STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395618	A. BUILDING _____ B. WING _____	**07/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MULBERRY HEALTHCARE AND REHABILITATION CENT	**411 1/2 W MAHONING STREET PUNXSUTAWNEY, PA 15767**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to enhance each resident's dignity by answering call bells timely for one of five residents reviewed (Resident 1). Findings include: The facility's policy regarding answering call bells, dated April 20, 2020, indicated that staff were to answer the resident's call bell as soon as possible. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated March 6, 2020, indicated that the resident was alert and oriented, could sometimes make her needs known, required the extensive assistance of one to two staff for hygiene and toileting, was frequently incontinent of urine, always incontinent of bowel, and had [DIAGNOSES REDACTED]. The resident's care plan, dated February 27, 2020, revealed that the call bell was to be kept within reach. Electronic call bell logs/records for June and July 2020 revealed that there were delayed responses to Resident 1's call bell as follows: June 8 at 7:04 a.m. - 18 minutes June 8 at 3:43 p.m. - 19 minutes June 9 at 6:52 p.m. - 14 minutes June 13 at 8:32 a.m. - 26 minutes June 14 at 8:47 a.m. - 14 minutes June 14 at 7:28 p.m. - 18 minutes June 19 at 4:56 p.m. - 25 minutes June 19 at 6:28 p.m. - 19 minutes June 27 at 8:30 a.m. - 15 minutes June 28 at 10:49 a.m. - 38 minutes July 2 at 9:22 a.m. - 28 minutes July 3 at 4:11 a.m. - 19 minutes July 3 at 5:54 p.m. - 19 minutes July 5 at 12:03 p.m. - 20 minutes Interview with Resident 1 on July 6, 2020, at 1:34 p.m. revealed that depending on how busy the staff were, it could take a while to have your call bell answered. Interview with the Director of Nursing on July 6, 2020, at 5:00 p.m. confirmed that the response to Resident 1's call bell was not timely on the above dates/times. 28 Pa. Code 201.29(j) Resident rights. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the physician was notified timely about a change in condition for one of five residents reviewed (Resident 1). Findings include: The facility's policy regarding changes in condition, dated April 20, 2020, indicated that the nurse would notify the resident's physician when there was a significant change in the resident's physical, emotional or mental condition. A significant change of condition was a major decline or improvement in the resident's status that would not normally resolve itself without interventions by staff, or by implementing standard disease-related clinical interventions. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated March 6, 2020, indicated that the resident was alert and oriented; could sometimes make her needs known; was dependent for transfers; required the extensive assistance of one to two staff for bed mobility, hygiene and toileting; had no pressure ulcers; was frequently incontinent of urine; always incontinent of bowel; and had [DIAGNOSES REDACTED]. The resident's care plan, dated February 27, 2020, revealed that she was at risk for skin breakdown and staff were to observe for changes in the resident's skin condition and report abnormalities. Wound records, dated February 28, 2020, revealed that the resident had pink, intact tissue to the left buttock. Wound records, dated March 5, 2020, revealed that the resident developed a Stage II (superficial opening) pressure ulcer (skin breakdown caused by prolonged, unrelieved pressure) on the left buttocks that measured 0.6 x 0.5 x 0.1 centimeters (cm). There was no documented evidence that the physician was notified about the resident's Stage II pressure ulcer. Interview with the Director of Nursing on July 6, 2020, at 5:00 p.m. confirmed that there was no documented evidence that the physician was notified about Resident 1's Stage II pressure ulcer. 28 Pa. Code 211.12(d)(3)(5) Nursing services.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services by failing to complete physician-ordered treatments for two of five residents reviewed (Residents 2, 3). Findings include: physician's orders [REDACTED]. The resident's Treatment Administration Record (TAR) for June 2020 revealed that there was no documented evidence that the treatment was completed as ordered on June 18, 2020, and there was no documented evidence that the wound was healed on that date. Interview with Registered Nurse 1 on July 6, 2020, at 10:52 a.m. confirmed that there was no documented evidence that Resident 2's treatment was completed as ordered during the day shift on June 18, 2020, or that the wound was healed on that date. physician's orders [REDACTED]. The treatment was to be done every day on the evening shift. The resident's TAR for April 2020 revealed that there was no documented evidence the treatment was completed as ordered on the evening shift on April 16, 2020. physician's orders [REDACTED]. The resident's TAR for June 2020 revealed that there was no documented evidence the boot was in place on the evening shift on June 10, 2020. physician's orders [REDACTED]. The resident's TAR for June 2020 revealed that there was no documented evidence the treatment was completed as ordered on the evening shift on June 10, 2020, and there was no documented evidence that the area was healed on that date. Interview with the Director of Nursing on July 6, 2020, at 4:30 p.m. confirmed there was no documented evidence that physician-ordered treatments and devices were completed/applied as ordered for Residents 2 and 3 on the above dates, and there was also no documented reason(s) regarding why the treatments were not competed. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 proper infection control practices were performed by staff related to the use of personal protective equipment (PPE) for two of five residents reviewed (Residents 4, 5). Findings include: Admission information for Resident 4 revealed that the resident was admitted to the facility on [DATE]. physician's orders [REDACTED]. eye protection. Observations of Resident 4's room on July 6, 2020, at 12:01 p.m. revealed that a sign was posted on the wall outside the room, which indicated that staff were to follow droplet precautions when entering the resident's room. Observations on July 6, 2020, at 12:03 p.m. revealed that Occupational Therapist 2 put on a gown, gloves, and eye shield and entered the resident's room. She put on two surgical-type face masks but did not put on an N-95 mask. Interview with Occupational Therapist 2 on July 6, 2020, at 12:05 p.m. confirmed that she was aware that she should have put on an N-95 mask, and that she did not do so. Interview with the Assistant Director of Nursing on July 6, 2020, at 12:30

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395618	A. BUILDING _____ B. WING _____	**07/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MULBERRY HEALTHCARE AND REHABILITATION CENT	**411 1/2 W MAHONING STREET PUNXSUTAWNEY, PA 15767**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) p.m. confirmed that Occupational Therapist 2 should have used an N-95 mask when entering Resident 4's room. The facility's policy regarding transmission-based precautions (special infection control procedures to prevent the spread of infectious organisms), dated April 2, 2020, indicated that for contact precautions, staff were to wear gloves when in contact with a resident's environment. physician's orders [REDACTED]. - bacteria in the colon that can cause severe diarrhea). Observations of Resident 5's room on July 6, 2020, at 9:00 a.m. revealed that there was a sign posted on the wall adjacent to the door that read, Stop. All visitors report to the nursing station prior to entering room. Observations on July 6, 2020, at 2:15 p.m. revealed that Physical Therapy Assistant 3 was in Resident 5's room providing therapy to the resident. Physical Therapy Assistant 3 was not wearing gloves and her bare hand was in direct contact with the bare skin of Resident 5's right leg, below the hem of the resident's pants. Interview with Assistant Director of Nursing on July 6, 2020, at 2:20 p.m. confirmed that Resident 5 was in contact precautions due to [DIAGNOSES REDACTED], and Physical Therapy Assistant 3 should have been wearing gloves. Interview with Physical Therapy Assistant 3 on July 6, 2020, at 2:26 p.m. confirmed that she was not wearing gloves while in Resident 5's room, and that she should have had gloves on. She stated that she used hand sanitizer to cleanse her hands when she left the room. Interview with the Director of Nursing on July 6, 2020, at 3:34 p.m. revealed that hand sanitizer was not effective against [DIAGNOSES REDACTED]. and Physical Therapy Assistant 3 should have used the antimicrobial soap found in the resident's bathroom to wash her hands. 28 Pa. Code 211.12(d)(1)(5) Nursing services.