STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285078	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Joseph Villa Nursing Center	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)
F 0689 Level of Harm - Actual harm 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** Licensure Reference Number 175 NAC 12-006.09(I) Based on observation, interview, and record review, the facility failed to implement intervention to prevent the potential for hot liquid burns on 2 (Residents 1 and 2) of 3 sampled residents. The facility census was 156. Findings are:A record review of the facility's undated Precautions for Handling Hot Beverages education prior to this incident revealed staff shall monitor, serve, and hold hot beverages in a safe manner to prevent burns. The temperature (temp) of any hot beverage would be allowed to cool to 130 degrees Fahrenheit (F). Additional precautions may be implemented based on the needs and make-up of the residents served. These precautions may include: Assessing and identifying those individuals served who are at high risk for burning themselves with hot beverages. Ensuring staff monitors the identified high-risk residents at mealtimes and when hot beverages were served. Utilizing specialized spill proof lids and cups for those residents identified at high risk for spilling and the potential for burns. Assess individuals who request beverages hotter than 130 F for the ability to independently and safely consume the hot beverage. A record review of the undated Coffee/ Drink Carts: education and procedure prior to this incident revealed that the coffee cart for the main dining room would contain 1 air pot regular coffee, 1 air pot decaffeinated (decaf) coffee, and the coffee would have ice put in it and the coffee temp recorded on the proper form on the cook's counter. The coffee/drink carts for stations 1 and 2 would contain 1 air pot regular coffee, 1 air pot decaffeinated (decaf) coffee, and the coffee would be properly iced. It did not reveal the coffee/drink carts for stations 1 and 2 would have the temps checked or recorded. A record review of the facility's Resource: Serving Line Food Temperature Log dated 05/31/2026 - 06/09/2026 revealed only 1 line for coffee for each day and each meal. It did not reveal coffee temp recording lines or sheets for the coffee/drink carts for stations 1 and 2, or between meals. A record review of the facility's undated Current List Of Devices For Dining Room Or Meals list revealed Resident 1 was added to the list on 06/03/2026 as needing a lidded cup for hot beverages, and Resident 2 was not on the list. A.A record review of Resident 1's Resident Census dated 06/09/2026 revealed the resident was admitted on [DATE]. A record review of Resident 1's Continuity of Care Document dated 06/10/2026 revealed the resident had diagnoses of cognitive communication deficit (difficulty communication due to disruptions in brain function), Parkinson's disease without dyskinesia (a neurological disorder where the resident exhibits symptoms such as tremors, rigidity, and slowed movement), Dysphasia, oropharyngeal phase (difficulty swallowing that originates in the mouth and throat), unspecified convulsions (sudden muscle spasms), unspecified severe protein-calorie malnutrition (extreme deficiency in calorie and protein intake), Other vascular myelopathies (spinal cord injury or dysfunction caused by impaired blood supply), and muscle weakness. A record review of Resident 1's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 05/22/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) score of 11 which indicated the resident was moderately cognitively impaired (difficulty thinking and comprehending). The resident required setup or clean-up assistance with eating and oral hygiene (cleaning), partial/moderate (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	assistance with bathing and toileting, and substantial/maximal assistance with dressing, footwear, and personal hygiene. The resident was independent with rolling in bed, required setup/clean-u assistance with sit to lying, sit to stand, and lying to sitting on the side of the bed, partial/moderate assistance with chair/bed to chair transfer and toilet transfer, and dependent on staff for tub/shower transfers. The resident had no pain or skin problems in the lookback period. A record review of Resident 1's Care Plan with a last care conference date of 05/27/2026 revealed the resident had Problem areas of cognitive loss / dementia, behavioral symptoms, psychotropic (medications that alter the mind) drug use, falls, wandering/elopement risk (walks around aimlessly or exit seeking), and pain. The resident had a focus area of the resident was at risk for dehydration (harmful reduction in the amount of fluid in the body) related to Parkinson's disease, malnutrition, anemia, diverticulosis (bulging pouches in the intestine) and constipation and the interventions with an approach start date of 05/28/2026 included keeping fluids accessible and assisting with fluids as needed. The resident had a Problem area of Nutritional Status and an intervention with an approach start date of 06/04/2026 that was edited on 06/09/2026 included covered cups for all liquids. The resident had a Problem area of Skin, and an intervention with an approach start date of 06/09/2026 that revealed on 06/03/2026, the resident spilt coffee on self resulting in burns to upper right chest/breast, right abdomen (stomach area), and right thigh. The resident was on wound care. Dietary was no longer sending coffee on the hydration stations and nursing staff to assist the resident when getting hot liquids. A record review of the facility's Incident Tracking Form dated June 2026 revealed Resident 1 was on the list for the 06/03/2026 burn because of a coffee spill. A record review of Resident 1's Search Progress Notes dated 05/12/2025 - 06/11/2026 revealed Registered Nurse (RN)-A charted on 06/03/2026 at 5:10 PM that Resident 1 screamed hot. The resident was drinking coffee that the resident had gotten from the coffee Keurig and accidentally spilled on self. The resident's clothes were wet, so the staff took the resident to their room and noticed an open area to the resident's chest/breast, lateral (side of) the abdomen and thigh. The resident's provider was notified and orders were received to apply Xeroform (a wound dressing) to the open areas. On 06/04/2026 at 12:36 AM, RN-A assessed the coffee burnt area, the skin was peeling and a few blisters filled area on the abdomen were noted. On 06/04/2026 at 9:48 AM Licensed Practical Nurse (LPN)-B charted LPN-B observed burn and blisters to Resident 1's right chest/abdomen. Noted multiple blisters throughout the entire area. Blisters were different sizes and some had ruptured (broke), and some were intact. Also noted redness to right anterior (front of) thigh. The progress notes did not reveal any safety assessments for the resident's ability to safely drink hot liquids that was completed prior to the coffee spill burn incident on 06/03/2026. A record review of the Administrator's Witness Statement dated 06/03/2026 revealed that Resident 1 got themself a cup of coffee, spilled it on the resident, and the resident sustained a burn to the right chest, abdomen, and upper thigh that contained blisters. Interviews with the Station 1 staff that was working at the time of the incident revealed they all denied observing the incident. The microwave was moved to an area that the residents could not access it, the coffee push pots temperatures were checked, and were pulled from the stations. A record review of Dietary Assistant (DA)-C's Witness Statement dated 06/03/2026 revealed DA-C was on duty when Resident 1's burn incident happened. DA-C checked the temp of the coffee pots on Station 1 were around 150 degrees F, and Station 2's coffee pots were around 146 degrees F. DA-C brought both pots down to a temperature of under 130 degrees F and then DA-C was instructed to remove the coffee pots from both Stations. A record review of Resident 1's Wound Management Detail Report dated 06/04/2026 revealed the resident had a burn/coffee spill and the wound location was the right chest. The wound was 25 centimeters (cm) long and 10 cm wide. Noted red skin with multiple blisters of different sizes. Some had ruptured, and some were still intact. The right thigh burn was 10 cm long and 8 cm wide. Areas of redness due to coffee spill. A record review of Resident 1's Most Recent Observations list dated 05/19/2026 - 06/09/2026 did not reveal a safety assessment for the resident's ability to safely drink hot liquids. A record review of Resident 1's Functional Abilities (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Assessments dated 05/19/2026 and 05/21/2026 did not reveal a safety assessment for the resident's ability to safely drink hot liquids. A record review of Resident 1's Risk Assessments dated 05/24/2026 did not reveal a safety assessment for the resident's ability to safely drink hot liquids. A record review of Resident 1's Electronic Medical Record dated 05/19/2026 - 06/09/2026 did not reveal a safety assessment for the resident's ability to safely drink hot liquids prior to the coffee burn incident on 06/03/2026. A record review of Resident 1's Physical Therapy (PT) Evaluation & Plan of Treatment and Treatment Encounter Notes dated 05/20/2026 - 06/03/2026 did not reveal PT assessed or made recommendations for the resident's ability to safely consume hot liquids. A record review of Resident 1's Occupational Therapy (OT) Evaluation & Plan of Treatment and Treatment Encounter Notes dated 05/25/2026 - 06/03/2026 revealed the resident was assessed for functional abilities with eating and the resident did not need adaptive utensils and the resident currently used regular utensils but reported difficulty with food control. They did not reveal OT assessed or made recommendations for the resident's ability to safely consume hot liquids. A record review of Resident 1's Speech Therapy (SLP) Evaluation & Plan of Treatment and Treatment Encounter Notes dated 05/28/2026 - 06/03/2026 revealed the resident was assessed for good safety awareness, safe swallow precautions, and food and fluid intake texture needs, but did not reveal SLP assessed or made recommendations for the resident's ability to safely consume hot liquids. An observation on 06/09/2026 at 1:20 PM revealed that Resident 1 had dark red skin damage to the upper right chest, right abdomen, and right upper thigh with 1 open blister on the right upper chest and 2 on the right abdomen that were being treated with Xeroform. In an interview on 06/09/2026 at 2:42 PM, RN-A confirmed RN-A was the nurse on that evening. RN-A was behind the desk and heard Resident 1 say hot a couple of times. RN-A went to the resident and took the resident's shirt and fanned it to cool it down. RN-A took the resident to the resident's room and noticed a red area and blisters, first upper chest and abdomen and then slowly developed into blisters. The thigh never developed a blister, just red. When removing the resident's shirt, the resident said it hurt. The resident complained of pain at the time, but after the 1st day never complained of pain. The nurse's station had a cart that had coffee on it and RN-A assumed the resident got their coffee from there. That cart was no longer there. RN-A has not assessed anyone for hot liquid safety. Before the event, there was no system in place to keep any resident from getting their own coffee. It was a push carafe with coffee in it and the carafe was not monitored by the nursing staff. The night of Resident 1's burn, they came and checked the temps and took everything. RN-A confirmed Resident 1 was confused, they thought the resident had dementia, and the resident was self-mobile in a wheelchair. In an interview on 06/09/2026 at 3:19 PM, Medication Tech (MT)-G confirmed MT-G did not see Resident 1 spill the coffee on self but heard the resident yell out. When MT-G looked, the resident had split coffee on self and was very shaky. The resident was shaking and yelling out at the same time. The hot coffee did cause the resident pain, and the resident was very confused. The resident got the coffee from the coffee pots that were siting in front of the nurse's station. There was not a process in place before the burn incident to keep the residents from getting hot coffee themselves. There was not a list of residents that MT-G was aware of that needed lids on their cups, the only thing they knew was which residents needed assistance with meals. In an interview on 06/09/2026 at 3:33 PM, Nursing Assistant (NA)-F confirmed NA-F was on break at the time of the incident but did assist Resident 1 in removing the resident's clothes after the coffee was spilled. Resident 1 was complaining of pain at that time. NA-F confirmed the coffee was out in the open at the nurse's station, and anyone had access to it. There was nothing in place to stop any resident from getting a cup of coffee themselves. In an interview on 06/09/2026 at 1:47 PM, Occupational Therapist (OT)-D confirmed there was not a regular assessment Therapy was doing to assess a resident for hot liquid safety. The Therapy staff would just observe the residents and make recommendations if they had concerns with a resident's fine motor skills. In an interview on 06/09/2026 at 1:47 PM, OT-E confirmed OT-E has made recommendations for a lidded cup if OT-E observed a resident had concerns with fine motor skills or positioning that would indicate the resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	needed a lid. OT-E stated they did make that recommendation on Resident 1. In an interview on 06/09/2026 at 4:14 PM, the Administrator confirmed the facility did not have an accident prevention or hot liquid safety policy. In an interview on 06/09/2026 at 1:44 PM, the Administrator confirmed the facility did not do hot liquid safety assessments on the residents other than what Therapy staff did. In an interview on 06/10/2026 at 2:04 PM, the Administrator confirmed there were no assessments completed on residents for hot liquid safety until after Resident 1's incident, all they had was what Therapy was doing from a functional standpoint. The Administrator confirmed there was not a process in place prior to the burn incident on 06/03/2026 to prevent a resident from getting a cup of coffee, and getting burnt. The Administrator confirmed Resident 1 did receive a burn and blisters and should not have. B.A record review of Resident 2's Resident Census dated 06/10/2026 revealed the resident was admitted on [DATE]. A record review of Resident 2's Continuity of Care Document dated 06/10/2026 revealed the resident had diagnoses of Hemiplegia and Hemiparesis following cerebral infarction affecting the dominant side (paralysis on the dominant side of the body after a stroke), aphasia following a cerebral infarction (language disorder following a stroke), dysphagia following a cerebral infarction swallowing disorder following a stroke), Bipolar Disorder (extreme highs and lows of mood), Presbyopia (far sighted), depression, and anxiety. A record review of Resident 2's MDS dated [DATE] revealed the resident had a BIMS score of 13 which indicated the resident was cognitively aware (able to think and comprehend). The resident required setup or clean-up assistance with eating, required substantial/maximal assistance with oral hygiene, and was dependent on staff for toileting, dressing, bathing, footwear, and personal hygiene. The resident was partial/ moderate assistance with rolling in bed and required substantial/maximal assistance with all other mobility and transfer needs. A record review of Resident 2's Care Plan with a last care conference date of 04/22/2026 revealed the resident had Problem areas of cognitive loss / dementia, Impaired vision related to cataracts and presbyopia, mood state, psychotropic drug use, falls, and pain. The resident had a Problem area of Nutritional Status and an intervention with an approach start date of 06/09/2026 that was edited on 06/09/2026 included resident to use cup with lid when drinking hot liquids and Resident 2's dietary preferences included enjoyed coffee all hours of the day. A record review of Resident 2's Search Progress Notes dated 05/01/2025 - 06/10/2026 did not reveal any safety assessments for the resident's ability to safely drink hot liquids that was completed prior to the coffee spill burn incident on 06/03/2026. A record review of Resident 2's Most Recent Observations list dated 05/19/2026 - 06/09/2026 did not reveal a safety assessment for the resident's ability to safely drink hot liquids. A record review of Resident 2's Functional Abilities Assessments dated 05/19/2026 and 05/21/2026 did not reveal a safety assessment for the resident's ability to safely drink hot liquids. A record review of Resident 2's Risk Assessments dated 05/24/2026 did not reveal a safety assessment for the resident's ability to safely drink hot liquids. A record review of Resident 2's Electronic Medical Record dated 05/19/2026 - 06/09/2026 did not reveal a safety assessment for the resident's ability to safely drink hot liquids prior to the coffee burn incident on 06/03/2026. A record review of Resident 2's Physical Therapy Discharge Summary dated 12/04/2024 - 12/20/2024 revealed the resident had not been assessed by PT since 12/20/2024. It did not reveal PT assessed or made recommendations for the resident's ability to safely consume hot liquids. A record review of Resident 2's Occupational Therapy (OT) Evaluation & Plan of Treatment and Treatment Encounter Notes dated 06/09/2026 - 07/08/2026 revealed the resident was assessed for functional abilities with eating and the resident did not have concerns with self-feeding. On 06/09/2026 reports mild spillage with eating. It did not reveal OT assessed or made recommendations for the resident's ability to safely consume hot liquids. A record review of Resident 2's Speech Therapy (SLP) Evaluation & Plan of Treatment and Treatment Encounter Notes dated 12/04/2024 - 12/20/2024 revealed the resident had not been assessed by SLP since 12/20/2024. An observation on 06/10/2026 at 7:16 AM revealed that Resident 2 was seated in a wheelchair at Station 2's nurse's station with an overbed table in front of the resident and a cup of coffee without a lid on the overbed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	table. The resident was holding the cup of coffee by the handle with the resident's right hand. An observation on 06/10/2026 at 7:51 AM revealed that Resident 2 was seated in a wheelchair at Station 2's nurse's station with an overbed table in front of the resident and a 3/4 full cup of coffee without a lid on the overbed table. The resident was asleep until the nurse walked by and woke the resident up. The resident then grabbed the cup and slowly took 2 sips from the cup and sat it back down An observation on 06/10/2026 at 10:54 AM revealed that Resident 2 was seated in a wheelchair at Station 2's nurse's station with an overbed table in front of the resident and a 3/4 full cup of coffee without a lid on the overbed table. The resident had a gown on over the resident's clothing and there were large brown stains on the front of the gown where the resident had spilled the coffee. In an interview on 06/09/2026 at 2:42 PM, RN-A confirmed before 06/03/2026, there was no system in place to keep any resident from getting their own coffee. It was a push carafe with coffee in it and carafe was not monitored by the nursing staff. In an interview on 06/09/2026 at 3:19 PM, Medication Tech (MT)-G confirmed there was not a process in place before 06/03/2026 to keep the residents from getting hot coffee themselves. There was not a list of residents that MT-G was aware of that needed lids on their cups, the only thing they knew was which residents needed assistance with meals. In an interview on 06/09/2026 at 3:33 PM, Nursing Assistant (NA)-F confirmed prior to 06/03/2026 the coffee was out in the open at the nurse's station, and anyone had access to it. There was nothing in place to stop any resident from getting a cup of coffee themselves. In an interview on 06/09/2026 at 1:47 PM, Occupational Therapist (OT)-D confirmed there was not a regular assessment Therapy was doing to assess a resident for hot liquid safety. The Therapy staff would just observe the residents and make recommendations if they had concerns with a resident's fine motor skills. In an interview on 06/09/2026 at 1:47 PM, OT-E confirmed OT-E has made recommendations for a lidded cup if OT-E observed a resident had concerns with fine motor skills or positioning that would indicate the resident needed a lid. In an interview on 06/09/2026 at 4:14 PM, the Administrator confirmed the facility did not have an accident prevention or hot liquid safety policy. In an interview on 06/09/2026 at 1:44 PM, the Administrator confirmed the facility did not do hot liquid safety assessments on the residents other than what Therapy staff did. In an interview on 06/10/2026 at 2:04 PM, the Administrator confirmed there were no assessments completed on residents for hot liquid safety until after the incident, all they had was what Therapy was doing from a functional standpoint. The Administrator confirmed there was not a process in place prior to 06/03/2026 to prevent a resident from getting a cup of coffee, and getting burnt. In an interview on 06/10/2026 at 2:04 PM, Administrator confirmed the Administrator observed Resident 2 had a cup of coffee in front of the resident and there was not a lid on it. The Administrator confirmed the resident had coffee stains down the front of the resident. The Administrator confirmed the resident's care plan revealed included resident to use cup with a lid when drinking hot liquids. The Administrator checked the cup and said the coffee in the cup was not hot. In an interview on 06/10/2026 at 11:01 AM, LPN-H confirmed Resident 2 did have hot coffee in the cup at 7:15 AM, and the cup did not have a lid on it.