STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285097	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Omaha	5505 Grover Street Omaha, NE 68106

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Licensure Reference Number 175 NAC 12-006.05(H) & 175 NAC 12-006.02(H)Based on record review and interviews, the facility failed to protect residents from potential abuse for 1 (Resident 1) of 3 sampled residents. The facility staff identified a census of 56.The findings are:Record review of facility policy titled Abuse, Neglect and Exploitation dated 11/2017 revealed: -Resident Protection after Alleged Abuse, Neglect and Exploitation - The facility will make efforts to protect all residents after alleged abuse, neglect and/or exploitation. Examples of ways to protect a resident from harm during an investigation of abuse, neglect and exploitation may include, but are not limited to: -Reassignment of nursing staff duties. -Time off for nursing staff. -Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse should: -Respond to the needs of the resident and protect them from further incident (document) -Notify the Director of Nursing and Administrator (document) -Initiate an investigation immediately -Notify the attending physician, resident's family/legal representative and Medical Director. -Obtain witness statements, following appropriate policies. Suspend the accused employee pending completion of the investigation. Remove the employee from resident care areas immediately. -In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must: -Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law. -Have evidence that all alleged violations are thoroughly investigated. -Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in process.Record review of Resident 1's Progress Notes dated 08/21/25 revealed a late entry for 08/15/25 that identified an allegation of potential abuse of Resident 1 by Nursing Assistant (NA)-E.Record review of facility investigation identified NA-E and Registered Nurse (RN)-F as the only staff members involved in the incident.Record review of facility nursing schedule for August 2025 revealed NA-E was scheduled to work the overnight shift on 08/16/25, 08/17/25, 08/18/25, 08/20/25, and 08/21/25.Interview on 09/30/25 at 1:35 PM with the facility Administrator (ADM) confirmed NA-E was scheduled to work 08/16/25, 08/17/25, 08/18/25, 08/20/25, and 08/21/25. The ADM reported that NA-E was sent home for unrelated events on 08/16/25. The ADM confirmed that NA-E was not suspended as part of the potential abuse investigation until 08/21/25. The ADM further confirmed that NA-E had the potential to care for residents on 08/17/25, 08/18/25, and 08/20/25 and that Resident 1 was not protected from potential abuse and should have been.

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 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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview, the facility failed to report an allegation of potential abuse to the State Agency within prescribed timeframes for 1 (Resident 1) of 3 sampled residents. The facility staff identified a census of 56.The findings are:Record review of facility policy titled Abuse, Neglect and Exploitation dated 11/2017 revealed: - Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse should: -Respond to the needs of the resident and protect them from further incident (document) -Notify the Director of Nursing and Administrator (document) -Initiate an investigation immediately -Notify the attending physician, resident's family/legal representative and Medical Director. -Obtain witness statements, following appropriate policies. Suspend the accused employee pending completion of the investigation. Remove the employee from resident care areas immediately. -Contact the State Agency and the local Ombudsman office to report the alleged abuse. -If a crime, or suspicion of a crime has occurred, notify the local law enforcement agency. -Monitor and document the resident's condition, including the response to medical treatment or nursing interventions -Document actions taken in steps above in the medical record. -In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must: -Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protected services where state law provides for jurisdiction in long-term care facilities) in accordance with State law.Record review of Resident 1's Clinical Census printed 09/29/25 showed the facility admitted the resident on 01/23/19.Record review of Resident 1's Medical Diagnosis printed 09/29/25 revealed the resident had diagnoses which included bipolar disorder (a condition characterized by dramatic shifts in mood, energy, and activity levels that affect a person's ability to carry out day-to-day tasks. These shifts in mood and energy levels are more severe than the normal ups and downs that are experienced by everyone), cognitive social or emotional deficit following nontraumatic intracerebral hemorrhage (a stroke), osteoarthritis, and generalized anxiety disorder (a condition characterized by excessive anxiety and worry about a variety of events or activities [e.g., work or school performance] that occurs more days than not, for at least 6 months). Record review of Resident 1's annual 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 08/03/25 revealed Resident 1 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 1's Progress Notes (PN) revealed on a PN dated 8/21/2025 that a nurse was notified of bruising on Resident 1's mid-left thigh to her mid-left calf. The bruise measured 36 centimeters (cm) by (x) 29.5 cm. Resident 1 reported that on July 19 a CNA and the floor nurse entered the room to provide incontinence care. The resident reported that the CNA applied all of their body weight on Resident 1's left leg and caused her to develop a hematoma.Further review of Resident 1's PNs revealed a note marked as a late entry on 8/21/2025 written by Registered Nurse (RN)-D. The note showed that Resident 1 reported to RN-D that Resident 1 had a hematoma on the left thigh and that it was caused by a Nursing Assistant (NA) pressing hard on the thigh during personal cares.Record review of a handwritten statement written by Nursing Assistant (NA)-E revealed NA-E and RN-D entered Resident 1's room to provide incontinent care. RN-D reported to NA-E that Resident 1 reported that NA-E broke [gender] leg. NA-E wrote that [gender] asked RN-D to chart about Resident 1's behavior and RN-D responded that it was nothing to worry about. NA-E wrote that [gender] reported the event to the facility Administrator (ADM). NA-E signed the note. The note was dated 8/21/25 with a notation that the events occurred a week ago.Record review of staff interview performed by the ADM on 08/21/25 with Certified Medication Assistant (CMA)-F revealed CMA-F noticed the bruise on Monday (08/18/25), and asked the resident what happened. Resident 1 reported the bruise happened over the weekend, it was caused by staff, and the resident reported that the staff person who caused the bruise was fired.Record review of a signed statement from NA-B dated 08/21/25 revealed on 08/17/25 NA-B entered Resident 1's room to perform

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Licensure Reference Number 175 NAC 12-006.09(H)Based on record review and interview, the facility failed to ensure a process was in place to notify residents of scheduled appointments for 1 (Resident 2) of 3 residents sampled. The facility staff identified a census of 56.Record review of Resident 2's Clinical Census printed 9/29/25 showed the facility admitted the resident on 5/27/2025.Record review of Resident 2's Medical Diagnosis printed 9/29/25 revealed the resident had diagnoses which included carcinoma in situ (carcinoma in the stage of development when the cancer cells are still within their site of origin) of the cervix, anemia due to antineoplastic (inhibiting or preventing the growth and spread of tumors or malignant cells) chemotherapy, thrombocytopenia (persistent decrease in the number of platelets in the blood that is often associated with hemorrhagic conditions).Record review of Resident 2'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 07/24/25 revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids detecting cognitive impairment) score of 14. According to the MDS manual, a score of 14 indicated the resident was cognitively intact.Record review of facility provided appointment calendar dated 09/11/25 revealed Resident 2 had a cardiology appointment at 10:00 AM. Further review of the appointment calendar showed one line through the resident's appointment and a notation of resident canceled.Record review of Resident 2's Progress Notes (PN) dated 09/11/25 at 2:56 PM revealed Resident 2's hematology and oncology provider's office called to inquire about the missed appointment with the cardiologist. Further review of the PN showed the nurse asked Resident 2 about the missed appointment. Resident 2 reported that [gender] was not informed of the appointment and when transportation arrived to provide transport, Resident 2 was eating breakfast. The hematology and oncology provider's office at that time informed facility staff the resident could not miss the appointment due to an upcoming scheduled procedure.Interview on 09/30/25 at 3:18 PM with the Director of Nursing (DON) revealed when a resident had an appointment the nurse documents the appointment information within the resident's medical record and sends the information to transportation utilizing a box in the copy room.Interview on 09/30/25 at 3:22 PM with the Medical Records Clerk (MRC) revealed [gender] hung the facility appointment sheet at each of the nurse's stations, and the nurse or nurse assistant was responsible to let the resident know the morning of the appointment. The MRC reported that they were not sure that the nursing department notified residents of scheduled appointments.Interview on 09/30/25 at 3:28 PM with Nursing Assistant (NA)-B revealed it was the nurse's responsibility to notify a resident of a scheduled appointment. NA-B further revealed that it was the nursing assistant's responsibility to assist a resident in dressing and being ready when a resident's transportation was at the facility.Interview on 09/30/25 at 3:30 PM with Unit Manager (UM)-C revealed that transportation or medical records were responsible for notifying the resident of a scheduled appointment and nursing assistants should remind the resident in the morning and assist the resident with getting ready so that the resident was ready to go when transportation arrived.Interview on 09/30/25 at 4:24 PM with the facility Administrator revealed the facility did not have a policy or procedure regarding appointments.