

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Mulberry Healthcare and Rehabilitation Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 411 1/2 W Mahoning Street Punxsutawney, PA 15767	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>42079</p> <p>Based on review of policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for two of four residents reviewed (Residents 2, 3).</p> <p>Findings include:</p> <p>The facility's abuse policy, dated April 18, 2024, indicated that residents were not to be exposed to abuse, neglect, mistreatment and misappropriation. Neglect was defined as failure of the facility, its employees so service providers to provide goods and services necessary to avoid physical harm, mental anguish, emotional distress, or mental illness. Neglect was the unwillful act to neglect goods and services to a patient. Examples include failure to follow the care plan, failure to make accessible goods for resident, failure to reposition patient, medication errors, and call light response times.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated October 8, 2024, revealed that the resident was understood and could understand others, had moderately impaired cognition, had no behaviors, required substantial/maximal assistance from staff for sit to stand and had diagnoses that included cerebral palsy (neurological disorder that affect a person's ability to move, balance, and maintain posture). A care plan for Resident 2 regarding a self-care deficit revealed that the resident was an extensive assist of two staff with ETAC device (type of sit to stand transfer device).</p> <p>A nursing note for Resident 2, dated October 26, 2024, at 3:45 p.m., revealed that the resident was being transferred with ETAC device with assist of a nurse aide, and when standing at the bar to transfer to the shower chair her knees buckled and she fell to the floor. Upon entering the room the resident was lying on her back with her feet closest to the bar.</p> <p>The facility's investigation, dated October 26, 2024, revealed that Nurse Aide 1 transferred Resident 2 from the shower chair to the wheelchair with only one staff assist instead of two. Nurse Aide 1 was educated.</p> <p>A witness interview from Nurse Aide 1, dated October 26, 2024, revealed that she was transferring Resident 2 in the shower room and had to lower her to the floor because she was going down.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Certified Registered Nurse Practitioner (CRNP) note for Resident 2, dated November 9, 2024, revealed that the resident admitted to some increased pain in her left shoulder as well as neck region. Resident 2 stated that had been ongoing since last week. The resident stated that she did have a fall.</p> <p>An interview with Nurse Aide 1 on November 13, 2024, at 2:26 p.m., confirmed that she was transferring Resident 2 in the shower room by herself instead of two staff because she was trying to get things done and caught up. Nurse Aide 1 confirmed that she was trained on the use of the ETAC lift and was aware that the lift required a two-person assist.</p> <p>An interview with Resident 2 on November 13, 2024, at 2:54 p.m., revealed that she remembers falling and Nurse Aide 1 was holding the wheelchair, and there was no one to hold the orange handle. She said that even though the fall was not her fault, she has to go to therapy and that she had shoulder pain and back pain after the fall.</p> <p>A skills review for Nurse Aide 1, dated August 8, 2024, revealed that she was trained on transferring a resident using a mechanical lift with a mandatory assist of two staff.</p> <p>Interview with the Director of Nursing on November 13, 2024, at 1:38 p.m. and 3:31 p.m. confirmed that Nurse Aide 1 transferred Resident 2 by herself instead of with two, and the resident fell. Nurse Aide 1 failed to follow the care plan and Nurse Aide 1 was suspended.</p> <p>A quarterly MDS assessment for Resident 3, dated October 18, 2024, revealed that the resident was understood and sometimes understood others, had severely impaired cognition, had no behaviors, required substantial/maximal assistance from staff for sit to stand, and had diagnoses that included dementia.</p> <p>A nursing note for Resident 3, dated October 27, 2024, at 1:28 p.m., revealed that during morning care two nurse aides were rolling Resident 3, when he said, I am going to bite you. The nurse aide jerked her arm away with her hand hitting him in the face.</p> <p>Information reported to the regulatory body, dated October 27, 2024, revealed that Nurse Aide 1 and Nurse Aide 2 were performing care, Resident 3 was combative, and Nurse Aide 1 jerked away and accidentally hit the resident's face with the back of her hand.</p> <p>A witness interview from Nurse Aide 2, dated October 27, 2024, revealed that when providing care to Resident 3, who was combative, the resident told Nurse Aide 1 that he was going to bite her and opened his mouth in a biting motion. Nurse Aide 1 jerked her arm away and smacked the resident on the right side of the face. Nurse Aide 1 said that it was an accident. Nurse Aide 2 suggested giving Resident 3 a break, but Nurse Aide 1 continued to provide care and getting more frustrated, which made the resident more combative and the resident hit Nurse Aide 1, breaking her glasses.</p> <p>A witness interview from Nurse Aide 1, dated October 27, 2024, revealed that when providing care to Resident 3, the resident was being combative and said he was going to bite her. It was a quick reaction that Nurse Aide 1 hit the resident in the face with the back of her hand by accident.</p> <p>An interview with Nurse Aide 1 on November 13, 2024, at 2:26 p.m. revealed that she was rolling Resident 3 toward her when she tried to bite her. She used her other hand to push his face away from her. Then Resident 3 hit her and knocked her glasses off.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Registered Nurse 3 on November 13, 2024, at 2:05 p.m. revealed that she was informed of the situation with Resident 3. After conducting interviews, Nurse Aide 2 wanted to stop and reapproach with care, but Nurse Aide 1 said no. Registered Nurse 3 confirmed that staff should have stopped and reapproached Resident 3 when he was not combative. Nurse Aide 1 was removed from the floor.</p> <p>Interview with the Director of Nursing on November 13, 2024, at 1:38 p.m. confirmed that Nurse Aide 1 had a reactionary response of jerking her arm away when providing care to Resident 3 when the resident tried to bite her.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 201.29(j) Resident Rights.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services.</p>		