STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285143	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Mulberry at Waverly	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47312 Licensure Reference Number 175 NAC 12-006.09(H) Based on observation, record review and interview; the facility failed to monitor wounds for 2 (Residents 5 and 8) of 2 sampled residents. The facility census was 46. Findings are: Review of Resident 5's Minimum Data Set (MDS- a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care), dated 5/24/24, confirmed the following: -admitted [DATE] and most recent reentry on 5/20/24 from the hospital -Diagnosis of septicemia (bacterial infection in blood), diabetes and osteomyelitis (infection in the bone) -Has an infection of the foot, surgical wound and received surgical wound care and application of dressings to feet Review of Resident 5's comprehensive care plan (CCP- written instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.), dated 8/8/24, revealed the following: -Focus: Surgical Wound: Resident has a surgical wound and is at risk for infection, pain, and a decrease in functional abilities, initiated 5/20/24. Interventions: -Routinely evaluate and document the wound dimensions, drainage, and condition of surrounding tissue. Notify the physician as needed for changed. -Monitor and document for signs and symptoms of infection such as foul-smelling drainage, redness, swelling, tenderness, fever, and red lines or streaking originating at the wound. Notify the physician when detected. -Focus: Resident has ongoing or is at risk for bacterial/viral infection related to external fixator and wound, initiated 3/20/24. Interventions: -Administer hygienic care to infected and surrounding area to prevent spread of infection Review of the facility Wound Treatment Management policy, undated, revealed the following: (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5. Treatment decisions will be based on: a. Etiology of the wound: i. Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage. ii. Surgical. iii. Incidental (i.e. skin tear, medical adhesive related skin injury.) b. Characteristics of the wound: i. Pressure injury stage (or level of tissue destruction if not a pressure injury). ii. Size-including shape, depth, and presence of tunneling and/or undermining. iii. Volume and characteristics of exudate (drainage). iv. Presence of pain. v. Presence of infection or need to address bacterial bioburden (number of bacteria present on a surface). vi. Condition of the tissue in the wound bed. vii. Condition of peri-wound (around the wound) skin. c. Location of the wound. -8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing. b. Changes in the characteristics of the wound (see above). Review of the facility Skin Assessment policy, dated 8/30/24, revealed the following: -7. Documentation of skin assessment: c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). An interview on 8/7/24 at 9:47 AM with Resident 5 revealed that [gender] had originally admitted to the facility in March after a hospitalization for a worsening diabetic ulcer to [gender] left heel that required partial removal of [gender] left heel bone and that [gender] is seen by a wound doctor every other week. Resident 5 further revealed that [gender] had been in the hospital due to cellulitis (bacterial skin infection) of [gender] left lower extremity and returned to the facility in May. An interview on 8/7/24 at 3:19 PM, the Licensed Practical Nurse (LPN) confirmed that weekly skin evaluations should include all wounds that the resident has, including both new and old, a wound description including how the wound bed looks, if there is any drainage and if so what it looks like, any odor, any signs and symptoms of infection, and what the skin looks like around the wound. A. Observation on 8/7/24 at 9:47 AM revealed Resident 5 sitting in [gender] wheelchair in [gender] room. The observation further revealed a wound vac (a device that drains seeping liquid from a wound that is used to reduce the incidence of infection and aid in the healing proves by forming an airtight cover and pumping the liquid out) to [gender] left heel along with an external fixator to [gender] left lower extremity with multiple pin insertion sites. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 5's Weekly Skin Evaluation, dated 5/20/24, 5/22/24 and 5/29/24, revealed the following: Site left heel, Description: wound 2-centimeter (cm) (W-Width) x 1.2 (L-Length) x 2.5 cm (D-Depth). Evaluation of the left heel did not contain information regarding wound observation, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor. Review of Resident 5's Weekly Skin Evaluation, dated 6/14/24 revealed the following: Site left heel, Description: wound 2.0 cm (W) 1.4 cm (L) x 2.2 cm (D). Evaluation does not contain information regarding wound observation, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor. Review of Resident 5's Weekly Skin Evaluation, dated 6/5/24, 6/26/24, 7/8/24, 7/24/24, 7/31/24 and 8/6/24, revealed no documentation of the wound observation, measurements, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor. Review of Resident 5's progress notes from 5/8/24 to 8/8/24 revealed no documentation regarding wound observation, measurements, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor. An interview on 8/7/24 at 3:27 PM, the Assistant Director of Nursing (ADON) confirmed that a full description, including wound observation, measurements, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor, of residents' wounds. The ADON confirmed during the interview Resident 5's skin were not complete. B. Review of Resident 8's MDS, dated [DATE], confirmed the following: -admitted [DATE] and most recent reentry was 7/22/24 from the hospital -Diagnosis of right lower limb cellulitis, septicemia, and diabetes -Had an infection of the foot, diabetic foot ulcer and other open lesion(s) on the foot -Received application of dressings to feet Review of Resident 8's CCP, dated 8/8/24, revealed the following: -Focus: Diabetes: Resident has a diagnosis of diabetes and is at risk for unstable blood sugars and abnormal lab results, initiated 7/22/24. Interventions initiated 8/1/24: -Weekly skin checks to monitor skin for redness, circulatory problems, infection, and breakdown. Notify physician of any new skin conditions. -Inspect feet during bathing and as needed for open areas, sores, pressure areas, blisters, edema or redness and report to the nurse. -Focus: Wound Management Wound to RLE (right lower extremity). 7/11: blister bottom of left foot, initiated on 9/26/23 and revised on 7/12/24. Interventions: -Monitor ulcer for signs of infections. -Monitor ulcer for signs of progression. -Notify provider if no signs of improvement on current wound regimen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 8/8/24 at 12:00 PM with Resident 8 revealed Resident 8 admitted to the facility in September 2023 with a wound vac to [gender] right foot due to an amputation of [gender] right little toe because of a diabetic foot ulcer that would not heal. Resident 8 revealed that the area to the bottom of [gender] left foot was due to [gender] standing outside bare foot on the cement when the temperature was 90 degrees out in July and that [gender] was hospitalized in July due to an infection. Resident 8 revealed that [gender] is followed by a wound doctor every other week for both wounds. Observation on 8/8/24 at 11:51 AM of wound care with the LPN revealed an open area to the bottom of Resident 8's left foot. An observation of the wound revealed irregular oblong shaped area, peri-wound with no redness, wound bed dull pink in color, no drainage or odor and no signs or symptoms of infection. Measurements of the wound were not obtained by the LPN. Wound care was completed with no concerns. The observation further revealed a dry dressing intact to Resident 8's right foot. Review of Resident 8's progress notes from 5/8/24 to 8/8/24 revealed no documentation regarding wound observation, measurements, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor except on 7/12/24 and 8/5/24. Review of Resident 8's Weekly Skin Evaluation, dated 5/10/24, 5/17/24, 5/24/24, 5/31/24, 6/7/24, 7/19/24, 7/26/24, and 8/2/24, revealed no documentation of the wound observation, measurements, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor. Review of Resident 8's Weekly Skin Evaluation, dated 6/21/24 and 6/28/24, revealed the following: Site: other, Description: right foot, surgical wound small open area 0.3 cm diameter and did not contain information regarding wound observation, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor. An interview on 8/8/24 at 12:01 AM, the LPN confirmed that Resident 8 is followed by a wound doctor every other week and had been since admitting to the facility with the right surgical wound and since July for the left foot wound. The LPN further confirmed that [gender] had not measured Resident 8's wounds. An interview on 8/7/24 at 3:27 PM, the Assistant Director of Nursing (ADON) confirmed that a full description, including wound observation, measurements, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor, of residents' wounds were not completed for Resident 8.

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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** 47312 Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2) Based on observations, record review and interview; the facility staff failed to monitor a pressure ulcer condition for 1 (Resident 10) of 1 sampled residents. The facility staff identified a census 46. Findings are: Review of Resident 10's Minimum Data Set,(MDS, afederally mandated assessment tool used for care planning) dated 6/21/24, revealed that following: -admitted to the facility on [DATE] and the most recent reentry was on 8/3/23 from the hospital -Functional limitation in Range of Motion to both lower extremities -Required total assist from staff with bed mobility and transfers -Has an indwelling catheter (tube inserted into the bladder for continuous drainage of urine) and colostomy (procedure that creates an opening for the large intestine in the abdomen to allow passage of stool) -Diagnoses of paraplegia (loss of muscle function in the lower half of the body) and spina bifida (a birth defect that causes the spinal cord not to develop properly) -One unstageable pressure ulcer, that was not present on admit) caused by a non-removeable dressing/device -Received pressure reducing device to chair and bed, nutrition or hydration intervention, pressure ulcer care and applications of ointments/medications other than to feet Review of Resident 10's Progress Note (PN) dated 6/16/24 revealed Resident 10 was identified with a brown areas that measured 0.7x0.5 centimeters (cm) and 0.5 cm by 0.5cm's. Review of Resident 10's Weekly Skin Evaluation, dated 6/18/24, 6/21/24, 6/23/24, 6/25/24, 6/28/24, 6/30/24, 7/3/24, 7/9/24, 7/16/24, 7/23/24, and 7/30/24, revealed no documentation of the wound observation, measurements, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor. Record review of Resident 10's PN dated 7/21/2024 revealed a late entry indicating Resident 10 had been seen by a wound nurse on 6/21/2024 and 7/05/2024. According to the late entry PN dated 7/21/2024 the wound nurse asessed Resident 10 with a stage 3 (loss of skin tissue that extends to the subcutaneous fat (deepest layer of skin) but does not expose bone, muscle or tendon) to Resident 10 sacral area. that measure 1.3 cm by 1.5 cm by (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/7/24 at 2:01 PM revealed Resident 10 in bed and positioned on [gender] left side. An observation with the Registered Nurse (RN) of wound care to Resident 10's sacral (located at the bottom of the spine) ulcer revealed an open area with no active drainage, dried irregular shaped area on bed pad, wound bed covered with slough (dead cells making up yellow/white material located in a wound bed), wound edges rolled into wound, surrounding skin reddened and no odor. Wound care completed with no concerns and no measurements obtained by the facility RN. Review of Resident 10's CCP, dated 8/8/24, revealed the following: -Focus: I have a risk for pressure injuries with a history of pressure injuries to my coccyx and behind left ear which have healed. 6/21/24 Unstageable pressure ulcer to coccyx, 6/25/24 Stage 1 to sacrum, date initiated 12/13/22 and revised on 6/26/24. Interventions: -Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning. I often refuse to be repositioned. I like to lay on my left side and do not allow staff to reposition me off my side. I will let staff know if I need boosted up in bed. I don't like to reposition because I often feel nauseated when they do, we will try to offer resident something to help relieve/nausea, date initiated 12/13/22 and revised 6/26/24. -I have a low air loss mattress on my bed, initiated 1/16/23 and revised 8/23/23. Review of Resident 10's progress note, dated 6/16/24, revealed the following: at 0115 (1:15 AM) when repositioning resident and doing peri cares noted brown areas to sacrum measuring 0.7x0.5cm and 0.5x0. 5cm. Also, redness noted to left hip area. Resident lays in bed on left side, refuses any other position. Educated and encouraged to alternate sides but resident continues to refuse. Review of Resident 10's progress notes from 6/17/24 to 8/8/24 revealed no documentation regarding wound observation, measurements, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor except on 7/21/24 when a late entry was documented that Resident 10 had been seen by the wound nurse on 6/21/24 and 7/5/24. The noted revealed the following: resident was seen by Wound Nurse on 6/21/24 for sacral wound. Wound is a stage 3 pressure injury (loss of skin tissue that extends to the subcutaneous fat (deepest layer of skin) but does not expose bone, muscle or tendon) measurements as follows: L-1.2cm W-1.0cm D-0.1cm, minimal exudate serosang (serosanguineous- thin watery combination of blood and serum that is clear and straw-colored), no odor, wound edges flush with wound base, [gender] was again seen on 7/5/24 by wound nurse for stage 3 pressure injury to sacral area, measurements: L-0.9cm, W-0.2cm, D-0.1cm, exudate minimal serosang, no odor. Resident has been educated on repositioning [gender] continues to refuse and PCP (primary care physician) is aware of this refusal. Review of Resident 10's Weekly Skin Evaluation, dated 6/18/24, 6/21/24, 6/23/24, 6/25/24, 6/28/24, 6/30/24, 7/3/24, 7/9/24, 7/16/24, 7/23/24, and 7/30/24, revealed no documentation of the wound observation, measurements, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor. Review of the wound nurse's documentation, dated 8/2/24, revealed the following: Stage 3 pressure injury to sacral area, L: 1.3, W: 1.5, D: 0.1, no undermining, adhered slough, minimal serosang exudate, no odor, wound edges flush with wound bed, peri wound clean dry and intact. Facility staff report patient previously had a wound to her sacral area that required a wound vac. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 8/7/24 at 3:27 PM with the Assistant Director of Nursing (ADON) revealed a full description, including wound observation, measurements, type of tissue and color of wound bed, drainage, signs and symptoms of infection, condition of peri-wound skin and odor, of residents' wounds. The ADON confirmed monitoring of the pressures was not completed for Resident 10.0