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	05/03/2023

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number 175 NAC 12-006.05(21) Based on observation, record review and interview; the facility failed to ensure that resident's dignity was maintained for 2 (Resident 40 and 24) of 3 residents reviewed as evidenced by exposure of an incontinence brief and tube feeding bottles in visual sight in a common area of the facility for Resident 40 and the use of a sign on Resident 24's door that described personal hygiene care needs. The sign was in sight of visitors and other residents that passed by the room. The facility census was 62. Findings are: A. Record review of Resident 40's quarterly Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) dated 3/23/23 identified that Resident 40 was admitted to the facility on [DATE] with diagnoses that included Cerebral Vascular Accident (CVA, stroke), Aphasia (the inability to speak or comprehend) and Traumatic Brain Injury. The MDS identified that Resident 40 was severely cognitively impaired, required extensive to total assistance with activities of daily living and received all nutrition and hydration through a feeding tube. Observation on 4/30/23 between 3:00 PM and 4:45 PM revealed Resident 40 seated in a wheelchair on the second floor of the facility in the common area. Resident 40 had on a T-shirt and an incontinence brief with no pants to cover the resident's brief or lower extremities and had a tube feeding bag and tubing hanging from a pole next to the resident in sight of other residents. A blanket was on the floor next to the wheelchair and several residents were present in the common area. Several staff walked past the resident and did not pick up the blanket to cover the resident. Observation on 5/1/23 between 12:30 PM and 2:20 PM and on 5/2/23 at 12:30 PM revealed Resident 40 seated in a wheelchair on the second floor of the facility in the common area. Resident 40 had on a T-shirt and long pants and had a tube feeding bag and tubing hanging from a pole next to the resident in sight of other residents in the common area. Interview on 5/2/23 at 12:42 PM with the Assistant Director of Nursing (ADON) confirmed that this could be a dignity issue for Resident 40 as [gender] would be unable to say if it bothered [gender] to have others see a tube feeding bag, tubing, and pole. The ADON confirmed that Resident 40 should have been dressed in long pants instead of being covered by a blanket on 4/30/23. (continued on next page)

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

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	05/03/2023

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/02/23 at 12:47 PM with the Director of Nursing (DON) confirmed that Resident 40's tube feeding bag and pole were not covered and this could be a dignity issue to have others see those items and the resident was not able to tell staff that it bothered Resident 40. The DON confirmed that Resident 40 should have been dressed in long pants instead of being covered by a blanket and that it was a dignity issue for others to see the resident's incontinence brief on 4/30/23. Record review of a Policy/Procedure entitled Dignity and Respect dated April 2021 revealed the following procedures: 1. Residents shall be appropriately dressed in clean clothes arranged comfortably on their persons. 2. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. B. Observations on 04/30/23 at 07:17 AM and 4:00 PM, 5/1/23 at 10:47 AM, and 5/2/23 at 7:07 AM revealed a sign on the outside of the door to Resident 24's room in a large plastic sleeve that said (Resident 24) uses the big bathroom. The sign could be seen from the hallway and anyone that passed by the room. Interview on 05/02/23 at 07:20 AM with Licensed Practical Nurse (LPN) F confirmed the sign present on Resident 24's door and that it could clearly be seen from the hallway. LPN F confirmed that this could be a dignity issue for Resident 24. Interview on 05/02/23 at 07:50 AM with the facility Administrator (ADM) confirmed the sign present on the outside of Resident 24's door. The ADM confirmed that it was a dignity issue for Resident 24 and should not have been on the outside of the doorway and visible to other residents or visitors. Record review of a facility Policy / Procedure entitled Dignity and Respect dated April 2021 revealed that it is the policy of this facility that all residents be treated with kindness, dignity, and respect.

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	05/03/2023

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number 175 NAC 12-006.05(15) Based on observation, record review and interview; the facility failed to ensure full visual privacy in 11 (resident rooms 103, 104, 105, 206, 207, 209, 224, 228, 229, 237, 238) of 20 dual occupancy rooms as evidenced by no privacy curtains present that would surround the bed near the doorway to ensure visual privacy from the doorway or the resident's roommate. The facility census was 62. Findings are: Record review of a facility Policy and Procedure entitled Dignity and Respect and dated April 2021 revealed the following: 1. Residents shall be appropriately dressed in clean clothes arranged comfortably on their persons. 2. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the resident from people that passed by the room. Observation on 04/30/23 at 6:51 AM revealed that upon opening the door to the room, staff were in the room providing care to Resident 11 and exposed skin was observed from the doorway. There was no privacy curtain present to ensure full visual privacy. Observation on 5/2/23 at 8:15 AM with the Corporate Resource Manager (CRM) revealed that the CRM knocked on the door to room [ROOM NUMBER] and was told to come in. When the CRM opened the door, staff were in the room providing personal cares to Resident 2 while in bed and were able to see the residents exposed skin from the doorway. There was no privacy curtain present to ensure full visual privacy. Observation on 05/02/23 between 7:40 AM and 8:30 AM with Administrator, Maintenance Supervisor, and the CRM revealed that there were no privacy curtains present around the bed by the doorway that would provide visual privacy from the doorway or the residents roommate if they had to exit the room in double occupancy resident rooms 103, 104, 105, 206, 207, 209, 224, 228, 229, 237, 238. Interview on 5/2/23 at 8:25 AM with the facility Administrator confirmed that there were no privacy curtains present in resident rooms 103, 104, 105, 206, 207, 209, 224, 228, 229, 237, 238. The Administrator confirmed that, without privacy curtains, the residents could be visibly seen from the hallway or the residents' roommate.

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	05/03/2023

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 17285 Licensure Reference Number 175 NAC 12.006-15 Based on observation and interview, the facility failed to ensure that resident rooms were home like with personal items in use in 5 (resident rooms 129, 130, 132, 136, 140) of 17 occupied resident rooms on the 1st floor of the facility. The facility census was 62. Findings are: Observation on 05/02/23 between 2:30 PM to 02:44 PM with the facility Administrator revealed that resident rooms 129, 130, 132, 136, and 140 were not home like and did not contain personal items or pictures to make the rooms feel home like and to provide visual stimulation to the residents that resided in those rooms. Interview on 05/02/23 at 02:50 PM with the Administrator confirmed that resident rooms 129, 130, 132, 136, and 140 did not appear home like and did not have any personal items or pictures present. Interview on 05/02/23 at 03:04 PM with the facility Social Services Worker confirmed that resident rooms 129, 130, 132, 136, and 140 were not home like and confirmed that the facility had not attempted to provide a home like environment by getting pictures or personal items for the residents that resided in those rooms.

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	05/03/2023

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 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. 40338 LICENSURE REFERENCE NUMBER 175 NAC 12.006-02(8) Based on record review and interview; the facility failed to report an elopement for 1 (Resident 50) of 1 sampled resident to the required state agency within the required time frame of 2 hours. The facility staff identified a census of 62. The findings are: Record review of Resident 50's Incident of Elopement dated 3/27/23 revealed the following: On 3/27/23 at 9:20 AM the facility door alarm sounded. Staff initiated response and went to exit doors. The administrator exited the building and noted Resident 50 outside in the parking lot stepping off the driveway. Resident was redirected and escorted back into the building. Record review of the facility report dated 3/30/23 revealed the required state agency was notified on 3/28/23 at 9:09 AM. Record review of the facility Elopement Policy and Procedure revised on 2/2022 revealed the following: -In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will: 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: No later than two hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury. Not later than twenty-four hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported to: the administrator of the facility the state survey agency APS as appropriate An Interview with DON on 5/3/23 at 06:46 AM confirmed the facility did not report the elopement for Resident 50 until the following day after it occurred.

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	05/03/2023

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number 175 NAC 12-006.05(5) Based on record review and interview, the facility failed to ensure the resident and /or the resident's representative were notified in writing of the reason for transfer to the hospital for 1 (Resident 66) of 1 resident reviewed for hospitalization . The facility census was 63. Findings are: Record review of Resident 66's Clinical Progress Notes dated 2/3/23 revealed that Resident 66 was sent to the hospital directly from an offsite Urology appointment. Record review of Resident 66's Electronic Medical Record revealed no documentation related to a written notice of the reason for transfer to the hospital provided to the resident and / or resident's representative for the hospitalization on [DATE]. An interview on 5/2/23 at 1:00 PM with the facility Social Services Worker confirmed that no written notice of transfer to the hospital on 2/3/23 had been provided to Resident 66 or the resident's representative.

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	05/03/2023

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident’s assessment is updated at least once every 3 months. 17285 Licensure Reference Number 175 NAC 12-006.09B2 Based on record review and interview, the facility failed to ensure that residents' Minimum Data Set (MDS, a required comprehensive assessment of the resident used to create an individualized comprehensive care plan) assessments were completed within the required 14 days after the Assessment Reference Date (ARD, the last day of the observation period that the assessment covered for that resident) for 5 (Residents 26, 24, 43, 40 and 1) of 5 residents reviewed. The facility census was 62. Findings are: A. Record review of Resident 26's Quarterly MDS revealed that the ARD was identified as 3/16/23. The MDS was completed on 4/18/23 and should have been completed on 3/30/23. The MDS was completed a total of 19 days late. B. Record review of Resident 24's Quarterly MDS revealed that the ARD was identified as 3/16/23. The MDS was completed on 4/19/23 and should have been completed on 3/30/23. The MDS was completed 20 days late. C. Record review of Resident 43's Quarterly MDS revealed that the ARD was identified as 3/22/23. The MDS was completed on 4/24/23 and should have been completed on 4/5/23. The MDS was completed 18 days late. D. Record review of Resident 40's Quarterly MDS revealed that the ARD was identified as 3/23/23. The MDS was completed on 4/28/23 and should have been completed on 4/6/23. The MDS was completed 22 days late. E. Record review of Resident 1's Quarterly MDS revealed that the ARD was identified as 3/25/23. The MDS was completed on 4/24/23 and should have been completed on 4/8/23. The MDS was completed 16 days late. Interview on 05/02/23 at 11:29 AM with the facility MDS Coordinator confirmed the ARD dates and the completion dates of the MDS Assessments for Residents 26, 24 43, 40 and 1 and confirmed that the MDS assessments were not completed by the 14th day after the ARD and should have been completed within 14 days of the ARD.

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	05/03/2023

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Based on record review and interview, the facility failed to ensure a new PASARR (Pre-Admission Screening and Resident Review, a screening to determine the presence of a mental illness or intellectual disability) review had been completed after a diagnosis of a mental disorder was identified for 1 (Resident 19) out of 1 reviewed for PASARR. The facility census was 62. Findings are: Record review of Resident 19's Face Sheet identified that Resident 19 was admitted [DATE] with diagnoses that included Anxiety Disorder, identified on 3/30/22, and Unspecified Dementia with other Behavioral Disturbance identified on 10/1/22. Review of Resident 19's Admission Level 1 PASARR completed on 4/13/15 revealed that there was no evidence to suggest mental illness and no further screening was required unless the individual was suspected or found to have a mental illness condition. Record review of Resident 19's Annual Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) dated 5/6/22, section A1500 for PASARR, revealed that Resident 19 was not considered by the State level 2 PASARR process to have a serious mental illness or intellectual disability or a related condition. The MDS further identified Resident 19 to have a current psychiatric diagnosis of Anxiety Disorder, Psychotic Disorder (results in difficulty determining what is real and what is not real) and Post Traumatic Stress Disorder. Record review of Resident 19's Electronic Medical Record revealed that a new PASARR had not been completed after 3/30/22 when the resident received a mental illness diagnosis of Anxiety Disorder. Interview on 05/01/23 at 1:04 PM with the Social Services Director confirmed that Resident 19 had a new diagnosis of Anxiety Disorder that was identified on 3/30/22 and confirmed that a new referral for PASARR screening had not been requested for Resident 19 until 5/1/23.

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	05/03/2023

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 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. 40338 LICENSE REFERENCE NUMBER 175 NAC 12.006.09D2 Based on observation, record review and interview; the facility failed to ensure geri sleeves (a protective covering for arms) were in place as ordered for 1 (Resident 43) of 2 sampled residents. The facility staff identified a census of 62. The findings are: Record review of Resident 43's current physician orders revealed an order dated 4/27/23 for geri sleeves to elbows every shift. Record review ofa progress note for Resident 43 dated 4/9/23 revealed the resident should wear sleeves at all times in room and out of room per Hospice nurse three times a day. Observation on 04/30/23 at 11:30 AM revealed Resident 43 did not have geri sleeves on (gender) arms. Observation on 05/01/23 at 7:52 AM revealed Resident 43 did not have geri sleeves on (gender) arms. Observationn on 5/2/23 at 8:49 AM revealed Resident 43 was up in wheelchair and did not have geri sleeves on bilateral arms. Bruising noted to left arm. An interview with the DNS (Director of Nursing Services) on 5/2/23 at 9:35 AM confirmed the order for geri sleeves from Hospice. The DON confirmed that Resident 43 did not have sleeves on bilateral arms.

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	05/03/2023

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 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** 40338 LICENSURE REFERENCE NUMBER 175 NAC 12.006.09D2a Based on observation, record review and interview; the facility staff failed to ensure an air loss mattress was set to relieve pressure and failed to reposition for pressure relief for 1(Resident 16) of 3 sampled resident resulting in additional pressure ulcers. The facility staff identified a census of 62. The findings are: Review of Resident 16's electronic medical record revealed that Resident 16 was hospitalized on [DATE] and returned to the facility on [DATE] with the following identified wound areas: - Coccyx unstageable (full thickness tissue loss in which the actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown, or black) in the wound bed) pressure ulcer. - Left and right gluteal folds stage 1 pressure ulcer (a red nonblanchable area with no open areas). -Right 3rd toe trauma, right 4th toe trauma, right 4th toe base trauma, right 5th toe trauma, right 3rd/4th toe, right 4th/5th toe. -Right exterior foot #1 SDTI (Suspected Deep Tissue Injury; a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying tissue from pressure and/or shear), -Right exterior foot #2 SDTI. -Right great toe trauma -Right hip SDTI. -Right medial foot SDTI. -Left inner ankle scab. -Right Forearm bruise. -Moisture Associated Skin Damage (MASD) to the scrotum. Further review of the electronic medical record revealed a new SDTI to the left hip that was identified on 4/27/23. (continued on next page)

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	05/03/2023

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 16's Care Plan dated 4/27/23 revealed the following intervention to prevent skin breakdown: - Encourage to turn and reposition, provide assistance as necessary with a date initiated of 11/28/22. -Low air loss mattress, Prevalon boots on Bilateral Lower Extremities when in bed. Observation on 5/1/23 at 6:30 AM revealed Resident 16 lying in bed on (gender) left side. Observation on 5/1/23 at 8:00 AM revealed Resident 16 lying in bed on (gender) left side. Resident 16 was lying on a low air loss mattress that was set on static mode (a setting that does not deflate any of the chambers in the mattress. The real value of a loss air loss mattress is the rotating deflation of the chambers that support the user, giving relief to otherwise constant pressure between the resident and the mattress). Observation on 5/1/23 at 9:00 AM revealed Resident 16 lying in bed on (gender) left side. Resident 16 was lying on a low air loss mattress that was set on static mode. Observation on 5/1/23 at 11:00 AM revealed Resident 16 lying in bed on (gender) left side. Observation on 5/2/23 at 6:30 AM revealed Resident 16 lying in bed on (gender) right side. Resident 16 was lying on a low air loss mattress that was set on static mode. Observation on 5/2/23 at 8:00 AM revealed Resident 16 lying in bed on (gender) right side. Observation on 5/2/23 at 9:00 AM revealed Resident 16 lying in bed on (gender) right side. Resident 16 was lying on a low air loss mattress that was set on static mode. Observation on 5/2/23 at 11:00 AM revealed Resident 16 lying in bed on (gender) right side. Observation on 5/2/23 at 11:54 AM revealed Resident 16 lying in bed on (gender) right side. Observation of wound care on 5/2/23 between 12:44 PM-1:27 PM with the ADON (Assistant Director Of Nursing) revealed during the observation ADON reported the SDTI on the left hip was a new wound being treated with Skin Prep (a wipe that forms a barrier on the skin). During the observation the ADON confirmed the settings on the low air loss mattress was set on Static mode. An interview with the ADON on 5/2/23 at 12:58 PM regarding the air mattress setting of static revealed that when cares are being provided the bed is placed on static so it is not alternating during cares. Interview with Nursing Assistant (NA)-B on 5/2/23 at 1:27 PM revealed nursing assistants do not touch the setting on the low air loss mattress. Interview with the ADON on 5/2/23 at 1:30 PM confirmed that mattress was set on static most of the time and would have to check on who can adjust settings on the air mattress. (continued on next page)

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	05/03/2023

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 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 5/2/23 at 2:52PM revealed the mattress remained on Static mode. Interview on 5/2/23 at 2:57 PM with the DNS (Director of Nursing Service) confirmed mattress should be on alternating and not static due to static mode not providing pressure relief.

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	05/03/2023

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 40338 LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D7 Based on record review and interview; the facility staff failed to implement interventions to prevent elopement for 2 (Resident 31 and 50) of 2 sampled residents. The facility staff identified a census of 62. The findings are: A Record review of the Policy and Procedure for Elopement with a revision date of 2/2022 revealed residents identified to be at risk for elopement will have an individualized care plan and interventions implemented. Residents whose assessment identified wandering behavior shall also be considered at risk for elopement. If the resident is identified at risk for elopement, the following steps will be taken and or verified that completed by the individual completing the assessment: -An alarm bracelet may be placed on the resident to audibly alert staff of attempts to exit. -The residents care plan shall address behavior using resident specific goals and approaches as assessed by the Interdisciplinary Team (IDT). -Residents with an elopement incident from the facility either on or off the grounds shall be considered at higher risk for further attempts at elopement. These residents will have the following precautionary measures implemented to prevent repeat incidents of elopement: -Resident will wear an alarm bracelet to alert staff if trying to leave the facility. -The bracelet will be checked daily to assure that it is functional, and checks will be logged. Record review of the progress notes for Resident 31 revealed the following: On 3/28/2023 at 9:40 PM, Resident 31 called 911 wanting to leave the facility. The police arrived and spoke to Resident 31 and redirected resident in the facility. On 3/29/2023 at 5:18 AM, Resident 31 was exit seeking and pulled the fire alarm. On 4/5/2023 at 8:39 PM Resident 31 was noted wandering most of the shift. Review of the facility investigation report dated 4/3/23 revealed a door alarm sounded at 8:18 AM. According to the report Staff initiated response and went to the front exit door, nurse followed procedure and paged overhead. Resident easily redirected and escorted back into building by staff. Change of condition elopement assessment completed by DNS (Director of Nursing Service). (continued on next page)

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	05/03/2023

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 31's Elopement Evaluation dated 3/29/23 revealed Resident 31 was a high risk for elopement. Record review of Resident 31's Care Plan revealed the following: -Elopement risk/wanderer related to impaired safety awareness with an actual elopement on 3/29/23. -The Date of Resident 31's elopement risk/wanderer was initiated on 03/30/2023. -Will not leave facility unattended through the review date. Date Initiated: 04/03/2023. -Safety will be maintained through the review date. Date Initiated: 04/03/2023. - Will demonstrate happiness with daily routine through the review date. Date Initiated: 04/03/2023. -Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Date Initiated: 03/30/2023 -Wander guard (a device to alert staff if resident exits the building) placed on Resident 31. Date Initiated: 03/30/2023 An observation on 4/30/23 at 6:30 AM revealed a white device located on the door frame of Resident 31's room which was in the off position and the door to the room was in an open position. Resident 31 did not have a wander guard device on. An observation on 4/30/23 at 9:00 AM revealed the white device located on the door frame of Resident 31's room remained in the off position. Resident 31 was lying in the resident's bed and did not have a wander guard device on. (continued on next page)

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	05/03/2023

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation on 4/30/23 at 11:37 AM revealed the white device in the doorway of Resident 31's room remained in the off position, the door to the resident;s room was open and Resident 31 did not have a wander guard on. An observation on 4/30/23 at 12:33 PM revealed the white device located on the door frame of Resident 31's room remained in the off position and Resident 31 did not have a wander guard on. An observation on 4/30/23 at 1:06 PM revealed the white device located on the door frame of Resident 31's room remained in the off position and Resident 31 did not have a wander guard on. An observation on 4/30/23 at 2:04 PM revealed the white device located on the door frame of Resident 31's room remained in the off position and Resident 31 did not have a wander guard on. An interview with Nursing Assistant (NA)-G on 4/30/23 at 1:17 PM revealed Resident 31 has a wander guard on their leg and sometimes the resident takes the wander guard off. NA-G was not sure if Resident 31 has a wander guard on right now. An interview conducted on 4/30/23 with NA-E at 1:21 PM revealed Resident 31 did not have a wander guard and NA-E was unaware of what the white device was on the door of Resident 31's room. NA-E confirmed at this time there was no wander guard on Resident 31's legs or arms. An interview conducted with NA-D on 4/30/23 at 2:10 PM revealed that Resident 31 wanders at night. NA-D revealed Resident 31 was to have a wander guard on and that Resident 31 takes off the wander guard easily and frequently. NA-D stated that there is an additional intervention in place which includes a door alarm (the white device on the doorframe of Resident 31's room) which if Resident 31 opens the door it makes a loud alarm. NA-D verified at this time the door alarm was off and was unsure why the door alarm was off. An interview conducted with Registered Nurse (RN)-H on 4/30/23 at 2:21 PM revealed Resident 31 wanders and the staff round often (check on) on Resident 31. RN-H revealed that Resident 31 had a witnessed elopement and that Resident 31 knows the exact seconds 12 seconds that the front door takes to lock after a visitor leaves the front door. RN-H revealed that Resident 31 does not utilize a wander guard at the facility. It had previously been care planned that Resident 31 was to utilize a wander guard but Resident 31 refused it. RN-H revealed Resident 31 does have a door alarm on the door which functions and makes a loud noise when the door is open, however the alarm is not being used as Resident 31's roommate prefers the door open. B. A review of the progress notes for Resident 31 revealed on 3/6/2023 at 2:56 AM Resident 31 was found lying on their left side next to the wheelchair facing toward the doorway between the middle kitchen isle and stove. Resident 31 had a laceration located on back of their head. 911 was called for immediate attention. Resident 31 stated (gender) was looking for something to eat and another resident (Resident 50) came through the kitchen doors wondering what Resident 31 was doing in the kitchen. Resident 50 proceeded to pick Resident 31 up from the wheelchair and then push Resident 31 down to the floor resulting in injury. (continued on next page)

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	05/03/2023

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility report dated 3/6/23 revealed at approximately 12:15 AM, while doing rounds NA-D heard someone yelling in the kitchen and went to investigate and noted Resident 50 standing at the kitchen door telling Resident 31 to stay on the ground. Resident 31's wheelchair was on its side, just inside the kitchen door. Resident 31 was lying on the floor in front of the prep tables. Resident 31 stated (gender) was hungry and went into the kitchen to find something to eat and that Resident 50 came into the kitchen and pushed Resident 31 down. Preventative measures put into place revealed new doorknobs with self-locking mechanisms were placed on kitchen doors to prevent residents from going into the kitchen unattended. All staff educated that residents are not allowed in the kitchen area, and kitchen doors shall remain locked when dietary staff are not present. Observation at 6:00 AM on 4/30/23 upon entering the facility revealed there were 2 kitchen doors that enter the kitchen. One door had a mechanism and the other door was open. Observational revealed there were no dietary staff present at this time in the kitchen. C. Record review of the progress notes for Resident 50 revealed on 3/27/2023 at 2:54 am a Late Entry note revealed the Facility Administrator exited the building and noted Resident 50 outside in the parking lot stepping off the driveway. Resident 50 was easily redirected and escorted back into the facility. An elopement assessment was completed and determined the resident to be low risk. The Medical Doctor (MD) and family notified. Interventions were to implement every 15 minute checks x 72 hours. A record review of Resident 50's Elopement Risk assessment dated [DATE] revealed Resident 50 was a low risk for elopement. The Elopement Risk Assessment revealed an answer to the question Does the wandering place the resident at significant risk of getting to a potentially dangerous place (stairs, outside facility) and the staff answered the question as not applicable because the resident has no history or current behaviors of wandering. Record review of the Facility Report dated 3/28/23 revealed the door alarm sounded at 9:20 AM and staff initiated response and went to the exit doors. The Administrator exited the building and noted Resident 50 outside in the parking lot stepping off the driveway. Resident 50 was easily redirected and escorted back into the building without difficulty. The interventions put into place were as follows: -verbal and written education to staff. -Plan of Care updated to include resident's change of condition. -RN evaluation completed. -Change of Condition Elopement Assessment completed. -The Director of Nursing reviewed all resident elopement assessments and plan of care interventions. -Communication placed at First and Second Floor Nurses Station. (continued on next page)

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	05/03/2023

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 50's current Care Plan revealed no focus area for elopement risk. Interview with Resident 50 on 4/30/23 at 1:00 PM revealed Resident 50 wanted to leave and wanted to get a car. An interview was conducted with NA-O on 4/30/23 at 2:19 PM which revealed Resident 50 does wander frequently and the intervention in place was visual checks. NA-O revealed Resident 50 does have a wander guard. An interview on 4/30/23 with RN-H revealed Resident 50 does wander. RN-H was unaware if Resident 50 has a wander guard on. RN-H stated the facility staff redirect Resident 50 when wandering. An interview on 4/30/23 at 2:48 PM with the Administrator revealed the facility staff were surprised that Resident 50 was at low risk per the elopement risk assessment dated [DATE] and the facility did not put additional interventions in place. The Immediate Jeopardy situation began on 3/6/23 when Resident 31 was found lying in the kitchen and ended on 4/30/23 when the facility provided the following information to remove the immediacy of the immediate jeopardy situtation. Based on the following information the immediate jeopardy was abated: -Resident 50 will be reassessed for elopement risk, Wander guard will be placed on the resident and monitoring implemented on the electronic health record. The resident's care plan will be updated with the intervention on 4/30/23. -Resident 31 will be reassessed for elopement risk, Wander guard will be placed on resident and monitoring implemented on the electronic health record. The resident's care plan will be updated with interventions on 4/30/23. To protect other potential residents: -The DNS (Director of Nursing Services) will audit all resident's elopement risk, interventions and care plan to ensure monitoring and interventions are in place. This will be completed by end of day 4/30/23. -The kitchen door will have an automatic lock installed by 4/30/23. -The DNS or designee will educate staff on 4/30. Education will include the need to implement immediate monitoring and interventions for residents identified high risk for elopement. Education will also include expectation that kitchen doors are to be locked at all times when staff are not present and the expectation of new lock/code system on the dietary door. Monitoring: -The DNS or designee will audit new admissions and high risk residents daily X 5, then 3X/week for 12 weeks to ensure monitoring and interventions are in place for those residents at risk. (continued on next page)

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	05/03/2023

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The ED (Executive Director) or designee will verify that the doors to the kitchen are locked when staff are not present every shift X 3 days. -The Maintenance Director will audit functioning of automatic locks daily X 7 days, then 3X/week for 12 weeks.

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	05/03/2023

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 40338 LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D8a Based on observation, record review and interview; the facility failed to ensure interventions were in place to prevent a significant weight loss and ensure hydration for 1 (Resident 16) of 4 sampled residents. The facility staff identified a census of 62. The findings are: On 04/30/23 at 10:30 AM interview was conducted with Resident 16's family member which revealed Resident 16 had lost weight and the family member didn't think the facility ever gave Resident 16 breakfast. Continued interview in Resident 16's room revealed there was not a water pitcher available for Resident 16. During the interview Resident 16's family member reported the facility never has a pitcher of water for Resident 16. The facility may bring the resident a glass of water at times. Record review of Resident 16's documented weights in the electronic medical records revealed the following; -4/21/2023 at 12:55 PM, 152.1 Lbs in the wheelchair -4/19/2023 at 1:57 PM, 152.5 Lbs in the wheelchair -4/10/2023 at 9:04 PM, 152.7 Lbs -3/13/2023 at 9:41 PM, 152.6 Lbs -2/16/2023 at 9:02 PM, 152.6 Lbs in the wheelchair -1/18/2023 at 2:06 PM, 152.5 Lbs in the wheelchair -1/16/2023 at 4:14 PM, 159.2 Lbs Hospital weight -1/16/2023 at 3:29 PM, 185.4 Lbs Hospital weight 2/17/2023 1:23 PM Incorrect entry -1/16/2023 at 12:31 AM, 159.2 Lbs Hospital weight -1/4/2023 at 1:34 PM, 159.2 Lbs Hospital weight 1/6/2023 1:29 PM Incorrect entry -12/5/2022 at 2:43 PM, 189.8 Lbs in the wheelchair -12/4/2022 at 12:03 PM, 188.5 Lbs in the wheelchair The weight of 189.8 Lbs. on 12/5/22 and the weight on 4/21/23 of 152.1 Lbs. is a difference of 37.7 lbs in 4 months or -19.58% weight loss. (continued on next page)

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	05/03/2023

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 0692 Level of Harm - Actual harm Residents Affected - Few	Record review of the MDS (Minimum Data Set; a federally mandated comprehensive assessment tool used for care planning) dated 2/17/23 revealed a weight of 153 and no identified weight loss was coded. The MDS further revealed Resident 16 required limited assistance with eating. Record review of Resident 16's Care Plan for Activities of Daily Living Self Care Performance Deficit dated 11/28/22 revealed the following interventions with dates of when the intervention was initiated: -11/18/22: Needs 1 to1 assistance for all meals. Requires upright position when eating in bed. Date Initiated: 11/28/2022 -11/21/22: Please have Resident 16 up in chair in dining room for all meals. Resident 16 needs assist to dine. Date Initiated: 11/28/2022 -Staff to assist Resident 16 up by 7:00 AM per (gender) request. Date Initiated: 12/14/2022 Observation on 5/01/23 at 8:46 AM revealed Resident 16 was lying in bed. No breakfast tray was in the room and Resident 16 did not have a water pitcher with water. Observation on 5/01/23 at 9:13 AM revealed Resident 16 continued to be in bed with no breakfast tray. Observation on 5/1/23 at 10:55 AM revealed Resident 16 was lying in bed in Resident 16's room and there was no water pitcher or food within the room. Observation on 5/01/23 at 11:05 AM revealed Resident 16 lying in bed. Resident 16 did not have a breakfast tray in the room and no water pitcher avalable. Observation on 5/1/23 at 12:43 PM revealed Resident 16 was in the dining room knocking on the table and requested coffee and food. Resident 16's family member assisted Resident 16 in setting up food. Resident 16 was able to eat without difficulty. Interview on 5/1/23 at 11:30 AM with Registered Nurse (RN)-H confirmed that Resident 16 had not had a breakfast tray delivered as Resident 16 was asleep. RN-H stated that Resident 16 does not usually eat breakfast. RN-H was unaware of Resident 16's request to be up by 7:00 AM and that the resident wanted to eat all meals in the dining room due to needing assistance with meals. Observation on 5/2/23 at 9:30 AM revealed Resident 16 was lying in bed and there was no water pitcher or breakfast tray in room. (continued on next page)

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	05/03/2023

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 0692 Level of Harm - Actual harm Residents Affected - Few	Observation on 5/2/23 at 10:30 AM revealed Resident 16 was lying in bed and there was no water pitcher in the room, however Resident 16's breakfast tray was sitting in the room untouched. Observation on 5/02/23 at 11:54 AM revealed Resident 16 was lying in bed and Resident 16's family member removed the breakfast tray from the room with Resident 16's meal untouched. Interview with RN-C on 5/2/23 at 11:54 AM confirmed the breakfast tray for Resident 16 had not been touched as Resident 16 was asleep in the bed. Observation on 5/02/23 at 12:00 PM revealed Resident 16 was in bed and reported being hungry. Observation on 5/2/23 at 12:45 PM revealed Resident 16 was in the dining room with the resident's family member and Resident 16 was eating lunch. Resident 16 ate 100% of their lunch meal and reported it was good. Interview on 5/2/23 at 2:30 PM with the DNS (Director of Nursing Service) confirmed the care plan of Resident 16 addressed that Resident 16 requested to be up by 7:00 AM and to be in the dining room for all meals due to need for assistance. DNS stated that Resident 16 really hasn't been getting up for breakfast since the resident went onto hospice. The DNS further confirmed Resident 16's significant weight loss of 37. 7 lbs.

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	05/03/2023

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21492 LICENSURE REFERENCE NUMBER 175 NAC 12-006.10D Based on record review and interview; the facility staff failed to ensure 2 (Resident 44 and 171) of 10 sampled residents were free of significant medication errors. The facility staff identified a census of 62. Findings are: A. Record review of an Order Summary Report (OSR) sheet printed on 5-03-2023 of active orders for Resident 171 revealed Resident 171 was admitted to the facility on [DATE] with the diagnoses that included Diabetes, Major Depressive Disorder and Dementia. Further review of Resident 171's OSR printed on 5-03-2023 revealed Resident 171's practitioner ordered medications that included Lispro insulin 4 units to be given before meals and further ordered if Resident 171's blood sugar (BS) levels were between 7 and 120 the Lispro insulin was to be held. Record review of Resident 171's Medication Administration record (MAR) for 6-2021 revealed the following information: - June,2021 at 7:30 AM: -6-19-2021, BS was 89 and insulin was administered. -6-20-2021, BS was 91 and insulin was administered. -6-22-2021, BS was 100 and insulin was administered. -6-27-2021, BS was 27 and insulin was administered. -6-27-2021, BS was 61 and insulin was administered. -June 2021 at 11:30 AM: - 6-19-2021, BS was 104 and insulin was administered. -6-23-2021, BS was 93 and insulin was administered. -6-24-2021, BS was 74 and insulin was administered. -June 2021 at 4:30 PM: -6-24-2021, BS was 105 and insulin was administered. -6-26-2021, BS was 47 and insulin was administered. (continued on next page)

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	05/03/2023

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 0760 Level of Harm - Actual harm Residents Affected - Few	-July 2021 at 7:30 AM: -7-04-2021, BS was 118 and insulin was administered. -7-06-2021, BS was 102 and insulin was administered. -7-07-2021, BS was 113 and insulin was administered. -July 2021 at 11:30 AM: -7-02-2021, BS was 82 and insulin was administered. -7-03-2021, BS was 86 and insulin was administered. -July 2021 at 4:30 PM: -7-05-2021, BS was 100 and insulin was administered. -7-16-2021, BS was 100 and insulin was administered. -August 2021 at 7:30 AM: -8-07-2021, BS was 101 and insulin was administered. Review of Resident 171's Progress Note (PN) dated 8-07-2021 at 12:47 PM revealed Resident 171 was laying in bed diaphoretic (excessive sweating), with cold and clammy skin. Further review of Resident 171's PN dated 8-07-2021 revealed Resident 171 was lethargic, eye rolled back and had a blood sugar of 33. According to Resident 171's PN dated 8-07-2021 orange juices and Glucerna was given with a resident blood sugar level of 37. The facility staff called 911 as Resident 171 was not getting better. On 5-03-2023 at 7:58 AM an interview was conducted with the Director of Nursing (DON). During the interview review of Resident 171's MAR's for June, July and August of 2021 were reviewed. The DON confirmed insulin was given when it should not have been. The DON further confirmed Resident 171 was sent to the hospital on 8-07-2021 due to low blood sugar levels. The DON confirmed insulin was given at 7:30 AM on 8-07-2021 at 7:30 AM when it should have not been given. The DON confirmed the error was a significant medication error. On 5-03-2023 at 8:20 AM an interview was conducted with Registered Nurse (RN) C. During the interview review of Resident 171's MAR for 8-07-2021 was completed. During the interview RN C confirmed insulin should not have been given on 8-07-2021 at 7:30 AM and that Resident 171 was sent to the hospital related to low BS level. B. Record review of Resident 44's OSR printed on 5-02-2023 revealed Resident 44's practitioner ordered medications that included Humalog insulin . According to the Humalog insulin order nursing staff were to hold the insulin if Resident 44's blood sugar level was below 120. (continued on next page)

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	05/03/2023

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 0760 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident 44's MAR for April 2023 revealed the following information for the administration of the Humalog insulin: -8:00 AM: -4-02-2023, BS was 119 and insulin was administered. -4-05-2023, BS 111 and insulin was administered. -4-09-2023, BS was 111 and insulin was administered. -11:30 AM: -4-09-2023, BS was 113 and insulin was given. -4-12-2023, BS was 102 and insulin was administered. On 5-02-2023 at 1:30 PM an interview was conducted with the DON. During the interview review of Resident 44's MAR for April 2023 were reviewed. The DON confirmed during the interview Humalog insulin was administered to Resident 44 with blood sugar levels were below 120. According to Mount [NAME]. org a normal BS level is between 70 and 100. According to www.CDC.gov symptoms of low BS levels include shaking, sweating and confusion.

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	05/03/2023

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 47733 LICENSURE REFERENCE NUMBER 175 NAC12-006.04D2 Based on record review and interview; the facility failed to ensure there was a qualified Dietary Manager (DM). This had the potential to affect 59 of 62 residents in the building. The facility staff identified a census of 62. Findings are: Record review of the facility's Job description states The individual must be a Certified Dietary Manager, Certified Food Service Manager or has a similar national certification from a national certifying body for food service management and safety. On 5/2/23 at 11:50 AM an interview was conducted with the Administrator (ADM). During the interview the ADM revealed the Dietary Manager had not started the classes for certification or completed a program for Dietary Management.

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	05/03/2023

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 21492 LICENSURE REFERENCE NUMBER 175 NAC 12-006.02 Based on observations, record review, and interviews; the facility administration staff failed to ensure effective management of facility resources to maintain the highest practical wellbeing of residents and the facility environment as evidenced by failure to implement an effective plan of action to maintain correction for previously cited areas of deficient practice and failure to ensure the facility identified and developed plans of action to identify multiple issues of deficient practice. The facility staff identified a census was 62. Findings are: Review of the facility during the current survey revealed the following deficiencies: -F550. The facility failed to ensure resident dignity was maintained for 2 of 3 residents. -F583. The facility failed to ensure full privacy in 11 of 20 dual occupancy rooms. -F584. The facility failed to ensure that rooms appeared homelike in 5 of 17 rooms. -F609. The facility failed to report an elopement for 1 resident in the required time frame. -F623. The facility failed to ensure the resident and/or the resident's representative were notified in writing of the reason for transfer to the hospital. -F638. The facility failed to ensure residents Minimum Data set (a federally mandated assessment tool used for care planning) were completed within 14 days od the Assessment reference date. -F644. The facility failed to ensure a new PASSAR (Pre-admission Screening and Resident Review) were completed after a diagnosis of mental illness was identified. -F684. The facility failed to ensure Geri Sleeves were in place as ordered for 2 residents. -F676. The facility failed to ensure an air loss mattress was set to relieve pressure and failed to ensure residents were turned and repositioned for pressure relief. -F689. The facility failed to implement interventions to prevent elopement and failed to implement interventions to prevent elopement into the kitchen. -F692. The facility failed to ensure interventions were in place to prevent weight loss and failed to implement interventions to prevent potential dehydration for a sampled resident. -F760. The facility failed to ensure 2 residents were free of significant medication errors. (continued on next page)

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	05/03/2023

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-F801. The facility failed to have a qualified Dietary Manager. -F865. The facility failed to have a effective Quality Assurance and Process Improvement (QAPI) program. -F880. The facility staff failed to donn personal protective equipment (PPE) and preform hand hygiene and gloves changes in a manner to prevent potential cross contamination during personal cares and treatments. On 5-03-2023 at 11:05 AM an interview was conducted with the facility Administrator. During the interview the Administrators reported the elopement (see F689), infection control (see F880) medication errors (see F760) and skin breakdown (see 684 and F686) were not identified as a issue in the facility to work on.

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	05/03/2023

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 21492 LICENSURE REFERENCE NUMBER 175 NAC 12-006.07C Based on record review and staff interviews; the facility Quality Assessment Performance Improvement Plan (QAPIP) failed to identify ongoing issues relevant to F550, F580, F609, F657, F676, F689, F712, F730, F755, F758, F761, F812, F835 and F867 and implement plans of action to identify and correct the deficient practice. The QAPI failed to ensure repeated deficiencies at F692 and F697 were corrected and the correction maintained. This deficient practice had the potential to affect all residents who reside in the facility. The facility staff identified a census of 92. Findings are: Record review of a undated facility Quality Assurance and Performance Improvement (QAPI) program revealed the following information: -Goal: -1. Implement a QAPI program that involves all staff and focuses on benchmarks to ensure quality of care and quality of life. -3. Continued improvement of management of risk including but not limited to preventative interventions to reduce adverse outcomes. On 5-02-2023 at 2:00 PM an interview with Nursing Assistant (NA) K was conducted. During the interview NA K reported not knowing what the QAPI committee was working on. On 5-02-2023 at 2:12 PM an interview was conducted with NA L. During the interview NA L reported not being sure what the QAPI committee was working on or who the members were. On 5-02-2023 at 2:15 PM an interview was conducted with Dietary Assistant (DA) M. During the interview DA M reported not knowing what QAPI was. On 5-03-2023 at 6:40 AM an interview with NA N was completed. During the interview NA N reported not knowing what the QAPI committee was working on or who the members were. On 5-3-2023 at 6:52 AM an interview was complete with Registered Nurse (RN) C. During the interview RN C reported not knowing what QAPI was or who was on the committee. On 5-3-2023 at 11:05 AM an interview was completed with the facility Administrator. During the interview the facility Administrator reported elopement was not identified as a QAPI issue that needed to be worked on, infection control was not identified as an issue, and medication errors were not identified as an issue the QAPI committee needed to work on.

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	05/03/2023

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number 175 NAC 12-006.17B Based on observation, record review and interview; the facility staff failed to apply personal protective equipment and perform hand hygiene and glove changes in a manner to prevent cross contamination for 1 (Resident 64) of 11 residents observed for personal care and wound cares. The facility census was 62. Findings are: Record review of an undated facility Policy and Procedure entitled Hand Hygiene identified the following policies: 3. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents. e. Before and after handling an invasive device (tube feeding would fall under this). g. Before handling clean or soiled dressing, gauze pads etc. h. Before moving from contaminated body site to a clean body site during resident care. i. After contact with residents' intact skin. Record review of Resident 64's Admission Minimum Data Set (MDS, a comprehensive assessment used to develop a resident care plan) dated 4/6/23 identified that Resident 64 was admitted on [DATE] and had a Gastrostomy Tube (GT, a tube inserted into the stomach to provide nutrition) in place that provided 26-50 percent of calories to the resident. Record review of Resident 64's active Physician Orders dated 5/1/23 identified that Resident 64 had orders for the GT to be cleansed daily with normal saline and covered with a dry dressing. Observation on 5/3/23 at 9:05 AM with Registered Nurse (RN) C revealed a sign present on the exterior of Resident 64's room which read: Stop. Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of infections in nursing homes) Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities: Device care or use: feeding tube. Observation of Resident 64's GT site care on 5/3/23 between 9:05 AM to 9:20 AM with RN C identified the following concerns with infection control practices: - RN C did not apply a personal protective gown prior to entering Resident 64's room. (continued on next page)

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	05/03/2023

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- After performing hand hygiene and applying gloves, the soiled dressing around Resident 64's GT site was touched, removed, and discarded and the site cleaned with normal saline and dried. RN C did not perform hand hygiene or apply clean gloves prior to placing a new, clean dressing over the GT site and taped it into place. - With no hand hygiene performed or application of new gloves, RN C grasped the GT with bare hands, unclamped the GT and administered 30 Millimeters of water from a syringe into the GT to clear it of potential clogs. With bare hands, RN C then clamped the GT closed and returned the syringe to the water pitcher. - With no hand hygiene performed after grasping the GT with bare hands and no hand hygiene performed prior to leaving the residents room, RN C assisted Resident 64 to put on their shoes and assisted the resident to walk to the main lobby area on the first floor of the facility. Interview on 05/03/23 at 09:20 AM with RN C confirmed that Resident 64 was in a EBP room and RN C confirmed that no gown was applied. RN C confirmed that no glove changes or hand wash had been completed between the removal of the soiled dressing and placement of the clean dressing and no gloves had been used when Resident 64's GT was touched. RN C confirmed that no hand wash had been performed after the completion of the GT flush procedure or prior to leaving the room with the resident. Interview on 05/03/23 at 09:57 AM with the Director of Nursing (DON) confirmed that Resident 64 was in an EBP room and a gown should have been applied. The DON confirmed that RN C should have washed hands and changed gloves after touching a soiled dressing and before applying a new dressing. The DON confirmed that the GT should not have been touched with bare hands and that RN C should have washed hands after working with the GT and prior to leaving the room.