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	01/08/2026

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Licensure Reference Number 175 NAC 12-006.07(C) Based on observation, interview, and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program identified and addressed concerns related to deficient practice identified on the survey and ensure correction for repeat deficient practice from previous surveys were maintained. This had the potential to affect all residents that resided in the facility. The facility census was 148. Findings are:A record of the facility's Quality Assessment and Assurance (QAA) policy with a revised date of 7/21 revealed the purpose of the policy was to assist in improving quality of care and quality of life to each of the facility's residents. To identify and respond to quality deficiencies and develop positive outcomes that are sustainable (maintained) over time. During the recent survey with an exit date of 01/08/2026 the following deficiencies and repeat deficiencies were identified: F580 - The facility failed to notify the resident's representative and medical practitioner of a change in AIMS scale score for Resident 7 F628 - The facility failed to communicate with the hospital at transfer with the resident's current needs for Resident 154 and ensure transfer discharge documentation was completed for Resident 6 that was sent to the emergency department for evaluation and treatment. F644 - The facility failed to ensure a new PASARR referral had been completed after a diagnosis of a mental disorder was identified for Resident 10. F677 - The facility failed to assist or offer oral hygiene for Resident 17. F684 - (Repeat deficiency) - The facility failed to follow up on requested lab work related to Resident 47's recurrent UTIs, complete neurological assessments after an unwitnessed fall on resident 71, 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, and failed to ensure weekly weights were completed for Resident 2. F686 - The facility failed to ensure air mattress was functioning to prevent the potential for pressure ulcer development for Resident 123. F689 - (Repeat deficiency) - The facility failed to complete quarterly bed assist devices assessments on Resident 5. F695 - The facility failed to set Resident 47's oxygen flowrate to the prescribed settings. F699 - The facility failed to assess and identify situational stressors and triggers related to post-traumatic stress disorder on resident 39. F756 - The facility failed to identify irregularities related to antipsychotic medication and adverse symptom monitoring for Resident 7 and ensure that a physician provided a rationale for the use of multiple medications for hypertension for Resident 6. F801 - The facility failed to ensure the Dietary Manager was qualified. F804 - The facility failed to ensure food was maintained at a palatable temperature for food delivered to resident's rooms. This had the potential to affect 40 residents who receive room trays F812 - The facility staff failed to perform hand hygiene between Residents 43, 107, 145, 149, 2, 97, 70, 163, 82, 110, 66, 143, 37, 30, 142, and 87 while assisting with eating in a manor to prevent cross contamination. F880 - (Repeat deficiency) - The facility failed to perform hand hygiene between glove changes in a manor to prevent cross contamination during peri care on Resident 1,17, and 47 and clean the nebulizer mask and nebulizer medication chamber between uses to prevent potential contamination on resident 160. State tag: 12-006.06A - The facility failed to ensure that the process for the resolution of grievances was displayed in a prominent location in the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility. This had the potential to affect all residents that resided in the facility. A record review of the facility's last standard survey results from the 08/22/2024 survey revealed the facility was cited for:F689 (Free of Accident Hazards/Supervision/Devices) - RepeatF690 (Bowel/Bladder Incontinence, Catheter, UTI)F803 (Menus Meet Resident Needs/Prep in Adv/Followed)F761 (Label/Store Drugs and Biologicals)F887 (COVID-19 Immunization)F880 (Infection Prevention & Control) - RepeatF757 (Drug Regimen is Free from Unnecessary Drugs) - RepeatF684 (Quality of Care) - RepeatF583 (Personal Privacy/Confidentiality of Records) In an interview on 01/08/2026 at 11:53 AM, Nursing Assistant (NA)-W confirmed NA-W had no idea what the quality assurance (QA) was or what the committee was working on. In an interview on 01/08/2026 at 11:53 AM, NA-X confirmed NA-X had no idea what the quality assurance (QA) was or what the committee was working on. In an interview on 01/08/2026 at 12:01 PM, Medication Aide (MA)-V confirmed MA-V knew the word QAPI but did not know anything else about it. MA-V confirmed MA-V had no idea what was being worked on or when the committee met. In an interview on 01/08/2026 at 11:55 AM, the facility's Administrator confirmed the Administrator was not sure why the above cited areas were not identified prior to the start of the survey. The facility does work on items from the previous survey but once audits show the area improved it falls off, and the facility failed to maintain the correction. The Administrator confirmed the only reason the Administrator could think of was because the facility had a lot of new staff, a new pharmacy, and the Medical Director's office has had staff turnover.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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). 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. The findings are: A. 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: -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. 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. 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. 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. B. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 128's EHR revealed the absence of daily fluid intake monitoring. 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. 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. 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. C. Record review of Resident 16's MDS dated [DATE] revealed the facility staff assessed the following about the resident: -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. 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: -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. An observation on 01-05-2026 at 1:30 PM revealed Resident 16 had an air mattress on the bed and the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	low-pressure light was on. An observation on 01-06-2026 at 9:05 AM revealed Resident 16's air mattress had a low-pressure light on. An observation on 01-06-2026 at 12:35 PM revealed Resident 16's air mattress had a low-pressure light on. An observation on 01-07-2026 at 11:00 AM revealed Resident 16's air mattress had a low-pressure light 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 16'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 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. D. 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. A record review of Resident 47's Resident Census dated 01/07/2026 revealed the resident was admitted on [DATE]. 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). 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). 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the 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. 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. A record review of Resident 47's Progress Notes dated 12/07/2024 – 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. 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. 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. 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. 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. 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. 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. E. 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. A record review of Resident 2's Resident Census dated 01/07/2026 revealed the resident was admitted on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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). 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. A record review of Resident 2's Weight dated 06/01/2025 to 01/06/2026 revealed that the resident was not weighed: - 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 An observation on 01/05/2026 at 10:05 AM revealed the resident had edema on both legs and feet. 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. 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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. A record review of the facility's Post fall Assessment with a revision date of 10/2025 revealed the following: -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. A record review of Resident 71's Face Sheet revealed diagnoses of delusional disorders, chronic pain, epilepsy, fall on same level, syncope and collapse. 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. 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. 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. 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.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure food was maintained at a palatable temperature for food delivered to residents rooms. This had the potential to affect 40 residents who receive room trays. The facility staff identified a census of 148.Findings are:Interview on 1/06/2026 at 10:30 AM with Resident 15 revealed food was cold and not warm enough. Resident 15 confirmed they ate meals in the residents room.Observation on 1/6/26 at 12:33 PM of a test tray taken to hall 900 by the Dietary Manager (DM).Using the facility thermometer, the DM obtained the following temperatures;-tomato soup was 108.3 degrees-philly steak sandwich was 107 degrees-tater tots were 119 degrees-peaches were 43 degrees Interview with the DM on 1/6/25 at 12:35 PM confirmed the temperature for the tomato soup, philly steak sandwich and tater tots should have been above 135 degrees and the temperature for the peaches should have been below 41 degrees. The DM confirmed the facility did not have plate warmers or insulated plate covers. Interview on 01/07/2026 at 10:00 AM Resident 106 revealed food was not hot enough. Resident 106 confirmed they ate meals in the residents room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006.18(D) Based on observation, interview, and record review, the facility staff failed to perform hand hygiene between residents while assisting 16 (Residents 43, 107, 145, 149, 2, 97, 70, 163, 82, 110, 66, 143, 37, 30, 142, and 87) of 27 sampled residents with eating in a manor to prevent cross contamination. The facility census was 148. Findings are: A record review of the facility's Feeding a Resident policy with a reviewed date of 6/21 revealed staff should wash hands before and after assisting the residents with meals. A. An observation on 01/06/2026 at 8:16 AM revealed that Nursing Assistant (NA)-P was assisting Residents 163 and 82 and NA-Q was assisting Residents 97 and 70 with eating their meals going back and forth between residents with the same hand and touching the residents and the resident's silverware without performing hand hygiene (cleaning) between residents. An observation on 01/06/2026 at 8:29 AM revealed NA-D was assisting Residents 66 and 110 with their meal while touching the Resident's clothing, plate, and the resident's silverware with NA-D's right hand and going back and forth between assisting residents with no hand hygiene between residents. An observation on 01/06/2026 at 8:33 AM revealed Registered Nurse (RN)-L assisted Residents 37 and 142 with their meals using RN-L's right hand going back and forth between assisting the residents with no hand hygiene. Licensed Practical Nurse (LPN)-R assisted Residents 30 and 143 with their meals using LPN-R's left hand going back and forth using the resident's silverware without hand hygiene. An observation on 01/06/2026 at 11:49 AM revealed NA-P assisted Residents 2 and 75 with their meals using their right hand for both residents without hand hygiene between the residents. NA-P used NA-P's right hand to wipe soup from Resident 75's clothing and face, then turned and gave Resident 2 a bite of food without hand hygiene between residents. NA-S assisted Residents 97 and 70 with their meals while NA-S was touching the resident's silverware without hand hygiene between the residents. An observation on 01/07/2026 at 8:00 AM with the Director of Nursing (DON) revealed NA-U assisted Residents 110 and 87 with eating their meals using each resident's silverware with no hand hygiene between residents. NA-U assisted Resident 110 wiped the resident's mouth and adjusted the resident's clothing, then assisted Resident 87 with the same right hand. No hand hygiene was performed between residents. In an interview on 01/07/2026 at 8:00 AM, the DON confirmed that staff should not go back and forth assisting residents with meals without performing hand hygiene between residents. B. Observation on 01/06/2026 at 12:01 PM revealed LPN E set up food for Resident 145 and then started (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feeding Resident 149 without performing hand hygiene between resident contact. Resident 145 was assisted throughout the meal at times and handed them items while feeding Resident 149. Observation on 01/06/2026 at 12:02 PM revealed LPN F assisted Residents 103 and 107 to eat with no hand hygiene performed between resident contact. Observation on 01/07/2026 at 7:30 AM revealed NA C assisted Resident 103 and Resident 145 to eat with no hand hygiene between resident contact. Interview with DON on 1/7/26 at 8:00 AM revealed staff were not completing hand hygiene between residents and should be. Interview with DON on 1/8/26 at 8:20 AM revealed there were 27 residents in the main dining area that were assisted with dining Record Review of the facility's Feeding a Resident policy with a reviewed date of 6/21 revealed staff should wash hands before and after assisting the resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **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.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to communicate with the hospital and failed to provide transfer documentation during a hospital transfer for 2 (Residents 6 and 154) of 4 sampled residents. The facility staff identified a census of 148.The findings are: A. A record review of a facility policy entitled Transfer Resident to Hospital dated Revised 1/2021 revealed: -Purpose: To provide prompt and safe transfer of resident from the facility and to ensure continuity of care through provision of pertinent resident information. -9. INTERACT Nursing Home to Hospital Transfer Form Observation. -10. Nurse will contact emergency department nurse to give report to include Resident's COVID-19 status. -11. Document in the Resident's Progress Notes the basis for the transfer, conversations with the physician/nurse practitioner, family and hospital nurse. -13. Nurse will complete documentation in HER to include but no limited to: -a. Physician Discharge Order in Resident Orders -b. Progress Notes -c. Disposal/returned medications (if applicable) -d. Diagnosis at time of transfer -e. Location resident was transferred to -f. Who transported resident i.e., ambulance, family, etc. -g. Add census line to indicate hospital leave. Record review of Resident 154's Face Sheet printed 01/06/2026 revealed the facility admitted Resident 154 on 08/29/2025. Further review of the face sheet identified Resident 154 had conditions that included stage four chronic kidney disease (severe kidney damage where the kidneys struggle to filter waste), type 2 diabetes mellitus with complications (a common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production), and obstructive sleep apnea (when breathing repeatedly stops and starts while asleep which causes throat muscles to relax, blocking the airway). Record review of Resident 154's progress notes dated 10/15/2025 showed Resident 154 was discharged to the hospital for pneumonia and respiratory failure. Further review of the progress note showed Resident 154's Power of Attorney was notified of the hospital transfer. Record review of Resident 154's electronic medical record (EMR) which included progress notes, observations, and scanned documents lacked evidence that a transfer form or communication with the hospital was completed at the time of transfer. An interview on 01/07/2026 at 7:43 AM with the Director of Nursing (DON) confirmed there was no evidence to support the transfer form and hospital communication was completed. The DON further confirmed the transfer form and hospital communication should have been completed. B. A record review of Resident 6's Continuous Care Summary revealed Resident 6 had the following diagnoses: Vascular Dementia (a significant decline in mental abilities), Hypertension (high blood pressure), Congestive heart failure (a condition where the heart can't pump enough blood to meet the body's needs), Bradycardia (slow heart rate), Transient Cerebral Ischemic Attack (temporary blockage of (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood flow to the brain), Cerebral infarction (the death of brain tissue due to a severe lack of blood flow) A record review of Resident 6's Minimum Data Set (MDS – a federally mandated assessment tool used for all residents in Medicare or Medicaid certified nursing homes) revealed Resident 6 had a Brief Interview for Mental Status (BIMS – a federally mandated assessment tool used to assess the cognitive (ability to acquire knowledge and understanding through thought, experience and the senses) status of residents in nursing homes) of 3 which indicated they were severely cognitively impaired. A record review of Resident 6's Nursing Progress note dated 12/13/2025 by Licensed Practical Nurse K (LPN) revealed Resident 6 had fallen and was sent to the Emergency Department for evaluation. A record review of Resident 6's electronic medical record (EMR) which included progress notes, observations and scanned documents lacked evidence that a transfer form was completed at the time of the transfer. An interview on 1/8/2025 at 10:40AM with the Assistant Director of Nursing (ADON) confirmed there was no evidence to support the transfer form had been completed and that it should have been completed.

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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** 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) referral had been completed after a diagnosis of a mental disorder was identified for 1 (Resident 10) of 1 reviewed for PASRR. The facility census was 148.Findings are:Record review of a facility policy entitled Preadmission Screening and Resident Review (PASRR) Program dated August 2023 revealed the following information: The facility will coordinate assessments with the pre-admission screening and resident review (PASARR) program under the state approved Medicaid program. Coordination includes:b. Referring all level 2 residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level 2 resident review upon a significant change in status assessment. 5. A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident with a mental illness or intellectual disability for resident review. Record review of Resident 10's admission Face Sheet dated 5/24/24 revealed an admission date of 5/24/24. Diagnoses listed included: Adjustment Disorder with depressed Mood 5/24/24, Depression 5/24/24 and PTSD [Post Traumatic Stress Disorder, a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event and may result in repeated, involuntary memories, distressing dreams or flashbacks of the traumatic event] 8/27/24. Record review of Resident 10's PASRR Level 1 screen completed on 5/14/24 at the time of admission revealed that a Level 2 PASRR evaluation and determination was not required at that time and no diagnoses or suspicion of serious mental illness or intellectual disability or related condition was indicated. Record review of Resident 10's quarterly Minimum Data Set [MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems] dated 10/1/24 revealed a diagnoses of PTSD. The MDS identified that Resident 10 had severe cognitive impairment, rejected care 1-3 days per week and required maximal assistance with activities of daily living. Record review of Resident 10's significant change MDS dated [DATE] revealed moderate cognitive impairment, a diagnosis of PTSD, adjustment disorder with depressed mood and depression. The MDS identified that the resident was not currently considered to have a serious mental illness or intellectual disability or related condition. Interview on 01/07/2026 at 7:49 AM with the facility Administrator confirmed that no recommendation had been made to the PASRR agency for a review of Resident 10's mental health condition after a significant change MDS had been completed on 1/13/25 for Resident 10. The Administrator confirmed this should have been done after the diagnoses of PTSD was identified on 8/27/24.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 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.

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F 0686 Level of Harm - Minimal harm or potential for 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** 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.

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F 0689 Level of Harm - Minimal harm or potential for 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 complete quarterly bed assist devices assessments and regular preventive maintenance checks on 1 (Resident 5) of 1 sampled resident's bed assist device. The facility census was 148. Findings are:A record review of the facility's Bed Mobility Assist Devices policy dated February 2021 revealed A Bed Mobility Device Evaluation should be completed upon assessed need and reviewed quarterly, annually, and with significant change thereafter. Environmental staff would install and inspect for safety prior to use and preventative maintenance would be done bi-monthly and as needed. A record review of Resident 5's Resident Census dated 01/08/2026 revealed the resident was admitted on [DATE]. A record review of Resident 5's Face Sheet dated 01/07/2026 revealed the resident had diagnoses of Epilepsy (a brain disorder causing recurring seizures), Unspecified Dementia (confusion of unknown cause), Schizoaffective Disorder (serious mental illness), Morbid Obesity (very overweight), Panic Disorder, Major Depression, Obstructive Sleep Apnea, and Sepsis (severe infection). A record review of Resident 5's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 12/11/2025 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 required setup or clean-up assistance with oral hygiene (cleaning), dressing, and footwear, supervision or touch assistance with personal hygiene and toileting, and partial/moderate assistance with bathing. The resident was independent with bed positioning and sit to stand, required setup or cleanup assistance with chair to bed transfer, supervision or touching assistance with toilet transfers, and partial/moderate assistance with tub or shower transfers. A record review of Resident 47's Care Plan with a last care conference date of 12/11/2025 revealed a problem area of the resident was at risk for injury related to having an assist rail in place to aid in bed mobility. The approaches were that an order was obtained from the resident's physician for the ongoing assist rail, monitor for signs or injury related to the assist rails, and resident had assist rails for self-positioning on both sides of the bed. The problem start date and approach dates were all 12/04/2025. A record review of Resident 5's Orders dated 01/07/2026 revealed an order dated 12/04/2025 for okay for bilateral (both sides) assist rails for self-positioning in bed and transfers. A record review of Resident 5's Observation History list dated 06/01/2023 - 01/07/2026 revealed the only Bed Assist Device Evaluation completed For Resident 5 was dated 06/13/2025. A record review of the facility's Daily Report of Maintenance dated 12/05/2025 - 01/06/2026 revealed the only entry for Resident 5's Bed Assist rails was on 01/07/2025 when Licensed Practical Nurse (LPN)-N entered Resident 5's right assist rails was loose and needed tightened. An observation on 01/05/2026 at 9:49 AM revealed that there was a washer and nut on the bedside table as you entered Resident 5's room. The resident's one quarter length bed rail on the right-hand side of the bed was very loose, and the top was bowed away from the bed. An observation on 01/06/2026 at 7:52 AM revealed that there was a washer and nut on the bedside table as you entered Resident 5's room. The resident's one quarter length bed rail on the right-hand side of the bed was very loose, and the top was bowed away from the bed. An observation on 01/06/2026 at 2:08 PM revealed that there was a washer and nut on the bedside table as you entered Resident 5's room. The resident was sleeping on bed with the resident's legs hanging off the right side of the bed. The bed rail on the right-hand side of the bed was very loose, and the top was bowed away from the bed. An observation on 01/07/2026 at 6:30 AM revealed that there was a washer and nut on the bedside table as you entered Resident 5's room. The resident's one quarter length bed rail on the right-hand side of the bed was very loose, and the top was sticking out away from the bed. An observation on 01/07/2026 at 7:28 AM revealed LPN-O exited Resident 5's room and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	go to the nurse's station to document that Resident 5's bed rail was loose and needed tighten on the Daily Report of Maintenance clipboard. In an interview on 01/05/2026 at 9:49 AM, Resident 5 confirmed the resident did not know what the washer and nut on the bedside table was from and the resident did not know there was a problem with the bed rail. In an interview on 01/07/2026 at 6:30 AM, Resident 5 confirmed the resident got in and out of bed by self daily and used the bed rail to assist with getting in and out of bed and into the wheelchair. In an interview on 01/07/2026 at 6:48 AM, Nursing Assistant (NA)-O confirmed NA-O works with Resident 5 Monday through Friday. The resident usually got up on their own, the bed rail was always in the upright position, and NA-O was not aware of any problems with the bed rail. In an interview on 01/07/2026 at 7:13 AM, LPN-N confirmed that LPN-N worked with the resident on the day shift since 01/05/2026. LPN-N confirmed that Resident 5 used the bed rail to assist with transfers and with naps. LPN-O confirmed that LPN-O was not aware of any problems with the resident's bed rail. In an interview on 01/07/2026 at 9:51 AM, the Minimum Data Set Coordinator (MDSC) confirmed the resident has had bed assist rails for a long time. The original order was in 2021. At some point the order fell off the system and a new order was received. MDSC confirmed the last bed assist device assessment that was completed was 06/13/2023 and they should have been done quarterly but were not. MDSC confirmed if there was a problem with loose bed rails, it would have been caught when they done the quarterly assessment. A new assessment was not completed when they got the new order for the bed assist rails and should have been. In an interview on 01/07/2026 at 1:19 PM, LPN-N confirmed the bed assist rail on Resident 5's bed was loose and should not have been. In an interview on 01/07/2026 at 1:02 PM, the Director of Nursing (DON) confirmed the bed assist device assessment should have been completed quarterly and annually and was not. In an interview on 01/08/2026 at 11:30 AM, the DON confirmed there were no preventive maintenance logs completed for Resident 5's bed assist devices.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(g) Based on observation, interview, and record review, the facility failed to set 1 (Resident 47) of 3 sampled resident's oxygen flowrate to the prescribed settings. The facility census was 148. Findings are:A record review of the facility's Oxygen Administration policy with a revised date of 5/21 revealed the facility must have a physician's order to apply oxygen and the flow should be adjusted to the ordered rate. 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. A record review of Resident 47's Resident Census dated 01/07/2026 revealed the resident was admitted on [DATE]. A record review of Resident 47's Face Sheet dated 01/07/2026 revealed the resident had diagnoses of Dependence on Supplemental Oxygen, Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure, and Chronic Diastolic (Congestive) Heart Failure (CHF). 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). The resident was on oxygen. 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 respiratory complications due to need for oxygen therapy. A goal of keeping the resident's oxygen saturations greater than 90 percent (%), and interventions of administer medications per doctor of medicine's (MD) orders and administer oxygen continuously to keep saturations greater than 90%. A record review of Resident 47's Order History dated 01/06/2026 revealed the resident had an order for oxygen per nasal cannula (a tube that goes on the nose to deliver oxygen) at 2 liter per minute (l/m) during day, 4 l/m at rest and while sleeping with Average Volume-Assured Pressure Support (AVAPS)(a machine used to treat Respiratory Failure). An observation on 01/06/2026 at 7:48 AM revealed Resident 47 was sitting up in the wheelchair with a nasal cannula in the resident's nose and the oxygen concentrator (a machine used to purify oxygen from the room) was set at 3.5 l/m. An observation on 01/07/2026 at 6:19 AM revealed Resident 47 was sitting up in the wheelchair with a nasal cannula in the resident's nose and the oxygen concentrator was set at 3.5 l/m. An observation on 01/07/2026 at 1:40 PM with Licensed Practical Nurse (LPN)-G revealed Resident 47 was sitting up in the wheelchair with a nasal cannula in the resident's nose and the oxygen concentrator was set at 4 l/m and LPN-G decreased it to 2 l/m. In an interview on 01/07/2026 at 1:40 PM. LPN-G confirmed Resident 47 was sitting in the wheelchair with oxygen on and the oxygen concentrator was set at 4 l/m and should been set at 2 l/m.

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St. Joseph Villa Nursing Center	2305 South 10th Street Omaha, NE 68108

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Licensure Reference Number 175 NAC 12-006.09(B)(ii) Based on observation, record review, and interview, the facility failed to assess and identify situational stressors and triggers related to post-traumatic stress disorder on 1 (Resident 39) of 4 sampled residents. The facility census was 148. Findings are:A record review of the facility's Trauma Informed Care and Behavioral Health Management policy with a revision date of 9/2022 revealed the following: -Posttraumatic Stress Disorder (PTSD) a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event and may result in repeated, involuntary memories, distressing dreams or flashbacks of the traumatic event. -2. If a diagnosis is confirmed or the resident answers yes to the above question, the Life Event Checklist will be completed as part of the admission Social History Observation. If the resident voices suicidal or homicidal ideation, ensure their safety as well as safety of others in the community and referral should be made to psychiatry. -7. Residents admitted with a diagnosis of history of trauma or PTSD will receive care and services to address the problem/illness. -8. Resident and/or resident representative are active participants in identifying triggers for behaviors and developing coping interventions. A record review of Resident 39's Face Sheet revealed diagnoses of post traumatic stress disorder, schizoaffective disorder, major depressive disorder, anxiety disorder, and bipolar disorder. A record review of Resident 39'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 39 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15. A score of 15 indicated the resident was cognitively intact. Further review of the MDS revealed that the resident had a diagnosis of post traumatic stress disorder. A record review of Resident 39's electronic medical record, which included progress notes and observations, revealed that a trauma informed care assessment was not completed. In an interview on 01/06/2026 at 11:13 AM Resident 39 confirmed a history of childhood trauma. In an interview on 01/08/2026 at 11:36 AM the Social Service Director confirmed that a trauma informed care assessment was not completed for Resident 39.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12(A)(vi). Based on record review and interview, the facility failed to identify drug irregularities related to antipsychotic medication and adverse symptom monitoring for Resident 7 and failed to ensure the physician provided rationale for the use of multiple hypertensive (high blood pressure) medications for Resident 6 of 6 residents sampled. 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 the facility policy titled Pharmacist Consultant Duties and Responsibilities dated 05-2021 revealed the consultant pharmacist reviews the medications for each resident for any irregularities and to: verify appropriateness of the medications involved; evaluate disease state management; ensure appropriate medication monitoring to maximize safety and efficacy and to prioritize patient goals, safety and quality of life. The policy also revealed the consultant pharmacist reviews each resident chart to identify any irregularities: -medication use without indications -untreated indications -improper medication selection -sub-therapeutic dosage -over-dosage -adverse drug reactions -drug interactions -failure to receive medications -potentially inappropriate medications in the elderly -gradual dose reductions (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-psychotropic medications -medication duration -medication monitoring -medication cost -medication errors -regulatory issues -other pertinent issues as needed. A. 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 Abnormal Involuntary Movement Scale (AIMS) tests revealed the facility conducted an AIMS on Resident 7 on 09-17-2025 and the score was 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 with the Consultant Pharmacist (CP) on 01-08-2025 at 8:35 AM revealed the increase in AIMS score was not noted on the November 2025 Drug Regimen Review (DRR) or the December 2025 DRR therefore a recommendation to update the physician was not submitted. 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 act on the results. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. A record review of Resident 6's Continuous Care Summary revealed Resident 6 had the following diagnoses: Dementia (a significant decline in mental abilities), Hypertension (high blood pressure), Congestive heart failure (a condition where the heart can't pump enough blood to meet the body's needs), Bradycardia (slow heart rate), Transient Cerebral Ischemic Attack (temporary blockage of blood flow to the brain), Cerebral infarction (the death of brain tissue due to a severe lack of blood flow) A record review of Resident 6's Minimum Data Set (MDS – a federally mandated assessment tool used for all residents in Medicare or Medicaid certified nursing homes) revealed Resident 6 had a Brief Interview for Mental Status (BIMS – a federally mandated assessment tool used to assess the cognitive (ability to acquire knowledge and understanding through thought, experience and the senses) status of residents in nursing homes) of 3 which indicated they were severely cognitively impaired. A record review of Resident 6's Medication Administration Record (MAR) for 12/7/2025 to 1/5/2026 revealed Resident 6 received the following anti-hypertensive (medications used to treat high blood pressure) medications: Amlodipine 10mg tablet daily. Doxazosin 1mg tablet at bedtime daily. Hydralazine 100mg tablet every 8 hours. Lisinopril 10mg daily. A record review of a Pharmacy admission Medication Regimen Review (MRR) reviewed on 5/15/2025 by Registered Nurse L (RN) and signed by the provider on 06/04/2025 revealed a review request for the provider for the medications Amlodipine, Hydralazine, Doxazosin and Lisinopril for duplicate therapy (multiple medications from the same drug class for the same disease without a clear reason). No rationale was given for the duplicate therapy. A record review of a Pharmacy admission Medication Regimen Review (MRR) reviewed on 07/30/2025 by an RN and signed by the provider on 08/06/2025 revealed a review request for the provider for the medications Amlodipine, Hydralazine, Doxazosin and Lisinopril for duplicate therapy (multiple medications from the same drug class for the same disease without a clear reason). No rationale was given for the duplicate therapy. A record review of a Pharmacy admission Medication Regimen Review (MRR) reviewed on 12/18/2025 by an RN and signed by the provider on 12/31/2025 revealed a review request for the provider for the medications Amlodipine, Hydralazine, Doxazosin and Lisinopril for duplicate therapy (multiple medications from the same drug class for the same disease without a clear reason). No rationale was given for the duplicate therapy. A record review of the facility nursing policy dated November 2017 and reviewed on 5/21 titled Drug Regimen Review (DRR) revealed the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The consultant pharmacist reviews the medications for each resident for any irregularities and verify appropriateness of the medications involved; evaluate disease state management, ensure appropriate medication monitoring to maximize safety and efficacy; and prioritize patient goals, safety, and quality of life. The consultant pharmacist reviews each resident chart to identify and address any irregularities: 5. Regulatory issues (I.E., specific documentation in the chart; CMS requirements) CMS requirements: F756 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. An interview on 1/8/2025 at 11:00AM with the Assistant Director of Nursing (ADON) confirmed a rationale for duplicate therapy was not present.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on record review and interview the facility failed to ensure there was a qualified Dietary Manager (DM) or qualified nutrition professional full-time, part-time, or on a consultant basis. This had the potential to affect all residents in the building. The facility staff identified a census of 148. Findings are:Record review of employee files revealed the Dietary Manager was not certified. An Interview with the Administrator on 1/7/26 at 6:50 AM confirmed the DM had not completed the test to become certified and the facility did not have a full time dietician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18BBased on observation, interview and record review the facility failed to perform hand hygiene between glove changes in a manor to prevent cross contamination during perineal care (the cleansing of the perineum-the area between the anus and genitals-to maintain hygiene, prevent infection, reduce odor, and promote skin health) on Resident 1, 17, and 47 and failed to clean the nebulizer mask and nebulizer medication chamber (a machine used to deliver aerosolized medications to the lungs) between uses to prevent potential contamination for Resident 160. A total sample of 3 residents were observed for perineal care and 4 residents were observed for nebulizer equipment. The facility staff identified a census of 148.Findings are:A. Record review of a Policy Titled Perineal Care dated 3/2021 revealed Purpose: To establish routine practices for providing perineal care, which will cleanse, prevent skin breakdown, prevent infection, and prevent odors. All residents will receive perineal care, as needed, in the morning before breakfast, every evening with evening care at bedtime, as needed after bowel movement or urination, and each time the resident is incontinent. 2. Identify yourself and explain procedure to resident. 3. Wash hands 7. Put on Gloves. Remove brief. Remove gloves, wash hands and apply new gloves. 10. Wash peri area thoroughly 14. Remove gloves, wash hands and apply clean gloves. 15. Apply protective barrier ointment to front peri area. 16. Remove gloves, wash hands and apply clean gloves. 17. Turn resident on side away from you. 18. Lather wash cloth and wash rectal area and buttocks if using soap and water, otherwise use disposable peri-wipes. 19. Rinse all cleansed areas where soap and water were used and dry thoroughly. 20. Remove gloves and wash hands 21. Put on clean gloves. 22. Apply lotion, or moisture barrier to buttocks and rectal area if indicated. 23. Position resident for comfort. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	24 Remove gloves and wash hands. B. Record Review of Residents 1's Quarterly MDS (MDS, a federally mandated comprehensive assessment tool used to determine a residents functional capabilities and helps nursing home staff identify health problems) dated 12/29/25 revealed Resident 1's cognition was severely impaired and was dependent on staff for toileting hygiene, personal hygiene and dressing. An Observation on 1/7/25 at 7:26 AM revealed Nursing Assistant (NA)-A and NA-B were in Resident 1's room at the bedside with gloves on, a trash bag and container of wipes had been placed on the foot of the bed. NA-A explained the procedure to Resident 1. NA-A removed Resident 1's brief and noted that the resident had a bowel movement (BM). NA-A used the brief to remove some of the BM and folded the brief down between the residents legs. Using the same soiled gloves, NA-A removed clean wipes out of the package and wiped outside of labia. Using the same soiled gloves NA-A removed more wipes out of package, wiped labia again and discarded the soiled wipes. Using the same soiled gloves, NA-A pulled more wipes out of the package. Using the same soiled gloves. NA-A turned resident on left side, used brief to remove some of the BM. NA-A folded up brief and pulled out from under resident and got BM on the bottom sheet. Using the same soiled gloves NA-A pulled more wipes out of the package with multiple wipes coming out of the package. NA-A wiped rectal area multiple times with one wipe before throwing away and using another. Using same soiled gloves, NA-A put left over wipes back in package and placed the package on the bedside table. Using the same soiled gloves, NA-A placed the top sheet on top of the BM that was on the bottom sheet and put the clean brief on Resident 1. Using the same soiled gloves NA-A put sweat pants on and rolled Resident 1 with NA-B to get the pants on. Using the same soiled gloves NA-A removed the resident's gown, picked a shirt up off the floor and proceeded to place it on the resident. NA-A removed their gloves and went to the hall to obtain the residents wheelchair (w/c), pushed w/c into room and donned (put on) new gloves without performing hand hygiene. NA-A and NA-B assisted resident with transfer into the wheelchair. Interview with NA-A on 1/7/26 at 7:47 AM confirmed that the gloves were soiled after cleaning up the BM and the wipes had been contaminated by the soiled gloves. NA-A confirmed hand hygiene and glove changes should have been performed. NA-A also confirmed the wipes should have been thrown away if not used and not put back in the package. C. Record Review of Resident 47's Quarterly MDS dated [DATE] revealed a Brief Interview for Mental Status (BIM's, used to measure cognitive impairment in nursing home residents categorized as 0-7 as severely impaired, 8-12 as moderately impaired and 13-25 as cognitively intact) of 15 and was dependent on staff for toileting hygiene, personal hygiene and dressing. An observation on 1/7/26 at 1:42 PM revealed NA-B and NA-D assisted Resident 47 with toileting and exited the room. An observation on 1/7/26 at 1:58 PM NA-D reentered Resident 47's room donned gloves after performing hand hygiene and assisted resident with perineal care. NA-D removed the soiled gloves and applied new gloves without performing hand hygiene. NA-D placed a barrier ointment on the right glove and placed the ointment on the resident's bilateral buttocks. NA-D removed the soiled gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and put on new gloves without performing hand hygiene. NA-D placed a clean brief under Resident 47. NA-D took trash into the bathroom in a bag, removed gloves and performed hand hygiene. Interview with NA-D on 1/7/26 at 2:01 PM confirmed NA-B and NA-D had not washed their hands when changing gloves and should have. D. 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 required substantial assistance with toileting 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 dated 12/31/2024 to cleanse the peri-area after each incontinent episode. A continuous observation on 01/07/2025 from 6:47 AM through 7:05 AM revealed NA-M performed hand hygiene, donned (applied) a gown and gloves, removed Resident 17's brief and cleaned the resident. NA-M doffed (removed) gloves. Without the benefit of hand hygiene, NA-M donned new gloves and applied a clean brief. NA-M assisted Resident 17 to don clothing and come to a sitting position on the edge of the bed. NA-M assisted Resident 17 into the wheelchair. NA-M doffed gloves and assisted Resident 17 to put on a button-down shirt. Without the benefit of hand hygiene, NA-M donned new gloves and finished Resident 17's morning routine. When completed, NA-M bagged dirty linens for transport, doffed gloves and gown, and exited the room. An interview on 01/07/2025 at 7:06 AM with NA-M confirmed hand hygiene was not performed between glove changes and should have been. E. A record review of the facility's Nebulizer Cleaning policy with a revision date of 5/2021 revealed the following: -1. Check equipment (nebulizer medication chamber and mask) prior to treatment to assure that it is clean and dry. -2. After pulmonary treatment, cleanse the medication chamber and mask with running water. Place chamber and mask on clean paper towel to air dry. Store tubing in unzipped zip lock bag or breathable bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 160's Face Sheet revealed diagnoses of chronic obstructive pulmonary disease with (acute) exacerbation, chronic respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, dependence on supplemental oxygen, and centrilobular emphysema. A record review of Resident 160's Physician Orders dated 1/6/26 revealed a medication order for albuterol sulfate solution for nebulization; 2.5 mg /3 mL (0.083%); amt: 3 ml; inhalation to ne administered as needed. An observation on 01/05/2026 at 7:50 AM revealed Resident 160's nebulizer mask and nebulizer chamber were laying on top of a stand with no barrier underneath the mask and condensation in the medication chamber. An observation on 01/05/2026 at 12:48 PM revealed Resident 160's nebulizer mask and nebulizer chamber were laying on top of a stand with no barrier underneath the mask and condensation in the medication chamber. An observation on 01/06/2026 at 9:13 AM revealed Resident 160's nebulizer mask and nebulizer chamber were laying on top of a stand with no barrier underneath the mask and condensation in the medication chamber. In an interview on 01/06/2026 at 11:03 AM Registered Nurse (RN)-H confirmed that the nebulizer medication chamber and nebulizer mask were not cleaned and on a barrier and should have been.