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 _____	C 06/17/2024

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THE MULBERRY AT WAVERLY	11041 NORTH 137TH ST WAVERLY, NE 68462

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F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12-"Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities and Intermediate Care Facilities" have been included in the survey report as they apply to deficient practices identified.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.09 Based on record review and interview; facility staff failed to follow protocol related to incomplete assessments when determining the death of 2 of 3 sampled residents; Resident 1 was pronounced dead and later discovered breathing while at the funeral home and Resident 2 had no evidence vital signs were assessed and verified at the time of death. The facility was notified on 6/4/24 at 4:20 PM of an Immediate Jeopardy (IJ) which began on 6/3/24. The IJ was removed on 6/4/24, as confirmed by surveyor onsite verification. The facility census was 48. Findings are:	F 684	F000 INITIAL COMMENTS F000 On half of the Mulberry at Waverly, I respectfully submit our Plan of Correction for your approval. The response or provider plan of correction herein shall not be considered or construed as an admission of the ability of the citation or alleged deficiency to which it is addressed. F684 Quality of Care F684 CORRECTION TO RESIDENT(S)	6/17/24

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

Electronically Signed | 06/28/2024

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F 684	Continued From page 1 A review of the facility's undated checklist "Death In Facility" revealed the following related to procedures for a resident death: -"Note the absence of vital signs, no BP (blood pressure), no Pulse, no Respirations." -Notify the responsible party. -Call the physician and obtain a telephone order for the Time of Death, permission to release body to mortuary, physician name and indicate whether an autopsy was to be performed. -If patient is on hospice, notify hospice agency. -Call the coroner/sheriff to inform of the resident's death in the facility. -Call the mortuary. -After the coroner/sheriff has gone, assign a nurse aide to perform 'postmortem care'. -"Complete Death Record and place back in the chart once completed." -"Gather all medical records information after appropriate nursing charting completed." A. A review of Resident 1's Plan of Care with a print date of 6/4/24 revealed the following: -The resident was admitted on [redacted] and had diagnoses of: [redacted] -Had a terminal illness and received hospice care that identified the resident/responsible party did not wish to have Cardiopulmonary Resuscitation (CPR) performed. A review of Resident 1's "Record of Death" dated 6/3/24 at 9:40 AM revealed Registered Nurse (RN)-A had pronounced the resident deceased at that time and notified the hospice nurse, hospice	F 684	AFFECTED. On 6/3/24 Register nurse failed to take the resident's blood pressure upon residents passing. The nurse was suspended by the Administrator pending investigation. SYSTEM CHANGES (IDENTIFICATION AND CORRECTION For RESIDENTS POTENTIALLY AFFECTED) Current residents of the facility have the potential for being affected. On 6/6/24 The Administrator, DON and Clinical Consultant reviewed and updated the Death of a Resident process. A checklist at the facility was revised. All Staff were educated on the checklist used upon a facility death on 6/6/24 and new hires will be trained upon hire. MONITORING PROCESS FOR THE SYSTEM CHANGE INCLUDING FREQUENCY AND TITLE OF THE PERSON RESPONSIBLE. DON and/or designee will identify change of resident condition and need for notification through routine clinical processes, i.e. clinical start up, and follow-up accordingly. The Administrator and/or Designee will audit for compliance through review of the facility 24-hour report and the daily clinical meeting. Audits will be 5x/week x 4 weeks, 3x/week x 4 weeks, 1x/week x 4 weeks with the results taken to the QAPI Committee monthly x 3 months. Date Certain 6/17/24	

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F 684	Continued From page 2	F 684		

physician and the facility medical director. The document included a section "authorization for release body" that was dated 6/3/24 at 10:00 AM. Additionally, the document indicated the funeral home attendant had signed for receipt of the resident's body at 11:00 AM (1 hour and 20 minutes after the resident was pronounced dead).

A review of Resident 1's Progress Note dated 6/3/24 at 9:30 AM revealed RN-A "observed that patient was not breathing by visual assessment. Unable to locate carotid pulse (a pressure signal that can be felt in the neck over the carotid artery) digitally.

A review of the facility's printed timeline for the events on 6/3/24 revealed the following regarding the resident's death and facility actions:
-9:30 AM; Nursing Assistant (NA)-C reported to RN-A Resident 1 was not breathing. RN-A noted the resident was not breathing and had no carotid pulse.
-9:40 AM; RN-A notified the hospice nurse that the resident had no pulse and notifications to the physician and funeral home would be completed.
-9:55 AM; the resident's responsible party was notified of the resident's death.
-11:10 AM; the resident was picked up at the facility by the funeral home.
-12:30 PM; facility was notified by the hospital the resident was transported to the hospital from the funeral home and the resident was still alive.
-12:35 PM; the Administrator notified the Regional Director of Operations and Nurse Consultant of the situation.
-1:00 PM; the Sheriff arrived at the facility.
-1:30 PM; a facility investigation was initiated.
-2:00 PM; the Administrator notified the state agency.

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F 684	Continued From page 3 -2:24 PM; RN-A was suspended pending the investigation. -3:00 PM; education of nursing staff began and is ongoing. During an interview with RN-A on 6/4/24 at 10:43 AM and 12:35 PM the following was confirmed regarding Resident 1's death and the facility process related to a resident death: -RN-A used the facility's death checklist as a guide to follow the protocol related to Resident 1's death. -RN-A stated on 6/3/24 at 9:30 AM [gender] assessed for the absence of respirations by visually observing the resident's chest for 2 minutes and used a stethoscope to listen for heart sounds for 1 minute. RN-A also confirmed a blood pressure reading was not obtained as part of the vital signs assessment. RN-A then pronounced the resident as dead and notified the hospice nurse at 9:40 AM. -RN-A revealed [gender] had knowledge prior to the incident, about the facility's procedure to assess the absence of vital signs (no BP, no pulse, no respirations) and to have a second licensed nurse verify the absence of vital signs. RN-A also confirmed a second licensed nurse was not called upon to verify the absence of Resident 1's vital signs at the time of the presumed death. -RN-A revealed [gender] was re-educated the afternoon of 6/3/24 about the facility's process regarding the death of a resident, that included an assessment to determine the absence of respirations and a pulse. In addition a 2nd nurse should verify the absence of vital signs if one is available. When a 2nd nurse is not available, the DON was to be notified and the sheriff or coroner would also be notified and should come to the	F 684		

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F 684	Continued From page 4 facility. An interview with the Funeral Director on 6/4/24 at 12:00 PM confirmed the following: -On 6/3/24 the funeral home had arranged for Capital City Transport to pick up the resident's body from the facility after being notified of Resident 1's death. -The resident was brought to the funeral home in a body bag on a gurney at approximately 11:45 AM. -The Funeral Director transferred the resident from the gurney and placed [gender] onto the table to prepare for the embalming process. The Funeral Director then adjusted the position of the resident's head and turned away from the resident briefly and "heard a noise, like a gasp or grunting sound" then turned around and found the resident was breathing. -Emergency services were contacted immediately, and the resident was transported via ambulance to the hospital for additional care. -The Funeral Director revealed the resident had been at the funeral home for approximately 5 minutes total from the time the resident was received until [gender] was transported to the hospital. An interview with Resident 1's Responsible Party on 6/6/24 at 9:40 AM confirmed [gender] was notified by the hospice nurse on 6/3/24 at 9:47 AM that the resident's "last breath" was at 9:40 AM on the same day. The Responsible Party revealed [gender] was at the facility in the parking lot when the call was received about the resident's death, then entered the building but did not wish to see the resident's body at that time. The Responsible Party also stated while inside the facility visiting with the Social Services	F 684		

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Director [gender] had not seen or heard any staff members in the resident's room for a period of approximately 15 minutes. The Responsible Party left the facility shortly after and stated at 12:43 PM, the hospital notified [gender] there was a patient brought in that [gender] was responsible for. The hospital informed [gender] the resident was found breathing while on the table at the funeral home. The Responsible Party stated [gender] was upset by this because "I would have went in to see [gender] while at the facility if I had known [gender] was still alive" and then did so while the resident was at the hospital before [gender] passed away later that day.

During an interview on 6/4/24 at 2:25 PM with the Director of Nurses (DON) in the presence of the Administrator, Regional Director of Operations, Nurse Consultant and the Assistant Director of Nurses (ADON), confirmed licensed nurses were expected to do the following when determining the death of a resident:
-Verify the resident's code status as Do Not Resuscitate (DNR) and assess the resident for the absence of respirations and pulse.
-When a second licensed nurse is available, that nurse must verify the absence of vital signs.
-When a second licensed nurse is not available, the DON was to be notified and the coroner should be contacted to verify the resident's death.
-The DON also confirmed a second licensed nurse was on duty in the facility at the time of the resident's presumed death on 6/3/24 at 09:40 AM and RN-A did not have the second nurse verify the absence of the resident's vital signs.

B.
A record review on 6/5/24 of Resident 2's electronic medical record revealed the resident

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F 684	Continued From page 6 was admitted on [redacted] and had the following diagnoses; [redacted] A review of Resident 2's Nursing Progress Note dated 4/27/24 at 11:42 PM revealed the resident had died and the Time of Death (TOD) was noted at 6:55 PM with notifications made to the resident's spouse, physician, the Sheriff and funeral home. The resident's body was released to the mortician at 9:35 PM. A record review of Resident 2's Nursing Progress Note dated 4/27/24 revealed no evidence of documentation regarding the unidentified nurse completing an assessment to determine the absence of vital signs at the time of death. A review of Resident 2's vital signs records dated 4/27/24 revealed no evidence the resident's absence of vital signs were assessed and documented and there was no "Record of Death" completed per the facility's process. An interview with the facility's Nurse Consultant on 6/6/24 at 3:30 PM confirmed there was no documented evidence an assessment was completed to determine the absence of vital signs by the unidentified nurse on duty at the time of the resident's death and should have been done. In addition there was no evidence the "Record of Death" was completed per the facility's protocol. The facility submitted the following abatement statement to remove the immediacy of the situation on 6/4/24 at 5:23 PM: -Immediate Corrective Actions included the RN on duty was suspended pending an investigation	F 684		

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F 684	Continued From page 7 to determine processes and procedures were followed to determine end of life. On 6/3/24 and 6/4/24 the RN was educated by the DON or designee and followed by suspension. -The DON or designee began educating current staff and agency staff on 6/3/24 on the following processes: 1. The process for determining the death of a resident with an updated guidance tool. 2. Change of condition. -At Morning Stand up the leadership team will discuss any new hires and agency staff, to verify that they were educated in the above procedures. This will be completed 5 days a week for 12 weeks and audited by the Administrator/DON or designee. -The updated guidance tool will be utilized on suspected deaths. -All new staff will be educated by DON or designee on the above processes during orientation to the building. -Education will continue until clinical staff are educated prior to their next scheduled shift on the processes listed above. This will be completed by the DON or designee. -All staff will be re-educated on the process listed above during the all-staff meeting scheduled for 6/13/24 by the DON or designee. At the time of the survey, the violation was determined to be at the immediate jeopardy level "J". Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. At the time of exit, the severity of the deficiency was lowered to a "D" level.	F 684		