

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER St. Joseph's Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 North 18th Street Norfolk, NE 68701	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H) Based on record review and interview; the facility failed to submit an investigation related to the unexpected death of Resident 1 to the State Agency within the required time frames. The sample size was 4 and the facility census was 56. Findings are: A. Review of the facility Abuse: Prevention of and Prohibition Against Policy dated 4/25 revealed the following;-the policy of the facility was to ensure each resident was free from abuse neglect, and misappropriation of resident property, exploitation, and mistreatment.-the facility was to provide oversight and monitoring to ensure that its staff delivered care and services in a way that promoted and respected the rights of the residents to be free from abuse, neglect, misappropriation of resident property, exploitation, or use of technology to infringe on the resident's rights. -to assist the facility staff in recognizing incidents of possible abuse, neglect, misappropriation, or exploitation definitions were provided which included adverse events. An adverse event was described as an untoward, undesirable, and usually an unanticipated event that caused death or serious injury, or the risk thereof.-all allegations of potential abuse, neglect, exploitation, or misappropriation were to be reported immediately to the administrator.-allegations of abuse, neglect, misappropriation of resident property or exploitation was to be reported to the appropriate State or Federal agencies in the applicable timeframes. The facility was to notify law enforcement in the event of a potential crime, and Adult Protective Services within 2 to 24 hours depending upon the nature of the case and complete a written report which was to be submitted to the State Agency within 5 business days of the allegation. B. Review of Resident 1's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 1/27/26 revealed the resident was admitted [DATE] with diagnoses of metabolic encephalopathy (brain dysfunction caused by chemical, systemic, or organ-system failures), end-stage kidney disease, chronic respiratory failure, anemia, heart failure, diabetes and chronic obstructive pulmonary disease. The resident's cognition was moderately impaired and the resident did not have a condition or a chronic disease that might result in a life expectancy of less than 6 months. Review of the resident's current Care Plan undated revealed the resident needed hemodialysis (life-saving medical procedure that filters waste, toxins, and excess fluids from the blood when the kidneys fail) due to renal failure. The resident had occasionally refused to go to dialysis and to take ordered medications. Interventions included the following:-check fistula (surgically created connection between an artery and a vein, typically in the arm, designed to provide long-term, high-flow access to blood for hemodialysis) in left arm daily for bruit (an abnormal, blowing, or whooshing sound heard through a stethoscope during medical auscultation, indicating turbulent blood flow, usually caused by narrowed or diseased arteries) and thrill (palpable, vibratory sensation felt by a clinician during physical examination, usually indicating turbulent blood flow). -encourage the resident to go to scheduled dialysis appointments.-monitor for any signs of infection to fistula site. Review of Resident 1's Nursing Progress Notes revealed on 4/19/26 at 12:40 AM the resident was found nonresponsive with no pulse and was not breathing. The resident was lying in bed with blood around the resident's body and on the floor. The resident was observed to have a small (continued on next page)</p>

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

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

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>open area to the bottom of the fistula of the resident's left arm and blood to the tips of fingers to the resident's right hand. There was no sign of trauma to the site and no sharp objects located next to the resident's body. Review of the Facility Reported Incidents for 2026 revealed no evidence the facility reported Resident 1's unexpected death to the State Agency. During an interview with the Director of Nursing (DON) on 4/29/26 at 11:00 AM the DON confirmed the resident's death was unanticipated and untoward. The facility did complete an investigation to ensure no neglect was attributed to the resident's death however, the facility failed to report Resident 1's unexpected death and to then send the results of the facility investigation to the State Agency within the required timeframe.</p>		