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	10/07/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensure Reference Number 175 NAC 12-006.09(H)Based on observation, interview, and record review; the facility failed to implement pain management interventions during the provision of wound care for 1 (Resident 1) of 2 sampled residents. The facility staff identified a census of 50.The findings are:Record review of a facility policy entitled Pain Recognition and Management revised 04/2025 revealed: -2. To the extent possible, staff will: -a. Recognize when a resident is experiencing pain and identify circumstances when pain can be anticipated; -b. Evaluate existing pain and the causes; and -c. Manages or prevents pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. -4. Management: -b. Medication(s) received, refused and response to medication will be documented on the Electronic Medication Administration Record (e-MAR). -c. If the pain management program is not effective, the licensed nurse will contact the resident's physician.Record review of Resident 1's Clinical Census printed on 10/2/2025 showed the facility admitted the resident on 01/24/2025. Record review of Resident 1's Medical Diagnosis printed on 10/2/2025 showed Resident 1 had diagnoses of depression, stage four pressure ulcer of the sacral region, osteoarthritis, and pain in the right knee.Record review of Resident 1'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 07/18/2025 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 11/15. According to the MDS manual, a score of 11 indicated Resident 1 had moderate cognitive impairment. The MDS identified Resident 1 entered the facility with one stage-four pressure ulcer present on admission. According to the MDS Manual, a stage four press ulcer is a full thickness loss with exposed bone, tendon, or muscle. Further review of the MDS identified the following about Resident 1's Pain during the assessment reference period: -The resident almost constantly had pain or hurting over the last 5 days; -The pain occasionally made it hard for Resident 1 to sleep at night; -The pain frequently limited Resident 1's day-to-day activities; -Resident 1 rated pain at 7 on a scale of 0-10, with 10 being the worst pain. -Resident 1 received opioid pain medication; received scheduled and as-needed (PRN) pain medications, and received non-medication intervention for pain. Record review of Resident 1's Order Summary Report printed 10/02/2025 revealed orders for acetaminophen (non-opioid pain reliever) 1000 milligrams (mg) three times daily and oxycodone (an opioid pain reliever) 5 mg every four hours PRN pain.Record review of Resident 1's October 2025 Medication Administration Record (MAR) printed 10/7/2025 revealed Resident 1 received scheduled acetaminophen on 10/7/2025 at 6:00 AM with a pain rating of 5 out of 10 and administration of PRN oxycodone on 10/7/2025 at 5:17 AM with a pain rating of 5 out of 10.Observation on 10/7/2025 from 10:20 AM to 10:53 AM of Physician Assistant (PA)-B and the Assistant Director of Nursing (ADON) performing a negative pressure wound therapy (NWPT or wound vac, an active wound care treatment that uses controlled sub-atmospheric {negative} pressure to assist and accelerate wound healing. The therapy may be gauze based, foam based, or peel and stick, and includes an evacuation tube and a computerized pump that applies the negative pressure) dressing change revealed a softball sized stage four pressure ulcer approximately three centimeters (cm) deep to Resident 1's sacrum. The wound bed was beefy red and tissues surrounding the wound were intact. There was no noted odor. PA-B performed a wound assessment including measurements while ADON assisted Resident 1 to remain on the left side. PA-B cleansed the wound utilizing wound cleanser and a gauze square. PA-B informed Resident 1 that the cleanser was cold. Upon PA-B cleansing the wound, Resident 1 yelled out Ow! PA-B continued the wound treatment as ordered and placed Amchoplast (a skin substitute used in wound treatment designed to support wound healing and protection of the wound) in the base of the wound and applied drape around the wound. PA-B cut black foam to the size of the wound and placed the black foam in the wound bed. Resident 1 yelled out Ow! was facial grimacing and began to cry while both of Resident 1's shoulders were moving up and down. The ADON began rubbing Resident 1's back and utilized conversation to distract the resident. PA-B continued with the wound treatment and applied the top layer of drape while the ADON held the black foam in place. Resident 1 began crying again and yelled out that hurts! and was whimpering. PA-B and the ADON continued with the wound treatment, and Resident 1 continued crying and facial grimacing and yelling out Ouch! Oww! That Hurts! The wound dressing was completed, and the wound dressing was attached to the wound vac. The ADON powered on the wound vac device and when suction was applied, Resident 1 again yelled out Ow!

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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 1-005.06(D)Based on observation, interview, and record review; the facility failed to perform hand hygiene between glove changes during the provision of wound care for 1 (Resident 2) of 3 sampled residents. The facility staff identified a census of 50.The findings are:Record review of a facility policy entitled Hand Hygiene revised 10/2022 revealed facility staff were to perform an alcohol-based hand rub containing at least 62 percent (%) alcohol; or alternatively, soap and water before handling clean or soiled dressings, gauze pads, etc.; before moving from a contaminated body site to a clean body site during resident care; after handling used dressings and contaminated equipment; and after removing gloves.Observation on 10/7/2025 from 9:54 AM through 10:05 AM of Licensed Practical Nurse (LPN)-A performing wound care treatments for Resident 2 revealed LPN-A washed hands with soap and water for 32 seconds and donned (applied) a gown and gloves. LPN-A washed the resident's right and left posterior thighs. LPN-A doffed (removed) gloves, and without performing hand hygiene donned a new pair of gloves. LPN-A washed Resident 2's right posterior heel and doffed gloves. Without performing hand hygiene, LPN-A donned new gloves and performed the wound treatment to Resident 2's right posterior heel. LPN-A doffed gloves, and without performing hygiene donned new gloves. LPN-A proceeded with the left and right posterior thigh treatment as ordered, and doffed gloves. Without performing hand hygiene, LPN-A donned new gloves and re-applied the treatment to Resident 2's right posterior heel as ordered. LPN-A doffed gloves, performed hand hygiene, and exited the room.An interview on 10/7/2025 at 10:07 AM with LPN-A confirmed hand hygiene had not been performed between glove changes and should have been.