STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495426	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mulberry Creek Nursing & Rehab Center	300 Blue Ridge Street Martinsville, VA 24112

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 28567 Based on staff interview and clinical record review, the facility staff failed to ensure 2 of 36 residents were free of unnecessary medications, Residents #63 and #139. The findings included: 1. For Resident #63, the facility staff administered the medication Amiodarone for a heart rate less than 60. The provider order read to hold this medication for heart rate less than 60. Resident #63's diagnoses included, but were not limited to, paroxysmal atrial fibrillation and chronic obstructive pulmonary disease. Section C (cognitive patterns) of Resident #63's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/28/24 included a brief interview for mental status (BIMS) summary score of 4 out of a possible 15 points. Resident #63's comprehensive care plan included the focus area at risk for cardiac complications related to atrial fibrillation, hypertension, and congestive heart failure. Interventions included, but were not limited to, administer medications as ordered, observe parameters, and check pulse as ordered. Resident #63's clinical record included a provider order for the medication Amiodarone HCl Oral Tablet 200 mg by mouth two times a day related to atrial fibrillation hold if heart rate 60 or below. A review of Resident #63's medication administration record (MAR) for May 2024 revealed that the facility nursing staff documented they had administered the medication for a heart rate of less than 60 at 9:00 a.m. on 05/02/24 (53), 05/03/24 (42), 05/04/24 (54), 05/05/24 (53), and on 05/08/24 (58). On 05/08/24 at 1:30 p.m., during a meeting with the Administrator and Director of Nursing (DON) the issue with the medication being administered for a pulse less than 60 was reviewed. On 05/08/24 at 3:03 p.m., Licensed Practical Nurse (LPN) #1 was interviewed regarding the administration of the medication at 9:00 a.m. on 05/03/24. LPN #1 stated they were unsure if they had administered the medication, and they could have marked the medication in error. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495426	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mulberry Creek Nursing & Rehab Center	300 Blue Ridge Street Martinsville, VA 24112

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/24 at 4:50 p.m., LPN #3 was interviewed regarding the administration of the medication at 9:00 a. m. on 05/05/24 and 05/08/24. LPN #3 reviewed the MAR with the surveyor and stated they were unsure if they had administered the medication. On 05/08/24 at 8:16 p.m., the DON transcribed a progress note that read, MD made aware of bp medication given with no adverse reactions noted. On 05/09/24 at 12:19 p.m., during a meeting with the Administrator and DON the DON stated a medication error had been completed and they were re-educating the nursing staff. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #139, the facility nursing staff failed to follow the provider ordered parameters for the administration of the blood pressure medications Isosorbide and Topiramate. Resident #139's diagnoses included, but were not limited to, hypertension, diabetes, and myocardial infarction type 2. Section C (cognitive patterns) of Resident #139's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/29/24 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Resident #139's comprehensive care plan included the focus area risk for cardiac complications related to hypertension. Interventions included administer medications as ordered and observe parameters. Resident #139's clinical record included provider orders for the following medications: Topiramate 50 mg give 1 tablet once a day. Hold for systolic blood pressure less than 110. Isosorbide extended release (ER) 60 mg give 1 tablet once a day. Hold for systolic blood pressure less than 100. (The systolic blood pressure is the top number of an individuals blood pressure reading). A review of the medication administration records revealed that on 05/01/24 the facility nursing staff documented they administered both these medications for a blood pressure (BP) of 88/62. On 05/08/24 at 1:30 p.m., during a meeting with the Administrator and Director of Nursing (DON) the issue with the medications being administered for a BP of 88/62 on 05/01/24 was reviewed. On 05/08/24 at 7:14 p.m., the DON transcribed a progress note that read, MD made aware of bp medication given, no adverse reactions noted. On 05/09/24 at 12:19 p.m., during a meeting with the Administrator and DON the DON stated a medication error had been completed and they were re-educating the nursing staff. No further information regarding this issue was provided to the survey team prior to the exit conference.