

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455744	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/23/2024
NAME OF PROVIDER OR SUPPLIER  Mulberry Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  1670 Lingleville Rd Stephenville, TX 76401	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458</b></p> <p>Based on observation, interviews, and record reviews the facility failed to ensure the resident had a right to a safe, clean, comfortable, and homelike environment for 2 ( Resident #8 and Resident #10) of 6 residents reviewed for rights in that:</p> <ol style="list-style-type: none"> <li>1. Resident #8's bathroom was observed to be unsafe and unsanitary.</li> <li>2. Resident #8 and Resident #10 complained of roaches in their rooms and bathrooms.</li> </ol> <p>This deficient practice could place residents at risk of living in an unsanitary environment, and psychosocial harm due to diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #8's Face Sheet, dated [DATE], revealed a [AGE] year-old male who was admitted to the facility on [DATE], with diagnoses of Acute (sudden) upper respiratory infection (a viral infection that affects the nose, sinuses, or throat), Complete lesion of L2 level of lumbar spinal cord (a spinal cord injury (SCI) that can cause permanent disability, significant morbidity, or even mortality), sequela (a condition which was the consequence of a previous disease or injury), Hypoglycemia (condition in which your blood sugar level is lower than the standard range), Acute (sudden) diastolic (congestive) heart failure (the left ventricle has become stiffer than normal), and Spinal stenosis (occurs when the space inside the backbone is too small), lumbar region (the part of the spine that's located between the ribs and pelvic) without neurogenic claudication (without the spinal nerves in the lower spine compressed).</p> <p>Record review of Resident #8's Quarterly MDS Assessment, dated [DATE], Section C- Cognitive Response Patterns revealed a BIMS score of 13, which indicated intact cognitive response.</p> <p>Record review of Resident #10's Face Sheet, dated, revealed a [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses of Essential (primary) hypertension, Dysphagia (difficulty swallowing), unspecified; Chronic kidney disease, stage 4 (severe), Chronic obstructive pulmonary disease, and Cerebral infarction (stroke caused by a blockage or interruption of blood flow to the brain), unspecified.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record Review of Resident #10's Quarterly MDS Assessment, dated [DATE], Section C- Cognitive Response Patterns revealed a BIMS score of 08, which indicated a moderate impairment response.</p> <p>During an interview on [DATE] at 10:22 a.m., Resident #10 said the night prior she had seen a large roach crawl under her chest of drawers that was across the room from her bed. Resident #10 said the bug was not a water roach but a large regular cock roach. Resident #10 said she saw large roaches in her bathroom often. Resident #10 said this bothered her because she did not like roaches. Resident #10 said she always kept her house and bathroom clean when she lived at home. Resident #10 said her mom told her when she was growing up that if you had roaches in your house, you were unclean.</p> <p>During an interview on [DATE] at 10:34 a.m., Resident #8 said he was upset about the water roaches in the facility. Resident #8 said he had cock roaches in bathroom and the roaches came out at night. Resident #8 said he would turn on the light and the roaches would run everywhere. Resident #8 said his sink in his bathroom was about to fall off the wall and the toilet was unsteady. Resident #8 said someone needed to replace the base of his toilet. As investigator opened the bathroom door, Resident #8 said he was glad someone looked at his bathroom because he had reported the need for repairs to the housekeeper and no one had fixed the sink or toilet. Resident #8 said he was a large man and he had to lean on something to go to the bathroom and he felt unsafe that the sink would fall off and he would hit his face on the floor and bust his chin. Resident #8 said he was also afraid his toilet would fall over, and he would fall and would not be able to get off the floor.</p> <p>During on observation on [DATE] beginning at 10:40 a.m., of Resident #8's bathroom, observed the sink was a wall mounted porcelain type attached only at the back of the sink. Observed the sink tilted slightly downward in front. Observed the sink was unsteady and moved when pressure was applied to the front. Observed the sink was attached to the wall behind the faucet with a board, approximately 12 inches long by 2 inches in width. Observed the board was screwed into the drywall on each end of the board. Observed the area across the top of sink between the board and faucet and along the sides where the sink met with the drywall, a thick layer of caulk had been applied to attach the sink to the wall. Observed on the right side of the sink, at the top the sink, a ,d+[DATE] inch gap where the sink had pulled away from the wall. Observed the toilet and observed a black substance and old off-white caulking material around the entire base of the toilet. When toilet was touched, the unit moved and was unsteady at the base of the toilet. Observed the toilet lid was lose and unsteady. Observed the right side of the toilet, between the unit and the wall and saw a piece of caulking material that was covered in a black substance, pulled away from the toilet approximately 6 inches in length. Observed the floor was covered in a yellow substance with dirt and fuzz. The area where the tile and drywall met was covered in a yellow, dark stain. Observed a died roach under the sink.</p> <p>During an interview on [DATE] at 2:52 p.m., the Administrator said he was not aware Resident #8's sink and toilet were in need of repair. The Administrator said the facility had remounted Resident #8's sink in the past and Resident #8 put pressure on the sink when he went to bathroom because he was a large man. The Administrator said the facility would need to find a different way to mount Resident #8's sink to be more secure.</p> <p>Record review of the facility pest control service log revealed an entry of log check and initials on [DATE] and the facility was serviced for roaches, spiders, and beetles based on a log check and documentation and initials on [DATE]</p> <p>(continued on next page)</p>		

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F 0584  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Record review of the facility's policy, Resident Rights, dated ,d+[DATE], revealed employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: be informed about rights and responsibilities.		

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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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45458</p> <p>Based on interview and record reviews the facility failed to ensure resident had the right to be free from abuse for 2 (Resident #4 and Resident #5) of 7 residents reviewed for abuse and neglect.</p> <p>The facility failed to prevent CNA D from verbally abusing Resident #4 and Resident #5 on 07/04/2024 witnessed by RN C when she yelled, screamed, and slammed the door.</p> <p>These failures could place residents at risk of fear, emotional distress, and decreased quality of life, and further abuse.</p> <p>Findings included:</p> <p>Record review of Resident #4's Face Sheet, dated 07/23/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses of Ataxic (lack of voluntary muscle control) cerebral palsy (disorder that affects a person's ability to move, maintain balance, and posture) , Other speech and language deficits following nontraumatic subarachnoid hemorrhage (bleeding in the area between the brain and spinal cord) and cerebral infarction (condition that occurs when blood flow to the brain is disrupted, causing tissue death in the brain), Anxiety disorder (mental health condition that can cause significant and uncontrollable feelings of fear and anxiety), unspecified (do not meet the exact criteria for any other anxiety disorder), and Dysphagia (difficulty swallowing), unspecified</p> <p>Record review of Resident #4's Quarterly MDS Assessment, dated 06/13/2024, Section C- Cognitive Response Patterns revealed a BIMS score of 09, which indicated a moderate impairment response.</p> <p>Record review of Resident #5's Face Sheet, dated 07/23/2024, revealed an [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses of Cerebral palsy (disorder that affects a person's ability to move, maintain balance, and posture), unspecified-Infantile (occurred before, during, or shortly after birth), Parkinsonism (brain condition that cause slowed movements, stiffness, and tremors), unspecified, Unspecified voice and resonance disorder (can involve issues with the quality, pitch, or volume of the voice).</p> <p>Record review of Resident #5's Annual MDS Assessment, dated 06/27/2024, Section C- Cognitive Response Patterns revealed a BIMS score of 05, which indicated a moderate impairment response.</p> <p>During an interview on 07/17/2024 at 4:47 a.m., LVN E said she had worked with CNA D and said CNA D's voice was loud and at times she talked to residents harshly. LVN E said she was not sure at times if CNA D was upset or stern.</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>During an interview on 07/17/2024 at 9:34 a.m., CNA D said she did not yell at Resident #4 or Resident #5 and denied she slammed the door. CNA D said RN C had threatened her that RN C was going to call the state and the police if she ever abused the residents. CNA D said the incident occurred on 07/04/2024. CNA D said she felt RN C was harassing her and she called the DON to report RN C. CNA D denied she ever yelled at any resident and said she had a loud voice naturally. CNA D said she had been trained and in-serviced on abuse and neglect.</p> <p>During an interview on 07/17/2024 at 9:46 a.m., the DON said RN C had brought the concern that CNA D had yelled at Resident #4 and Resident #5 to her on 07/04/2024. The DON said CNA D had also called her that day as well to report she felt harassed by RN C because RN C had threatened to report her to the state. The DON said the allegation of verbal abuse was not reported to HHSC Regulatory because Resident #4 and Resident #5 denied the allegation that CNA D yelled at them and said CNA D was just loud. The DON said CNA D could be loud and abrasive and once the staff got to know her, differences could be worked out and staff were able to work with CNA D. The DON said she did not document her interview with Resident #4 and Resident #5.</p> <p>During a confidential phone interview on 07/17/2024 at 1:01 p.m., the confidential person said RN C had reported she had witnessed CNA D yell and scream at Resident #4 and Resident #5 on 07/04/2024. The confidential person said she reported the incident to the DON and the Administrator per procedure. The confidential person said she had witnessed CNA D be loud, rude, and verbally aggressive toward residents in the past. The confidential person said she had filled out grievance forms about CNA D, but nothing became of them.</p> <p>During a group interview on 07/17/2024 at 1:37 p.m., with Resident #4 and Resident #5, Resident #5 said she knew CNA D and called her by her first name. Resident #5 said CNA D talked loudly when she came in the room on 07/04/2024, but she also yelled at her and Resident #4. Resident #5 said CNA D did not like it when she or Resident #4 pulled their call light. Resident #5 said she did not want to get anyone in trouble. Resident #5 looked around the room and refused to make eye contact at this point. Resident #5 said it made her nervous to think she would be yelled at and said CNA D yelled at her and Resident #4 sometimes. Resident #5 said she did not tell anyone because she did not want to get anyone in trouble. Resident #4 was observed during the conversation to sit in her wheelchair, hunched down, and quiet. When engaged, Resident #4 said she remembered CNA D yelled at her, but the questions made her nervous. Resident #4 called CNA D by her first name. Resident #4 said CNA D yelled sometimes in a mean way, but she was nervous to talk about it.</p> <p>During an interview on 07/17/2024 at 2:25 p.m., RN C said she witnessed CNA D as she walked by the nurses' station and enter the room of Resident #4 and Resident #5 and yell at the residents in loud, irritated tone of voice on the evening of 07/04/2024. RN C said she witnessed CNA D as she slammed the door and continued to yell and scream so loud she could hear CNA D's voice through the wall. RN C said CNA D told Resident #4 and Resident #5, to calm down, stop repeating questions, you already had your medication. RN C said when CNA D came out, RN C told CNA D that the screaming was unacceptable and if she did it again, RN C would report her to the state and the police. RN C said CNA D tone of voice was loud at times, but during the specific incident on 07/04/2024, CNA D sounded harsh, rude, and hateful. RN C said she reported the incident to the ADON, DON and Administrator immediately or less than hour after she witnessed the incident.</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>During an interview 07/18/2024 at 2:42 p.m., the Administrator said the allegation that CNA D was verbally aggressive to Resident #4 and Resident #5 was not reported to him but was reported to the DON. The Administrator said the DON had informed him she had interviewed Resident #4 and Resident #5 and they denied the allegation.</p> <p>During an interview on 07/18/2024 at 2:52 p.m., the DON said RN C reported to her that RN C had witnessed, in RN C's opinion, CNA D open Resident #4 and Resident #5's door and yell and scream at the residents and slam the door. The DON said she first checked on the residents and interviewed Resident #4 and Resident #5 and asked specific questions in regard to CNA D. The DON said Resident #4 and Resident #5 denied all the allegations. The DON said she reported the incident to the Administrator. The DON said she spoke with CNA D about the allegation and details. The DON said CNA D denied all allegations and said she had witnesses. The DON said she did not interview RN C because Resident #4 and Resident #5 denied the allegation. The DON said CNA D was not removed from the floor because there was not an investigation. The DON said she did not document the incident or interview the witnesses CNA D said saw her during the alleged incident.</p> <p>During a group interview on 07/18/2024 at 2:52 p.m., the Administrator said that he had not had any complaints or grievances forms from staff or residents concerning CNA D. The Administrator said he had never had any grievances forms that were filed to disappear. The DON said the facility did not have grievance forms disappear and all grievance forms were addressed promptly.</p> <p>Record review of CNA D's employee record revealed CNA D had no relevant disciplinary actions.</p> <p>Record review of the facility's policy, Preventing Resident Abuse, dated 12/2013, revealed the facility would condone any form of resident abuse and continually monitor the facility's policies and procedures. The abuse prevention/intervention program includes: encouraging all personnel to report any signs or suspected incidents of abuse to facility management immediately; training all staff and practitioners how to resolve conflict appropriately; training staff to understand and manage a resident's verbal and physical aggression.</p> <p>Record review of the facility policy, Abuse Investigations, dated 11/2010, revealed all reports of resident abuse and neglect shall be promptly and thoroughly investigated by facility management.</p> <ol style="list-style-type: none"> <li>1. Should an incident or suspect incident of resident abuse or neglect be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident.</li> <li>2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the of the investigation.</li> <li>3. The individual conducting the investigation will, as a minimum:             <ol style="list-style-type: none"> <li>c. Interview the person reporting the incident;</li> <li>d. Interview the witnesses;</li> <li>e. Interview staff members (on all shifts) who have had contact with the resident;</li> <li>f. Interview other residents to who the accused employee provides care or services to;</li> </ol> </li> </ol> <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>g. Review all events leading up to the event</p> <p>k. Focusing the investigation on determining if abuse or neglect has occurred, the extent, the cause;</p> <p>l. Provide complete and thorough documentation of the investigation.</p> <p>7. Employee(s) who had been accused of resident abuse would be suspended from duty until the results of the investigation had been reviewed by the administrator.</p> <p>Record review of the facility's policy, Reporting Abuse to Facility Management, dated 04/2012, revealed:</p> <p>It is the responsibility of our employees, facility, consultants, Attending Physicians, family, visitors, etc., to promptly report any incident or suspected incident of neglect or residence about to facility management without fear of retaliation.</p> <p>4. Employees must immediately report any suspected abuse or incidents of abuse to the Director of Nursing or in absence of the Director of Nursing, to the Nurse Supervisor on duty. Failure to report such an incident may result in legal/criminal action being filed against individual(s) withholding such information.</p> <p>8. The Administrator or Director of Nursing must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator or Director of Nursing must be called at home or paged and informed of such incident. The facility will take all necessary actions as a result of the investigation.</p> <p>12. A completed copy of documentation forms and written statements from witnesses must be provided to the administrator within two hours of the occurrence of an incident or suspected abuse. An immediate investigation will be made in a copy of the findings of such investigation will be provided to the administrator within three to five days.</p> <p>Record review of the facility's policy, Reporting Abuse to State Agencies and Other Entities/Individuals, dated 11/2010, revealed all suspected violations of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law. Policy Interpretation:</p> <p>1. Should a suspected violation of abuse and neglect be reported, the facility administrator, or his/her designee, will promptly notify the following persons or agencies of such incident:</p> <p>a. The State licensing/certification agency responsible for surveying/licensing the facility</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45458</p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 (Resident #4 and Resident #5) of 7 residents reviewed for abuse and neglect.</p> <p>The facility failed to report to the Health and Human Services Commission State Survey Agency and other officials when an alleged allegation of verbal abuse was reported by RN C when she witnessed CNA D verbally abuse Resident # on 07/04/2024.</p> <p>This deficient practice could place residents at risk of ongoing neglect.</p> <p>Findings included:</p> <p>Record review of Resident #4's Face Sheet, dated 07/23/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses of Ataxic (lack of voluntary muscle control) cerebral palsy (disorder that affects a person's ability to move, maintain balance, and posture), Other speech and language deficits following nontraumatic subarachnoid hemorrhage (bleeding in the area between the brain and spinal cord) and cerebral infarction (condition that occurs when blood flow to the brain is disrupted, causing tissue death in the brain), Anxiety disorder (mental health condition that can cause significant and uncontrollable feelings of fear and anxiety), unspecified (do not meet the exact criteria for any other anxiety disorder), and Dysphagia (difficulty swallowing), unspecified</p> <p>Record review of Resident #4's Quarterly MDS Assessment, dated 06/13/2024, Section C- Cognitive Response Patterns revealed a BIMS score of 09, which indicated a moderate impairment response.</p> <p>Record review of Resident #5's Face Sheet, dated 07/23/2024, revealed an [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses of Cerebral palsy (disorder that affects a person's ability to move, maintain balance, and posture), unspecified-Infantile (occurred before, during, or shortly after birth), Parkinsonism (brain condition that cause slowed movements, stiffness, and tremors), unspecified, Unspecified voice and resonance disorder (can involve issues with the quality, pitch, or volume of the voice).</p> <p>Record review of Resident #5's Annual MDS Assessment, dated 06/27/2024, Section C- Cognitive Response Patterns revealed a BIMS score of 05, which indicated a moderate impairment response.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/17/2024 at 2:25 p.m., RN C said on the evening of 07/04/2024, she witnessed CNA D as she walked by the nurses' station and enter the room of Resident #4 and Resident #5 and yell at the residents in loud, irritated tone of voice. RN C said she witnessed CNA D as she slammed the door and continued to yell and scream so loud she could hear through the wall. RN C said CNA D told Resident #4 and Resident #5, to calm down, stop repeating questions, you already had your medication. RN C said when CNA D came out, she told CNA D that the screaming was unacceptable. RN C said CNA D tone of voice was loud at times, but during the specific incident on 07/04/2024, that time, CNA D sounded harsh, rude, and hateful. RN C said she notified the Administrator, DON and ADON and reported what she witnessed immediately or less than hour after she witnessed the incident. RN C said she was never questioned about the incident and continued to observe CNA D work the floor.</p> <p>During an interview 07/18/2024 at 2:42 p.m., the Administrator identified himself as the facility's Abuse Coordinator. The Administrator said the allegation that CNA D was verbally aggressive to Resident #4 and Resident #5 was not reported to him but was reported to the DON. The Administrator said the DON had informed him she had interviewed Resident #4 and Resident #5 and they denied the allegation.</p> <p>During a group interview on 07/18/2024 at 2:52 p.m., the DON said RN C reported to her that RN C had witnessed, in RN C's opinion, CNA D open Resident #4 and Resident #5's door and yell and scream at the residents and slam the door. The DON said she first checked on the residents and interviewed Resident #4 and Resident #5 and asked specific questions in regard to CNA D. The DON said Resident #4 and Resident #5 denied all the allegations. The DON said she reported to the incident to the Administrator. The DON said she spoke with CNA D about the allegation and details. The DON said CNA D denied and said she had witnesses. The DON said she did not interview RN C because Resident #4 and Resident #5 denied the allegation. The DON said CNA D was not removed from the floor because there was not an investigation. The DON said she did not document the incident or investigate the any further, including the witnesses CNA D had reported. The DON said she did not report the incident to the state.</p> <p>Record review of the facility's policy, Preventing Resident Abuse, dated 12/2013, revealed the facility would condone any form of resident abuse and continually monitor the facility's policies and procedures. The abuse prevention/intervention program includes: encouraging all personnel to report any signs or suspected incidents of abuse to facility management immediately; training all staff and practitioners how to resolve conflict appropriately; training staff to understand and manage a resident's verbal and physical aggression.</p> <p>Record review of the facility policy, Abuse Investigations, dated 11/2010, revealed all reports of resident abuse and neglect shall be promptly and thoroughly investigated by facility management.</p> <ol style="list-style-type: none"> <li>1. Should an incident or suspect incident of resident abuse or neglect be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident.</li> <li>2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the of the investigation.</li> <li>3. The individual conducting the investigation will, as a minimum: <ul style="list-style-type: none"> <li>c. Interview the person reporting the incident;</li> </ul> </li> </ol> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Mulberry Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  1670 Lingleville Rd Stephenville, TX 76401	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>d. Interview the witnesses;</p> <p>e. Interview staff members (on all shifts) who have had contact with the resident;</p> <p>f. Interview other residents to who the accused employee provides care or services to;</p> <p>g. Review all events leading up to the event</p> <p>k. Focusing the investigation on determining if abuse or neglect has occurred, the extent, the cause;</p> <p>l. Provide complete and thorough documentation of the investigation.</p> <p>7. Employee(s) who had been accused of resident abuse would be suspended from duty until the results of the investigation had been reviewed by the administrator.</p> <p>Record review of the facility's policy, Reporting Abuse to Facility Management, dated 04/2012, revealed:</p> <p>It is the responsibility of our employees, facility, consultants, Attending Physicians, family, visitors, etc., to promptly report any incident or suspected incident of neglect or residence about to facility management without fear of retaliation.</p> <p>4. Employees must immediately report any suspected abuse or incidents of abuse to the Director of Nursing or in absence of the Director of Nursing, to the Nurse Supervisor on duty. Failure to report such an incident may result in legal/criminal action being filed against individual(s) withholding such information.</p> <p>8. The Administrator or Director of Nursing must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator or Director of Nursing must be called at home or paged and informed of such incident. The facility will take all necessary actions as a result of the investigation.</p> <p>Record review of the facility's policy, Reporting Abuse to State Agencies and Other Entities/Individuals, dated 11/2010, revealed all suspected violations of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law. Policy Interpretation:</p> <p>1. Should a suspected violation of abuse and neglect be reported, the facility administrator, or his/her designee, will promptly notify the following persons or agencies of such incident:</p> <p>a. The State licensing/certification agency responsible for surveying/licensing the facility</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45458</p> <p>Based on interviews and record reviews, the facility failed to have evidence that all violations in response to abuse, neglect, exploitation, or mistreatment, were thoroughly investigated for 2 (Resident #4 and Resident #5) of 7 residents reviewed for abuse and neglect.</p> <p>The facility failed to investigate the allegation of verbal abuse by CNA D on 07/04/2024 towards Resident #4 and Resident #5 witnessed by RN C.</p> <p>The failure could place residents at risk of allegation of abuse not being thoroughly investigated and at risk of ongoing abuse.</p> <p>Findings included:</p> <p>Record review of Resident #4's Face Sheet, dated 07/23/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses of Ataxic (lack of voluntary muscle control) cerebral palsy (disorder that affects a person's ability to move, maintain balance, and posture) , Other speech and language deficits following nontraumatic subarachnoid hemorrhage (bleeding in the area between the brain and spinal cord) and cerebral infarction (condition that occurs when blood flow to the brain is disrupted, causing tissue death in the brain), Anxiety disorder (mental health condition that can cause significant and uncontrollable feelings of fear and anxiety), unspecified (do not meet the exact criteria for any other anxiety disorder), and Dysphagia (difficulty swallowing), unspecified</p> <p>Record review of Resident #4's Quarterly MDS Assessment, dated 06/13/2024, Section C- Cognitive Response Patterns revealed a BIMS score of 09, which indicated a moderate impairment response.</p> <p>Record review of Resident #5's Face Sheet, dated 07/23/2024, revealed an [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses of Cerebral palsy (disorder that affects a person's ability to move, maintain balance, and posture), unspecified-Infantile (occurred before, during, or shortly after birth), Parkinsonism (brain condition that cause slowed movements, stiffness, and tremors), unspecified, Unspecified voice and resonance disorder (can involve issues with the quality, pitch, or volume of the voice).</p> <p>Record review of Resident #5's Annual MDS Assessment, dated 06/27/2024, Section C- Cognitive Response Patterns revealed a BIMS score of 05, which indicated a moderate impairment response.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/17/2024 at 2:25 p.m., RN C said she witnessed CNA D as she walked by the nurses' station and enter the room of Resident #4 and Resident #5 and yell at the residents in loud, irritated tone of voice. RN C said she witnessed CNA D as she slammed the door and continued to yell and scream so loud she could hear through the wall. RN C said CNA D told Resident #4 and Resident #5, to calm down, stop repeating questions, you already had your medication. RN C said when CNA D came out, she told CNA D that the screaming was unacceptable. RN C said CNA D voice tone was loud at times, but at during the specific incident on 07/04/2024, that time, CNA D sounded harsh, rude, and hateful. RN C said she notified Administrator, DON and ADON and reported what she witnessed immediately or less than hour after she witnessed the incident. RN C said she was never questioned about the incident and continued to observe CNA D work the floor.</p> <p>During an interview 07/18/2024 at 2:42 p.m., the Administrator identified himself as the facility's Abuse Coordinator. The Administrator said the allegation that CNA D was verbally aggressive to Resident #4 and Resident #5 was not reported to him but was reported to the DON. The Administrator said the DON had informed him she had interviewed Resident #4 and Resident #5 and they denied the allegation. The Administrator said he did not investigate the incident further based on the statement of the DON and no documentation was obtained.</p> <p>During a group interview on 07/18/2024 at 2:52 p.m., the DON said RN C reported to her that RN C had witnessed, in RN C's opinion, CNA D open Resident #4 and Resident #5's door and yell and scream at the resident and slam the door. The DON said she first checked on the residents and interviewed Resident #4 and Resident #5 and asked specific questions in regard to CNA D. The DON said Resident #4 and Resident #5 denied all the allegations. The DON said she reported to the incident to the Administrator. The DON said she spoke with CNA D about the allegation and details. The DON said CNA D denied and said she had witnesses. The DON said she did not interview RN C because Resident #4 and Resident #5 denied the allegation. The DON said CNA D was not removed from the floor because there was not an investigation. The DON said she did not document the incident or investigate the incident any further, including the witnesses CNA D had reported.</p> <p>Record review of the facility's policy, Preventing Resident Abuse, dated 12/2013, revealed the facility would condone any form of resident abuse and continually monitor the facility's policies and procedures. The abuse prevention/intervention program includes: encouraging all personnel to report any signs or suspected incidents of abuse to facility management immediately; training all staff and practitioners how to resolve conflict appropriately; training staff to understand and manage a resident's verbal and physical aggression.</p> <p>Record review of the facility policy, Abuse Investigations, dated 11/2010, revealed all reports of resident abuse and neglect shall be promptly and thoroughly investigated by facility management.</p> <ol style="list-style-type: none"> <li>1. Should an incident or suspect incident of resident abuse or neglect be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident.</li> <li>2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the of the investigation.</li> <li>3. The individual conducting the investigation will, as a minimum:             <ol style="list-style-type: none"> <li>c. Interview the person reporting the incident;</li> </ol> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>d. Interview the witnesses;</p> <p>e. Interview staff members (on all shifts) who have had contact with the resident;</p> <p>f. Interview other residents to who the accused employee provides care or services to;</p> <p>g. Review all events leading up to the event</p> <p>k. Focusing the investigation on determining if abuse or neglect has occurred, the extent, the cause;</p> <p>l. Provide complete and thorough documentation of the investigation.</p> <p>7. Employee(s) who had been accused of resident abuse would be suspended from duty until the results of the investigation had been reviewed by the administrator.</p> <p>Record review of the facility's policy, Reporting Abuse to Facility Management, dated 04/2012, revealed:</p> <p>4. Employees must immediately report any suspected abuse or incidents of abuse to the Director of Nursing or in absence of the Director of Nursing, to the Nurse Supervisor on duty. Failure to report such an incident may result in legal/criminal action being filed against individual(s) withholding such information.</p> <p>12. A completed copy of documentation forms and written statements from witnesses must be provided to the administrator within two hours of the occurrence of an incident or suspected abuse. An immediate investigation will be made in a copy of the findings of such investigation will be provided to the administrator within three to five days.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45458</p> <p>Based on observation, interviews and record reviews, the facility failed to ensure the resident environment remains free of accident hazards as possible 2 (Resident #7 and Resident #8) of 6 reviewed for accidents</p> <p>The DON brought a dog to work at the facility that bit Resident #7 on the ankle and was aggressive toward Resident #8.</p> <p>This was determined at no actual harm with the potential for more than minimal harm at past non-compliance due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the investigation dated on 07/08/2024 when staff were in-serviced no dogs were allowed at the facility.</p> <p>This deficient practice could place residents at risk of an unsafe environment that could lead to a diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #7's Face Sheet, dated 07/23/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses of Major depressive disorder (a mental illness that can cause a persistent low mood and loss of interest in activities that are usually enjoyable), recurrent severe without psychotic features, Chronic (persisting) obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe), and Dysphagia (difficulty swallowing), oropharyngeal phase (the first phase of swallowing and involves the mouth and throat).</p> <p>Record review of Resident #7's Quarterly MDS Assessment, dated 05/17/2024, Section C- Cognitive Response Patterns revealed a BIMS score of 15, which indicated intact cognitive response.</p> <p>Record review of Resident #8's Face Sheet, dated 07/23/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE], with diagnoses of Acute (sudden) upper respiratory infection (a viral infection that affects the nose, sinuses, or throat), Complete lesion of L2 level of lumbar spinal cord (a spinal cord injury (SCI) that can cause permanent disability, significant morbidity, or even mortality), sequela (a condition which was the consequence of a previous disease or injury), Hypoglycemia (condition in which your blood sugar level is lower than the standard range), Acute (sudden) diastolic (congestive) heart failure (the left ventricle has become stiffer than normal), and Spinal stenosis (occurs when the space inside the backbone is too small), lumbar region (the part of the spine that's located between the ribs and pelvic) without neurogenic claudication (without the spinal nerves in the lower spine compressed).</p> <p>Record review of Resident #8's Quarterly MDS Assessment, dated 06/21/2024, Section C- Cognitive Response Patterns revealed a BIMS score of 13, which indicated intact cognitive response.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 07/17/2024 at 5:48 a.m., observed a small, silver bowl in the floor of the DON's office and a small dog crate under the desk with a blanket. Observed there was no dog present.</p> <p>During an interview on 07/17/2024 at 5:50 a.m., the DON said she previously brought her dog to work but did not at the present time. The DON said the last time she brought her dog to the facility was approximately 11 or 12 days prior.</p> <p>During an interview on 07/17/2024 at 10:25 a.m., NA A said the DON brought her dog to the facility in the past. NA A said the dog snapped at her in an aggressive way on one occasion because she walked up and startled the dog. NA A said the dog did not make contact with her. NA A said she did not report the incident to the DON or Administrator because she did not think the incident was relevant. NA A said the incident had occurred within the last two months, but she could not remember the date.</p> <p>During an interview on 07/17/2024 at 2:25 p.m., RN C said the DON's dog had snapped at her in an aggressive manner on Hall 5 one day and she put her foot out to block the dog. RN C said she was not in-serviced on whether or not it was allowed for staff to bring a pet to work. RN C said she did not think it was appropriate for a staff member to bring a pet to the facility because the staff needed to concentrate on their assigned tasks. RN C said the incident had occurred within the last month, but she could not remember the date.</p> <p>During an interview on 07/18/2024 at 10:34 a.m., Resident #8 said approximately a month prior, as he sat on his scooter by the nurses' station, he was approached by the DON's dog. Resident #8 said he was sitting by the birdcage and the dog ran up to him like it wanted to be petted and Resident #8 reached down, and the dog snapped at him in a defensive manner. Resident #8 said he was not afraid of dogs, but the incident made him mad because he did not want other residents to be bitten.</p> <p>During an interview on 07/18/2024 at 11:40 a.m., the DON said she was not aware that her dog had nipped or snapped residents or was aggressive toward residents or other people.</p> <p>During an interview on 07/18/2024 at 12:23 p.m., the Business Office Manager said she was aware the DON brought her dog to work, and she kept the dog in her office 99% of the time. The Business Office Manager said the dog would approach residents, visit resident in their rooms, and laid on their beds. The Business Office Manager said the dog's favorite place to run up to was to the bird cage in the rotunda area or the side door where the dog went out to go the restroom. The Business Office Manager said the dog at one time ran up to a resident's family member and pressed his nose to back of her leg, but the dog never nipped. The Business Office Manager said the dog approached others.</p> <p>During an interview 07/18/2024 at 3:58 p.m., Resident #7 said she was bit on the ankle by the DON's dog a couple of months prior. She said she was walking by the nurses' station and the dog reached out and bit her on the right ankle on the outside of the ankle. Resident #7 said the bite broke the skin. Resident #7 said she did not tell anyone because she did not want to cause trouble. When asked to explain, Resident #7 said she had to go to the nurses to get her meds and she wanted to keep the peace. Resident #7 said she was afraid of the dog after the incident. Observation no scar on Resident #7's right ankle, on outer side where Resident #7 pointed when she showed where the dog had bitten her.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #7's Progress Notes, dated 03/12/2024 to 07/17/2024, revealed no injury or open area to Resident #7's ankle.</p> <p>Record review of a facility in-service sign-in sheet, dated 07/08/2024, revealed staff were informed, No dogs allowed by staff. Do not bring your pets to work day or night by the Administrator.</p> <p>Record review of the facility's dog policy, [Facility Name] and [Facility Name] Doggie Contract, not dated, revealed if the dog is a disturbance to the resident population, the dog must leave. This could include but it's not limited to barking, biting, pooping, smelling, growling, chasing, aggravating, spitting, howling, peeing, humping, rolling, hunting, etc.</p> <p>4. revealed the dog must be: friendly to all residents, staff, and family members.</p> <p>5. revealed the dog must be: not allowed to wander the facility alone without the resident with the dog.</p> <p>There was no policy that outlined and directed situations when employees brought dogs to the facility provided to this investigator when requested multiple times while on-site 07/17/2024 - 07/23/2024.</p> <p>Record review revealed the DON did not have a contract or facility documentation signed that indicated she would agree to the [Facility Name] Doggie Contract and facility policy. Record review revealed the DON's dog was up to date on vaccinations.</p> <p>This was identified as PNC, correction date of in-service (07/08/24)</p>		