STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155600	A. BUILDING 00 B. WING	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MULBERRY HEALTH & REHABILITATION CENTER	502 W JACKSON ST MULBERRY, IN 46058

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 13, 14, 15, 16 and 17, 2023 Facility number: 000470 Provider number: 155600 AIM number: 100289210 Census Bed Type: SNF/NF: 103 SNF: 17 Total: 120 Census Payor Type: Medicare: 4 Medicaid: 84 Other: 32 Total: 120 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 24, 2023.	F 0000	Mulberry Health & Retirement Community respectfully request paper compliance in lieu of an onsite follow up survey.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to accurately code a resident's discharge status in the Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for MDS assessments. (Resident 129)	F 0641	Mulberry Health completes quarterly MDS review for accuracy, and would have identified the concern at that time. Corrective action was taken	03/17/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heidi Wallar	MSN	03/07/2023

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	Finding includes: The record for Resident 129 was reviewed on 2/15/23 at 2:56 p.m. Diagnoses included, but were not limited to, fracture of left pubis, hypertensive chronic kidney disease, pulmonary fibrosis, chronic kidney disease, and hypertension. A discharge MDS assessment, dated 1/13/23, indicated the resident was discharged to an acute hospital on 1/1/23. During an interview, on 2/15/23 at 10:07 a.m., the Director of Nursing indicated Resident 129 was discharged home with daughter and not to the hospital. The discharge MDS assessment, completed on 1/13/23, was coded wrong. During an interview, on 2/17/23 at 11:00 a.m., the MDS Coordinator indicated the MDS assessment was coded wrong and should have been coded as discharged to the community. The facility followed the RAI manual. 3.1-31(i)		immediately and MDS discharge location was changed to accurate code proper resident's discharge status. The resident was coded on the MDS of discharge location being hospital however MDS discharge location was home. MDS was immediately modified. All MDS discharge locations were audited upon surveyor finding and to be correct. All residents who have MDS for discharges have the potential to be affected. MDS to continue to follow regulatory guidelines per the RAI manual and CMS, along with EDS audits. MDS nurse will review all residents to ensure proper documentation exists in their MDS as it pertains to discharge location. MDS nurse will complete a review for accuracy on the ARD for each resident to ensure proper coding for discharge location. A CQI audit tool will be completed by MDS for the first 60days to ensure accurate documentation for discharge location. Director of Nursing and MDS coordinator will report to the facility's Quality Assurance Committee on their results of the audits, and any actions necessary to ensure 100% accuracy.	

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F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

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	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to document targeted behaviors in the comprehensive care plan for a resident receiving an antipsychotic medication for delusional behaviors for 1 of 3 residents reviewed for comprehensive care plans. (Resident 101) Finding includes: The record for Resident 101 was reviewed on 2/14/22 at 2:49 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, right femur fracture, vascular dementia, restlessness and agitation, Alzheimer's disease, delusional disorder, depression, and mood disorder. A history and physical, dated 6/15/22, indicated Resident 101 had a diagnosis of dementia and no diagnosis of schizoaffective disorder. A physician's order, dated 8/31/22, indicated to add a diagnosis of schizoaffective disorder due to hallucinations and delusions. A history and physical, dated 12/16/22, indicated Resident 101 had a diagnosis of schizoaffective disorder and the diagnosis was very unclear and there was no prior documentation to support. She had no documentation for schizoaffective disorder or no use of psychotropic medication prior to	F 0656	Corrective action was taken for this resident identified, and dx of schizoaffective disorder was discontinued off care plan, and care plan updated. Diagnosis of schizoaffective disorder was audited on all comprehensive care plans immediately with no further residents with this diagnosis. No further residents have the potential to be affected without any further residents having the diagnosis schizoaffective. During monthly behavior meeting diagnosis for antipsychotics will be reviewed to ensure diagnosis is current and care-planned appropriately. A CQI audit tool will be completed by Social Service Director on a monthly basis for 90days to ensure compliance. SSD will report to the facility's Quality Assurance Committee on the results of the audits, and any action necessary to achieve 100% compliance.	03/17/2023

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	starting quetiapine on 11/22. A review of Resident 101's admission agreement, dated 10/13/22, had a document titled "Consent for use of psychotropic medications therapy". The document lacked indication of resident information, medication she was prescribed, diagnosis, who the information was reviewed with, or a signature of consent for the medication. A care plan, dated 10/18/22, indicated Resident 101 had episodes of resisting care, verbally and physically abusive towards staff and other residents, agitated with redirection. She had diagnoses of Alzheimer's disease, dementia, schizoaffective disorder, and delusional disorder. A care plan, with a revision date of 2/14/23, indicated Resident 101 had episodes of delusions. She had diagnoses of dementia, Alzheimer's disease, schizoaffective disorder, and delusional disorder. She had trauma history. A document, titled "Note from Prescribing Psychiatrist," dated 2/3/23, indicated Resident 101 had a schizoaffective disorder diagnosis from another facility. Schizoaffective disorder was not appropriate for the use of Olanzapine. The diagnosis was to be changed to delusional disorder effective 2/3/23. During an interview, on 2/17/23 at 9:20 a.m., the Social Service Director indicated Resident 101's care plan was not updated to remove the diagnosis of schizoaffective disorder. No policy on care plans was provided by the time of exit. 3.1-35(a)			

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	3.1-35(b)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to accurately assesses and document bruising on the skin for 2 of 2 residents reviewed for skin issues and skin assessments. (Resident 2 and 20) Findings include: 1. During an observation of Resident 2, on 02/13/23 at 12:39 p.m., the resident was found to have a red bruise on her left arm at the wrist area. During an observation of Resident 2, on 02/14/23 at 2:02 p.m., the resident was found to have a red bruise on her left arm at the wrist area. During an observation of Resident 2, on 02/15/23 at 1:10 p.m., the resident was found to have a red discoloration/bruise on her left forearm at the wrist area. The record for Resident 2 was reviewed on 02/13/23 at 2:48 p.m. Diagnoses included, but were not limited to, anemia, gastrointestinal hemorrhage, and thrombocytopenia (a low platelet count and platelets stop bleeding by clumping	F 0684	New skin assessments have been completed for the residents affected in the survey. Both areas identified in the survey were small bruises that were each less than the size of a quarter. All residents have the potential to be affected. Licensed nursing staff will be in-serviced on accurate completion of skin assessments. A CQI audit tool will be completed by nursing administration that audits 10% of the weekly skin assessment for four weeks to ensure accuracy. Director of Nursing will report to the facilities Quality Assurance committee on results of the audits, and any actions necessary to ensure 100% compliance.	03/17/2023

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	and forming plugs in blood vessel injuries). A physician's order, initiated on 11/24/22, indicated to give aspirin (a medication which was used to prevent platelets from sticking together and decreased the body's ability to form clots) 81 milligrams (mg) once a day for a history of stroke and atrial fibrillation (an irregular heart rhythm which could lead to blood clots in the heart). A care plan, initiated on 10/07/21, indicated the resident was at risk for bleeding related to the use of aspirin. The resident was to be observed for signs of abnormal bleeding. A weekly skin assessment, completed on 02/13/23 at 3:15 p.m., did not contain documentation or measurement of the bruise. During an interview, on 02/15/23 at 1:11 p.m., RN 3 indicated she was not aware of the bruising and was going to assess the resident. 2. During an observation of Resident 20, on 02/13/23 at 10:40 a.m., bruising was noted on the resident's right hand and forearm. The bruising was red and purple. Resident 20 indicated he hit his hand. During an observation of Resident 20, on 02/14/23 at 2:07 p.m., the resident continued to have bruising on his right forearm. During an observation of Resident 20, on 02/15/23 at 9:30 a.m., the resident continued to have bruising on his right forearm. During an observation of Resident 20, on 02/16/23 at 11:04 a.m., the resident continued to have bruising on his right forearm.			

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	The record for Resident 20 was reviewed on 02/16/23 at 1:14 p.m. Diagnoses included, but were not limited to, atrial fibrillation, congestive heart failure (when the heart muscle doesn't pump blood as well as it should) and hypertensive kidney disease (high blood pressure caused by the narrowing of your arteries which carry blood to your kidneys). A physician's order, initiated on 01/18/22, indicated to give apixaban (Eliquis-an anticoagulant medication used to treat and prevent blood clots) 5 mg twice a day for atrial fibrillation. A physician's order, initiated on 01/18/22, indicated to observe for side effects of (anticoagulant) medication to include bruising. A care plan, initiated on 12/28/21, indicated Resident 20 was a risk for side effects of the anticoagulant and to observed for signs of bleeding. A weekly skin assessment, completed on 02/15/23 at 5:59 p.m., did not contain documentation of the bruising. During an interview, on 02/16/23 at 11:04 a.m., RN 3 indicated she had completed the skin assessment on Resident 20 the evening before, and she would correct the assessment. A facility policy, titled "Skin Prevention-Non-Pressure Incidents/Accidents," dated May 2022 and provided by the Administrator in Training (AIT) on 02/17/23 at 2:53 p.m., indicated "...Nursing, in collaboration with the health care team, will assess and manage			

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	skin integrity for all residents...Observing skin for...bruises...PROCEDURE...Staff to report new areas to nurse...investigate areas...." 3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to date multi-dose bottles of medication when they were opened in 1 of 4 medication storage refrigerators reviewed for medication storage. (300 Unit)	F 0761	Corrective action for the residents identified in the survey was to dispose of medication for not proper labeling and unknown open date. All refrigerated medications	03/17/2023

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	Finding includes: During a medication storage observation in the 300 Unit medication refrigerator, on 02/14/23 at 9:45 a.m., with LPN 8, two (2) bottles of Ativan concentrate were found open without a date to indicated when the multi-dose bottles had been opened. During an interview, on 02/14/23 at 9:47 a.m., LPN 8 indicated the bottles should have been labeled with the date they had been opened. A facility policy, titled "Medication Storage and Labeling," dated January 2023 and provided by the Director of Nursing on 02/15/23 at 11:30 a.m., indicated "...multi-dose vials which have been opened...should be dated...." 3.1-25(j)		were audited for open dates. New medications ordered from pharmacy for these residents. All residents with refrigerated medication have the potential to be affected. All refrigerated medication has been audited for non-dated medication. Licensed nursing staff will be in-serviced for medication labeling and to date medication when opened. Nursing management will audit refrigerated medication for date opened labels. A CQI audit tool will be completed weekly for the first 30days and monthly for the next 90days to ensure compliance. Director of Nursing will report to the facility's Quality Assurance committee on results of the audits, and any actions necessary to ensure 100% accuracy.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §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			

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	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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to label, date and store food in a sanitary manner. This deficient practice had the potential to affect all residents who consume food from the kitchen. Findings include: During an observation, on 02/13/23 at 9:55 a.m., the kitchen cooler was noted with Dietary Manager (DM) and the following was observed: a. on the cooler shelf was a name brand open can of coffee like drink with no open date on the can. b. on the cooler shelf was a plastic bottle of name brand soda pop with no label or date on the bottle. c. on the cooler shelf was a large plastic cup from a gas station with an uncovered straw in the cup with no label or date on the cup. d. on the cooler shelf was a soft sided plastic lunch box with no label or date on the lunch box. During an interview, on 02/13/23 at 9:55 a.m., the DM indicated "I don't know" if the open and undated drinks and lunch container could be kept in the walk-in cooler. During an interview, on 02/16/23 at 2:28 p.m., the Registered Dietician (RD) indicated "we (facility)	F 0812	The items identified by the surveyor were removed corrected immediately. All residents have the potential to be affected. Culinary services will be in-serviced on where to place personal drinks and food. A CQI audit tool will be completed by the Culinary Services Director on a weekly basis for 90 days to ensure ongoing compliance. Culinary Service Director will report to the facility's Quality Assurance Committee on the results of the audits, and any action necessary to achieve 100% compliance.	03/17/2023

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	do not have a policy on that" for staff food in the walk-in cooler. The food "should at least have their name" and if food was open "then labeled" and "dated" to prevent potential food borne illness. A facility policy, titled "Shelf Life and Labeling Procedure," undated and received from the Executive Director (ED) on 02/17/2023 at 11:30 a.m., indicated " ...Foods will be labeled and used within appropriate timeframes to ensure safety and quality...Open resident food items must have an "open" date and a "use by" date" on the item...." 3.1-21(i)(1)			