STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Lakeview	1405 West Hwy 34 Grand Island, NE 68801

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 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 Based on observation, interview, and record review, the facility failed to provide an assessment by a licensed professional nurse for 1 (Resident 23) of 1 sampled residents with symptoms of a potential respiratory infection. The facility identified a census of 69. Findings are: A record review of Resident 23's Order Summary dated 12/2/24 reveal diagnoses of Allergic Rhinitis (an allergic reaction that causes sneezing, congestion and sore throat) entered on 06/08/23 and Chronic Sinusitis (an inflammation of the sinus or nasal passages occurring for more than 12 weeks at a time) entered on 07/25/24. The Order Summary dated 12/2/24 also revealed an order entered on 10-16-2024 for Mucinex (a medication that helps loosen congestion in the chest and throat, making it easier to cough out through the mouth) for the indication of cough. Instructions for the medication stated the medication should be administered as needed twice a day. The order did not include a stop date. A record review of Medication Administration Record (MAR) for the month of November 2024 revealed that Resident 23 received Mucinex 22 days out of 30. The MAR revealed that Mucinex was administered and followed up for effectiveness each time by a Medication Aide. Record review of Resident 23's progress notes revealed no documentation of respiratory assessments or nursing attention being directed towards Resident 23's cough. An observation on 12/2/24 at 3:35 PM in Resident 23's room revealed Resident 23 to be lying in bed with the head of the bed elevated approximately 30 degrees. Resident 23 was noted to have a cough that sounded deep and productive (producing mucus). An interview with Resident 23 on 12/2/24 at 3:35 PM revealed that the cough had been present for a while, however, within the last two weeks it had worsened. Resident 23 states that they made nursing staff aware of its worsening but was unable to recount the names of staff members notified. Resident 23 revealed that [gender] stay mostly in bed, including meals, and gets out of bed two-three times a day for toileting purposes. Resident 23 revealed [gender] take walks approximately four times a week with the restorative aide. An interview with LPN-H (Licensed Practical Nurse-H) on 12/04/24 at 9:57 AM revealed LPN-H was aware Resident 23 had a cough but was unaware Resident 23 had concerns about cough worsening. LPN-H confirmed that they are the full-time day shift nurse for Resident 23 and states [gender] were not notified that the Medication Aide was administering the as needed Mucinex and performing a follow-up on (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medication's effectiveness. LPN-H confirmed that there had not been a respiratory assessment completed by a nurse. An interview with DON (Director of Nursing) on 12/04/24 at 10:52 AM confirmed that there was no policy on what as needed medications should be followed up by the nurse as opposed to the Medication Aide. The DON confirmed there was no policy detailing procedures for performing focused assessments related to acute conditions. The DON confirmed it is best practice to perform focused assessments for acute symptoms or conditions. The DON stated resident does have diagnosis of chronic sinusitis but confirmed that Mucinex was ordered for an indication of cough, which Resident 23 did not have a chronic diagnosis for.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Licensure Reference Number 175 NAC 12-006.10 (D) Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% with an observed medication error rate of 7.41% (27 administrations and 2 errors). This affected 2 (Residents 14 and 17), of 10 sampled residents. The facility stated census of 69. Findings are: A. Record review of a facility policy titled Clinical Management Medication Administration dated 05-2017 revealed to verify the pharmacy prescription label on the drug and the medication administration record or the physician orders. If there is a discrepancy check the original physician order and notify the pharmacy do not give the medication until clarified. In an observation completed on 12/03/2024 at 12:15 PM Medication Aide G, (MA-G), obtained a box labeled with Resident 17's name and Ultra Eye Preservative Free Drop 0.4-0.3% with directions to instill one drop into both eyes every 2 hours as needed for dry eyes. MA-G then proceeded to administer the eye drop to Resident 17. In an interview on 12/03/24 12:32 PM with MA-G, MA-G stated that the resident received the eye drop on a routine basis and not on an as needed basis. The MA confirmed that the label read for the eye drop to be administered on an as needed basis not routinely. Record review of Resident 17's Medication Administration Record dated 12/03/24 revealed a physician order for Ultra Eye Preservative Free Drop 0.4-0.3% with directions to instill one drop into both eyes four times a day. In an interview on 12/03/2024 at 1:05 PM with the Director of Nursing (DON) confirmed that Resident 17's Ultra Eye Preservative Free Drop 0.4-0.3% label read to administer the eye drop every 2 hours as needed and the physician order read to administer the eye drop four times a day. The DON confirmed that the physician order and the label did not match. B. In an observation completed on 12/03/2024 at 12:30 PM MA-G obtained a white tube of medication labeled Diclofenac Gel 1% apply 4 GM (Grams) to knees four times daily. MA-G walked to Resident 14's room, knocked on the door, acknowledged the resident and then entered the resident's room. The MA informed Resident 14 they were going to apply the residents pain cream and asked the resident if they would like the cream applied to their back or their knees. Resident 14 stated they would like the cream applied to their back. The MA then applied the gel to the resident's back. Record review of Resident 14's Medication Administration Record dated 12/03/2024 revealed that Resident 14 had a physician order for Diclofenac Gel 1% to apply 4 Grams to the knees four times a day. In an interview on 12/03/2024 at 12:32 PM with MA-G, MA-G confirmed that the label on the tube of (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication read for the gel to be applied to the residents knees and the physician order read for the gel to be applied to the resident knees and that the order did not reflect that the gel was to be applied to the residents back or knees per the residents choice. In an interview on 12/03/2024 at 1:05 PM with the DON confirmed that Resident 14 did not have an order for Diclofenac Gel to be applied to their back. The order only indicated it was to be applied to the resident's knees. The DON confirmed that the gel should only be applied as directed in the order.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** License Reference Number 175 NAC 12-006.119(A)(iv) Based on record reviews, observations, and interviews, facility failed to provide a physician ordered therapeutic diet with increased protein for 1 (Resident 22) of 1 resident sampled. The facility census was 69. Findings are: Record review of the Minimum Data Set (MDS, a standardized assessment tool used to comprehensively evaluate the health and functional capabilities of residents and for use when creating Care Plans) dated 11/10/24 for Resident 22 revealed the resident had a Brief Interview of Mental Status (a short cognitive screening tool used to assess a person's mental abilities in long-term care facilities) score of 14 a score of 13 to 15 means the individual is cognitively intact. Record review on 12/03/24 of the working Care Plan (a document outlining a resident's individual healthcare needs, including medical conditions, personal preferences, and specific care strategies to provide the best possible support and treatment) revealed that Resident 22 was admitted on [DATE], had diagnoses of non-pressure ulcer of the back with necrosis of the bone, pressure ulcer of the sacral region stage 4, severe protein-calorie malnutrition, type 2 diabetes, anemia, and paraplegia. The care plan also revealed that Resident 22 had a nutritional problem related to non-pressure chronic back ulcer, pressure ulcer of the sacral region stage 4, severe protein-calorie malnutrition and anemia. Supplements were to be to be given as ordered. Record Review of the Physician Orders printed on 12/04/2024 revealed dietary orders that Resident 22 was to receive a regular diet, regular texture, regular consistency with double portions of proteins with meals as well as snacks and supplements per the registered dietician's recommendations. Observation on 12/04/24 at 12:10 PM of Dietary Aide (DA-B) who served the resident meals to those who resided on the 500 hallway. DA-B served Resident 22 one scoop of meat and one sandwich to Resident 22. Interview on 12/04/24 at 12:30 PM with DA-B, who stated Resident 22 received two sandwiches instead of just one. Retrieved the dining room meal order ticket to show that Resident 22 is ordered to receive double protein servings. Interview on 12/04/24 at 12:55 PM with Resident 22 revealed Resident 22 that only one sandwich and one portion of protein was served with the noon meal. Interview on 12/04/24 at 12:57 PM with Activity Aide (ACT-A) who repeated the question to Resident 22 for clarification as Resident 22 only speaks Spanish. Resident 22 stated [gender] had uno (one) sandwich and held up one finger. Confirmation from ACT-A that Resident 22 had only one portion of protein during the noon meal. Interview on 12/04/24 at 01:00 PM with the Administrator confirmed Resident 22 has an order for double protein servings at meal time. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/04/2024 at 01:15 with DA-B revealed that Resident 22 had not been given the double servings of protein but instead another resident.