

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER St. Joseph Villa Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 South 10th Street Omaha, NE 68108	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(F)(i)(5). Based on interview and record review the facility failed to inform the physician and resident representative of a change in Abnormal Involuntary Movements Scale (AIMS) score for 1 (Resident 7) of 5 sampled residents. The facility census was 148. The findings are: Record review of the facility policy titled Abnormal Involuntary Movements Scale (AIMS) dated 02-2021 revealed the AIMS is a rating scale designed to measure involuntary movements known as Tardive Dyskinesia (TD). TD is a disorder that sometimes develops as a side effect of long-term treatment of antipsychotic medications. A score of 2 or higher on the AIMS scale is evidence of TD. If the patient has mild TD in two areas, or moderate movements in one area, then he or she should be considered for a diagnosis of TD and the results discussed with their physician. If a resident's score on the AIMS suggests the diagnosis of TD, the clinician must consider whether the resident still needs to be on an antipsychotic medication. The question should be discussed with the resident, their family and their physician. Record review of Resident 7's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 10-13-2025 revealed the facility staff assessed the following about the resident: -date of admission [DATE]-was rarely able to make (gender) self understood.-had diagnosis of anxiety disorder, bipolar disorder, and schizophrenia. -was taking an antipsychotic medication.-required total assistance with eating, dressing, hygiene, toileting, bathing, bed mobility and transfers. Record review of Resident 7's AIMS tests revealed the facility conducted an AIMS on Resident 7 on 09-17-2025 and the score was a zero. Record review of Resident 7's Medication Administration Record (MAR) revealed Resident 7 was receiving Seroquel (an antipsychotic medication) 25 milligrams (mg) daily and on 10-02-2025 an additional dose of Seroquel 100 mg was added at bedtime. The MAR also revealed on 10-09-2025 an additional dose of Seroquel 25mg was added at noon resulting in Resident 7 receiving Seroquel 25 mg in the morning and at noon and 100 mg at bedtime. Record review of Resident 7's AIMS tests revealed the facility conducted an AIMS on Resident 7 on 11-04-2025 and the score was 4. An interview conducted on 01-08-2026 with the Director of Nursing (DON) at 8:45 AM confirmed Resident 7 had an increase in the AIMS score and the facility did not update Resident 7's representative or the physician of the increase and should have.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 285078	Facility ID: 285078 If continuation sheet Page 1 of 9

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, and record review, the facility failed to assist with or offer oral hygiene during the morning routine for 1 (Resident 17) of 3 sampled residents. The facility staff identified a census of 148. The findings are: Record review of a facility policy entitled Oral Hygiene reviewed 5/2021 revealed the following: - Purpose: To ensure cleanliness; to prevent odor; to improve appetite; to prevent cavities, tartar buildup and gum disease; to stimulate circulation of blood in the gums. - Frequency: Every morning and bedtime. A record review of Resident 17's Face Sheet showed the facility admitted Resident 17 on 12/30/2024. Further review of the face sheet revealed Resident 17 had diagnoses that included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side, dysphagia (difficulty swallowing), and dementia (a usually progressive condition marked by the development of multiple cognitive deficits [such as memory impairment, aphasia, and the inability to plan and initiate complex behavior]). A record review of Resident 17's annual Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 01/05/2026 revealed Resident 17 was rarely or never understood and Resident 17 rejected care on one to three days during the assessment period. Further review of the MDS showed Resident 17 was dependent upon staff for wheelchair mobility and required supervision to complete oral hygiene. A record review of Resident 17's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) identified an intervention for assistance of one staff for dressing and hygiene dated 12/31/2024. A record review of Resident 17's Orders revealed a nursing order dated 07/09/2025 that read assist with brushing teeth every morning and every night. Document refusals in progress notes. A record review of Resident 17's Progress Notes dated 10/01/2025 through 01/05/2026 revealed the resident refused oral care on 10/14/2025 and 10/16/2025. A record review of Resident 17's Dental Visit Note dated 10/23/2025 revealed: -Oral hygiene - very poor today with heavy amounts of plaque and food debris, with moderate tartar accumulation. -The special needs of this patient render them incapable of maintaining adequate oral health care without daily assistance. -Encourage staff to assist patient with tooth brushing. An observation on 01/06/2025 at 10:33 AM revealed Resident 17 in [gender] bedroom watching television. Resident 17 had food debris in their mouth. A continuous observation on 01/07/2025 from 6:47 AM through 7:05 AM revealed Nursing Assistant (NA)-M assisted Resident 17 out of bed, to get dressed for the day, styled Resident 17's hair and assisted the resident with cleaning and donning eyeglasses. NA-M did not offer Resident 17 assistance to brush [gender] teeth. During an interview on 01/07/2025 at 7:06 AM, NA-M confirmed oral hygiene was not performed or offered and should have been as part of Resident 17's morning cares.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H) & 12-006.09(H)(iii)(3). Based on observation, interview and record review the facility failed to ensure fluid intakes and daily weights were monitored according to practitioner orders for Resident 128, failed to ensure an air mattress was functioning to promote healing of diabetic wounds for Resident 16, failed to follow up on requested lab work for recurrent urinary tract infections for Resident 47, failed to ensure weekly weights were completed for Resident 2 and failed to complete neurological assessments after an unwitnessed fall for Resident 71. The facility census was 148. The findings are:Licensure Reference Number 175 NAC 12-006.09 (H) & 12-006.09 (H)(iii)(3).</p> <p>Based on observation, interview and record review the facility failed to ensure fluid intakes and daily weights were monitored for Resident 128, failed to ensure an air mattress was properly functioning to promote healing of diabetic wounds for Resident 16, failed to follow up on requested lab work related to recurrent urinary tract infections for Resident 47, failed to monitor weekly weights for Resident 2 and failed to complete neurological assessments after an unwitnessed fall for Resident 2. The facility census was 148.</p> <p>The findings are:</p> <p>A.</p> <p>Record review of Resident 128's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 11-04-2025 revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -admit date was 08-01-2025 -had a diagnosis of heart failure -Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required limited assistance with bathing and shower transfers. -required supervision with dressing. <p>Record review of Resident 128's After Visit Summary (AVS) dated 08-01-2025 revealed Resident 128 had been in the hospital for heart failure and had orders for a 2000 milliliter (ml) fluid restriction and daily weights.</p> <p>Record review of Resident 128's Electronic Health Record (EHR) revealed no weights were listed from 11-19-2025 to 11-24-2025, 11-24-2025 to 12-5-2025 and from 12-08-2025 to 12-17-2025.</p> <p>An interview conducted on 01-08-2026 at 8:50 AM with the Assistant Director of Nursing (ADON) confirmed daily weights were not done and should have been.</p> <p>B.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident 128's EHR revealed the absence of daily fluid intake monitoring.</p> <p>An interview conducted on 01-06-2026 at 11:18 AM with Nursing Assistant (NA) Y revealed the fluid intake for Resident 128 was not recorded or restricted.</p> <p>An interview conducted on 01-07-2026 at 1:30 PM with Licensed Practical Nurse (LPN) N revealed Resident 128 was on a 2000 ml fluid restriction and was to receive 480 ml of fluids with each meal and 240 ml on the day shift, 200 ml for the evening shift and 120 ml for night shift. The interview also revealed that the amount of fluids Resident 128 consumed in a 24-hour period was not tracked or recorded.</p> <p>An interview on 01-08-2026 at 8:50 AM with the ADON confirmed the amount of fluid Resident 128 consumed in a 24-hour period was not monitored to ensure the 2000 ml fluid restriction was followed.</p> <p>C.</p> <p>Record review of Resident 16's MDS dated [DATE] revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -had a diagnosis of Diabetes Mellitus -BIMS was scored as a 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required limited assistance with bed mobility. -required total assistance with dressing, toileting, bathing and transfers. -had a diabetic foot wound. <p>Record review of Resident 16's Comprehensive Care Plan (CCP) revealed Resident 16 was at risk for skin tears, bruises and pressure injuries related to weakness and diabetes and had a diabetic foot ulcer to the right heel. The goal was for Resident 16's skin to remain intact. The interventions were:</p> <ul style="list-style-type: none"> -air mattress to bed. -antibiotics as ordered. -apply lotion to resident's arms. -apply lotion to areas of concern. -monitor skin with bathing and clothes changes. -cover arms and legs with protective clothing as resident will allow. -transfer with fragile skin in mind. <p>An observation on 01-05-2026 at 1:30 PM revealed Resident 16 had an air mattress on the bed and the</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>low-pressure light was on.</p> <p>An observation on 01-06-2026 at 9:05 AM revealed Resident 16's air mattress had a low-pressure light on.</p> <p>An observation on 01-06-2026 at 12:35 PM revealed Resident 16's air mattress had a low-pressure light on.</p> <p>An observation on 01-07-2026 at 11:00 AM revealed Resident 16's air mattress had a low-pressure light on.</p> <p>An interview with the Wound Nurse (WN) I on 01-07-2026 at 12:45 PM confirmed the low-pressure light was on to Resident 16's air mattress and revealed (gender) would refer to the owner's manual to find out what the low-pressure light meant.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 01-07-2026 at 2:30 PM confirmed Resident 16's air mattress was being replaced and provided the manufacturer's information which revealed if the low-pressure light remains on for longer than 30 minutes to call and have the mattress serviced.</p> <p>D.</p> <p>A record review of the facility's Antibiotic Stewardship policy with a revision date of 2/2024 revealed the test results for a culture and sensitivity (a lab test that indicates the bacteria and the antibiotic that would treat it) should be treated as high priority and communicated to the provider as soon as possible.</p> <p>A record review of Resident 47's Resident Census dated 01/07/2026 revealed the resident was admitted on [DATE].</p> <p>A record review of Resident 47's Face Sheet dated 01/07/2026 revealed the resident had diagnoses of Urinary Tract Infection (UTI), Other specified bacterial agents as the cause of diseases classified elsewhere (History Of) Note: Citrobacter Freundii (a bacteria) UTI, Other Escherichia coli (E. coli)(a bacteria) as the cause of diseases classified elsewhere, Extended spectrum beta lactamase (ESBL)(a very hard to treat bacteria) resistance, and 11/17/2025 - Sepsis, unspecified organism (History Of).</p> <p>A record review of Resident 47's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 10/24/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 15 which indicated the resident was cognitively aware (able to think and comprehend). The resident was dependent on staff for all activities of daily living and mobility except the resident required set-up or clean-up assistance with eating and oral hygiene (cleaning).</p> <p>A record review of Resident 47's Care Plan with a last care conference date of 10/22/2025 revealed a problem area of the resident was at risk for infection related to incontinence (lack of control) of bowel and bladder, history of UTIs, chronic respiratory failure, recent influenza, Chronic Obstructive Pulmonary Disease, and recent pneumonia (lung infection). 01/17/2025 the resident was on an antibiotic for pneumonia, on 10/02/2025 the resident was on an antibiotic for a UTI, on 10/21/2025 the</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>resident was on an antibiotic for a UTI, on 12/10/2025 a Microgen urinalysis (UA) had a UTI. The goal for the resident with a target date of 02/28/2026 was the resident would remain infection free through next review. The Care Plan had an Approach start date: 01/07/2026 for Macrobid ordered to treat UTI noted from Microgen UA. Created: 01/07/2026.</p> <p>A record review of Resident 47's Family Medicine 60-day review dated 12/3/2025 revealed the last UA and culture was on 11/21/2025. The resident had at least 3 UTIs in the past 2 months and the resident's urine had not been sent for special testing in order to properly treat the resident.</p> <p>A record review of Resident 47's Progress Notes dated 12/07/2024 &dash; 01/06/2026 revealed on 12/02/2025 LPN-G documented the resident completed the antibiotic on 12/01/2025 and a urine specimen was collected for a Microgen UA and sent out, awaiting results. On 12/03/2025 the resident's physician documented that per the nursing staff, the resident had urinary symptoms, and staff was to monitor closely and await further culture and sensitivity for UTI.</p> <p>A record review of Resident 47's Order History dated 01/06/2026 revealed the resident's provider ordered a Deoxyribonucleic Acid (DNA)/Microgen UA after the resident completed the antibiotic on 12/02/2025.</p> <p>A record review of Resident 47's Resident Documents dated 01/06/2025 revealed the last urinalysis and urine culture results were from 11/21/2025.</p> <p>A record review of Resident 47's MicroGenDX Summary of Final Results with a reported date of 12/11/2025 revealed the UA was collected 12/08/2025, received 12/10/2025, and reported 12/11/2025, and the resident was positive for a UTI.</p> <p>In an interview on 01/05/2026 at 10:53 AM, Resident 47 confirmed the resident thought the resident currently had a UTI. The resident confirmed the resident had been on 2 antibiotics that did not work and the facility had recently retested the resident for a UTI, but the resident had not heard of anything further since the test.</p> <p>In an interview on 01/07/2026 at 6:19 AM, Resident 47 confirmed the resident had off and on burning when the resident urinates, and it was hard for the resident to urinate.</p> <p>In an interview on 01/06/2026 at 3:10 PM, the Director of Nursing (DON) confirmed that Resident 47's Microgen UA test results that were ordered on 12/02/2025 were sent to the Assistant Director of Nursing's (ADON) old email address. The facility was unaware the results were in the ADON's old email until they were requested on 01/06/2026. The provider was not notified of the results until 01/06/2025 and then the provider ordered a new antibiotic to treat the resident's UTI.</p> <p>E.</p> <p>A record review of the facility's Physician Orders, Following policy dated June 29, 2021 revealed all physician orders would be followed as prescribed and if not, the reason would be recorded in the medical record.</p> <p>A record review of Resident 2's Resident Census dated 01/07/2026 revealed the resident was admitted on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident 2's Face Sheet dated 01/07/2026 revealed the resident had diagnoses of Chronic Diastolic (Congestive) Heart Failure (CHF) and Abnormal Weight Loss.</p> <p>A record review of Resident 2's MDS dated [DATE] revealed the resident had a BIMS of 12 which indicated the resident was moderately cognitively impaired. The resident was dependent on staff for all activities of daily living and mobility except the resident required substantial/maximal assistance with oral hygiene and to roll in bed, and the resident needed supervision or touching assistance with eating. The resident did have weight loss, but the MDS did not indicate the resident had a weight gain.</p> <p>A record review of Resident 2's Care Plan with a last care conference date of 12/24/2025 revealed a problem area of the resident was at risk for dehydration related to the resident on diuretic medication (medication used to remove excess fluid in the body) and a problem area of nutritional status with a goal of the resident would not have any significant weight changes. An intervention for the weight changes was to monitor the resident's weights and notify the MD of changes.</p> <p>A record review of Resident 2's Orders dated 01/06/2026 revealed the provider ordered weekly weights with a start date of 02/25/2022 and the resident was on Spironolactone (a diuretic) and Torsemide (a diuretic).</p> <p>A record review of Resident 2's Progress Note dated 12/30/2025 revealed the Registered Dietician (RD) documented the resident had weight fluctuations and Lasix (a diuretic) was ordered for 5 days due to increased edema (swelling from excess fluid in arms and/or legs) to bilateral lower extremities (both lower legs). Continue to follow resident status and notify RD of significant changes or concerns.</p> <p>A record review of Resident 2's Weight dated 06/01/2025 to 01/06/2026 revealed that the resident was not weighed:</p> <ul style="list-style-type: none"> - 12/12/2025 - 01/06/2025 - 11/28/2025 - 12/10/2025 -10/22/2025 - 11/05/2025 -08/21/2025 - 09/03/2025 -08/08/2025 - 07/24/2025 <p>An observation on 01/05/2026 at 10:05 AM revealed the resident had edema on both legs and feet.</p> <p>An observation on 01/07/2026 at 7:40 AM revealed Resident 2 was sitting in the wheelchair with a shoe on the right foot and edemawear and a pressure-reducing boot on the left foot. Both legs and feet appeared very swollen.</p> <p>In an interview on 01/06/2026 at 7:39 AM, Licensed Practical Nurse (LPN)-G confirmed Resident 2 had a lot of edema in the legs and Cardiology was following the resident and adjusting the resident's medications.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 01/06/2026 at 3:10 PM, the DON confirmed the weights were not being completed weekly and should have been.</p> <p>F.</p> <p>A record review of the facility's Post fall Assessment with a revision date of 10/2025 revealed the following:</p> <ul style="list-style-type: none"> -Neurological assessment should be initiated with all falls: Initiate Neurological assessment form DGE 047 for falls. -Nurses will assess the resident's condition following the fall and document every shift for 72 hours after the fall. <p>A record review of Resident 71's Face Sheet revealed diagnoses of delusional disorders, chronic pain, epilepsy, fall on same level, syncope and collapse.</p> <p>A record review of Resident 71's 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) revealed Resident 71 was admitted on [DATE]. A Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) was not conducted as Resident 71 is rarely/never understood.</p> <p>A record review of the facility's Post Fall Huddle dated 10/2/25 revealed that resident 71 rolled out of bed. Facility staff walked by resident 71's room and noticed resident 71 sitting on the floor in front of the wheelchair. The facility staff then notified the nurse.</p> <p>A record review of Resident 71's electronic medical record, which included progress notes, observations, and scanned documents, revealed that neurological checks for Resident 71's unwitnessed fall on 10/2/2025 were not completed.</p> <p>In an interview on 1/6/2026 at 11:59 AM the Director of Nursing confirmed that no neurological checks were found in Resident 71's electronic medical record.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1). Based on observation, interview and record review the facility failed to ensure the proper functioning of an air mattress for 1 (Resident 123) of 1 residents sampled. The facility census was 148. The findings are: Record review of Resident 123's Minimum Data Set, dated [DATE] (MDS: a federally mandated assessment tool used for care planning) revealed the facility staff assessed the following about the resident:-had a diagnosis of malnutrition, and Inclusion Body Myositis (IBM: a slow-progressing inflammatory, muscle disease that causes the gradual weakening of the muscles).-Brief Interview of Mental Status (BIMS) was scored as a 10. According to the MDS Manual a score of 8-12 indicates moderate cognitive impairment.-required total assistance with eating, dressing, hygiene, toileting, bathing, transfers and bed mobility.-was always incontinent of bowel and bladder.-had a recent weight loss-current body weight was 93 pounds.-was at risk of developing a pressure ulcer. Record review of Resident 123's care plan printed on 01-06-2026 revealed Resident 123 was at risk of developing a pressure ulcer related to weakness and reduced mobility. The goal was for Resident 123's skin to remain intact through the review date. Approaches to reach the goal were:-air pressure mattress-refer to the Medication Administration Record (MAR) for current treatment.-complete a pressure ulcer risk assessment quarterly and as needed.-apply treatments per physician's orders.-Bunny boots (pressure-relieving boots) on feet at all times.-apply lotion frequently to areas of concern.-assess skin with during daily cares as needed for bruises and skin tears.-complete bath/skin reports with showers-transfer with fragile skin in mind. An observation conducted on 01-05-2026 at 11:06 AM revealed Resident 123 was lying in bed and the air mattress pump was not on. An observation conducted on 01-05-2026 at 12:00 AM revealed Resident 123 was lying in bed and the air mattress pump was on and the low-pressure light on the pump was on.An observation 01-06-2026 at 7:35 AM revealed Resident 123 was lying in bed and the air mattress was on and the low-pressure light on the pump was on.An observation on 01-07-2026 at 5:35 AM revealed Resident 123 lying in bed and the air mattress was not on.An observation on 01-07-2026 at 6:35 AM revealed Resident 123 was lying in bed and air mattress was not on.An observation on 01-07-2026 at 7:35 AM revealed Resident 123 was lying in bed and the air mattress was off.An interview conducted on 01-07-2026 at 7:40 AM with Medication Aide (MA) J confirmed the air mattress was not on and should have been. An observation conducted on 01-07-2026 at 12:30 PM revealed Resident 123 was lying in bed and the air mattress was on and the low-pressure light on the pump was on.An interview with the Wound Nurse (WN) I on 01-07-2026 at 12:45 PM confirmed the low-pressure light was on to Resident 123's air mattress and revealed (gender) would refer to the owner's manual to find out what the low-pressure light meant.An interview with the Assistant Director of Nursing (ADON) on 01-07-2026 confirmed Resident 123's air mattress was being replaced and provided the manufacturer's information which revealed if the low-pressure light remains on for longer than 30 minutes to call and have the mattress serviced.</p>		