

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0605	Based on a State Licensure, Civil Rights Compliance, and complaint survey completed on September 25, 2025, it was determined that Mulberry Healthcare and Rehabilitation Center was not in compliance with the following requirements of the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0605		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0605	<p>Continued from page 1</p> <p>483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) Right to be Free from Chemical Restraints</p> <p>§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects</p>	F 0605	<p>Resident R19's orders were reviewed with her physician. Physician discontinued the as -needed Hydroxyzine at this time as she appears stable and comfortable with current routine medication orders. The Assistant Director of Nursing completed an audit of current residents receiving as needed psychotropic medication. Orders were clarified as indicated by each physician to address resident needs. The nursing staff were provided education on guidance for use of PRN (as needed) psychotropic medication, nonpharmacological interventions, and the 14 day re-evaluation. The Assistant Director of Nursing or designee will complete weekly audits x four weeks on residents receiving as needed psychotropic medications then Bi weekly x4 weeks, then monthly x2 months with audit results to the Quality Assurance Committee.</p>	<p>Completion Date: <b>12/08/2025</b> Status: <b>APPROVED</b> Date: <b>11/20/2025</b></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0605	<p>Continued from page 2</p> <p>brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <ul style="list-style-type: none"> <li>(i) Anti-psychotic;</li> <li>(ii) Anti-depressant;</li> <li>(iii) Anti-anxiety; and</li> <li>(iv) Hypnotic.</li> </ul> <p>§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <ul style="list-style-type: none"> <li>(1) In excessive dose (including duplicate drug therapy); or</li> <li>(2) For excessive duration; or</li> <li>(3) Without adequate monitoring; or</li> <li>(4) Without adequate indications for its use; or</li> <li>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</li> <li>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</li> </ul> <p>§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral</p>	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0605	Continued from page 3  interventions, unless clinically contraindicated, in an effort to discontinue these drugs;  §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and  §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.  §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.  This REQUIREMENT is not met as evidenced by:	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0605	<p>Continued from page 4</p> <p>Based on a review of facility policies and clinical records as well as staff interviews, it was determined that the facility failed to ensure that residents medication regime was free from unnecessary psychotropic medication (drugs that affect a person's mental state, emotions, and behavior) for one of 31 residents reviewed (Residents 19).</p> <p>Findings include:</p> <p>The facility's policy regarding antipsychotic medication use, dated May 15, 2025, indicated that residents will not receive as needed doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. The need to continue as needed orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the as needed order will be indicated in the order.</p>	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0605	<p>Continued from page 5</p> <p>A quarterly Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 19 dated August 5, 2025, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs and had diagnosis that included dementia.</p> <p>Physician's orders for Resident 19 dated June 20, 2025, included an order for the resident to receive 10 milligrams (mg) of hydroxyzine (a psychotropic medication used to treat anxiety) every four hours as needed for anxiety.</p> <p>Review of the Medication Administration Record for Resident 19 dated July 2025 and August 2025 revealed that 10 mg of hydroxyzine was administered to the resident on July 9, at 6:38 p.m.; July 12 at 12:08 p.m.; July 30 at 12:48 p.m.; and on August 13 at 1:48 p.m. There was no evidence that a practitioner documented a rationale for extending this as needed medication beyond 14 days or a duration for its use. There was also no documented</p>	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0605	<p>Continued from page 6</p> <p>evidence that non-pharmalogical interventions were attempted prior to administering the as needed doses of hydroxyzine on July 9 at 6:38 p.m.; July 30 at 12:48 p.m.; and on August 13 at 1:48 p.m.</p> <p>Interview with the Director of Nursing on September 24, 2025, at 1:48 p.m. revealed that there was no documented rationale for extending the use of as needed hydroxyzine for Resident 19 beyond 14 days when it was administered on the above dates and times.</p> <p>Interview with the Director of Nursing on September 25, 2025, at 11:34 a.m., respectively, revealed that there was no documented evidence that non-pharmalogical interventions were attempted before administering hydroxyzine to Resident 19 on the above-mentioned dates and times and there should have been.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0605	Continued from page 7	F 0605		
F 0675		F 0675		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0675	Continued from page 8  483.24 Quality of Life  § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by:	F 0675	Resident R36 was repositioned immediately at the time of the survey. The meal was checked for appropriate temperature and the resident was assisted to complete her meal. Occupational Therapy also evaluated resident R36 to ensure she had the most appropriate chair and make any recommendations for best possible positioning during meals. Education was provided to staff regarding proper positioning during meals. The Director of Nursing or designee will complete audits daily x 5 days at random meals to ensure proper positioning of residents in the dining room x2 weeks then weekly x 4 weeks, then monthly x 2 months with results to Quality Assurance.	Completion Date: <b>12/08/2025</b> Status: <b>APPROVED</b> Date: <b>11/20/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0675	<p>Continued from page 9</p> <p>Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents were positioned appropriately while eating for one of 31 residents reviewed (Resident 36).</p> <p>Findings include:</p> <p>The facility's policy regarding preparing the resident for a meal, dated May 15, 2025, indicated that residents should be positioned so his or her head and upper body are as upright as possible and with the head tipped slightly forward.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 36, dated June 5, 2025, indicated that the resident was cognitively impaired and dependent on two staff for daily care needs including eating. The resident's care plan, dated April 15, 2025, indicated that the resident required</p>	F 0675		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0675	Continued from page 10  supervision to limited assistance with meals.  Observations of Resident 36 on September 22, 2025 at 12:08 p.m. revealed that the resident was sitting in her specialized chair with the rear end tilted back for safety/positioning when her meal was served. The chair was not close enough to the table for her to reach her plate and her upper torso and head were reclined back. She was observed attempting to reach her plate and trying to pull herself closer to the table, but was not able to do so.  Interview with the Director of Nursing on September 22, 2025 at 12:21 p.m. confirmed that Resident 36's chair should have been placed in the upright position for the meal and that she should have been seated closer to the table in order to reach her food.  28 Pa. Code 211.10(a)(c)(d) Resident care policies.  28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.	F 0675		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689	<p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0689	<p>Resident R50 was not injured at the time of the incident. Nurse aide 2 was suspended at the time of the incident as part of the facility's self-reported investigation for failure to follow facility policy.</p> <p>All staff were re-educated on the facility policy regarding use of leg rests while in a wheelchair.</p> <p>Director of Nursing or designee will complete daily random observation audits of residents being transported in their wheelchairs to ensure safe practice. Audits will be completed daily x5 for 2 weeks then weekly x4 then monthly x 2 with results to Quality Assurance.</p>	<p>Completion Date: <b>12/08/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>11/20/2025</b></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689	<p>Continued from page 12</p> <p>Based on review of facility policies, clinical record reviews, facility investigation documents, and staff interviews, it was determined that the facility failed to ensure that each resident received assistance devices to prevent accidents for one of 31 residents reviewed (Resident 50).</p> <p>Findings include:</p> <p>The facility's policy regarding wheelchair leg rests, dated May 15, 2025, revealed that footrests serve valuable purposes. They support the weight of the legs for those in the wheelchair, who often lack the strength to keep their legs from otherwise dragging. They also serve a valuable safety purpose by keeping the person's feet out of the way of the wheels and inadvertently getting caught under the wheelchair when it is pushed (which could cause the person from being thrown from the wheelchair).</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and</p>	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689	<p>Continued from page 13</p> <p>care needs) for Resident 50, dated August 21, 2025, revealed that the resident was cognitively impaired, required assistance for daily care needs including transfers and locomotion, and had diagnoses that included cerebral palsy (disorder that affects body movements and muscle coordination). A care plan dated May 26, 2025 revealed that the resident, when out of bed, to be in bentley tilt in space wheelchair with wedge cushion and bilateral leg rests for transportation as tolerated daily.</p> <p>A witness interview from Nurse Aide 1 dated September 16, 2025 at 5:15 p.m. revealed that she was helping other residents when she heard Resident 50 shouting "Slow down Stop" my foot as he was in his wheelchair being pushed into the dining room for dinner by Nurse Aide 2. Resident 50's foot was caught under the wheelchair and he fell out of the chair onto his hands and knees.</p> <p>The facility's investigation dated September 16, 2025 at 4:45 p.m. revealed that Resident 50 had fallen on the floor out of wheelchair when Nurse</p>	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689	<p>Continued from page 14</p> <p>Aide 2 was pushing him in his wheelchair without leg rests to the dining room when she stopped pushing him, he fell to the floor.</p> <p>A witness interview from Nurse Aide 2 dated September 16, 2025 at 4:40 p.m. revealed that she did push Resident 50 in his chair to the dining room without leg rests. After stopping resident leaned forward with hands on floor. She asked him to sit back in chair but instead leaned further onto the floor.</p> <p>An interview with the Director of Nursing on September 24, 2025, at 2:25 p.m. confirmed that footrests should have been used when transporting Resident 50 in his wheelchair per his care plan.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services.</p>	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689	Continued from page 15	F 0689		
F 0700	<p>483.25(n)(1)-(4) Bedrails</p> <p>§483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0700	<p>Resident R36 was evaluated by the Occupational Therapist to ensure that bilateral bed -enabler bars were the most appropriate. An "In bed positioning/siderail evaluation" was completed on resident R36.</p> <p>The Director of Nursing or designee is completing a review of all resident's currently utilizing enabler bars to ensure that an up to date assessment is complete.</p> <p>Nursing staff will be provided education on the process for utilization of enabler bars on resident beds and proper completion of quarterly assessments.</p> <p>The Director of Nursing or designee will complete audits for completion weekly x4 then biweekly x 4 then monthly x 2 with results to Quality Assurance Committee.</p>	<p>Completion Date: <b>12/08/2025</b> Status: <b>APPROVED</b> Date: <b>11/20/2025</b></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0700	<p>Continued from page 16</p> <p>Based on a review of clinical records, as well as observation and staff interview, it was determined that the facility failed to thoroughly assess the potential entrapment risks from the use of bed rails for one of 31 residents reviewed (Resident 36).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 36, dated September 4, 2025, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had a diagnosis of congestive heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively).</p> <p>Physician's orders for Resident 36, dated May 2, 2025, included for the resident to have bilateral bed enabler bars to assist with repositioning, comfort, and bed mobility.</p>	F 0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0700	<p>Continued from page 17</p> <p>Observations of Resident 36 on September 22, 2025, at 10:58 a.m. revealed that the resident was resting in bed and the resident's bed was equipped with bilateral enabler bars.</p> <p>There was no documented evidence that Resident 36 was assessed for potential safety hazards prior to the enabler bars being applied to the resident's bed.</p> <p>Interview with the Director of Nursing on September 25, 2025, at 1:15 p.m. confirmed that bed rail/enabler safety assessment was not completed for Resident 36.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>	F 0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0804	<p>483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp</p> <p>§483.60(d) Food and drink Each resident receives and the facility provides-</p> <p>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;</p> <p>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0804	<p>The hot plate warmer was turned up to ensure sufficient heating of the plates during meal service.</p> <p>All staff were re-educated on proper temperatures during meal service.</p> <p>The Dietary Manager will audit food temperatures at the end of meal service for random meals daily x5 for 2 weeks, then 3 times per week for 2 weeks, then weekly x4 with results to Quality Assurance. Any food temperatures found to be outside of range or unpalatable will be replaced for an alternative preferred item.</p>	<p>Completion Date: <b>12/08/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>11/20/2025</b></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0804	<p>Continued from page 19</p> <p>Based on observations and staff interviews, it was determined that the facility failed to serve food items that were palatable.</p> <p>Findings include:</p> <p>Observations of the lunch meal on September 25, 2025 at 11:41 a.m. revealed that dietary staff began to prepare the north hall cart. At 11:55 a.m. the north hall cart was complete and left the kitchen at 11:58 a.m. The cart arrived on north hall at 11:59 a.m. and staff began to pass the trays at 12:00 p.m. At 12:05 p.m. all lunch trays were passed.</p> <p>A test tray was completed on September 25, 2025 at 12:16 p.m. revealing the turkey was 120.4 degrees Fahrenheit and tasted cold and was not palatable, and the capri blend vegetables were 120 degrees Fahrenheit and tasted cold and was not palatable.</p> <p>Interview with the Dietary Manager on September</p>	F 0804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0804	Continued from page 20	F 0804		
F 0812	<p>25, 2025 at 12:16 p.m. revealed that the turkey and vegetables were cold and not palatable.</p> <p>28 Pa. Code 211.6(f) Dietary Services.</p> <p>483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0812	<p>The expired grape juice that was gotten out of the freezer was discarded, the cooler wiped down for spills, and the open box of hamburger patties was discarded immediately by the dietary staff. The dietary staff was educated on checking labels for expiration, keeping spills cleaned up, and sealing boxes properly when closing along with general dietary sanitation reminders.</p> <p>The Dietary Manager is responsible for ongoing audits of sanitation in the kitchen and these audits will be completed daily x5 for 2 weeks, then weekly x 4, then monthly ongoing to ensure monitoring and compliance with results to Quality Assurance.</p>	<p>Completion Date: <b>12/08/2025</b> Status: <b>APPROVED</b> Date: <b>11/20/2025</b></p>



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812	Continued from page 22  Based on observations and staff interviews, it was determined that the facility failed to ensure that food was stored and prepared under sanitary conditions.  Findings include:  Observations in the main kitchen on September 22, 2025 at 9:10 a.m. revealed that there was a crate of grape juice cartons that expired on September 3, 2025. There was a puddle of spilled milk and a puddle of an unidentified substance laying on the floor inside the cooler. There was a tray of hamburger patties open and exposed to air in the freezer.  Interview with Dietary Aide 3 on September 22, 2025 at 9:10 a.m. revealed that the grape juice should have been discarded when it expired and that it was used for the breakfast meal that morning. She further stated the spills in the cooler should be cleaned up and that the hamburger patties should have been covered and sealed.	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812	Continued from page 23  Interview with the Dietary Manager on September 23, 2025 at 1:48 p.m. confirmed that the grape juice had expired and should have been thrown out, the spills should have been cleaned up and the hamburger patties should not have been exposed. She explained that the kitchen had been working very short staffed and they were doing their best for the residents.  28 Pa. Code 211.6(f) Dietary services.	F 0812		
F 0867		F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0867	<p>Continued from page 24</p> <p>483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) QAPI/QAA Improvement Activities</p> <p>§483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:</p> <p>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.</p> <p>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.</p> <p>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.</p> <p>§483.75(c)(4) Facility adverse event monitoring, including</p>	F 0867	<p>The facility has an established Quality Assurance Performance Improvement Plan with monthly committee meetings to review ongoing performance issues, audits, and ways for improvement. The Nursing Home Administrator maintains meeting minutes and data collection. This survey plan of correction will be reviewed with the committee members and ongoing audits reported through the committee. Additional attention will be paid to correction of repeat deficiencies in the areas of safety, palatable food, food procurement, and infection control. Staff will be educated on the actionable items for correction to draw attention to needed compliance. Ongoing reporting will be reviewed at monthly meetings.</p>	<p>Completion Date: <b>12/08/2025</b> Status: <b>APPROVED</b> Date: <b>11/20/2025</b></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0867	<p>Continued from page 25</p> <p>the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.</p> <p>§483.75(d) Program systematic analysis and systemic action.</p> <p>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.</p> <p>§483.75(d)(2) The facility will develop and implement policies addressing:</p> <ul style="list-style-type: none"> <li>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;</li> <li>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and</li> <li>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.</li> </ul> <p>§483.75(e) Program activities.</p> <p>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the</p>	F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0867	<p>Continued from page 26</p> <p>incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.</p> <p>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.</p> <p>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.</p> <p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:</p>	F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0867	Continued from page 27  (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.  This REQUIREMENT is not met as evidenced by:	F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0867	<p>Continued from page 28</p> <p>Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies.</p> <p>Findings include:</p> <p>The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) survey ending October 18, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending September 25, 2025, identified repeated deficiencies regarding safety/accidents, palatable food, food procurement and storage, and infection control.</p>	F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0867	Continued from page 29  The facility's plan of correction for a deficiency regarding safety/accidents, cited during the survey ending October 18, 2024, revealed that safety/accidents would be monitored by QAPI. The results of the current survey, cited under F689, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding abuse /neglect.  The facility's plan of correction for a deficiency palatable food, cited during the survey ending October 18, 2024 revealed that palatable food would be monitored by QAPI. The results of the current survey, cited under F804, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding palatable food.  The facility's plan of correction for a deficiency regarding food procurement and storage, cited during the survey ending October 18, 2024, revealed that food safety would be monitored by QAPI. The results of the current survey, cited under F812, revealed that the QAPI committee was	F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0867	Continued from page 30  ineffective in maintaining compliance with regulation regarding food procurement and storage.  The facility's plan of correction for a deficiency regarding infection control, cited during the survey ending October 18, 2024, revealed that infection control would be monitored by QAPI. The results of the current survey, cited under F880, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding infection control.  Refer to F689, F804, F812, F880.  28 Pa. Code 201.14(a) Responsibility of Licensee.  28 Pa. Code 201.18(e)(1) Management.	F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0867	Continued from page 31	F 0867		
F 0880	<p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention &amp; Control</p> <p>§483.80 Infection Control The facility must establish and 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.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p>	F 0880	<p>Nurse aide 4 was educated at the time of the survey on appropriate Personal Protective Equipment needed for resident R42's Enhanced Barrier Precautions. The Infection Control Nurse reviewed residents requiring Enhanced Barrier Precautions to ensure all line listing and signage was up to date. Staff was provided education regarding Enhanced Barrier Precautions and identification of residents requiring these precautions.</p> <p>The Infection Control Preventionist will complete random audits of care requiring Enhanced Barrier Precautions daily x5 for 2 weeks then weekly x 4, then monthly x2 months with results to Quality Assurance.</p>	<p>Completion Date: <b>12/08/2025</b> Status: <b>APPROVED</b> Date: <b>11/20/2025</b></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880	Continued from page 32  (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.  §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.  §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880	Continued from page 33  §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.  This REQUIREMENT is not met as evidenced by:	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880	Continued from page 34  Based on review of facility policies and clinical record reviews, as well as observations and staff interviews, it was determined that the facility failed to follow CDC guidelines to reduce the spread of infections and prevent cross-contamination related to an Multi-Drug resistant organism (MDRO bacteria that may make them resistant to some antibiotics) infection in the urine for one of 31 residents reviewed (Resident 42).  Findings include:  The facility's Infection Prevention and Control policy, dated May 15, 2025, revealed that contact precautions are intended to prevent the transmission of infectious agents which are spread through direct or indirect contact with the patient or the patient's environment. Contact precautions also apply where the presence of excessive wound drainage, urine or fecal incontinence, or other discharges from the body suggest an increased potential for environmental contamination and risk of	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880	<p>Continued from page 35</p> <p>transmission. Enhanced barrier protections are intended to prevent transmission of multi-drug-resistant organisms (MDRO's-bacteria that have become resistant to certain antibiotics) via contaminated hands and clothing of healthcare workers to high-risk residents.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 42, dated August 7, 2025, revealed that the resident was cognitively intact, required assistance for daily care needs, was frequently incontinent of bowel and bladder, and had diagnoses that included urinary tract infection.</p> <p>Review of a urine culture and sensitivity (laboratory test to attempt to grow bacteria and then test which medications will effectively work to stop the infection) final results for Resident 42, dated September 17, 2025, revealed that the urine culture was positive for MDRO.</p> <p>Observations of Nurse Aide 4 providing continence</p>	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880	<p>Continued from page 36</p> <p>care for Resident 42 on September 22, 2025 at 11:03 a.m. revealed that she was not wearing proper protective equipment that included a gown while providing care to the resident.</p> <p>Interview with Nurse Aide 4 on September 22, 2025, at 12:15 a.m. confirmed she should have worn a gown while providing care to Resident 42.</p> <p>Interview with the Director of Nursing on September 22, 2025, at 2:54 p.m. confirmed that Nurse Aide 4 should have had personal protective equipment including a gown on while providing care to Resident 42.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Nursing services.  (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.  This REGULATION is not met as evidenced by:	P 5520	The facility attempts to staff to meet state required number of staff hours and ratios for nursing assistants per current state regulations. The facility offers shift bonus for pick up shifts and for additional hours in case of call offs. Registered nurses, Licensed practical nurses, and nursing administration all assist to help fill in as needed. An active recruitment campaign is ongoing which includes sign on bonuses, shift differentials, and employee referral bonuses. Agency staff are contracted as available to fill in needed shifts. The Nursing Home Administrator and Director of Nursing meet daily to review staffing sheets to ensure proper staffing. Time and attendance is reviewed daily for ratios and staffing numbers. These calculations are recorded daily in labor tracking and submitted to the facility's management company ongoing.	Completion Date: <b>12/08/2025</b> Status: <b>APPROVED</b> Date: <b>11/20/2025</b>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	<p>Continued from page 1</p> <p>Based on review of nursing schedules and staffing information furnished by the facility, as well as staff interviews, it was determined that the facility failed to ensure a minimum of one nurse aide per 10 residents on the day shift for 18 of 21 days reviewed, failed to ensure a minimum of one nurse aide per 11 residents on the evening shift for 16 of 21 days reviewed, and failed to ensure a minimum of one nurse aide per 15 residents on the evening shift for 18 of 21 days (24-hour periods) reviewed.</p> <p>Findings include:</p> <p>Nursing time schedules provided by the facility for the weeks of June 8-14, 2025, July 1-7, 2025, and September 17-23, 2025, a review of facility census data indicated that on June 8, 2025, the facility census was 45, which required 4.50 nurse aides during the day shift. Review of the nursing time schedules revealed 3.68 nurse aides provided care during the day shift.</p>	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	<p>Continued from page 2</p> <p>On June 9, 2025, the facility census was 46, which required 4.60 nurse aides during the day shift. Review of the nursing time schedules revealed 4.06 nurse aides provided care during the day shift.</p> <p>On June 10, 2025, the facility census was 46, which required 4.60 nurse aides during the day shift. Review of the nursing time schedules revealed 4.06 nurse aides provided care during the day shift.</p> <p>On June 11, 2025, the facility census was 46, which required 4.60 nurse aides during the day shift. Review of the nursing time schedules revealed 3.65 nurse aides provided care during the day shift.</p> <p>On June 13, 2025, the facility census was 47, which required 4.70 nurse aides during the day shift. Review of the nursing time schedules revealed 4.19 nurse aides provided care during the day shift.</p> <p>On June 14 2025, the facility census was 47, which required 4.70 nurse aides during the day shift. Review of the nursing time schedules revealed 3.03</p>	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 3  nurse aides provided care during the day shift.  On July 1, 2025, the facility census was 47, which required 4.70 nurse aides during the day shift. Review of the nursing time schedules revealed 4.06 nurse aides provided care during the day shift.  On July 2, 2025, the facility census was 48, which required 4.80 nurse aides during the day shift. Review of the nursing time schedules revealed 3.61 nurse aides provided care during the day shift.  On July 3, 2025, the facility census was 48, which required 4.80 nurse aides during the day shift. Review of the nursing time schedules revealed 3.90 nurse aides provided care during the day shift.  On July 4, 2025, the facility census was 48, which required 4.80 nurse aides during the day shift. Review of the nursing time schedules revealed 3.87 nurse aides provided care during the day shift.  On July 5, 2025, the facility census was 48, which	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	<p>Continued from page 4</p> <p>required 4.80 nurse aides during the day shift. Review of the nursing time schedules revealed 3.35 nurse aides provided care during the day shift.</p> <p>On July 6, 2025, the facility census was 48, which required 4.80 nurse aides during the day shift. Review of the nursing time schedules revealed 3.13 nurse aides provided care during the day shift.</p> <p>On July 7, 2025, the facility census was 48, which required 4.80 nurse aides during the day shift. Review of the nursing time schedules revealed 4.10 nurse aides provided care during the day shift.</p> <p>On September 17, 2025, the facility census was 53, which required 5.30 nurse aides during the day shift. Review of the nursing time schedules revealed 5.10 nurse aides provided care during the day shift.</p> <p>On September 18, 2025, the facility census was 52, which required 5.20 nurse aides during the day shift. Review of the nursing time schedules revealed 4.58 nurse aides provided care during the day shift.</p>	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 5  On September 19, 2025, the facility census was 52, which required 5.20 nurse aides during the day shift. Review of the nursing time schedules revealed 4.87 nurse aides provided care during the day shift.  On September 21, 2025, the facility census was 52, which required 5.20 nurse aides during the day shift. Review of the nursing time schedules revealed 4.52 nurse aides provided care during the day shift.  On September 22, 2025, the facility census was 52, which required 5.20 nurse aides during the day shift. Review of the nursing time schedules revealed 4.13 nurse aides provided care during the day shift.  On June 9, 2025, the facility census was 46, which required 4.18 nurse aides during the day shift. Review of the nursing time schedules revealed 3.55 nurse aides provided care during the evening shift.  On June 10, 2025, the facility census was 46, which required 4.18 nurse aides during the day shift.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 6  Review of the nursing time schedules revealed 3.74 nurse aides provided care during the evening shift.  On June 12, 2025, the facility census was 48, which required 4.36 nurse aides during the day shift. Review of the nursing time schedules revealed 3.03 nurse aides provided care during the evening shift.  On June 13, 2025, the facility census was 47, which required 4.27 nurse aides during the day shift. Review of the nursing time schedules revealed 3.58 nurse aides provided care during the evening shift.  On June 9, 2025, the facility census was 48, which required 4.36 nurse aides during the day shift. Review of the nursing time schedules revealed 3.10 nurse aides provided care during the evening shift.  On July 1, 2025, the facility census was 48, which required 4.36 nurse aides during the day shift. Review of the nursing time schedules revealed 4.03 nurse aides provided care during the evening shift.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 7  On July 2, 2025, the facility census was 48, which required 4.36 nurse aides during the day shift. Review of the nursing time schedules revealed 3.16 nurse aides provided care during the evening shift.  On July 3, 2025, the facility census was 48, which required 4.36 nurse aides during the day shift. Review of the nursing time schedules revealed 3.10 nurse aides provided care during the evening shift.  On July 4, 2025, the facility census was 48, which required 4.36 nurse aides during the day shift. Review of the nursing time schedules revealed 3.32 nurse aides provided care during the evening shift.  On July 5, 2025, the facility census was 48, which required 4.36 nurse aides during the day shift. Review of the nursing time schedules revealed 2.97 nurse aides provided care during the evening shift.  On July 6, 2025, the facility census was 48, which required 4.36 nurse aides during the day shift. Review of the nursing time schedules revealed 2.81	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 8  nurse aides provided care during the evening shift.  On July 7, 2025, the facility census was 48, which required 4.36 nurse aides during the day shift. Review of the nursing time schedules revealed 3.13 nurse aides provided care during the evening shift.  On September 17, 2025, the facility census was 53, which required 4.82 nurse aides during the day shift. Review of the nursing time schedules revealed 4.52 nurse aides provided care during the evening shift.  On September 18, 2025, the facility census was 52, which required 4.73 nurse aides during the day shift. Review of the nursing time schedules revealed 4.23 nurse aides provided care during the evening shift.  On September 21, 2025, the facility census was 52, which required 4.73 nurse aides during the day shift. Review of the nursing time schedules revealed 4.65 nurse aides provided care during the evening shift.  On September 22, 2025, the facility census was 52,	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 9  which required 4.73 nurse aides during the day shift. Review of the nursing time schedules revealed 4.52 nurse aides provided care during the evening shift.  On June 9, 2025, the facility census was 46, which required 3.07 nurse aides during the day shift. Review of the nursing time schedules revealed 2.58 nurse aides provided care during the night shift.  On June 10, 2025, the facility census was 46, which required 3.07 nurse aides during the day shift. Review of the nursing time schedules revealed 2.16 nurse aides provided care during the night shift.  On June 12, 2025, the facility census was 48, which required 3.20 nurse aides during the day shift. Review of the nursing time schedules revealed 2.52 nurse aides provided care during the night shift.  On June 13, 2025, the facility census was 47, which required 3.13 nurse aides the day shift. Review of the nursing time schedules revealed 2.58 nurse aides provided care during the night shift.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 10  On July 1, 2025, the facility census was 48, which required 3.20 nurse aides the day shift. Review of the nursing time schedules revealed 1.58 nurse aides provided care during the night shift.  On July 2, 2025, the facility census was 48, which required 3.20 nurse aides the day shift. Review of the nursing time schedules revealed 2.23 nurse aides provided care during the night shift.  On July 3, 2025, the facility census was 48, which required 3.20 nurse aides the day shift. Review of the nursing time schedules revealed 2.42 nurse aides provided care during the night shift.  On July 4, 2025, the facility census was 48, which required 3.20 nurse aides the day shift. Review of the nursing time schedules revealed 2.39 nurse aides provided care during the night shift.  On July 5, 2025, the facility census was 48, which required 3.20 nurse aides the day shift. Review of	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 11  the nursing time schedules revealed 1.45 nurse aides provided care during the night shift.  On July 6, 2025, the facility census was 48, which required 3.20 nurse aides the day shift. Review of the nursing time schedules revealed 1.48 nurse aides provided care during the night shift.  On July 6, 2025, the facility census was 48, which required 3.20 nurse aides the day shift. Review of the nursing time schedules revealed 2.55 nurse aides provided care during the night shift.  On September 17, 2025, the facility census was 52, which required 3.47 nurse aides during the day shift. Review of the nursing time schedules revealed 2.77 nurse aides provided care during the night shift.  On September 18, 2025, the facility census was 52, which required 3.47 nurse aides during the day shift. Review of the nursing time schedules revealed 2.55 nurse aides provided care during the night shift.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 12  On September 19, 2025, the facility census was 52, which required 3.47 nurse aides during the day shift. Review of the nursing time schedules revealed 2.06 nurse aides provided care during the night shift.  On September 20, 2025, the facility census was 52, which required 3.47 nurse aides during the day shift. Review of the nursing time schedules revealed 2.97 nurse aides provided care during the night shift.  On September 21, 2025, the facility census was 52, which required 3.47 nurse aides during the day shift. Review of the nursing time schedules revealed 3.00 nurse aides provided care during the night shift.  On September 22, 2025, the facility census was 52, which required 3.47 nurse aides during the day shift. Review of the nursing time schedules revealed 2.58 nurse aides provided care during the night shift.  On September 23, 2025, the facility census was 52, which required 3.47 nurse aides during the day shift. Review of the nursing time schedules revealed 2.00	P 5520		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 13  nurse aides provided care during the night shift.  No additional excess higher-level staff were available to compensate for this deficiency.  Interview with the Nursing Home Administrator on September 25, 2025, at 1:30 p.m. confirmed that the facility did not meet the required nurse aide-to-resident staffing ratios for the days listed above.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 14  Nursing services.  (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight.  This REGULATION is not met as evidenced by:	P 5530	The facility attempts to staff to meet state required number of staff hours and ratios for licensed practical nurses per current state regulations. The facility offers shift bonus for pick up shifts and for additional hours in case of call offs. Registered nurses, and nursing administration all assist to help fill in as needed. An active recruitment campaign is ongoing which includes sign on bonuses, shift differentials, and employee referral bonuses. Agency staff are contracted as available to fill in needed shifts. The Nursing Home Administrator and Director of Nursing meet daily to review staffing sheets to ensure proper staffing. Time and attendance is reviewed daily for ratios and staffing numbers. These calculations are recorded daily in labor tracking and submitted to the facility's management company ongoing.	Completion Date: <b>12/08/2025</b> Status: <b>APPROVED</b> Date: <b>11/20/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 15  Based on a review of nursing schedules, staffing information provided by the facility, and staff interviews, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) per 25 residents on the day shift for 11 of 21 days (24-hour periods) reviewed, failed to ensure a minimum of one licensed practical nurse (LPN) per 30 residents on the evening shift for six of 21 days, and failed to ensure a minimum of one licensed practical nurse (LPN) per 40 residents on the overnight shift for 12 of 21 days (24-hour periods) reviewed.  Findings Include:  Nursing time schedules provided by the facility for the weeks of June 8-14, 2025, July 1-7, 2025, and September 17-23, 2025, a review of facility census data indicated that on June 10, 2025, the facility census was 46, which required 1.84 LPNs during the day shift. Review of the nursing time schedules revealed 1.74 LPNs provided care on the day shift.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 16  On June 12, 2025, the facility census was 46, which required 1.84 LPNs during the day shift. Review of the nursing time schedules revealed 1.68 LPNs provided care on the day shift.  On June 14, 2025, the facility census was 47, which required 1.88 LPNs during the day shift. Review of the nursing time schedules revealed 1.68 LPNs provided care on the day shift.  On July 3, 2025, the facility census was 48, which required 1.92 LPNs during the day shift. Review of the nursing time schedules revealed 1.00 LPNs provided care on the day shift.  On September 17, 2025, the facility census was 52, which required 2.08 LPNs during the day shift. Review of the nursing time schedules revealed 1.94 LPNs provided care on the day shift.  On September 18, 2025, the facility census was 53, which required 2.12 LPNs during the day shift.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	<p>Continued from page 17</p> <p>Review of the nursing time schedules revealed 2.03 LPNs provided care on the day shift.</p> <p>On September 19, 2025, the facility census was 52, which required 2.08 LPNs during the day shift. Review of the nursing time schedules revealed 2.00 LPNs provided care on the day shift.</p> <p>On September 20, 2025, the facility census was 52, which required 2.08 LPNs during the day shift. Review of the nursing time schedules revealed 2.06 LPNs provided care on the day shift.</p> <p>On September 21, 2025, the facility census was 52, which required 2.08 LPNs during the day shift. Review of the nursing time schedules revealed 2.03 LPNs provided care on the day shift.</p> <p>On September 22, 2025, the facility census was 52, which required 2.08 LPNs during the day shift. Review of the nursing time schedules revealed 2.03 LPNs provided care on the day shift.</p>	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 18  On September 23, 2025, the facility census was 52, which required 2.08 LPNs during the day shift. Review of the nursing time schedules revealed 1.87 LPNs provided care on the day shift.  On June 10, 2025, the facility census was 46, which required 1.53 LPNs during the evening shift. Review of the nursing time schedules revealed 1.48 LPNs provided care on the evening shift.  On July 1, 2025, the facility census was 48, which required 1.60 LPNs during the evening shift. Review of the nursing time schedules revealed 1.58 LPNs provided care on the evening shift.  On September 17, 2025, the facility census was 53, which required 1.73 LPNs during the evening shift. Review of the nursing time schedules revealed 0.52 LPNs provided care on the evening shift.  On September 19, 2025, the facility census was 52, which required 1.53 LPNs during the evening shift. Review of the nursing time schedules revealed 1.48	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 19  LPNs provided care on the evening shift.  On September 20, 2025, the facility census was 52, which required 1.73 LPNs during the evening shift. Review of the nursing time schedules revealed 1.42 LPNs provided care on the evening shift.  On September 21, 2025, the facility census was 52, which required 1.73 LPNs during the evening shift. Review of the nursing time schedules revealed 0.97 LPNs provided care on the evening shift.  On June 10, 2025, the facility census was 46, which required 1.15 LPNs during the evening shift. Review of the nursing time schedules revealed 1.06 LPNs provided care on the overnight shift.  On June 11, 2025, the facility census was 46, which required 1.15 LPNs during the evening shift. Review of the nursing time schedules revealed 0.97 LPNs provided care on the overnight shift.  On June 14, 2025, the facility census was 48, which	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 20  required 1.20 LPNs during the evening shift. Review of the nursing time schedules revealed 1.03 LPNs provided care on the overnight shift.  On July 1, 2025, the facility census was 48, which required 1.20 LPNs during the evening shift. Review of the nursing time schedules revealed 1.00 LPNs provided care on the overnight shift.  On July 3, 2025, the facility census was 48, which required 1.20 LPNs during the evening shift. Review of the nursing time schedules revealed 1.06 LPNs provided care on the overnight shift.  On July 4, 2025, the facility census was 48, which required 1.20 LPNs during the evening shift. Review of the nursing time schedules revealed 0.00 LPNs provided care on the overnight shift.  On July 7, 2025, the facility census was 48, which required 1.20 LPNs during the evening shift. Review of the nursing time schedules revealed 1.00 LPNs provided care on the overnight shift.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 21  On September 17, 2025, the facility census was 52, which required 1.30 LPNs during the evening shift. Review of the nursing time schedules revealed 1.03 LPNs provided care on the overnight shift.  On September 19, 2025, the facility census was 52, which required 1.30 LPNs during the evening shift. Review of the nursing time schedules revealed 0.97 LPNs provided care on the overnight shift.  On September 21, 2025, the facility census was 52, which required 1.30 LPNs during the evening shift. Review of the nursing time schedules revealed 1.06 LPNs provided care on the overnight shift.  On September 22, 2025, the facility census was 52, which required 1.30 LPNs during the evening shift. Review of the nursing time schedules revealed 1.03 LPNs provided care on the overnight shift.  On September 23, 2025, the facility census was 52, which required 1.30 LPNs during the evening shift.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 22  Review of the nursing time schedules revealed 0.77 LPNs provided care on the overnight shift.  No additional excess higher-level staff were available to compensate for this deficiency for the dates listed above.  Interview with the Nursing Home Administrator on September 25, 2025, at 1:30 p.m. confirmed that the facility did not meet the required LPN-to-resident staffing ratios for the dates listed above.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5640	Continued from page 23  Nursing services.  (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.  This REGULATION is not met as evidenced by:	P 5640	The facility attempts to staff to meet state required number of staff hours for minimum of 3.2 hours of direct resident care per resident per day. The facility offers shift bonus for pick up shifts and for additional hours in case of call offs. Registered nurses, Licensed practical nurses, and nursing administration all assist to help fill in as needed. An active recruitment campaign is ongoing which includes sign on bonuses, shift differentials, and employee referral bonuses. Agency staff are contracted as available to fill in needed shifts. The Nursing Home Administrator and Director of Nursing meet daily to review staffing sheets to ensure proper staffing. Time and attendance is reviewed daily for ratios and staffing numbers. These calculations are recorded daily in labor tracking and submitted to the facility's management company ongoing.	Completion Date: <b>12/08/2025</b> Status: <b>APPROVED</b> Date: <b>11/20/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>021802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5640	<p>Continued from page 24</p> <p>Based on review of nursing schedules and staff interviews, it was determined that the facility failed to provide 3.20 hours of direct resident care for each resident for 19 of 21 days (24-hour periods) reviewed.</p> <p>Findings include:</p> <p>Nursing time schedules provided by the facility for the weeks of June 8-14, 2025, July 1-7, 2025, and September 17-23, 2025, revealed that the facility provided only 3.02 hours of direct care for each resident on June 8, 2025; 3.15 hours of direct care for each resident on June 9, 2025; 2.98 hours of direct care for each resident on June 10, 2025; 2.97 hours of direct care for each resident on June 12, 2025; 2.86 hours of direct care for each resident on June 13, 2025; 2.68 hours of direct care for each resident on June 14, 2025; 2.80 hours of direct care for each resident on July 1, 2025; 2.68 hours of direct care for each resident on July 2, 2025; 2.69 hours of direct care for each resident on July 3,</p>	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395618</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>09/25/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MULBERRY HEALTHCARE AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767</b>		
STATE LICENSE NUMBER: <b>021802</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5640	Continued from page 25  2025; 2.63 hours of direct care for each resident on July 4, 2025; 2.59 hours of direct care for each resident on July 5, 2025; 2.51 hours of direct care for each resident on July 6, 2025; 2.91 hours of direct care for each resident on July 7, 2025; 2.85 hours of direct care for each resident on September 17, 2025; 2.98 hours of direct care for each resident on September 18, 2025; 2.83 hours of direct care for each resident on September 19, 2025; 2.89 hours of direct care for each resident on September 21, 2025; 3.02 hours of direct care for each resident on September 22, 2025; and 2.99 hours of direct care for each resident on September 23, 2025.  Interview with the Nursing Home Administrator on September 25, 2025, at 1:30 p.m. confirmed that the facility did not meet the required daily hours of direct resident care for each resident on the days listed above.	P 5640		



# Certified End Page

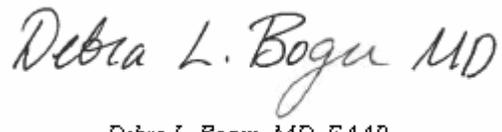
**MULBERRY HEALTHCARE AND REHABILITATION CENTER**

**STATE LICENSE NUMBER: 021802**

**SURVEY EXIT DATE: 09/25/2025**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY