

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  06/24/2025
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.10(D)</p> <p>Licensure Reference Number 175 NAC 12-006.10(A)(ii)</p> <p>Based on observation, interview, and record review, the facility failed to ensure 2 (Residents 4 and 5) of 2 sampled resident's insulin (a hormone produced in the pancreas which regulates the amount of glucose in the blood) was administered as ordered and to ensure staff followed the 5 rights for medication administration. The facility census was 44.</p> <p>Findings are:</p> <p>A record review of the facility's Timely Administration of Insulin policy dated 8/23 revealed:</p> <ul style="list-style-type: none"> <li>-All insulin will be administered in accordance with physician's orders.</li> <li>-Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise specified in the physician orders.</li> <li>-Procedure includes reviewing the resident's name, medication name, medication dosage, time to be administered, and the route of the administration.</li> </ul> <p>A record review of the facility's Medication Administration policy dated 8/2023 revealed:</p> <ul style="list-style-type: none"> <li>- Ensure that the six rights of medication administration are followed:</li> </ul> <ol style="list-style-type: none"> <li>1.Right resident</li> <li>2. Right drug</li> <li>3. Right dose</li> <li>4.Right route</li> <li>5.Right time</li> <li>6.Right documentation</li> </ol> <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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Administer medication as ordered in accordance with the manufacturer specifications.</p> <p>A record review of the manufacturer specifications on the novolog.com website regarding NovoLOG insulin administration revealed that NovoLog starts acting fast and to eat within 5-10 minutes after administration and take the medication exactly as ordered.</p> <p>A.</p> <p>A record review of Resident 4's Care Plan Report with an admission date of 9/18/2024 revealed a focus area of at risk for alteration in blood sugar levels, hypoglycemia (low blood sugar) and/or hyperglycemia (high blood sugars) due to Diabetes Mellitus (uncontrolled blood sugars), with a goal to have decrease risks for developing signs/symptoms of hyperglycemia or hypoglycemia.</p> <p>A record review of Resident 4's current diagnosis dated 6/23/2025 revealed Diabetes Mellitus.</p> <p>A record review of Resident 4's Minimum Data Set (MDS, a comprehensive assessment used to develop a resident's care plan) dated 06/10/2025 revealed the resident had a Brief Interview for Mental Status (BIMS, a score of a resident's cognitive abilities) of 15/15 which indicated the resident was cognitively aware. The resident was set up or clean up assist for eating and dependent for dressing and toileting. The MDS revealed the resident was receiving insulin injections.</p> <p>A record review of Resident 4's Order Summary Report dated 04/09/2025 revealed the resident had an order for NovoLOG FlexPen Insulin, inject 5 units subcutaneous before meals for Diabetes and to hold for blood sugars less than 100 and Basaglar KwikPen, inject 22 units subcutaneous in the morning for Diabetes Mellitus.</p> <p>A record review of Resident 4's EMAR (Electronic Medication Record) Resident Details report dated 06/24/2025 revealed that the NovoLOG FlexPen Insulin was documented as administered at 9:19 AM and was scheduled for 6:30 AM.</p> <p>A record review of Resident 4's Treatment Administration Record dated 06/24/2025 with a print time of 9:56 AM revealed that the NovoLOG FlexPen Insulin was documented as given and the and Basaglar KwikPen insulin was not signed as given.</p> <p>An interview on 6/24/2025 at 8:00 AM with LPN (Licensed Practical Nurse)-A confirmed Resident 4 had not yet received the insulin that was ordered for 6:30 AM before meals. It was also confirmed that the blood sugar was obtained but the insulin had not been given as ordered.</p> <p>An observation on 6/24/2025 at 8:00 AM revealed Resident 4 in the dining room eating breakfast.</p> <p>An interview on 6/24/2025 at 8:00 AM with Resident 4 confirmed the resident had not received insulin prior to eating breakfast.</p> <p>An interview on 6/24/2025 at 8:50 AM with the Director of Nursing (DON) confirmed that insulin is to be given within the ordered parameters. DON confirmed the insulin for Resident 4 was not given as ordered.</p> <p>An observation on 06/24/2025 at 9:15 AM revealed LPN-A administered 5 units of NovoLOG FlexPen insulin to Resident 4. The observation did not reveal Resident 4 receiving the Basaglar KwikPen Insulin.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 6/24/2025 at 9:15 AM with LPN-A confirmed that Resident 4's insulin was given late and outside of the ordered parameters of 6:30 AM.</p> <p>B.</p> <p>A record review of Resident 5's Care Plan Report with an admission date of 6/16/2023 revealed a focus area of Diabetes with a goal to have reduced risk for complications related to Diabetes. Interventions included administering diabetic medications as ordered.</p> <p>A record review of Resident 5's MDS dated [DATE] revealed a diagnosis of Diabetes Mellitus, and Hyperlipidemia (high levels of fat particles in the blood). Resident 5 had a BIMS score of 13/15 which indicated the resident was cognitively aware. The MDS revealed Resident 5 was independent for eating, dressing, and bathing. The MDS revealed the resident was receiving insulin injections.</p> <p>A record review of resident 5's Treatment Administration Record dated 06/01/2025-06/30/2025 revealed the resident had an order for Insulin Aspart, inject 10 units subcutaneously before meals for Diabetes Mellitus to be given at 6:30 AM.</p> <p>A record review of Resident 5's EMAR (Electronic Medication Record) Resident Details report dated 06/24/2025 revealed that the Aspart Injection Solution (Insulin Aspart) was documented as administered at 7:58 AM with a scheduled time of 6:30 AM.</p> <p>An interview on 6/24/2025 at 8:00 AM with LPN-A confirmed that Resident 5 received the insulin at 7:58 AM and the insulin was ordered for 6:30 AM.</p> <p>An observation on 06/24/2025 at 8:30 AM of Resident 5 in the dining room eating breakfast.</p> <p>An interview on 6/24/2025 at 8:50 AM with the DON it was further confirmed that insulin is to be given within the ordered parameters and the insulin for Resident 5 was not given as ordered.</p>		