy (OT) to evaluate as well and psych orders. A record review of Resident 1's Progress Notes dated 06/12/2025 did not reveal the resident brought back alcohol when the resident returned to the facility and did not reveal the resident's room had been searched for drugs or alcohol when the resident returned to the facility. A record review of an email that the SSD provided on 03/24/2025 revealed SS staff contacted our Ombudsman (an independent official who investigates complaints and works to resolve disputes) to get more information about confiscating (taking) alcohol that residents have in their rooms due to a resident drinking that has an invoked POA and a low score on their BIMS assessment. Per the Ombudsman, the facility is not able to confiscate the alcohol even if the consumption is detrimental to residents' health and continue to have physician educate resident on the health impacts these choices make. The Ombudsman verified that the facility should ensure it is not staff providing the alcohol, as that would be an issue, but resident or family/friends of the residents' have the right to purchase with or for the resident. A record review of Resident 1's Electronic Medical Record (EMR) did not reveal: - Notification to the invoked POA that the resident had an unsecured bottle of alcohol in the resident's room. - (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notification to the provider that the resident had an unsecured bottle of alcohol in the room available for consumption (drinking or eating) outside of the provider's order of holidays/special events. - A self-administration (taking without supervision) assessment to determine if the resident was safe to self-administer the alcohol. - Education from the provider to the resident on the risks versus benefits of using alcohol. In an interview on 06/23/2025 at 3:45 PM, Resident 1 confirmed the resident did not bring alcohol back to the facility when the resident returned on 06/12/2025. The resident confirmed the resident has had a bottle of alcohol on the shelf in the resident's room and not locked up for a long time. In an interview on 06/24/2025 at 9:30 AM, Nursing Assistant (NA)-D confirmed NA-D was the NA that had Resident 1 when the resident returned to the facility on [DATE] and the resident did not bring back any bags or have any alcohol on the resident. NA-D confirmed NA-D had seen a bottle of Vodka (clear alcohol) in the resident's room, unsecured and on a shelf a couple of days prior to the resident getting intoxicated and NA-D notified the former nurse (FN)-E that was on that day, and FN-E told NA-D that it was okay, the resident had an order for it. In an interview on 06/24/2025 at 10:28 AM, NA-D confirmed that FM-E, SSD, and LPN-F were all aware Resident 1 had a bottle of alcohol in the room but said the resident had an order for it. NA-D was not aware of any other residents that had alcohol in their rooms. In an interview on 06/24/2025 at 10:47 PM, LPN-I confirmed LPN-I was training with FN-E when one of the NAs notified FM-E that Resident 1 had a bottle of alcohol in the resident's room, and FN-E just responded it was okay, the resident had an order for it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/24/2025 at 12:45 PM, the SSD confirmed the resident did not return to the facility with any bags or anything in Resident 1's pockets that the SSD was aware of. The SSD confirmed the SSD was not aware that the resident had alcohol in the room. The resident would not tell the SSD where the resident got the alcohol, just that the resident had it forever so the SSD was not sure when the resident got it. The SSD confirmed the SSD was not aware of the resident having alcohol in the room prior to the incident on the evening of 06/12/2025. The SSD confirmed the SSD searched the room while the resident went to the ER to see if the resident had brought any drugs back to the facility because the resident had a history of having a pipe, drugs and a lighter in the room, but did not see any alcohol in the room at that time. The SSD confirmed that some residents were allowed to keep alcohol in their room if they had a provider's order for it, but Resident 1's order was just for special events and holidays, and the resident should not have had alcohol in the room. The SSD confirmed that there was a similar incident with a different resident awhile ago and the SSD contacted the Ombudsman, and the Ombudsman told the SSD that the facility could not confiscate alcohol from a resident unless the resident said they could. Later in the interview the SSD confirmed a couple of days to a week before the incident on the evening of 06/12/2025, the SSD was told the resident had alcohol in the room by an NA and the SSD told the NA the resident could have alcohol in the room if there was an order for it. The SSD confirmed the resident allowed the SSD to throw away the bottle of alcohol the evening of 06/12/2025 when the resident was intoxicated and it looked like the same bottle, Barton's Vodka. The SSD confirmed the SSD did not find the bottle of alcohol when the SSD searched the room and the resident was clever. The SSD confirmed that prior to the incident, the SSD saw the resident had orders for alcohol, so the SSD did not take the Vodka. After the resident was found intoxicated, the resident said it was okay to dump it out. In an interview on 06/24/2025 at 11:04 AM, Medication Aide (MA)-G confirmed MA-G was not aware of any other residents in the facility that had alcohol in the room but was aware of a resident in room [ROOM NUMBER]B that had a bottle of alcohol in the nurse's station refrigerator. The resident had an order for it and the nurse had to measure it out and give it to the resident. In an interview on 06/24/2025 at 11:18 AM, LPN-H confirmed LPN-H was not aware of any residents that had alcohol in their rooms. In an interview on 06/24/2025 at 10:37 AM, Resident 1's invoked POA confirmed that the invoked POA was not aware that Resident 1 had a bottle of alcohol in the room until after the invoked POA had been contacted that the resident had been intoxicated, and he should not have had. The invoked POA confirmed the invoked POA was not even aware the resident drank alcohol. The invoked POA confirmed following the notification that the resident was intoxicated, the invoked POA's family member told the invoked POA the resident had a bottle of Vodka in the room on the counter, and it was out in the open and could be accessed anytime. In an interview on 06/24/2025 at 1:33 PM, the DON confirmed that when the DON wrote the telephone order from the provider for a toxicology screen, that would include screening for alcohol, but it was not done. The DON confirmed that the DON was not aware that Resident 1 had an unsecured bottle of alcohol in the resident's room until after it was reported the resident was intoxicated. The DON confirmed that Resident 1 should not have been allowed to have a unsecured bottle of alcohol in the resident's room. The DON was not aware of any residents that were allowed to have alcohol in the room.