

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/14/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18Based on observation, interview, and record review; the facility failed to ensure infection control measures including the use of Enhanced Barrier Precautions (EBP-targeted use of Personal Protective Equipment (PPE-use of protective wear such as gown, gloves, and eye shields) during the provision of care to prevent potential transmission of Multi-Drug Resistant Organisms (MDRO's- germ/pathogen that has developed resistance to multiple classes of antimicrobials [antibiotics or antifungals]) was implemented for Resident's 2, and 3, and infection control measures to prevent potential infections during wound care were followed for Residents 2 and 4. The sample size was 4 and the facility census was 63.Findings are: A. Review of the facility policy Standard and Transmission Based Precautions with a revision date of 4/2025 revealed the facility implemented infection control measures to prevent the spread of communicable diseases and conditions. Standard Precautions (applied to the care of all residents) were implemented regardless of suspected or confirmed infection or colonization (infection absent of illness). Enhance Barrier Precautions were used in conjunction with Standard Precautions and expanded the use of Personal Protective Equipment (PPE) through the use of gown and gloves during high-contact resident care activities which provided opportunities for indirect transfer of MDRO's to staff hands and clothing and the indirect transfer to residents. Residents with wounds and/or indwelling medical devices were at especially high risk of both acquisition and/or colonization with MDRO's. The use of gown and gloves was indicated for wound care, for residents with known or colonized MDRO's, and for resident's with indwelling medical device during the provision of high-contact care activities including wound care, dressing, bathing, transferring, hygiene provision, changing of linens, toileting assistance, changing of incontinence products, and device care (such as urinary catheters, dialysis catheter, feeding tubes, and ventilators). Review of the facility policy Hand Hygiene with a revision date of 4/2025 revealed the facility provided the necessary supplies, education, and oversight to ensure healthcare workers performed hand hygiene, which was the most effective measure to prevent the spread of infection, based on accepted standards. Hand hygiene was a general term that applied to hand washing, antiseptic hand wash, and alcohol-based hand rub. Hand Hygiene was indicated on multiple occasions including but not limited to when hands were visibly soiled, before and after reporting to duty, before and after direct contact with residents, before and after putting on gloves, and whenever moving from a contaminated body site to a clean body site, any contact with bodily fluids, after handling contaminated dressings or equipment and after removal of PPE. Review of the facility policy Skin and Wound Monitoring and Management with a revision date of 12/2023 revealed the facility provided the necessary treatment of wounds to promote healing and prevent infection. B. Review of Resident 2's Minimum Data Set (MDS-federally mandated comprehensive assessment used in the development of resident care plans) dated 4/28/26 revealed the resident was dependent on staff for Activities of (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 285160	If continuation sheet Page 1 of 3

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Daily Living (ADL's) including all hygiene, dressing, transfers, and bed mobility. The resident was involuntary of bowel and incontinent of bladder. Diagnoses included brain dysfunction, dementia and arthritis. The resident was at risk for a had a pressure ulcer (skin and tissue damaged caused by prolonged pressure, friction, or moisture). Review of Resident 2's Care Plan with a revision date of 6/25/26 revealed the resident had impaired skin integrity related to fragile skin, had impaired cognition, and required staff assistance with ADL's. In addition, staff were to implement EBP during care. During an observation of the provision of care for Resident 2 on 7/13/26 at 11:05 AM Nurse Aides (NA's) H and I entered the resident's room, completed hand hygiene and donned (put on) gloves, and the transferred the resident from bed to a wheelchair using a mechanical stand-up lift and transferred the resident from the wheelchair to the toilet. The resident used the toilet and staff performed toileting care however, staff did not wear gowns which was required for Resident 2 due to chronic pressure sore/wound and the need for EBP. During an observation of the provision of wound care for Resident 2 on 7/14/26 at 7:15 AM Registered Nurse (RN)-K obtained supplies to complete wound care, entered the residents' room and placed the wound care supplies directly on the bedside stand, completed hand hygiene and then without wearing gloves, removed a positioning bolster from behind the resident, positioned the resident on the left side, then donned gloves but no gown. The RN then cleaned the wound on the resident's buttock/removed gloves and completed hand hygiene. Next RN-K donned clean gloves and applied a clean dressing to the wound. After that RN-K removed the gloves, and assisted the resident to reposition, reapplied the positioning bolsters, covered the resident and completed hand hygiene. The RN then gathered the unused wound care supplies that were placed directly on the resident's bedside stand and returned an opened container of gauze sponges to the treatment cart (used for treatments for other residents of the facility). During an interview on 7/14/26 at 11:55 AM the Assistant Director of Nursing (ADON) revealed Resident 2 was on EBP's due to the presence of a chronic wound and required the use of gown and gloves during the provision of high contact care provision including transfers, toileting, and wound care. In addition, the ADON confirmed that care including transfers, toileting, on 7/13/26 by NA's H and I, and wound care by RN-K had all been completed while not wearing the required gowns to prevent transmission of potential pathogens to staff's hands or clothing and then potentially to other residents. The ADON also confirmed that wound care supplies brought into a resident's room should be placed on a clean surface and/or not come in contact with surfaces that were potentially unclean and those items not used should be discarded and not returned to the treatment cart for use. C. Review of Resident 3's MDS dated [DATE] revealed the resident had cognitive impairment and received assistance with hygiene, dressing, transfers, and bed mobility. The resident was involuntary of bowel and had a urinary bladder catheter. In addition, the resident had diagnoses including multiple trauma including fractures, Obstructive Uropathy (obstruction of the urinary system), and heart disease. The resident was at risk for and had pressure sores. Review of Resident 3's Care Plan with a revision date of 5/5/26 revealed the resident had impaired cognition, self-care deficits, a gluteal (buttock) pressure ulcer, an indwelling urinary catheter due to obstruction or urinary flow, and staff were to use EBP during care provision as indicated. During an observation of the provision of care on 7/13/26 at 11:20 AM Resident 3 was transported using a wheelchair to the bathing room to bathe. NA-O donned gloves and assisted the resident to stand and transfer into bathing chair using a walker and gait belt to support the resident. The resident required substantial physical assistance and verbal directions. The resident's urinary catheter drainage bag was secured by NA-O to the walker for the transfer and then to bathing chair post transfer. NA-O then assisted the resident to remove clothing with substantial assist. NA-O was wearing gloves but no gown despite the presence of the indwelling urinary catheter (continued on next page)		

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