STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455744	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mulberry Manor	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on observation, interview, and record review, the facility failed to treat residents with respect, dignity, and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 18 residents (Resident #4) reviewed for resident rights. The facility failed to ensure staff treated Resident #4 with respect and dignity while performing wound care without the privacy curtain being pulled. This failure could place residents at risk of a diminished quality of life and lead to a loss of self-esteem and isolation. Findings included: Resident #4 Review of Resident # 4's face sheet dated 06/14/2024 revealed an [AGE] year-old female admitted on [DATE] and her latest admission on 12/29/2023. Review of Resident #4's diagnosis revealed: Hypertension (high blood pressure), Pseudomonas (type of bacteria), Diarrhea, and Pruritis (itchy skin). Review of Resident # 4's MDS assessment dated [DATE] revealed, Section C- Cognitive Behavior revealed a BIMS score of 12 (moderately impaired). Section M-Skin Conditions revealed Skin and ulcer/Injury Treatments, G. Application of nonsurgical dressings, H. Applications of ointments/medications. Review of Resident # 4's care plan dated 06/14/2023 revealed: Psychosocial Well-Being: Problem-Resident admitted to facility with a stage 4 pressure wound to medial coccyx. Goal-Resident wound will be treated without complications. Urinary Incontinence- Problem-resident is incontinent of bowel and bladder. Approach: explain plan of care. Remote dignity by ensuring privacy while providing care. During an observation on 06/11/2024 at 2:47 PM, Resident #4's wound care was performed with LVN-B without pulling the privacy curtain closed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/2024 at 3:03 PM, LVN-B stated she should have closed the curtain for resident privacy. She stated even though she had closed the residents door, someone could have opened it, with resident being exposed. During an interview on 06/11/2024 at 3:00sPM, Resident #4 stated she would prefer for the curtain to be pulled, so that if anyone opened the door, she would not feel embarrassed. During an interview on 06/11/2024 at 3:05 PM, the DON stated the privacy curtain should have absolutely been pulled for privacy while performing resident wound care. She stated the ADON, and the DON monitored the privacy/dignity training and performed random checkoffs for staff members. The DON stated the negative impact could have been embarrassment for the resident. She stated her expectations were for the privacy curtain to be pulled. She stated the failure occurred when the aide didn't pull the curtain in order to prevent the resident from being seen when staff performed resident care. During an interview on 06/14/24 at 10:43 AM, the ADON stated not pulling the curtain closed would be a dignity issue. She stated the curtain provided privacy for residents when staff performed resident care. The ADON stated she was in charge of trainings and monitored their education with random checks. She stated the negative impact for residents would have possibly made the resident uncomfortable if the curtain was not pulled. The ADON stated she could not say what the failure was. She stated her expectations were to give the resident privacy and give them the comfort they needed. During an interview on 06/14/24 at 2:44 PM, the DON stated the curtains should be pulled for privacy while performing resident care as well as while transferring the resident from the bed to wheelchair. She stated the ADON, and the DON monitored the privacy/dignity training and performed random checkoffs for staff members. She stated the failure occurred when the aide didn't pull the curtain in order to prevent the resident from being seen when staff performed resident care. The DON stated the negative impact could have been embarrassment for the resident. She stated her expectations were for the privacy curtain to be pulled. Review of facility policy Quality of Life-Dignity date August 2009 revealed: Policy statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Policy Interpretation and Implementation: 1. Resident shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth 10. Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 11. Demeaning practices and standards of care that compromise dignity are prohibited.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on observation, interview, and record review, the facility failed to provide services related to protecting the resident's privacy for 1 (Resident #28) of 18 residents reviewed for resident rights. 1. The facility failed to ensure staff treated Resident #28 with respect and dignity while performing peri-care without the privacy curtain being pulled. 2. The facility failed to ensure staff treated Resident #28 with respect and dignity while performing transferring of Resident from bed to chair with a Hoyer Lift without the privacy curtain being pulled. This failure could place residents at risk of a diminished quality of life and lead to a loss of self-esteem and isolation. Findings included: Resident #28 Review of Review of Resident # 28's face sheet dated 06/14/2024 revealed a [AGE] year-old male admitted on [DATE] and her latest admission on 12/26/2023. Review of Resident #28's diagnosis revealed: Hypertension (high blood pressure), Lack of coordination, and Diarrhea. Review of Resident # 28's MDS assessment dated [DATE] revealed, Section C- Cognitive Behavior a BIMS score of 15 (cognitively intact). Section H-Bladder and Bowel, resident always incontinent. Section GG-Functional Abilities and Goals, Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). Review of Resident # 28's care plan dated 03/13/2024 revealed: No evidence of Category- Resident is continent of bladder uses urinal, and incontinent bowel. Approach-Provide incontinent care as needed post each incontinent episode. Approach-provide privacy. Admission-Resident requires use of Hoyer/mechanical lift and is at risk for injury. Goal-resident will be transferred safely and be free from significant injury through next quarter. Approach-Provide privacy. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 06/12/2024 at 10:15 AM, CNA L and the NA performed peri-care and did not pull the privacy curtain. During this time another CNA (unknown) opened the door and asked if they needed help. The curtain still had not been pulled for privacy of the resident. During an interview on 06/14/24 at 10:43 AM, the ADON stated not pulling the curtain closed would be a dignity issue. She stated the curtain provided privacy for residents when staff performed resident care. The ADON stated she was in charge of trainings and monitored their education with random checks. She stated the negative impact for residents would have possibly made the resident uncomfortable if the curtain was not pulled. The ADON stated she could not say what the failure was. She stated her expectations were to give the resident privacy and give them the comfort they needed. During an interview on 06/14/24 at 2:44 PM, the DON stated the curtains should be pulled for privacy while performing resident care as well as while transferring the resident from the bed to wheelchair. She stated the ADON, and the DON monitored the privacy/dignity training and performed random checkoffs for staff members. She stated the failure occurred when the aide didn't pull the curtain in order to prevent the resident from being seen when staff performed resident care. The DON stated the negative impact could have been embarrassment for the resident. She stated her expectations were for the privacy curtain to be pulled. Review of facility policy Quality of Life-Dignity date August 2009 revealed: Policy statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Policy Interpretation and Implementation: 1. Resident shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth 10. Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 11. Demeaning practices and standards of care that compromise dignity are prohibited.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 44728 Based on record review and interview the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 4 (Resident #2, Resident #7, Resident #28, Resident #51) of 18 residents reviewed for comprehensive care plans. The facility failed to develop a PASRR care plan Resident #2. The facility failed to develop care plan goals for Resident #28 related to his ADL Functions. The facility failed to ensure LVN N administered Resident #51's Insulin Glargine 7 times during a 2-month review period, per physician order. The facility failed to ensure RN F administered Resident #51's Insulin Glargine 4 times during a 2-month review period, per physician order. The facility failed to ensure LVN D administered Resident #51's Insulin Glargine 1 time during a 2-month review period, per physician order. The facility failed to ensure LVN M administered Resident #51's Insulin Glargine 1 time during a 2-month review period, per physician order. The facility failed to ensure LVN B changed Resident #7's central line dressing, when LVN B documented she had changed the central line dressing. The Facility failed to ensure LVN C changed Resident #7's central line dressing, when LVN C documented he had changed the central line dressing. These failures could affect residents by placing them at risk for not having their individual needs met. Findings included: Resident #2 Record review of Resident #2's face sheet dated [DATE] revealed a [AGE] year-old male originally admitted on [DATE], with the following diagnoses hypertension (high blood pressure), type 2 diabetes mellitus (body does not make enough insulin or does not use insulin well), pressure ulcer of right buttock, stage 3, muscle wasting, paranoid schizophrenia, and major depressive disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Admission MDS dated [DATE] revealed Section C- Cognitive Patterns, Resident #2 had a BIMS score of 0 meaning an interview was not conducted with resident because Resident #2 was rarely/never understood. Record review of Resident #2's PASRR Level 1 Screening dated [DATE] revealed Resident #2 was PASRR positive and required PASRR services. Record review of Resident #2's Comprehensive Care Plan dated [DATE] revealed no evidence of Resident #2's PASRR services identified in the Comprehensive Care Plan. Resident #28 Review of Resident # 28's face sheet dated [DATE] revealed a [AGE] year-old male admitted on [DATE] and her latest admission on [DATE]. Resident #28's diagnosis was, Hypertension (high blood pressure), Lack of coordination, and Diarrhea. Review of Resident # 28's MDS assessment dated [DATE] revealed, Section C- Cognitive Behavior a BIMS score of 15 (cognitively intact). Section H-Bladder and Bowel, resident always incontinent. Section GG-Functional Abilities and Goals, Dependent - Helper does ALL the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). Record review of Resident #28's Care Plan dated [DATE] revealed no evidence of goals for the target date for his ADL Functions. Resident #51 Record review of Resident #51's face sheet dated [DATE] revealed a [AGE] year-old male originally admitted on [DATE], with the following diagnoses heart failure, hypertension (high blood pressure), type 2 diabetes mellitus (body does not make enough insulin or does not use insulin well), peripheral vascular disease, coronary artery disease and wound infection. Record review of Resident #51's Annual MDS dated [DATE] revealed Section C- Cognitive Patterns Resident #51 had a BIMS score of 14 meaning cognitive intact. Record review of Resident #51's care plan dated [DATE] revealed; Diabetic status will remain stable AEB by resident blood sugar staying within the resident's normal limits through next quarter. Edited on [DATE]. Interventions for Resident #51 revealed: Administer medications as ordered and monitor for side effects, effectiveness. Date Initiated: [DATE], Revision on: [DATE]. Record review of Resident #51's physician order dated [DATE] revealed: Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/ml (3ml) 25 units subcutaneous twice per day, with a start date of [DATE], no evidence of specific parameters. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #51's electronic MAR for the months of [DATE] and [DATE] revealed insulins being held: 1. [DATE] Lantus 25 units held at 7:00AM recorded by LVN N. 2. [DATE] Lantus 25 units held at 7:00AM recorded by LVN N. 3. [DATE] Lantus 13 units given at 8:00PM recorded by RN F. 4. [DATE] Lantus 25 units held at 7:00AM recorded by LVN N. 5. [DATE] Lantus 25 units held at 7:00AM recorded by LVN N. 6. [DATE] Lantus 25 units held at 7:00AM recorded by LVN N. 7. [DATE] Lantus 25 units held at 8:00PM recorded by LVN D. 8. [DATE] Lantus 13 units given at 8:00PM recorded by RN F. 9. [DATE] Lantus 12 units given at 8:00PM recorded by RN F. 10. [DATE] Lantus 25 units held at 7:00AM recorded by LVN N. 11. [DATE] Lantus 25 units held at 8:00PM recorded by LVN M. 12. [DATE] Lantus 25 units held at 7:00AM recorded by LVN N. 13. [DATE] Lantus 10 units given at 8:00PM recorded by RN F. Review of Resident #51's electronic progress notes for [DATE] and [DATE] revealed no evidence of notification of physician for holding ordered insulin or adjusting units of insulin given. Observation on [DATE] at 2:30 PM revealed Resident #41 sitting in wheelchair at nurses station. Resident #41 appeared to be clean and alert but would only respond with head nod to questions. Resident #7 Record review of Resident #7's face sheet dated [DATE] revealed [AGE] year-old female originally admitted on [DATE] with most recent readmission on date [DATE]. Resident #7's diagnoses included: encounter for surgical aftercare following surgery on the skin and subcutaneous tissue (surgery involving skin and below skin tissue), presence of left artificial knee joint (previous left knee surgery), encounter for removal of internal fixation device (surgery revision), methicillin resistant staphylococcus aureus infection (antibiotic resistant infection), and pain. Record review of Resident #7's quarterly MDS dated [DATE] revealed: BIMS score of 13 which indicated cognitively intact. Further review of the MDS Section O Special Treatments, Procedures, and Programs revealed resident received IV medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's care plan dated [DATE] revealed resident had right chest central line and was at risk for infection, pain, infiltration, cardiac and respiratory issues. The goal was for Resident #7 to be free from infections, infiltration, and adverse effects. The facility staff approach included for staff to assess IV site q shift and prn. Further review of care plan revealed Resident #7 had post-surgical history of infection. The goal was for Resident #7's infection to be cleared by the target date and for complications related to the infection. The facility staff approach included staff will administer medications as ordered, monitor lab work as ordered and report results to physician. Record review of Resident #7's electronic physician orders dated [DATE] revealed: Midline catheter: change catheter site dressing / securement device every week on Monday and as needed with transparent dressing with start date of [DATE]. Further investigation revealed midline catheter was really a central line. Record review of Resident #7's electronic MAR for the months of [DATE] and [DATE] revealed midline catheter dressing had been changed: 1. [DATE] by LVN B 2. [DATE] by LVN C 3. [DATE] by LVN B During an interview on [DATE] at 10:54 AM LVN C stated he had not changed the central line dressing and that if he had signed that he had performed it was signed in error. He stated he would sign off on task in MAR prior to performing task and would have made his best effort to perform the task. He stated the error may have been due to there were a lot of distractions in the facility and may have forgotten to perform. He stated that distractions resulted from him trying to make himself available to all residents and would be approached routinely by residents even if they were not assigned to him and he would attempt to help them. During an interview on [DATE] at 2:51 PM LVN B stated she worked on [DATE] and she did sign that central line dressing had been changed since the facility had a RN performing treatments that day and she thought the RN changed the dressing. She stated usually the RN treatment nurse would let her know treatment had been performed and she would sign that it had been completed. She stated that she should have verified by observing central line dressing had been changed and did not remember why she did not verify it prior to signing that it was completed in MAR. She stated she had been in-serviced about central line dressings yesterday on changing dressing per orders and verifying treatment done prior to checking off it had been performed. She stated she should not check off treatments she had not performed. During an attempted telephone interview on [DATE] at 3:10 PM with LVN B, LVN B did not answer and message to return call was left, LVN B did not return call. During an attempted telephone interview on [DATE] at 3:12 PM with LVN C, LVN C did not answer and message to return call was left, LVN C did not return call. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:56 AM LVN N stated she was an LVN N and had worked at the facility since [DATE]. LVN N stated she had received training on how to administer insulin. LVN N stated Lantus was a long-acting insulin that lasts for 8 to 10 hours and will be peak at 6 hours. LVN N stated there should have been parameters to follow in the physician's orders. LVN N stated Resident #51's Lantus order did not have parameters but would hold if his blood glucose was low. LVN N stated she had not contacted Resident #51's physician about holding his Lantus. LVN N stated she had used her nursing judgment from the history she had with Resident #51. LVN N stated her nursing judgement was based on the Texas Board of Nursing. LVN N stated she had never adjusted the units ordered for Lantus and the physician should have been contacted if the units were changed. LVN N stated the negative impact to residents for not following physician orders could have been residents could have been running high blood sugars, high blood sugars decrease wound healing, blood pressures be altered, could be eating and drinking more because sugars running high, and could have gone into diabetic coma. During an interview on [DATE] at 10: 30 AM the DON stated her expectation was that nursing staff follow physician orders, if they make any changes to medication dosage, they should have contacted the physician and document conversation with Dr and his recommendations. The DON stated she had been the DON at the facility for the past 2 years. The DON stated she had received training (when she started at facility and from her nursing education) and her staff had received training on how to administer insulin. The DON stated nursing staff were trained as part of their checked off at hire and during the yearly competencies. The DON stated Lantus was a long-acting insulin. The DON stated the units of Lantus was based on each resident's needs. The DON stated nurses should have followed the physician's order. The DON stated if nurse felt they needed to hold Lantus they should have contacted the physician and the conversation with the physician should have been documented in Resident's progress notes or on the MAR. The DON stated the standard of practice the facility followed was the Board of Nursing standards of Practice. The DON stated the negative impact to residents for not following physician orders could have been not having good control of blood glucose, which could have been hard on the body, that could have led to detrimental effects if blood glucose was too high or too low for too long. The DON stated what led to failure of LVN N not contacting physician was LVN N had worked at facility for several months and knew the physicians orders and parameter and got complacent of what his normal parameters are and it did not trigger to contact the physician. The DON stated she did not know of any of her nurses who would have changed medication dosage without speaking to physician first, the failure happened because staff did not document those conversations. The DON stated changing medications dosage without speaking with physician would be nurses practicing out of their scope, this could have caused detrimental effects to residents. During an interview on [DATE] at 11:27 am the MD stated his expectation was that nursing staff follow orders and contact him with any changes. The MD stated he did not have an issue with holding Lantus with a blood glucose below 100. The MD stated the Lantus dosage should not have been altered unless he was contacted. The MD stated Resident #51 missing the doses of Lantus did not have an adverse effect on resident. During an interview on [DATE] at 03:38 PM RN F stated she had adjusted Resident #51's Lantus before based on his blood glucose and if he was going to eat a snack or not. RN F stated another nurse had told her it was ok to give him lower dose. RN F stated she did not know if she had messaged the physician or she failed to document conversation with physician. RN F stated at another facility a resident died because their blood glucose bottomed out, she stated she guessed that incident skewed her judgement. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 8:13 PM the ADMN stated his expectation was nurses should have contacted physician before holding and/or changing dosage of medication. The ADMN stated residents could have been affected by infections not getting better, worsen, insulin being held could have caused them to have extremely low or extremely high blood glucose. The ADMN stated what led to failure was nurse staff used their judgement because they felt they knew the resident's routine and their blood sugar ranges. The ADMN stated his expectation was staff's documentation be done accurately, correctly and thorough. The ADMN stated staff should never assume someone else was going to complete a treatment and documents for them or you should not click prior to completing a treatment. The ADMN stated what led to failure was she had gotten busy and forgot to perform the task/treatment. The ADMN stated the effect on residents could have been treatments missed, infections or wounds could have gotten worse. The DON and the ADON were responsible for monitoring to ensure staff were performing tasks/treatment. During an interview on [DATE] at 2:18 PM the MDS Coordinator stated that if a resident was PASSAR positive it should have been incorporated in the Comprehensive care plan. The MDS Coordinator stated she was responsible for ensuring the comprehensive care plans were complete. The MDS Coordinator stated she did not have an excuse to why the documents had not been uploaded into the care plan. During an interview on [DATE] at 2:36 PM the DON stated the goal boxes should have been checked in the blanks and was an oversight the template had not been completed. She stated there were templates that the MDS applied, with it not being finished. The DON stated the potential for harm possibly could have been not giving the proper care to residents. The DON stated the facility protocol was for staff to go look at the Care Plans and should have been caught by now. She stated the negative impact for residents was staff not knowing exactly what they were supposed to be working on for them. During an interview on [DATE] at 2:30 PM the ADON stated the DON should have monitored as well as upper management that helped with resident Care plan. She stated staff should have followed up if they had seen there were no comment in the blanks. The ADON stated the failure occurred with staff not rechecking their work and with using a template, she stated it's a fill in the blank. She stated she felt the negative impact to residents could have been improper care with her expectations was for all goals and interventions to be completed. Record review of Policy and Procedure for Comprehensive Person-Centered Care Plan dated 2010 revealed: Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident . 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; e. Reflect treatment goals, timetables and objectives in measurable outcomes; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Texas Board of Nursing website, https://www.bon.texas.gov accessed on [DATE] revealed A nurse has a duty to the patient which cannot be superseded by hospital policy or physician's order. Record review of the Texas Board of Nursing website, https://www.bon.texas.gov/pdfs/practice_dept_, accessed on [DATE] revealed Scope of Practice Decision-Making Model dated [DATE]: 2. Is the activity or intervention authorized by a valid order If there is any question about the accuracy or appropriateness of an order, clarification must be sought [Board Rule 217.11(1)(N)] Record review of Texas Board of Nursing website, https://www.bon.texas.gov/rr_current/,d+[DATE].asp.html, accessed on [DATE] revealed Board Rule 217.11(1)(N) Clarify any order or treatment regimen that the nurse has reason to believe is inaccurate, non-efficacious or contraindicated by consulting with the appropriate licensed practitioner and notifying the ordering practitioner when the nurse makes the decision not to administer the medication or treatment; Record review of facility job description titled Registered Nurse dated February 2024 revealed: Monitor medication passes and treatment schedules to assure that medications are being administered as ordered and that treatments are provided as scheduled. Consult with the resident's physician and planning resident care, treatment, rehabilitation, etc. Notify the resident's physician and responsible party when there is a change in their resident's condition or unusual incident Document in the nurses notes appropriate information to indicate that the plan of care is being followed Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long term care. Record review of facility job description titled Licensed Vocational Nurse dated February 2024 revealed: Monitor medication passes and treatment schedules to assure that medications are being administered as ordered and that treatments are provided as scheduled. Consult with the resident's physician and planning resident care, treatment, rehabilitation, etc. Notify the resident's physician and responsible party when there is a change in their resident's condition or unusual incident Document in the nurses notes appropriate information to indicate that the plan of care is being followed Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long term care. 48883

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	455744	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mulberry Manor	1670 Lingleville Rd Stephenville, TX 76401

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 1 resident (Resident #28) reviewed for accidents and supervision. The facility failed to ensure CNA and NA locked (legs MUST BE in the maximum OPENED/LOCKED position) the Hoyer (mechanical) lift during the transfer of Resident #28. This failure could place residents at risk of injuries. Findings included: Review of Resident # 28's face sheet dated 06/14/2024 revealed a [AGE] year-old male admitted on [DATE] and his latest admission on 12/26/2023. Review of Resident #28's diagnosis revealed: Hypertension (high blood pressure), Lack of coordination, and Diarrhea. Review of Resident # 28's MDS assessment dated [DATE] revealed, Section C- Cognitive Behavior a BIMS score of 15 (cognitively intact). Section H-Bladder and Bowel, resident always incontinent. Section GG-Functional Abilities and Goals, Dependent - Helper does ALL the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). During an observation on 06/12/2024 at 10:15 AM, CNA L and the NA did not lock the Hoyer (mechanical) lift while Resident #28 was being transferred from his bed to his WC. During an interview on 06/12/2024 at 10:28 AM with CNA L, she stated she was supposed to have locked the Hoyer lift while transferring the resident from the bed to his WC. She stated she had never locked the Hoyer (mechanical) lift prior to this time as well. During an interview on 06/12/2024 at 11:00 AM with the ADON, she stated all nursing staff were trained on the Hoyer (mechanical) lift. She stated CNA L should have applied the brakes on the lift which would have prevented a possible fall. She stated the brakes should have been locked while lifting the resident from the bed as well as being placed in his wheelchair during all Hoyer (mechanical) lift transfers. The ADON stated she checks the CNAs and NAs off on their skilled checkoff sheets with the DON to aid in random checks when needed. She stated her last trainings for the Hoyer (mechanical) lifts were 02/27-02/29 2024. She stated not having the Hoyer (mechanical) lift locked, when needed, could have harmed the resident by tipping over with the resident being hurt. She stated the failure occurred with CNA L not having taken the time to calm herself as she was being watched. The ADON stated she could not have said why the NA went in for resident care as she had not assigned her to that hall. She stated her expectations were for the Hoyer (mechanical) lift to have locked breaks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of CNA L's Staff education/orientation dated 03/21/2024 revealed: Topic Equipment Portable Lift- 3. Portable Lift Operation-Lock wheels-when? V (verbal Verification) given with Meets Criteria marked per ADON's signature. Record Review of Hoyer lift equipment manual on 06/14/2024 https://learn.medcareequipment.com/en_US/drive-patient-lift-owners-manual revealed: When using an adjustable base lift, the legs MUST BE in the maximum OPENED/LOCKED position BEFORE lifting the patient.

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observation, interview, and record review, the facility failed to ensure residents received parenteral fluids administered consistent with professional standards of practice and in accordance with physician orders for 1 of 1 resident (Resident #7) reviewed for peripheral intravenous care. 1. The facility failed to ensure LVN A administered Resident #7's IV (intravenous) antibiotics consistent with professional standards of practice and in accordance with physician orders. 2. The facility did not ensure Residents #7's central line dressings were changed per the physician's order. 3. The facility failed to draw labs weekly per physician orders while Resident #7 was on IV antibiotics. An Immediate Jeopardy (IJ) was identified on [DATE] at 3:23 p.m. While the IJ was lowered on [DATE] at 11:22 p.m., the facility remained out of compliance at a severity level of no actual harm with a scope of pattern, due to the facility's need to evaluate the effectiveness of their corrective actions. These failures placed residents at risk of relapse of an ongoing infection and developing a secondary infection. Findings include: Resident #7 Record review of Resident #7's face sheet dated [DATE] revealed [AGE] year-old female originally admitted on [DATE] with most recent readmission on date [DATE]. Resident #7's diagnoses included: encounter for surgical aftercare following surgery on the skin and subcutaneous tissue (surgery involving skin and below skin tissue), presence of left artificial knee joint (previous left knee surgery), encounter for removal of internal fixation device (surgery revision), methicillin resistant staphylococcus aureus infection (antibiotic resistant infection), and pain. Record review of Resident #7's quarterly MDS assessment dated [DATE] revealed: BIMS score of 13 which indicated cognition was intact. Further review of the MDS Section O Special Treatments, Procedures, and Programs revealed resident received IV medication. Record review of Resident #7's care plan dated [DATE] revealed resident had right chest central line and was at risk for infection, pain, infiltration, cardiac, and respiratory issues. The goal was for Resident #7 to be free from infections, infiltration, and adverse effects. The facility staff approach included for staff to assess IV site q shift and prn. Further review of care plan revealed Resident #7 had post-surgical history of infection. The goal was for Resident #7's infection to be cleared by the target date and for complications related to the infection. The facility staff approach included staff will administer medications as ordered, monitor lab work as ordered and report results to physician. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #7's electronic physician orders dated [DATE] revealed: Midline catheter: change catheter site dressing / securement device every week on Monday and as needed with transparent dressing with start date of [DATE]. Record review of Resident #7's electronic MAR for the months of [DATE] and [DATE] revealed midline catheter dressing had been changed: 1. [DATE] by LVN B 2. [DATE] by LVN C 3. [DATE] by LVN B Resident #7's electronic physician orders dated [DATE] revealed: meropenem 1 gram to be administered IV every 8 hours for diagnosis of infection and inflammatory reaction due to internal left knee prosthesis (left artificial knee infection). Record review of Resident #7's electronic MAR for the months of [DATE] and [DATE] revealed meropenem had been administered: 1. [DATE] at 4:00 p.m. by LVN A 2. [DATE] at 8:00 a.m. by LVN A 3. [DATE] at 4:00 p.m. by LVN A 4. [DATE] at 12:00 a.m. by LVN A 5. [DATE] at 8:00 p.m. by LVN A Review of Resident # 7's electronic physician orders dated [DATE] revealed: lab CBC w/Diff (a blood test that measures red blood cell count, white blood cell count and platelet count), CMP (a blood test that measures the body's fluid balance, electrolytes like sodium and potassium, and how well the kidneys and liver are working), ESR (a blood test that measures the level of inflammation in the body), CRP (a blood test that can measure a protein produced by the liver in response to inflammation or infection in the body) lab to be drawn once a day on Thursday with start date of [DATE]. Record review of Resident #7's electronic MAR for the months of [DATE] and [DATE] revealed lab CBC w/Diff, CMP, ESR, and CRP lab was performed: 1. [DATE] by DON 2. [DATE] by LVN C 3. [DATE] by LVN A 4. [DATE] by LVN C (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #7's lab results dated [DATE] revealed WBC was 7.97 (acceptable range between 4.0 - 11.0), ESR was 37 (acceptable range between 0 - 30), and CRP was 0.4 (acceptable range between 0.0 - 0.6). Record review of Resident #7's lab results dated [DATE] revealed WBC was 11.42 (acceptable range between 4.0 - 11.0) indicated infection, ESR was 30 (acceptable range between 4.0 - 11.0), and CRP was 0. 6 (acceptable range between 0.0 - 0.6). Record review of Resident #7's hospital discharge paperwork dated [DATE] revealed a progress note from the IDP revealed she had original left total knee arthroplasty (surgical procedure in which parts of a damaged joint are removed and replaced) (in 2007, followed by revision in February 2020, then followed by two subsequent incision and drainage procedures in 2020. In [DATE], she underwent explant (removal of surgical hardware) of left knee arthroplasty and spacer placement. On [DATE] she underwent revision of left total knee arthroplasty. The plan was to continue meropenem (antibiotic medication), follow up on cultures, six weeks of antibiotic with end of treatment [DATE], monitor labs, supportive care, and placement of tunneled catheter ordered. Discharge planning included meropenem 1 gram every 8 hours with end date [DATE]. Patient to follow up in the ID (Infectious Disease) clinic in 3 weeks. Check lab CBC (a blood test that measures red blood cell count, white blood cell count and platelet count), CMP (a blood test that measures the body's fluid balance, electrolytes like sodium and potassium, and how well the kidneys and liver are working), ESR (a blood test that measures the level of inflammation in the body), CRP (a blood test that can measure a protein produced by the liver in response to inflammation or infection in the body) while on IV antibiotics. Provide central line dressing weekly and prn. During an observation and interview on [DATE] at 10:49 a.m., Resident #7 had IV bag of 100 mL of NS infusing into right chest double lumen central line. On the medication bag there were instructions to *ACTIVATE VIAL PRIOR TO USE*. In the vial white powder (meropenem 1 gram) was observed and was dry. No date and time were written on IV tubing or on IV bag and it was being infused at 100 mL/hr using IV pump. There was approximately 25 mL left of NS in bag. The central line dressing loose, pulled away from skin toward bottom of the dressing, was not sealed to maintain sterile environment and moved when Resident #7 lifted shirt. Resident #7 stated she did not know when the dressing had been changed last. She stated she did not remember if facility staff had ever changed out the dressing. Date observed on central line dressing to be [DATE]. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:14 a.m., the DON stated she expected for central line dressings to be changed every 7 days or prn when dressing was compromised. She stated central line dressing should be assessed by every nurse that is performing IV medication administration and she did not know why the central line dressing had not been changed since [DATE]. She stated central line dressings should be intact and it should not be loose at the bottom. The DON stated not performing dressing changes when needed or every 7 days could cause resident to have infection at the insertion site. She stated that she expected IV tubing to be timed and dated when it was hung. She did not know why tubing was not timed and dated. She stated the powdered medication in vial should have been activated by popping the seal from IV bag to powdered vial, then mixing into the solution in IV bag prior to medication being administered. She stated she had personally checked off LVN A on IV medication administration and did not know why she failed to mix medication into the bag. She stated that sometimes the pharmacy would send already mixed medication in solution and LVN A may have thought it was already mixed. She stated not mixing medication meant that resident did not get antibiotic as ordered and she had instructed LVN A to call physician to notify of missed dose. The DON stated she monitored IV medication was given correctly. During an interview on [DATE] at 11:21 a.m., LVN A stated she had administered IV medication that morning. She stated she hung medication with new tubing but did not label tubing with date or time. She stated the central line dressing should be intact and tight to skin. She stated she would change the central line dressing. LVN A stated loose central line dressing could cause resident to have infection and should be sealed. She stated she did not mix up the medication from vial into IV bag because it was coming premixed, and she thought medication was in the bag without her having to mix it. She stated not mixing the medication meant that resident did not get antibiotic dose. During an interview on [DATE] at 12:28 p.m., the Pharmacy Director with contracted pharmacy the facility used stated the pharmacy record showed as long as the pharmacy had been filling meropenem (antibiotic) medication to Resident #7, the facility had received medication in a snap together vial. He stated typically it was an insurance issue on how the medication was filled. He stated the pharmacy had written instructions on the bag label to activate vial prior to use but no separate instructions were sent to the facility. He stated the effect of facility staff not activating vial would interfere with mixing the medication and no antibiotic would have been infused if it was not activated prior to infusion. He stated the effect on the resident would be she would have gotten hydration with a little bit of sodium, and it would not have harmed her. He stated whatever the medication in the vial was prescribed to treat, would not have been treated and could have interfered with wound healing if Resident #7 missed doses. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a follow up interview on [DATE] at 02:49 p.m., the DON stated IV Certificate education should include management of the IV access site including central lines, and administration of IV medication including how to prepare medication. The DON stated IV Certification education was provided outside of the facility, but the curriculum matched what the contracted pharmacy had in their training. She stated no other residents in the facility had IV medication ordered currently that had to be activated prior to administration currently. The DON stated she talked to the nurse that was responsible for changing the central line dressing on [DATE]. She stated LVN B told her the central line dressing was not changed by LVN B due to there was a treatment nurse that day and LVN B assumed the treatment nurse would change the dressing. The DON stated she expected the nurses signing the MAR to verify that all treatments had been performed prior to leaving for the day and LVN B had been in-serviced on that. She stated Resident #7's wound had been healing and the surgeon had been pleased with the progress. She stated Resident #7 continued to have a wound vac in place and no impaired healing had been observed. The DON stated the facility reached out to Resident #7's attending physician that prescribed medication to notify her of the delayed meropenem dose and the facility was awaiting response. She stated the Medical Director of facility had been informed of delayed meropenem dose and new order obtained for medication dose to be rescheduled for 1300, 2100, and 0500 because of the medication error earlier. During a follow up interview at [DATE] at 03:30 p.m., LVN A stated it had been over a year ago when she was certified on IV medication and that she would assume that the IV Certification went over mixing IV medication. LVN A stated in the last month and a half she had been floating and working in different areas and times. She stated she usually did not work on the hall Resident #7 resided on and she had filled in 2 nights shifts on that hall. She stated she did notice the central line dressing was loose prior to administering IV meropenem medication that morning but had not noticed the date on the dressing. She stated the central line dressing was not secured to the skin and she had planned to change the dressing after medication had been administered. She stated central line dressing being loose could cause site infection. She stated she had administered meropenem to Resident #7 previously and medication had been delivered premixed with no need to activate the vial. She stated she did not feel that any negative outcome occurred to the resident from central line dressing not being changed or medication error. She stated she had called the Medical Director when she could not get ahold of the ordering physician, and a new order was received to administer another dose at 1:00 pm so that Resident #7 did not miss a dose, and then retime medication every 8 hours after the 1:00 p.m. dose. During a phone interview on [DATE] at 04:32 p.m., the Medical Director stated he expected staff to follow pharmacy instructions when administering medications. He stated that he was not familiar with the specifics of IV medication that had snap together vials but that he expected nurses to be trained on how to prepare medications that were being administered. The MD stated the effect of not getting meropenem as ordered for sepsis or infection may aggravate the infection and could have caused a flare up from the infection or relapse of an ongoing infection. He stated he assumed the nurses and the ADON, and the DON were who monitored medication was given as directed. He stated he was notified that medication was delayed and he did give directions to give medication and readjust every 8 hours with new time so that medication would not be missed. He expected IV tubing to be changed per protocol and not changing tubing could lead to secondary infection. He stated he expected tubing and medication bag to be labeled with a date because staff will get busy and may forget when bag / tubing was hung. He stated he expected central line dressings to be changed every 7 days per protocol and that it would be changed if dressing was compromised. He expected that dressing be secured to the skin and not changing could lead to secondary infection and insertion site infection risk. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an attempted telephone interview on [DATE] at 10:25 a.m., the Attending Physician did not answer the phone. Left message with office staff to please have her return phone call. The Attending Physician did not return call. During an attempted phone interview on [DATE] at 10:48 a.m., LVN D did not answer the phone and a message to return the call was left. The LVN D did not return call. During an attempted phone interview on [DATE] at 10:51 a.m., LVN B did not answer the phone and there was no option to leave a voice message. During a phone interview on [DATE] at 10:54 a.m., LVN C stated he had worked for the facility on and off for the last 3 years. He stated that if medication came with instructions to activate vial prior to use, there was a blue stem that needed to be snapped to break the seal. LVN C stated after seal broken then he would get NS into vial and mix with powdered medication. He stated the mixed liquid and medication in the vial would be drained back into IV bag prior to being administer. He stated he did not remember any of Resident #7's IV medication being delivered to facility pre-mixed, but the pharmacy had done that in the past for other residents. He stated when medication is pre-mixed, it is time sensitive so medication would only be delivered in lesser amounts. He stated he had not noticed medication not being prepared per instructions. He stated if medications were not mixed prior to administration, the effect on the resident would be that they only received hydration. He stated central line dressings should be changed once a week and as needed. He stated central line dressing would need to be changed if it was loose and could become looser with clothing changes. He stated the effect of not changing central line dressings every 7 days or as needed is hard to determine because if the dressings were still sealed, he believed the port of entry would not be exposed in some cases, but it could lead to skin breakdown from skin not being allowed to breath. He stated he had not changed the central line dressing and that if he had signed that he had performed it was signed in error. He stated he would sign off on task in MAR prior to performing task and would have made his best effort to perform the task. He stated the error may have been due to there are a lot of distractions in the facility and may have forgotten to perform. He felt that the facility had enough staff and was not shorthanded. He stated that distractions resulted from him trying to make himself available to all residents and would be approached routinely by residents even if they were not assigned to him and he would attempt to help them. During an interview on [DATE] at 11:15 a.m., LVN F stated she had worked at the facility for a little over a year. LVN F stated she had IV medication training prior to working at the facility and had a refresher on [DATE]. She stated if the medication label stated activate vial prior to use that meant the nurse must break seal then mix with the saline prior to IV administration. She stated Resident #7's IV medication had never come from pharmacy pre-mixed. LVN F stated she had not had any concerns about other nursing staff related to administering IV medication administration. She stated that not activating vial prior to medication administration could cause Resident #7 to not get medication, her wound may not have healed quickly, or the infection to become worse. She stated the central line dressing should be replaced every 72 hours. She stated nurses should change the central line dressing if dressing was loose, and not changing as ordered or as needed could cause infection. She stated nurses should document treatment performed in MAR after the nurse had completed the treatment. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on [DATE] at 11:18 a.m., RN E stated that she was the nurse at the IDP's office. She stated her expectation would be for central line dressing changes to occur every 7 days or prn for any soiled, loose, wet dressings. She stated loose meant that insertion cite was exposed by clear part of dressing becoming compromised. She stated the central line dressing site should be monitored every shift. RN E stated the effect of not changing the central line dressing routinely and as needed would cause highly increased risk for central line infection in the blood stream. She stated IDP was using meropenem to treat an active infection and she expected IV antibiotics to be administered per physician's orders. She stated IDP should be notified when IV antibiotics were missed, or medication was delayed, and she had not received any notification from the facility of the medication error. She stated the effect of missing or delaying doses of meropenem could cause Resident #7's active diagnosis to be not treated properly, delayed healing, cause the infection to worsen, and risk hurting the resident. Could also cause prolonged antibiotic treatment, rehospitalization , and incision site failure. RN E stated she was unsure if missing antibiotic doses would cause any risk for surgery hardware failure. She stated the failure of not administering antibiotics as ordered could expose residents to extended treatments. RN E stated she had made two attempts to contact facility requesting lab results as IDP ordered lab CBC w/Diff (a blood test that measures red blood cell count, white blood cell count and platelet count), CMP (a blood test that measures the body's fluid balance, electrolytes like sodium and potassium, and how well the kidneys and liver are working), ESR (a blood test that measures the level of inflammation in the body), CRP (a blood test that can measure a protein produced by the liver in response to inflammation or infection in the body) labs to be drawn weekly on Monday while on IV therapy. At that time, she stated she had not received any lab results from the facility and as a result IDP planned on drawing labs in their office during post hospitalization visit. During a follow up interview on [DATE] at 2:49 p.m., the DON stated the only labs that the facility had drawn from Resident #7 were done on [DATE]. She stated the facility had gotten a call from IDP office requesting labs on [DATE] and she did not know that labs had not been performed. She stated the facility should have drawn labs as ordered and the order would have been found on hospital discharge paperwork. She was unsure how often the order was for at that time. She stated the facility would be drawing labs when resident returned from physicians' visits in another town and would send results to IDP office. She stated it was her expectation that documentation in EMR be done after treatment had been performed. She stated she did not know why nurses had documented without performing the treatment. She stated nurses should not document something another nurse had stated they had performed. She stated the effect on the resident could be missed treatments. She stated that she monitors treatments are done by running EMR reports that would show when treatment had been missed and observing staff perform treatments. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 2:51 p.m., LVN B stated she had worked for the facility for 3 years in [DATE]. She stated she had received IV antibiotic medication administration training. LVN B stated when an IV was labeled activate prior to use and it was the antibiotic that Resident #7 used, the nurse should have snapped the connection from IV bag to vial, squeezed solution from IV bag into vial and mixed with powder, then with bag upside down squeezed bag to allow mixed solution into IV bag to prepare medication prior to it being infused. She stated she had not remembered seeing any premixed medication in the facility for Resident #7 after her most recent hospitalization . LVN B stated she had not had any concerns about other nursing staff not activating IV medication, but she would usually be the nurse who started medication dose in the morning with fresh tubing, so night nurse would not leave empty medication bag for her to observe. She stated tubing should be changed every 24 hours. She stated when new IV tubing was used then it should have a date, time, and nurses initial on it so that other staff know when it was first used. She stated missing IV antibiotic dose could cause Resident #7 to have longer healing time and would be considered a medication error. She was unsure what policy stated about central line dressing frequency but stated that it should be changed as ordered and prn when dressing was loose. LVN B stated not changing central line dressing when ordered or needed could cause another type of infection and significant problems by leaving area open for bacteria to get into insertion site. She stated she worked on [DATE] and she did sign that central line dressing had been changed since the facility had a RN performing treatments that day and she thought the RN changed the dressing. She stated usually the RN treatment nurse would let her know treatment had been performed and she would sign that it had been completed. She stated that she should have verified by observing central line dressing had been changed and did not remember why she did not verify it prior to signing that it was completed in MAR. She stated she had been in-serviced about central line dressings yesterday on changing dressing per orders and verifying treatment done prior to checking off it had been performed. She stated she should not check off treatments she had not performed. During a follow up interview on [DATE] at 3:00 PM, the DON stated there were no labs drawn for Resident #7 since being discharged from the hospital and admitted into facility. She stated she expected the nurse to look at the EMAR to know when the lab was ordered and that if a nurse signed off the EMAR that lab was collected after procedure had been performed. She stated the nurse should send lab to the hospital if they signed off that lab was collected. She stated the order revealed labs were to be drawn by an RN as it was to be drawn from central line and should have been done weekly. The DON stated it was her as DON that did the lab trackers and with the nurses being flagged in the EMAR to alert them to draw the labs. She stated there would be potential harm to the resident based off of her labs not being drawn, which could have caused the resident to have become septic. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on [DATE] at 3:26 p.m., LVN D stated she had worked for the facility for four or five years. She stated she had completed IV class but did not remember the date of original training, but the DON had a copy of certification. She stated she had received more training in IV administration on [DATE]. LVN D stated when an IV was labeled activate prior to use the seal needed to be broken and medication in vial mixed with solution from IV bag prior to administration. She stated the pharmacy had only delivered IV antibiotic medication that needed to be activated for Resident #7 since her most recent surgery. She stated she had no concerns about other nursing staff not mixing antibiotic medication prior to administering. She stated the effect of not mixing IV antibiotic could cause resident to not to get medication that she needed, and medication would not help whatever Resident #7 receiving medication for. She stated she believed the central line dressing needed to be changed every 7 days but would have to look at facility policy to verify that information. She stated the central line dressing would need to be changed if it had become loose, soiled, or damaged to prevent infection by bacteria getting under the dressing. She stated she assessed the dressing every time she administered IV medication and at least once a shift. LVN D stated she only documents completion of treatment in MAR when she completed the treatment that was ordered. During an attempted telephone interview on [DATE] at 3:52 p.m., Resident #7's emergency family member could not be reached with directions. The phone number dialed was not a working number. During a follow-up interview on [DATE] at 4:04 p.m., the DON stated Resident #7 was back from the ID physician's appointment and orthopedic surgeon's appointment. She provided paperwork the facility had received from ID physician's appointment but stated orthopedic surgeon did not send any additional paperwork from office visit. She stated that she was not sure why a new order from ID physician for PO antibiotic after IV antibiotic was completed. She stated Resident #7 was alert and more than likely would be able to answer basic questions about office visits. The DON stated she had started the afternoon dose of IV meropenem when the resident returned to facility after she had drawn blood from central line for lab work. During a follow up observation and interview on [DATE] at 4:09 p.m., Resident #7 sat in wheelchair in her room with an immobilizing brace on her left leg. IV pump on and alarm beeped with IV tubing connected to her central line. A staff member entered the room and informed the resident that she had notified the nurse of the pump alarm, and she was not allowed to touch the pump. IV meropenem had been pre-mixed prior to infusion and tubing labeled with paper tape. Resident #7 stated that she had a plastic surgeon appointment scheduled for [DATE] and that appointment was made prior to her ID physician and orthopedic surgeon's appointments. She stated she did not know why ID had ordered oral antibiotic in addition to IV antibiotic. Resident #7 stated that the orthopedic surgeon did not think that the wound vac had been healing her left knee surgical wound and that was why she was scheduled to see plastic surgeon tomorrow to discuss surgical options. She stated she was nervous about having another surgery since she almost died during the last surgery. The call light was in reach. Record review of summary of infectious disease physicians visit dated [DATE] revealed: Complete IV antibiotic on ,d+[DATE] as scheduled and we will send orders to remove PICC line. Start Levaquin 500mg PO daily on ,d+[DATE]. Follow up with orthopedic surgeon in 6 weeks .next appointment [DATE]. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a follow up interview on [DATE] at 11:12 a.m., the DON stated she did not think that increased WBC lab value on [DATE] had anything due to IV antibiotic administration and stated there was no way of proving Resident #7 had any missed doses just the delayed dose on ,d+[DATE]. She stated she thought the WBC lab could have been related to Resident #7's emotional distress on [DATE] or how the DON drew the lab. The DON stated that she may have drawn lab too quickly and she believed that may have affected lab value. She stated the facility faxed over lab results to IDP office and she would call and speak with RN E at the clinic to see how IDP interpreted the lab results. She stated at that time she had no information on how IDP had interpreted the lab value. She stated that she had spoken to the orthopedic surgeon's office who stated oral antibiotic daily after IV antibiotic would need to be administered for the remainder of resident's life. She stated she was told that the antibiotic may change to different antibiotic medication, but the resident would need treatment for the rest of her life. During a follow up interview on [DATE] at 03:12 p.m., Resident #7 stated she was seen by plastic surgeon for her left knee wound. She stated during the plastic surgeon's appointment, she was told the surgeon recommended a skin graft and if the graft did not work then they wanted to amputate. She said that she did not want an amputation. During an attempted telephone interview on [DATE] 11:23 a.m. with the MD, the MD did not answer and a message to return call was left. During an attempted telephone interview on [DATE] 11:23 a.m. with the IDP nurse, RN E, RN E did not answer and a message to return call was left. During an interview on [DATE] at 08:13 p.m., the ADMN stated he expected staff to not sign off on treatments unless they verified the treatment was done. He stated staff should not sign off on treatments prior to performing them. The ADMN stated that he expected dressings to be looked at to verify the date on the dressing and assess the site. He stated he felt the failure occurred due to staff becoming busy and had intention of performing but then forgot. The ADMN stated ADON monitors that treatments are performed, and DON was who monitored also. He stated the effect of not performing treatments could lead to infection. Record review of LVN A's certificate titled Texas IV Therapy Certification dated [DATE] revealed LVN A completed 14 contact hours of the course. Record review of LVN A's skills check off titled Medication Administration dated [DATE] revealed no evidence of activating vial on snap vial system had been performed. Record review of LVN A's skills check off titled Medication Administration dated [DATE] revealed no evidence of activating vial on snap vial system had been performed. Record review of facility policy titled Lab and Diagnostic Results - Clinical Protocol revised on [DATE] revealed: The physician will identify and order diagnostic and lab testing based on diagnostic

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and/or the residents' goals and preferences, for 1 of 18 residents (Residents #70) reviewed for respiratory care. The facility failed to ensure that Residents #70's oxygen tubing had been changed and dated once weekly. This failure placed residents that used oxygen/treatments at risk of respiratory complications and/or possible respiratory infections. Findings included: Review of Resident # 70's face sheet dated 06/14/2024 revealed an [AGE] year-old female admitted on [DATE]. Resident #70's diagnoses was, Chronic respiratory failure, heart disease, upper respiratory infection, cough, pain, anxiety, and shortness of breath. Review of Resident #70's Review of Resident #70's open ended (no end date) orders, dated 07/12/2023, revealed: Change nebulizer tubing every week on Sunday, once a day on Sunday 6:00 PM-6:00AM shift. Review of Resident # 70's MDS assessment dated [DATE] revealed, Section C- Cognitive Behavior a BIMS score of 09 (moderately impaired). Section O-Special Treatments-Respiratory Treatments-Oxygen Therapy. Review of Resident # 70's care plan dated 04/26/2024 revealed: Category-Oxygen Therapy. Problem-Potential for complications, s/sx (signs and symptoms) related to diagnosis of COPD. Goal-Will have respiratory rate within normal limits, be free of s/sx of respiratory distress, and maintain optimal functioning within limitations imposed by disease process through review date. Approach- Nebulizer treatments and/ or inhalers as ordered. Monitor for effectiveness, and side effects. During an observation on 06/14/2024 at 2:55 PM with the DON of Resident#70's Nebulizer tubing revealed it had 05/06/2024 written on it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/14/2024 at 2:55 PM the DON stated the Nebulizer tubing should have been changed since 05/06/2024. She stated the tubing should have been removed from the nebulizer, and staff should never have dated the tubing per policy. The DON stated she did not know how to respond to who should have been monitored. She stated Oxygen tubing, should be changed every Sunday at night whether the resident used it, or not. The DON stated there were some controversies dating the tubing when changed or not because it pops up on the computer Sunday night for the staff to change out. She stated she felt there was not a need to place the date on the tubing. She stated the Interdisciplinary Team should have monitored making rounds. and they can tell with by looking and the way they look. The DON stated the negative effects could have placed residents at potential higher risk of respiratory infection as well as hovering bacteria. She stated the failure occurred with not following the EMAR and changing the tubing on the nebulizer when time. The facility provided no evidence of a policy in which the respiratory tubing should be dated when changed.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on interviews and record reviews the facility failed to ensure physician visits were conducted once every 30 days for 2 of 18 residents (Resident #2, Resident #73) and every 60 days for 4 of 18 residents (Resident #25, Resident #46, Resident #51, Resident #56) who were reviewed for physician visits. The facility failed to have Resident #2 seen by physician at least once every 30 days for the first 90 days after admission on 3/13/2024. The facility failed to provide documentation that Resident #2 was seen in April 2024. The facility failed to have Resident #73 seen by physician at least once every 30 days for the first 90 days after admission on 2/7/2024. The facility failed to provide documentation that Resident #73 was seen in March 2024, April 2024 and May 2024. The facility failed to have Resident #25 seen by physician at least every 60 days after the first 90 days for the past year from March 2023. The facility failed to provide documentation that Resident #25 was seen April 2023 and August 2023. The facility failed to have Resident #46 seen by physician at least every 60 days after the first 90 days for the past year from March 2023. The facility failed to provide documentation that Resident #46 was seen December 2023. The facility failed to have Resident #51 seen by physician at least every 60 days after the first 90 days for the past year from March 2023. The facility failed to provide documentation that Resident #51 was seen April 2023. The facility failed to have Resident #56 seen by physician at least every 60 days after the first 90 days for the past year from March 2023. The facility failed to provide documentation that Resident #56 was seen April 2023. These failures could lead to a decline in health status or untreated conditions. Findings included: Resident #2 Record review of Resident #2's face sheet dated 06/14/2024 revealed a [AGE] year-old male originally admitted on [DATE], with the following diagnoses hypertension (high blood pressure), type 2 diabetes mellitus (body does not make enough insulin or does not use insulin well), pressure ulcer of right buttock, stage 3, muscle wasting, paranoid schizophrenia, and major depressive disorder. Record review of Resident #2's Admission MDS dated [DATE] revealed Section C- Cognitive Patterns Resident #2 had a BIMS score of 0 meaning an interview was not conducted with resident because Resident #2 was rarely/never understood. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's electronic charting and paper review revealed no physician visit for April 2024. Resident #73 Record review of Resident #73's face sheet dated 06/14/2024 revealed [AGE] year-old male originally admitted on [DATE] with the following diagnoses Alzheimer's disease, acute kidney failure, and hypertension (high blood pressure). Record review of Resident #73's Quarterly MDS dated [DATE] revealed Section C- Cognitive Patterns Resident #73 had a BIMS score of 0 meaning an interview was not conducted with resident because Resident #2 was rarely/never understood. Record review of Resident #73's electronic charting and paper review revealed no physician visits for March 2024, April 2024 and May 2024. Resident # 25 Record review of Resident #25's face sheet dated 06/14/2024 revealed [AGE] year-old female originally admitted on [DATE] with the following diagnoses respiratory failure, anxiety disorder, pain, kidney failure and type 2 diabetes mellitus (body does not make enough insulin or does not use insulin well). Record review of Resident #25's Quarterly MDS dated [DATE] revealed Section C- Cognitive Patterns Resident #25 had a BIMS score of 15 meaning cognitively intact. Record review of Resident #25's electronic charting and paper review revealed no physician visits for April 2023. Resident #51 Record review of Resident #51's face sheet dated 06/14/2024 revealed a [AGE] year-old male originally admitted on [DATE], with the following diagnoses heart failure, hypertension (high blood pressure), type 2 diabetes mellitus (body does not make enough insulin or does not use insulin well), peripheral vascular disease, coronary artery disease and wound infection. Record review of Resident #51's Annual MDS dated [DATE] revealed Section C- Cognitive Patterns Resident #51 had a BIMS score of 14 meaning cognitive intact. Record review of Resident #51's electronic charting and paper review revealed no physician visit for April 2023. Resident #56 Record review of Resident #56's face sheet dated 06/14/2024 revealed a [AGE] year-old male originally admitted on [DATE], with the following diagnoses hypertension (high blood pressure), major depressive disorder, anxiety, age related cognitive decline, pain and nicotine dependence. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #56's Quarterly MDS dated [DATE] revealed Section C- Cognitive Patterns Resident #56 had a BIMS score of 8 meaning moderate cognitive impairment. Record review of Resident #56's electronic charting and paper review revealed no physician visit for April 2023. During an interview on 06/14/2024 at 7:35 PM the DON stated her expectation was that residents should have been seen within 30 days of their admission, then every 30 days within the first 90 days, and then every 60 days after. The DON stated she was responsible for monitoring and ensuring residents received their physician visits timely. The DON stated residents could have been affected by not receiving their physician visits by orders not being reviewed by physician, and residents may not have been assessed accurately. The DON stated what led to failure was physicians not coming in to see their residents. The DON stated she had realized physicians were not seeing residents per the required guidelines and had been working with their MD on how to better track visits. The DON stated she was not sure what happened in April 2023 because there were several missed visits missed by the MD. During an interview on 06/14/2024 at 8:13 PM the ADMN stated his expectation was that residents be seen by physician per guidelines. The ADMN stated that residents should have been seen by their primary physician every 30 days for the first 90 days and then every 60 days thereafter. The ADMN stated he knew they had issues with physician visits not occurring in timely manner, but that the DON had been working on a better system to track physician visits. The ADMN stated the DON was responsible for monitoring physician visits. The ADMN stated residents could have been affected by having missed physician visits, residents like to see their physician, missed medication changes, or wounds not being assessed. The ADMN stated what led to failure was not being able to get physicians to come in timely manner. Record review of facility policy titled Physician Visits with the date of April 2013 revealed, The attending physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 48883 Based on interviews, and record review the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident and determined by considering the number, acuity, and diagnoses of the facility's resident population with accordance for 3 of 10 days reviewed for sufficient staffing. The facility failed to maintain nurse staffing at the level indicated by the PPD budget on 05/04/2024, 05/12/2024 and 06/01/2024. This failure could place the residents at risk of resident's needs, safety and psychosocial well-being not being met. Findings included: Record review of timesheets dated 05/04/2024 revealed 168.65 hours worked by direct care staff. Per facility PPD and census, 222.30 direct care staff hours were needed. Record review of timesheets dated 05/12/2024 revealed 199.39 hours worked by direct care staff. Per facility PPD and census, 228 direct care staff hours were needed. Record review of timesheets dated 06/01/2024 revealed 170.84 hours worked by direct care staff. Per facility PPD and census, 228 direct care staff hours were needed. During an interview on 06/10/2024 at 10:49 AM Resident # 7 stated there was not enough staff. Resident #7 stated at night she might have to wait an hour to be changed and she had issues with skin breakdown. Resident #7 stated she did not feel she was getting enough showers and normally got one shower a week but sometimes twice. During an interview on 06/10/2024 at 4:38 PM Resident # 29 stated the facility was short staffed on the weekends and at night. Resident #29 stated she had a fall recently, during the day. Resident #29 stated it took several staff to take care of her, she was fearful that if she were to fall on the weekend or at night and another resident were to fall also there would not be enough staff to take care of them both. During an interview on 06/10/24 at 8:50 PM RN K refused to answer any questions concerning the facility being short staffed or fear of retaliation. RN K stated, I value my job too much, and did not provide any other response. During a confidential interview on 06/12/2024 at 10:38 AM stated they were happy the state surveyors where in the building because it meant they would have the help they needed to take care of residents. Confidential interview was tearful as they explained there have been several times that there were only 2 aides to take care of the residents on five of the 6 halls. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/12/2024 at 2:52 PM Resident #4 stated it took staff a while to answer her call light. Resident #4 stated she felt they did not have enough people working at the facility. Resident #4 stated she had issues with her wound dressing falling off in the middle of the night and staff not putting another bandage on until the next afternoon. Resident #4 stated she was scared that loose stool would get into her wound. During an interview on 06/14/24 at 7:35 PM the DON stated the ADON was responsible for completing the daily staffing schedule. The DON stated she was responsible to monitor staffing. The DON stated her expectation was to have one CNA per 5 of 6 halls and 2 CNA's on the secure unit for the day shift. 2-3 nurses' day shift. The DON stated her expectation for the night shift was 4 aides and 2 nurses and with partial nurse. The DON stated their cooperate has a rate that provides the goal for direct care staff, the PPD rate was 2.85. The DON stated you multiply the PPD by the census and that gives the total direct care staff hours needed. The DON stated being short staffed could have affected residents by higher risk of falls, call lights not being answered timely, or potential for residents missing showers. The DON stated what led to failure was not having enough staff and they have tried to hire more staff. During an interview on 06/14/2024 at 8:13 PM the ADMN stated the ADON was responsible for scheduling and the DON will makes adjustments to the schedule. The ADMN stated his expectation was to reach the PPD goal daily or as close to it as they can. The ADMN stated not reaching the daily PPD goal could have caused skin break down from having to wait too long for peri care, people who fall could have had to lay in floor waiting to be evaluated. The ADMN stated he, the DON and the ADON monitored by using the staffing sheet. The ADMN stated what led to failure of being under the PPD goal was staff quit without giving notice, will call in, or will no show/no call. The ADMN stated he has a budget sheet, from corporate, that provided him with the PPD. The ADMN stated the PPD for direct care staff was 2.85. Record review of facility policy titled, Staffing dated April 2007 revealed Our facility provides adequate staffing to meet needed care and services for our resident population. Our facility maintains adequate staffing on each shift to ensure that our residents needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. Certified Nursing Assistants are available ton each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan. Record review of facility provided form revealed the direct care total (PPD) was 2.85.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observation, interview, and record review, the facility failed to ensure residents were free of significant medication errors for 2 of 2 residents (Resident #7 and #51) reviewed for medication errors. The facility failed to administer Resident #7's IV (intravenous) antibiotics as ordered by the physician on [DATE], [DATE] (two doses), [DATE], and [DATE]. An Immediate Jeopardy (IJ) was identified on [DATE] at 3:23 p.m. While the IJ was lowered on [DATE] at 11:22 p.m., the facility remained out of compliance at a severity level of no actual harm with a scope of pattern, due to the facility's need to evaluate the effectiveness of their corrective actions. The facility failed to ensure nursing staff administered Resident #51's Insulin Glargine as ordered by the physician. LVN N failed to administer Resident #51's Insulin Glargine 7 times during a 2-month review period, per physician order. RN F failed to administer Resident #51's Insulin Glargine 4 times during a 2-month review period, per physician order. LVN D failed to administer Resident #51's Insulin Glargine 1 time during a 2-month review period, per physician order. LVN M failed to administer Resident #51's Insulin Glargine 1 time during a 2-month review period, per physician order. These failures placed residents at risk of relapse of an ongoing infection and developing a secondary infection, and at risk of diabetic complications. Findings include: Resident #7 Record review of Resident #7's face sheet dated [DATE] revealed [AGE] year-old female originally admitted on [DATE] with most recent readmission on date [DATE]. Resident #7's diagnoses included: encounter for surgical aftercare following surgery on the skin and subcutaneous tissue (surgery involving skin and below skin tissue), presence of left artificial knee joint (previous left knee surgery), encounter for removal of internal fixation device (surgery revision), methicillin resistant staphylococcus aureus infection (antibiotic resistant infection), and pain. Record review of Resident #7's quarterly MDS assessment dated [DATE] revealed: BIMS score of 13 which indicated cognition was intact. Further review of the MDS Section O Special Treatments, Procedures, and Programs revealed resident received IV medication. (continued on next page)

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	455744	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mulberry Manor	1670 Lingleville Rd Stephenville, TX 76401

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #7's care plan dated [DATE] revealed resident had right chest central line and was at risk for infection, pain, infiltration, cardiac, and respiratory issues. The goal was for Resident #7 to be free from infections, infiltration, and adverse effects. The facility staff approach included for staff to assess IV site q shift and prn. Further review of care plan revealed Resident #7 had post-surgical history of infection. The goal was for Resident #7's infection to be cleared by the target date and for complications related to the infection. The facility staff approach included staff will administer medications as ordered, monitor lab work as ordered and report results to physician. Resident #7's electronic physician orders dated [DATE] revealed: meropenem 1 gram to be administered IV every 8 hours for diagnosis of infection and inflammatory reaction due to internal left knee prosthesis (left artificial knee infection). Record review of Resident #7's electronic MAR for the months of [DATE] and [DATE] revealed meropenem had been administered: 1. [DATE] at 4:00 p.m. by LVN A 2. [DATE] at 8:00 a.m. by LVN A 3. [DATE] at 4:00 p.m. by LVN A 4. [DATE] at 12:00 a.m. by LVN A 5. [DATE] at 8:00 p.m. by LVN A Record review of Resident #7's lab results dated [DATE] revealed WBC was 7.97 (acceptable range between 4.0 - 11.0), ESR was 37 (acceptable range between 0 - 30), and CRP was 0.4 (acceptable range between 0.0 - 0.6). Record review of Resident #7's lab results dated [DATE] revealed WBC was 11.42 (acceptable range between 4.0 - 11.0) indicated infection, ESR was 30 (acceptable range between 4.0 - 11.0), and CRP was 0. 6 (acceptable range between 0.0 - 0.6). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #7's hospital discharge paperwork dated [DATE] revealed a progress note from the IDP revealed she had original left total knee arthroplasty (surgical procedure in which parts of a damaged joint are removed and replaced) (in 2007, followed by revision in February 2020, then followed by two subsequent incision and drainage procedures in 2020. In [DATE], she underwent explant (removal of surgical hardware) of left knee arthroplasty and spacer placement. On [DATE] she underwent revision of left total knee arthroplasty. The plan was to continue meropenem (antibiotic medication), follow up on cultures, six weeks of antibiotic with end of treatment [DATE], monitor labs, supportive care, and placement of tunneled catheter ordered. Discharge planning included meropenem 1 gram every 8 hours with end date [DATE]. Patient to follow up in the ID (Infectious Disease) clinic in 3 weeks. Check lab CBC (a blood test that measures red blood cell count, white blood cell count and platelet count), CMP (a blood test that measures the body's fluid balance, electrolytes like sodium and potassium, and how well the kidneys and liver are working), ESR (a blood test that measures the level of inflammation in the body), CRP (a blood test that can measure a protein produced by the liver in response to inflammation or infection in the body) while on IV antibiotics. Provide central line dressing weekly and prn. During an observation and interview on [DATE] at 10:49 a.m., Resident #7 had IV bag of 100 mL of NS infusing into right chest double lumen central line. On the medication bag there were instructions to *ACTIVATE VIAL PRIOR TO USE*. In the vial white powder (meropenem 1 gram) was observed and was dry. No date and time were written on IV tubing or on IV bag and it was being infused at 100 mL/hr using IV pump. There was approximately 25 mL left of NS in bag. The central line dressing loose, pulled away from skin toward bottom of the dressing, was not sealed to maintain sterile environment and moved when Resident #7 lifted shirt. Resident #7 stated she did not know when the dressing had been changed last. She stated she did not remember if facility staff had ever changed out the dressing. Date observed on central line dressing to be [DATE]. During an interview on [DATE] at 11:14 a.m., the DON stated the powdered medication in vial should have been activated by popping the seal from IV bag to powdered vial, then mixing into the solution in IV bag prior to medication being administered. She stated she had personally checked off LVN A on IV medication administration and did not know why she failed to mix medication into the bag. She stated that sometimes the pharmacy would send already mixed medication in solution and LVN A may have thought it was already mixed. She stated not mixing medication meant that resident did not get antibiotic as ordered and she had instructed LVN A to call physician to notify of missed dose. The DON stated she monitored IV medication was given correctly. During an interview on [DATE] at 11:21 a.m., LVN A stated she had administered IV medication that morning. She stated she hung medication with new tubing but did not label tubing with date or time. She stated the central line dressing should be intact and tight to skin. She stated she would change the central line dressing. LVN A stated loose central line dressing could cause resident to have infection and should be sealed. She stated she did not mix up the medication from vial into IV bag because it was coming premixed, and she thought medication was in the bag without her having to mix it. She stated not mixing the medication meant that resident did not get antibiotic dose. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 12:28 p.m., the Pharmacy Director with contracted pharmacy the facility used stated the pharmacy record showed as long as the pharmacy had been filling meropenem (antibiotic) medication to Resident #7, the facility had received medication in a snap together vial. He stated typically it was an insurance issue on how the medication was filled. He stated the pharmacy had written instructions on the bag label to activate vial prior to use but no separate instructions were sent to the facility. He stated the effect of facility staff not activating vial would interfere with mixing the medication and no antibiotic would have been infused if it was not activated prior to infusion. He stated the effect on the resident would be she would have gotten hydration with a little bit of sodium, and it would not have harmed her. He stated whatever the medication in the vial was prescribed to treat, would not have been treated and could have interfered with wound healing if Resident #7 missed doses. During a follow up interview on [DATE] at 02:49 p.m., the DON stated IV Certificate education should include management of the IV access site including central lines, and administration of IV medication including how to prepare medication. The DON stated IV Certification education was provided outside of the facility, but the curriculum matched what the contracted pharmacy had in their training. She stated no other residents in the facility had IV medication ordered currently that had to be activated prior to administration currently. The DON stated she talked to the nurse that was responsible for changing the central line dressing on [DATE]. She stated LVN B told her the central line dressing was not changed by LVN B due to there was a treatment nurse that day and LVN B assumed the treatment nurse would change the dressing. The DON stated she expected the nurses signing the MAR to verify that all treatments had been performed prior to leaving for the day and LVN B had been in-serviced on that. She stated Resident #7's wound had been healing and the surgeon had been pleased with the progress. She stated Resident #7 continued to have a wound vac in place and no impaired healing had been observed. The DON stated the facility reached out to Resident #7's attending physician that prescribed medication to notify her of the delayed meropenem dose and the facility was awaiting response. She stated the Medical Director of facility had been informed of delayed meropenem dose and new order obtained for medication dose to be rescheduled for 1300, 2100, and 0500 because of the medication error earlier. During a follow up interview at [DATE] at 03:30 p.m., LVN A stated it had been over a year ago when she was certified on IV medication and that she would assume that the IV Certification went over mixing IV medication. LVN A stated in the last month and a half she had been floating and working in different areas and times. She stated she usually did not work on the hall Resident #7 resided on and she had filled in 2 nights shifts on that hall. She stated she did notice the central line dressing was loose prior to administering IV meropenem medication that morning but had not noticed the date on the dressing. She stated the central line dressing was not secured to the skin and she had planned to change the dressing after medication had been administered. She stated central line dressing being loose could cause site infection. She stated she had administered meropenem to Resident #7 previously and medication had been delivered premixed with no need to activate the vial. She stated she did not feel that any negative outcome occurred to the resident from central line dressing not being changed or medication error. She stated she had called the Medical Director when she could not get ahold of the ordering physician, and a new order was received to administer another dose at 1:00 pm so that Resident #7 did not miss a dose, and then retime medication every 8 hours after the 1:00 p.m. dose. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:15 a.m., LVN F stated she had worked at the facility for a little over a year. LVN F stated she had IV medication training prior to working at the facility and had a refresher on [DATE]. She stated if the medication label stated activate vial prior to use that meant the nurse must break seal then mix with the saline prior to IV administration. She stated Resident #7's IV medication had never come from pharmacy pre-mixed. LVN F stated she had not had any concerns about other nursing staff related to administering IV medication administration. She stated that not activating vial prior to medication administration could cause Resident #7 to not get medication, her wound may not have healed quickly, or the infection to become worse. She stated the central line dressing should be replaced every 72 hours. She stated nurses should change the central line dressing if dressing was loose, and not changing as ordered or as needed could cause infection. She stated nurses should document treatment performed in MAR after the nurse had completed the treatment. During a phone interview on [DATE] at 11:18 a.m., RN E stated that she was the nurse at the IDP's office. She stated her expectation would be for central line dressing changes to occur every 7 days or prn for any soiled, loose, wet dressings. She stated loose meant that insertion cite was exposed by clear part of dressing becoming compromised. She stated the central line dressing site should be monitored every shift. RN E stated the effect of not changing the central line dressing routinely and as needed would cause highly increased risk for central line infection in the blood stream. She stated IDP was using meropenem to treat an active infection and she expected IV antibiotics to be administered per physician's orders. She stated IDP should be notified when IV antibiotics were missed, or medication was delayed, and she had not received any notification from the facility of the medication error. She stated the effect of missing or delaying doses of meropenem could cause Resident #7's active diagnosis to be not treated properly, delayed healing, cause the infection to worsen, and risk hurting the resident. Could also cause prolonged antibiotic treatment, rehospitalization , and incision site failure. RN E stated she was unsure if missing antibiotic doses would cause any risk for surgery hardware failure. She stated the failure of not administering antibiotics as ordered could expose residents to extended treatments. RN E stated she had made two attempts to contact facility requesting lab results as IDP ordered lab CBC w/Diff (a blood test that measures red blood cell count, white blood cell count and platelet count), CMP (a blood test that measures the body's fluid balance, electrolytes like sodium and potassium, and how well the kidneys and liver are working), ESR (a blood test that measures the level of inflammation in the body), CRP (a blood test that can measure a protein produced by the liver in response to inflammation or infection in the body) labs to be drawn weekly on Monday while on IV therapy. At that time, she stated she had not received any lab results from the facility and as a result IDP planned on drawing labs in their office during post hospitalization visit. During a follow up interview on [DATE] at 2:49 p.m., the DON stated the only labs that the facility had drawn from Resident #7 were done on [DATE]. She stated the facility had gotten a call from IDP office requesting labs on [DATE] and she did not know that labs had not been performed. She stated the facility should have drawn labs as ordered and the order would have been found on hospital discharge paperwork. She was unsure how often the order was for at that time. She stated the facility would be drawing labs when resident returned from physicians' visits in another town and would send results to IDP office. She stated it was her expectation that documentation in EMR be done after treatment had been performed. She stated she did not know why nurses had documented without performing the treatment. She stated nurses should not document something another nurse had stated they had performed. She stated the effect on the resident could be missed treatments. She stated that she monitors treatments are done by running EMR reports that would show when treatment had been missed and observing staff perform treatments. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 2:51 p.m., LVN B stated she had worked for the facility for 3 years in [DATE]. She stated she had received IV antibiotic medication administration training. LVN B stated when an IV was labeled activate prior to use and it was the antibiotic that Resident #7 used, the nurse should have snapped the connection from IV bag to vial, squeezed solution from IV bag into vial and mixed with powder, then with bag upside down squeezed bag to allow mixed solution into IV bag to prepare medication prior to it being infused. She stated she had not remembered seeing any premixed medication in the facility for Resident #7 after her most recent hospitalization . LVN B stated she had not had any concerns about other nursing staff not activating IV medication, but she would usually be the nurse who started medication dose in the morning with fresh tubing, so night nurse would not leave empty medication bag for her to observe. She stated tubing should be changed every 24 hours. She stated when new IV tubing was used then it should have a date, time, and nurses initial on it so that other staff know when it was first used. She stated missing IV antibiotic dose could cause Resident #7 to have longer healing time and would be considered a medication error. She was unsure what policy stated about central line dressing frequency but stated that it should be changed as ordered and prn when dressing was loose. LVN B stated not changing central line dressing when ordered or needed could cause another type of infection and significant problems by leaving area open for bacteria to get into insertion site. She stated she worked on [DATE] and she did sign that central line dressing had been changed since the facility had a RN performing treatments that day and she thought the RN changed the dressing. She stated usually the RN treatment nurse would let her know treatment had been performed and she would sign that it had been completed. She stated that she should have verified by observing central line dressing had been changed and did not remember why she did not verify it prior to signing that it was completed in MAR. She stated she had been in-serviced about central line dressings yesterday on changing dressing per orders and verifying treatment done prior to checking off it had been performed. She stated she should not check off treatments she had not performed. During a follow up interview on [DATE] at 3:00 PM, the DON stated there were no labs drawn for Resident #7 since being discharged from the hospital and admitted into facility. She stated she expected the nurse to look at the EMAR to know when the lab was ordered and that if a nurse signed off the EMAR that lab was collected after procedure had been performed. She stated the nurse should send lab to the hospital if they signed off that lab was collected. She stated the order revealed labs were to be drawn by an RN as it was to be drawn from central line and should have been done weekly. The DON stated it was her as DON that did the lab trackers and with the nurses being flagged in the EMAR to alert them to draw the labs. She stated there would be potential harm to the resident based off of her labs not being drawn, which could have caused the resident to have become septic. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on [DATE] at 3:26 p.m., LVN D stated she had worked for the facility for four or five years. She stated she had completed IV class but did not remember the date of original training, but the DON had a copy of certification. She stated she had received more training in IV administration on [DATE]. LVN D stated when an IV was labeled activate prior to use the seal needed to be broken and medication in vial mixed with solution from IV bag prior to administration. She stated the pharmacy had only delivered IV antibiotic medication that needed to be activated for Resident #7 since her most recent surgery. She stated she had no concerns about other nursing staff not mixing antibiotic medication prior to administering. She stated the effect of not mixing IV antibiotic could cause resident to not to get medication that she needed, and medication would not help whatever Resident #7 receiving medication for. She stated she believed the central line dressing needed to be changed every 7 days but would have to look at facility policy to verify that information. She stated the central line dressing would need to be changed if it had become loose, soiled, or damaged to prevent infection by bacteria getting under the dressing. She stated she assessed the dressing every time she administered IV medication and at least once a shift. LVN D stated she only documents completion of treatment in MAR when she completed the treatment that was ordered. During an attempted telephone interview on [DATE] at 3:52 p.m., Resident #7's emergency family member could not be reached with directions. The phone number dialed was not a working number. During a follow-up interview on [DATE] at 4:04 p.m., the DON stated Resident #7 was back from the ID physician's appointment and orthopedic surgeon's appointment. She provided paperwork the facility had received from ID physician's appointment but stated orthopedic surgeon did not send any additional paperwork from office visit. She stated that she was not sure why a new order from ID physician for PO antibiotic after IV antibiotic was completed. She stated Resident #7 was alert and more than likely would be able to answer basic questions about office visits. The DON stated she had started the afternoon dose of IV meropenem when the resident returned to facility after she had drawn blood from central line for lab work. During a follow up observation and interview on [DATE] at 4:09 p.m., Resident #7 sat in wheelchair in her room with an immobilizing brace on her left leg. IV pump on and alarm beeped with IV tubing connected to her central line. A staff member entered the room and informed the resident that she had notified the nurse of the pump alarm, and she was not allowed to touch the pump. IV meropenem had been pre-mixed prior to infusion and tubing labeled with paper tape. Resident #7 stated that she had a plastic surgeon appointment scheduled for [DATE] and that appointment was made prior to her ID physician and orthopedic surgeon's appointments. She stated she did not know why ID had ordered oral antibiotic in addition to IV antibiotic. Resident #7 stated that the orthopedic surgeon did not think that the wound vac had been healing her left knee surgical wound and that was why she was scheduled to see plastic surgeon tomorrow to discuss surgical options. She stated she was nervous about having another surgery since she almost died during the last surgery. The call light was in reach. Record review of summary of infectious disease physicians visit dated [DATE] revealed: Complete IV antibiotic on ,d+[DATE] as scheduled and we will send orders to remove PICC line. Start Levaquin 500mg PO daily on ,d+[DATE]. Follow up with orthopedic surgeon in 6 weeks .next appointment [DATE]. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a follow up interview on [DATE] at 11:12 a.m., the DON stated she did not think that increased WBC lab value on [DATE] had anything due to IV antibiotic administration and stated there was no way of proving Resident #7 had any missed doses just the delayed dose on ,d+[DATE]. She stated she thought the WBC lab could have been related to Resident #7's emotional distress on [DATE] or how the DON drew the lab. The DON stated that she may have drawn lab too quickly and she believed that may have affected lab value. She stated the facility faxed over lab results to IDP office and she would call and speak with RN E at the clinic to see how IDP interpreted the lab results. She stated at that time she had no information on how IDP had interpreted the lab value. She stated that she had spoken to the orthopedic surgeon's office who stated oral antibiotic daily after IV antibiotic would need to be administered for the remainder of resident's life. She stated she was told that the antibiotic may change to different antibiotic medication, but the resident would need treatment for the rest of her life. During a follow up interview on [DATE] at 03:12 p.m., Resident #7 stated she was seen by plastic surgeon for her left knee wound. She stated during the plastic surgeon's appointment, she was told the surgeon recommended a skin graft and if the graft did not work then they wanted to amputate. She said that she did not want an amputation. During an attempted telephone interview on [DATE] 11:23 a.m. with the MD, the MD did not answer and a message to return call was left. During an attempted telephone interview on [DATE] 11:23 a.m. with the IDP nurse, RN E, RN E did not answer and a message to return call was left. During an interview on [DATE] at 08:13 p.m., the ADMN stated he expected staff to not sign off on treatments unless they verified the treatment was done. He stated staff should not sign off on treatments prior to performing them. The ADMN stated that he expected dressings to be looked at to verify the date on the dressing and assess the site. He stated he felt the failure occurred due to staff becoming busy and had intention of performing but then forgot. The ADMN stated ADON monitors that treatments are performed, and DON was who monitored also. He stated the effect of not performing treatments could lead to infection. Record review of LVN A's certificate titled Texas IV Therapy Certification dated [DATE] revealed LVN A completed 14 contact hours of the course. Record review of LVN A's skills check off titled Medication Administration dated [DATE] revealed no evidence of activating vial on snap vial system had been performed. Record review of LVN A's skills check off titled Medication Administration dated [DATE] revealed no evidence of activating vial on snap vial system had been performed. Record review of facility policy titled Lab and Diagnostic Results - Clinical Protocol revised on [DATE] revealed: The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. (continued on next page)

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	455744	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mulberry Manor	1670 Lingleville Rd Stephenville, TX 76401

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility policy titled Administration of IV Fluids and Medications Reconstituting and Adding Medications to an IV Bag dated 2011 revealed: Reconstituting and adding medications to an IV bag will be done by the professional nurse with documented IV education, as designated by the facility, and as allowed by state regulations. IV medication that is supplied in powdered form must be reconstituted prior to adding it to the IV bag. The nurse who administers the medication will be the same nurse who reconstituted the medication. The nurse reconstituting a medication must be aware of drug stability issues and administer the dose within the appropriate time frame. Consult with the IV pharmacist as needed. After reconstituting and adding medication to an IV bag the infusion must be started within one hour .Label IV bag with resident's name, medication added, dose, rate of infusion, date, time, and initials. Administer and document. Record review of facility policy titled Dressing Change for Vascular Access Devices dated 2011 revealed: Central venous access device and midline dressing changes will be done at established intervals and immediately if the integrity of the dressing is compromised, if moisture, drainage or blood is present, or for further assessment if infection is suspected. Transparent semi-permeable membrane dressings are changed every 7 days and PRN. Transparent semi-permeable membrane dressings are changed every 7 days and PRN. If a chlorh [TRUNCATED]

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44558 44728 Based on observations, interviews, and record review, the facility failed to store medications in a locked compartment for 3 of 6 (Medication Cart 1, 2 and 3) reviewed for medication storage. The facility failed to keep each resident's medications in their original containers/packaging. This failure could result in drug diversion. Findings included: During an observation on 06/10/24 at 8:45 PM, RN K was passing medications on hall 3. She was observed with 7 unlabeled pill cups, on top of medication cart #1, that contained resident medications outside of their original blister pack container that included heart, pain, thyroid, and muscle relaxer, antibiotic, and prostrate medications. There were also 3 unlabeled pill cups inside the first unlocked drawer that included narcotics Oxycodone, Hydromorphone and Trazadone outside of their original blister pack container and not locked behind 2 locks. During an observation on 06/10/24 at 8:58 PM staff member RN J's medication cart #2 on Hall 4 had 2 unnamed pill cups with a Residents 10:00 PM crushed Hydrocodone (pain narcotic) in one and residents 3:00 AM crushed Adderall (stimulant amphetamine) in another unnamed pill cup in the top drawer. On Hall 6, cart #3, there was one Resident unlabeled pill cup with a Tizanidine outside of the original container. During an interview on 06/10/24 at 8:50 PM RN J stated she was prefilling the resident medication pill cups because she was busy. RN J refused to answer any questions concerning being short staffed or fearing retaliation. She stated she did not know when her last training for medication storage was completed. RN J stated she was covering 3 halls and had 2 other carts that she was responsible for on halls 4 and 6. She stated the possible harm to residents could be a possibility of giving the resident a wrong medication. RN J stated she did not know when her last training was completed. She was then observed labeling the names of residents on the pill cups and placed them inside the top drawer of the Hall 3 med cart. The narcotics remained behind one lock. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/10/24 at 9:00 PM the DON stated there should never had been open pre-popped medications on the medication carts. She stated it was absolutely unacceptable and was not their policy. She stated staff had orientation upon hire with annual competencies. The DON stated if more trainings were prompted, she would have done so. She stated the DON and ADON monitored the staff and performed check offs when needed as well as observing staff without them knowing from afar. She stated the negative impact to residents were that they could have possibly gotten the wrong medication. The DON stated in passing medications that way could have possibly been detrimental. The DON stated the failure occurred in pre-popping the medication and not administering them as she goes. She stated her expectations were for staff to go from room to room, to pass the medications to each resident before popping the next resident medications. During an interview on 06/10/24 at 9:05 PM the ADMN stated his expectations were for staff to follow the policies they were provided. He stated if the resident refused, the medication should have been discarded properly or wasted with a second nurse. He stated the monitoring of staff passing meds was a team effort as in upper management. Record review of facility policy Storage of Medications dated 2007 revealed: Policy Statement: the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 1. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean safe and sanitary manner . 5. Drugs for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications . 8. Drugs shall be stored in an orderly manner in cabinets, drawers, cart, or automatic dispensing systems. Each residence medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on observations, interviews and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 (CNA L and NA) staff observed during incontinent care. The facility failed to ensure that staff (CNA L and NA) performed proper peri-care (incontinent care) or proper hand hygiene for Resident #28. These failures placed residents of the facility at risk of infections from incontinent care. Findings included: Record Review of resident #28's Face Sheet dated 06/14/2024 revealed a [AGE] year-old male admitted on [DATE] and his latest admission on 12/26/2023. Review of Resident #28's diagnoses revealed: Hypertension (high blood pressure), Lack of coordination, and Diarrhea. Record review of Resident # 28's MDS assessment dated [DATE] revealed, Section C- Cognitive Behavior a BIMS score of 15 (cognitively intact). Section H-Bladder and Bowel, resident always incontinent. During an observation on 06/12/2024 at 10:15 AM, CNA L and the NA performed peri-care with no hand hygiene or change of gloves between dirty and clean of resident care. The NA was observed in the resident room assisting CNA L with peri-care. CNA L and the NA had performed no hand hygiene or glove changes during the entire duration of resident care. During an interview on 06/12/2024 at 10:30 AM, CNA L stated she was aware she did not change gloves or wash her hands between clean and dirty and knew she should have done so. She stated she did not have hand sanitizer or gloves in the resident room or in her pocket. CNA L stated she was nervous with more people being in the room. During an interview on 06/12/2024 at 11:00 AM, the DON stated the staff were supposed to perform proper resident peri-care following all IC protocols. She stated in not doing so, the potential harm could have been spreading infections to other residents. She stated it was the ADON that monitored resident peri-care. The DON stated the failure was not making sure staff was in-serviced or not having random check offs. She stated her expectations were for every resident to be safe from further infections with staff to use the proper IC protocols they were taught. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/14/2024 at 10:43 AM, the ADON stated all staff should change their gloves when needed at all times. She stated with peri-care the policy was to change glove and sanitize hands after and in between when going from dirty to clean. The ADON stated it was herself and DON that monitored trainings and follow up. The ADON stated the harm to residents were possibilities of UTI's with the possibilities of spreading infections to other residents. She stated the failure was that staff were nervous as well as staff not having the proper supplies before resident care. The ADON stated her expectations were for staff to take enough gloves into the room and be prepared at all times. Record review of the policy titled Standard Precautions Hand Washing and Glove Use dated with 06/11/2024 revealed: All Employees are expected to practice standard precautions to reduce the risk of transmitting infections and the likelihood of exposure and contamination of self from bacteria and germs while in the facility. To protect the health and welfare of the employees and resident, frequent washing of the employees' hands and required. Any employee touching blood, body fluids, secretions, excretions and contaminated items must wear gloves. The employee must thoroughly wash their hands after the glove removal. Wearing of gloves does not insure total protection from contamination from germs. During the removal of gloves the potential exists for bodily contact with the infectious gloves. Clean gloves must be put on between each task and procedures involving the same residents. Hands must be washed promptly after glove removal.