

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2023
NAME OF PROVIDER OR SUPPLIER The Mulberry at Waverly		STREET ADDRESS, CITY, STATE, ZIP CODE 11041 North 137th St Waverly, NE 68462	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641</p> <p>Licensure Reference Number 175 NAC 12-006.17</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff donned (put on) and doffed (took off) the required PPE (personal protective equipment) when in a resident's room marked for transmission based precautions (TBP)(a resident that had or was exposed to COVID-19) to prevent the spread of COVID-19, ensure that the COVID-19 testing surface was sanitized (cleaned) to prevent the spread of COVID-19 and prevent cross contamination (spread of bacteria from one surface to another), ensure COVID-19 tests sat for 15 minutes before the result was read, ensure hand hygiene (cleaning) was completed between glove changes, and failed to ensure gloves, towels, and gauzes were changed between wound sites to prevent cross contamination. This had the potential to affect all 49 residents in the facility. The facility census was 49.</p> <p>Findings are:</p> <p>A. A record review of the facility's undated Transmission-Based (Isolation) Precautions policy revealed, signage that included what specific PPE was required and that the PPE would be readily available near the entrance of the room. Staff should don appropriate PPE before or upon entry to the room.</p> <p>An observation on 12/12/2023 at 7:22 AM revealed, that room [ROOM NUMBER] had a red sign at the entrance that revealed, an N-95 mask (a tight-fitting mask designed to filter out very small particles of bacteria), gown, gloves and eye protection was required to enter the room. rooms [ROOM NUMBER] had a sign at the entrance to the room that indicated the residents were in a [NAME] TBP zone. The [NAME] sign revealed, masks and eye protection were required to enter the room.</p> <p>An observation on 12/12/2023 at 7:31 AM revealed, Licensed Practical Nurse (LPN)-A had the door open to Red TBP room [ROOM NUMBER] and LPN-A leaned into room to belt line to talk to a staff member in the room. LPN-A did not have any PPE on including a mask.</p> <p>An observation on 12/12/2023 at 7:33 AM revealed, 3 Nursing Assistants (NA)-B, C, and D entered [NAME] TBP room [ROOM NUMBER] with Resident 5 in a shower chair. NA-B, NA-C, and NA-D had no PPE on.</p> <p>(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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an interview on 12/12/2023 at 7:50 AM with NA-B when [gender] exited the room of Resident 5's room revealed, NA-B was unaware that Resident 5 was in a [NAME] TBP isolation room. NA-D did revealed, that the 3 NA's discussed it when they were getting the resident ready and confirmed they should have had a mask and eye protection due to the resident had been exposed to COVID-19.</p> <p>In an interview on 12/12/2023 at 8:23 AM with the Director of Nursing (DON) revealed, that room [ROOM NUMBER] was a [NAME] TBP room due to the resident had an exposure to COVID-19.</p> <p>In an interview on 12/12/2023 at 2:45 PM with the DON revealed, LPN-A should have donned a N-95 mask, eye protection, a gown and gloves before leaning into a COVID-19 positive resident room. The DON further revealed, NA-B, NA-C, and NA-D should have donned a mask and eye protection before entering [NAME] TBP room [ROOM NUMBER].</p> <p>B. A record review of the undated [NAME] NINAXNOW COVID-19 AG CARD TEST HELPFUL TESTING TIPS revealed, the facility should have avoided cross-contamination (transfer of harmful bacteria from one person, object, or place to another) by decontaminating (chemical removal of dangerous substances) surfaces before processing a specimen.</p> <p>A record review of the facility's BinaxNOW COVID-19 Ag Card dated 12/2020 revealed, that at the COVID-19 test results should be read 15 minutes after closing the card. It was important to read the result promptly at 15 minutes and not before.</p> <p>An observation on 12/12/2023 at 7:35 AM revealed, Registered Nurse (RN)-E placed 2 COVID-19 BinaxNOW COVID-19 Ag Card tests directly on the top of the nurse treatment cart located in the hall of [NAME] Boulevard rooms. RN-E then took the cards down [NAME] Boulevard hallway to the nurse's station and threw them away in the trash can in the nurse's station. The observation revealed the treatment cart was not sanitized or a barrier placed.</p> <p>In an interview on 12/12/2023 at 7:38 AM, RN-E revealed, the BinaxNOW COVID-19 Ag Card COVID test cards were from Red TBP isolation room [ROOM NUMBER], Resident 6 and [NAME] TBP room [ROOM NUMBER], Resident 5. RN-E also revealed, the surface was not sanitized before or after the COVID test cards were placed on the nurse treatment cart and a barrier was not used to protect the surface.</p> <p>An observation on 12/12/2023 at 8:52 AM revealed, RN-E performed a BinaxNOW COVID-19 Ag Card test on Resident 8. RN-E opened the test card in the hallway, placed on the Nurse treatment cart, Put 6 drops on the card, carried the card in the room, swabbed Resident 8's nose, placed the swab in the card and sealed the card shut. RN-E carried the card around the room and kept shaking it. At 8:59 AM RN-E stated the result was negative but would give it a couple of more minutes. At 9:01 AM RN-E confirmed, the test was negative and discarded in the trash can in the resident's room.</p> <p>In an interview on 12/12/2023 at 9:01 AM RN-E confirmed, the test was negative after 9 minutes. RN-E revealed, they were supposed to wait for 10 minutes but if RN-E seen the line it was done. A positive test showed up right away.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation on 12/12/2023 at 9:08 AM revealed, RN-E performed a BinaxNOW COVID-19 Ag Card test on Resident 5. RN-E did not sanitize the overbed table, opened and placed the card on the overbed table, placed 6 drops of solution on the card, swabbed the resident's nose and sealed the card at 9:09 AM. RN-E kept picking up the card and putting back on the table. At 9:13 AM RN-E confirmed, the test was negative and discarded the test in the trash.</p> <p>In an interview on 12/12/2023 at 2:45 PM the DON revealed, RN-E should have sanitized the surfaces where the COVID test cards were placed before and after being placed there. RN-E should have waited as close as possible to 15 minutes before reading the result. They would retest Resident 8 and 5.</p> <p>C. A record review of the facility's undated Hand Hygiene policy revealed, staff would perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.</p> <p>A record review of the Weekly Wound Tracking Report dated 12/08/2023 revealed, Resident 2 had a Vascular (poor blood flow) wound on the left 2nd toe, left 4th toe, and right great toe.</p> <p>An observation on 12/12/2023 at 9:21 AM revealed, Licensed Practical Nurse (LPN)-F completed wound care on Resident 2. LPN-D gloved without doing hand hygiene, put a towel on the floor, filled the wash basins with water and Epsom salts. LPN-F removed socks from both feet, removed a dressings on the left 2nd toe, left 4th toe and right great toe. Resident 2 sat up and put feet in wash basins to soak. LPN-F grabbed several gloves, went to room and set supplies on bedside table, placed a towel on bed and applied gloves, no hand hygiene. LPN-F dried the left foot the right with same towel. LPN-F asked the resident to put feet on bed, resident's left foot and wounds were against the uncovered footboard. LPN-F cleaned the wash basins and put under the sink and removed gloves. LPN-F put on new gloves, no hand hygiene, removed 4x4 dressings out of the package and asked resident to move up in bed to get foot off footboard. LPN-F sprayed wound wash on the 4x4 and cleansed the 2 wounds on left foot, sprayed wound wash on another 4x4 and cleansed right great toe wound. No hand hygiene or glove changes. LPN-F then removed gloves, and put on new gloves, no hand hygiene. LPN-F picked through dressing pieces and applied 1 to wound on right great toe and applied border dressing. LPN-F then picked through dressings again and put 1 and border dressing on Left 2nd toe and placed final piece on left 4th toe and covered with border dressings. No glove changes or hand hygiene between wounds or body parts. LPN-F removed gloves and put supplies away. LPN-F then got another border dressing and changed the one on the left 4th toe because it was not sticking.</p> <p>In an interview on 12/12/2023 at 2:45 PM, the DON revealed, that LPN-F should have performed hand hygiene after removing gloves and before applying new gloves, should not have used the same towel to dry all 3 wounds, should not have used the same gauge to clean the 2 left toe wounds, should have performed hand hygiene and changed gloves between dressing each wound site and when going from the left to right foot.</p>		