

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/27/2023
NAME OF PROVIDER OR SUPPLIER Mulberry Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Strahl Street Franklin, TN 37064	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on policy review, document review, record review, and interview, the facility failed to protect the resident's right to be free from verbal abuse for 1 (Resident #4) of 7 residents reviewed for abuse. Dietary Staff (DS) DS #3 used profanity directed toward Resident #4 and called the resident a derogatory name.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled Resident Rights, revised in February 2021, indicated Employees shall treat all residents with kindness, respect and dignity . The policy further indicated that residents had the right to .b. be free from abuse, neglect, misappropriation of property, and exploitation . 2. Record review of the Resident Face Sheet revealed Resident #4 was admitted to the facility 01/13/2023, with diagnoses that included cognitive communication deficit, bipolar disorder, and pain disorder with related psychological factors. <p>A review of Resident #4's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/20/2023, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS indicated the resident exhibited verbal behavioral symptoms directed toward others, which occurred four to six days but less than daily during the assessment period. The MDS indicated the resident utilized a wheelchair for mobilization.</p> <p>Review of Resident #4's Care Plan Activity Report initiated on 3/23/2023 revealed a focus area of non-compliance. The care plan indicated Resident #4 had aggressive behaviors, could be very loud and was verbally abusive towards staff, embellished at times, and was accusatory to staff. Interventions directed staff to explain the benefits of allowing staff to perform their job, educate the resident regarding compliance with treatment and care, encourage and allow the resident to express their feelings and concerns when they refuse treatment, always tell the resident what you are going to help with and encourage the resident to help with decision making and care.</p> <p>Review of a facility Occurrence Report, dated 09/05/2023, revealed Resident #4 had a verbal altercation with a staff member. The report indicated DS #3 bumped into Resident #4's wheelchair with the food cart, and Resident #4 cursed at DS #3. The report revealed Resident #4 stated DS #3 did not apologize.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an undated typed statement completed by the Administrator, indicated that on 09/05/2023, Resident #4 reported to the Administrator that DS #3 hit their wheelchair while pushing the meal cart down the hall. The statement revealed that the resident stated they did not think it was done intentionally, and they were not hurt but was upset because DS #3 did not apologize to them. The statement indicated on 09/11/2023, Resident #4 told the Administrator that DS #3 cursed at the resident after he bumped into their wheelchair. The statement indicated the Administrator reminded the resident of their previous conversation regarding the incident in which the resident did not mention DS #3 cursing at them. The statement revealed that Resident #4 stated they did not want to make a big deal out of it. The statement indicated DS #3 was removed from the schedule while the facility investigated the incident.</p> <p>A review of a facility Occurrence Report, dated 09/11/2023, revealed Resident #4 reported DS #3 used profanity towards them. The report indicated the previous week, the resident reported DS #3 bumped into their wheelchair with the dietary meal cart. The resident stated they cursed at DS #3 because he did not say sorry, and DS #3 used profanity directed at the resident.</p> <p>Review of the typed statement of an interview with Resident #5, dated 09/12/2023 and conducted by the Director of Nursing (DON), revealed Resident #5 witnessed the incident between Resident #4 and DS #3. The statement indicated Resident #5 witnessed DS #3 come around the corner pushing the dietary cart and bump into Resident #4's wheelchair. The statement indicated DS #3 acknowledged he did not mean to bump into Resident #4. The statement indicated Resident #4 started cursing at DS #3, and every time DS #3 came onto the unit, Resident #4 would start cursing at him again. The statement indicated the last time DS #3 came down the hall with the cart, Resident #4 began cursing loudly at him, and DS #3 asked Resident #4, Why do you have to be such a [derogatory name].</p> <p>A review of Resident #5's annual MDS, with an ARD of 08/01/2023, revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>During an interview on 09/27/2023 at 4:30 PM, Resident #5 stated they witnessed an issue between a young man in dietary and Resident #4. Resident #5 stated the young man accidentally bumped into Resident #4's wheelchair, and Resident #4 got upset and started cursing at him. Resident #5 stated the young man from dietary walked by multiple times, and each time, Resident #4 would curse at him. Resident #5 said the young man did not say anything back to Resident #4 until the last time he walked by, and Resident #4 told him they would make sure he was fired. Resident #5 stated at that point, the young man said, Why do you have to be such a [derogatory name?] directed at Resident #4.</p> <p>Review of the undated handwritten statement from an interview with DS #3 conducted by the Administrator, revealed DS #3 stated he was pushing the hall cart and mistakenly bumped into Resident #4's chair. The statement revealed the resident started yelling and cursing at DS #3. The statement revealed DS #3 stated he said, My bad, and continued down the hall. The statement indicated every time DS #3 walked past Resident #4, they would curse at him, and the resident stated they would have him fired. The statement indicated DS #3 told Resident #4 to go lay [his/her] [expletive] down and be quiet and asked Resident #4, Why are you [expletive] at me.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/27/2023 at 4:11 PM, DS #3 stated he was coming out of the kitchen and accidentally bumped into Resident #4. DS #3 stated he said, My bad, and Resident #4 did not take the apology well. DS #3 stated he made several more trips, and Resident #4 cursed at him each time. DS #3 stated the last time he walked past Resident #4, they followed him to the kitchen door, cursing at him. DS #3 stated he told Resident #4 to Quit [expletive] and go lay down. DS #3 stated he could have just kept walking. He stated Resident #4 threatened they would get him fired.</p> <p>Review of a Disciplinary Warning issued to DS #3 dated 09/12/2023, indicated he received a warning related to the incident on 09/05/2023. The warning stated DS #3 admitted to speaking inappropriately to a resident while the resident was angry and speaking inappropriately to him. The warning indicated any other such infraction would result in immediate termination. The warning was signed by DS #3.</p> <p>During an interview on 09/27/2023 at 6:30 PM, the DON and Administrator stated Resident #4 did not initially report DS #3 cursed at them during the incident when DS #3 bumped the wheelchair of Resident #4. The DON and Administrator indicated they immediately sent DS #3 home, began their investigation, and did not feel the incident was abuse but more of a customer service issue. They indicated DS #3 did not act appropriately when the resident continued to yell at him repeatedly, and they provided education on customer service.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on policy review, document review, record review, and interview, the facility failed to ensure allegations of abuse and injuries of unknown origin were reported to the State Agency within two hours of learning of the allegations for 1 (Resident #1) of 7 residents reviewed for abuse.</p> <p>Findings included:</p> <p>1. A review of an undated facility policy titled Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedures revealed, When the facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The Facility will increase enforcement action, including, but not limited to: A. Taking steps to prevent further potential abuse. B. Reporting alleged violations and investigation within required timeframes pursuant to Federal and State statutes and regulations. Section, XIII. Response revealed A. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility shall: a. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment of resident property, are reported in the proper timeframe pursuant to this policy.</p> <p>A review of a facility policy titled Abuse Prevention and Intervention Strategies Nursing Policy and Procedures, revised in September 2016, revealed, 5. Investigation: The facility will investigate all injuries of unknown origin and all allegations of mistreatment, neglect, or abuse. All investigations will be conducted in a timely, thorough and objective manner. Further review revealed, 7. Report/Respond: Any incidents of substantiated abuse and neglect are reported and analyzed and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State, or Federal law.</p> <p>2. Review of Resident #1's Resident Face Sheet revealed the facility admitted the resident on 11/02/2022, with diagnoses that included unspecified intellectual disabilities and anxiety disorder.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/26/2023, revealed the Staff Assessment for Mental Status (SAMS) indicated the resident had short and long term memory problems and their cognitive skills for daily decision making were severely impaired. The MDS indicated the resident exhibited behaviors not directed towards others daily during the assessment period. The MDS indicated Resident #1 required extensive assistance from staff for bed mobility and transfers and was totally dependent on staff for locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing.</p> <p>Review of a facility Occurrence Report dated 07/09/2023 at 12:30 PM, revealed Licensed Practical Nurse (LPN) #4 documented she observed a bruised and swollen right-hand 5th digit and right shoulder on Resident #1, after the Certified Nursing Assistant (CNA) reported the resident had swelling and bruises on the fifth finger and right shoulder and no range of motion.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Progress Notes dated 07/09/2023 at 3:25 PM, signed by LPN #4, revealed that during routine care, a CNA discovered Resident #1's fifth digit was swollen, and the right shoulder was different from normal with bluish bruises. The note revealed the nurse assessed the resident with no range of motion of the right shoulder. The note revealed the Provider was notified and recommended the resident be sent to the hospital for further evaluation. The note revealed the resident was transferred to the hospital via ambulance at 1:30 PM. The note revealed the Director of Nursing (DON) and the resident's family were notified.</p> <p>A review of a file provided by the facility labeled Soft File, a file which contained the facility's investigation into Resident #1's injury of unknown origin, revealed no Incident Reporting System (IRS) form to verify the facility reported to the State Agency when they became aware of an injury of unknown origin.</p> <p>During an interview on 10/27/2023 at 2:26 PM, the Administrator stated she did not report the injury of unknown origin within 2 hours, because she knew what happened to Resident #1. The Administrator stated that their state had a rule that if they knew what happened or could determine no abuse within those two hours, they did not have to report it. The Administrator stated she knew within a short amount of time that Resident #1 had fallen on the night shift. The Administrator stated once she knew Resident #1 fell, she turned the investigation into a fall investigation instead of following the injury of unknown origin pathway, reporting to the State Agency, and sending the 5-day follow-up as required.</p> <p>Review of a file provided by the facility labeled Soft File, a file which contained the facility's investigation into Resident #1's injury of unknown origin, revealed no documentation of the exact time the Administrator became aware of Resident #1's fall.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on policy review, document review, record review, and interview, the facility failed to ensure a thorough investigation of an injury of unknown origin was completed for 1 (Resident #1) of 7 residents reviewed for abuse.</p> <p>Findings included:</p> <p>1. A review of an undated facility policy titled Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedures, revealed, IV. When the facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents additional abuse immediately. The facility will increase enforcement action including, but not limited to: C. Conducting a thorough investigation of the alleged violation. Further review revealed, V. The facility will develop written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the Quality Assurance and Performance Improvement (QAPI) program to allow the QAA (Quality Assessment and Assurance) committee to determine: a. If a thorough investigation is conducted. The policy revealed IX. The facility will investigate any allegations made alleging abuse, neglect, and exploitation of residents and misappropriation of resident property. Additionally, XIII. In response to allegation of abuse, neglect, exploitation, or mistreatment, the facility shall: B. Have evidence that all alleged violations are thoroughly investigated.</p> <p>A review of a facility policy titled Abuse Prevention and Intervention Strategies Nursing Policy and Procedures, revised in September 2016, revealed, It is the policy of this facility to protect its residents from abuse, neglect, involuntary seclusion, and misappropriation of property. In order to facilitate the above, the facility has implemented a program of abuse prevention and intervention strategies. The procedure included, 4. Identification: The facility will identify patterns or isolated incidents of unexplained functional regression or other evidence of physical, verbal, sexual or psychological abuse or punishment posing a serious and immediate threat to individuals. The facility will also identify events such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse; and determine the direction of the investigation. 5. Investigation: The facility will investigate all injuries of unknown origin and all allegations of mistreatment, neglect, or abuse. All investigations will be conducted in a timely, through and objective manner.</p> <p>2. A review of Resident #1's Resident Face Sheet revealed the facility admitted the resident on 11/02/2022 with diagnoses that included unspecified intellectual disabilities and anxiety disorder.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/26/2023, revealed the Staff Assessment for Mental Status (SAMS) indicated the resident had a short and long term memory problem and their cognitive skills for daily decision making were severely impaired. The MDS indicated the resident exhibited behaviors not directed towards others daily during the assessment period. The MDS indicated Resident #1 required extensive assistance from staff for bed mobility and transfers and was totally dependent on staff for locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Occurrence Report dated 07/09/2023 at 12:30 PM, revealed Licensed Practical Nurse (LPN) #4 documented she observed a bruised and swollen right hand 5th digit and right shoulder on Resident #1 after the Certified Nursing Assistant (CNA) reported the resident had swelling and bruises on the fifth finger and right shoulder and no range of motion.</p> <p>Review of a CNT [certified nurse technician] OBSERVATION form dated 07/09/2023, revealed CNA #13 took Resident #1 from CNA #6 to change the resident. The form revealed CNA #13 attempted to assist Resident #1 with standing, the resident did not want to stand, which CNA #13 documented as unusual. The form revealed CNA #13 noticed the resident was not moving their right arm, and there was discoloration and a dip in the arm. The form revealed CNA #13 immediately notified the nurse.</p> <p>Review of a facility Occurrence Report, dated 07/09/2023, revealed Registered Nurse (RN) #2 indicated CNA #9 reported to her that Resident #1 flipped themselves out of their chair. The report revealed RN #2 assessed Resident #1 and saw a red mark on the resident's left heel but no other injuries. The report revealed during the three hours before the fall, the resident was very restless. The report revealed CNA #9 was with the resident in the dining room at 1:00 AM, rolling the resident in the hallway at 2:00 AM, in the hallway with the resident near their room at 3:00 AM, and at approximately 3:15 AM, Resident #1 flipped themselves over the side of the chair onto the floor. The report revealed CNA #9 reported Resident #1 flipped over the side of the chair when CNA #9 went to the back of the chair to pull the resident back in the seat because the resident was leaning forward in the chair.</p> <p>Review of Resident #1's Progress Notes dated 07/09/2023 at 3:25 PM, signed by LPN #4, revealed that during routine care, a CNA discovered Resident #1's fifth digit was swollen, and the right shoulder was different from normal with bluish bruises. The note revealed the nurse assessed the resident with no range of motion of the right shoulder. The note revealed the Provider was notified and recommended the resident be sent to the hospital for further evaluation. The note revealed the resident was transferred to the hospital via ambulance at 1:30 PM. The note revealed the Director of Nursing (DON) and the resident's family were notified.</p> <p>During a telephone interview on 09/27/2023 at 10:52 AM, the Hospital Social Worker stated Resident #1 was admitted to their facility in July 2023 due to significant injuries. The Hospital Social Worker indicated he did not get information from the facility on how the injuries occurred. He stated Resident #1 was non-verbal and severely developmentally delayed. He stated he did not think the resident could pitch themselves out of the wheelchair but did not know for sure.</p> <p>During an interview on 09/27/2023 at 1:43 PM, RN #7 stated the resident had to be on a one-on-one (1:1) with staff at all times due to being a fall risk and the family's concern for the resident's safety. RN #7 stated she was working as the nurse on the second floor when the injury was discovered. RN #7 stated CNA #13 came and got her to look at the resident's arm. RN #7 stated the resident was not acting like their normal self and was just different like something was wrong with them. RN #7 stated to her knowledge, nothing was reported, but she was taking care of the residents on the west side. RN #7 stated from what she understood, CNA #13 was changing the resident, and the resident's arm just flopped. She stated she told CNA #13 to tell LPN #4 and that they needed to contact the Director of Nursing (DON).</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 09/27/2023 at 2:49 PM, CNA #9 stated Resident #1 was 1:1 with staff and had always been. CNA #9 stated the CNAs would alternate who cared for Resident #1 an hour at a time. CNA #9 stated she cared for the resident when the resident fell (07/09/2023). CNA #9 stated the resident was in their geriatric chair, it was between 2:00 AM and 3:00 AM, and the resident was screaming, yelling, fidgety, agitated, and sleepy but just seemed restless. CNA #9 stated she was sitting beside Resident #1 when the resident slid down in the chair. CNA #9 stated she went around the chair to pull the resident up, and in the time, it took her to get around the chair, the resident had flipped over the armrest. CNA #9 stated she yelled for help, but no one responded. CNA #9 stated she could not find the nurse, so she got the resident up. CNA #9 stated after she got the resident up, she went and told the nurse. CNA #9 stated the resident was agitated, even on the floor, moving around, and fidgeting.</p> <p>During a follow-up telephone interview on 10/26/2023 at 3:00 PM, CNA #9 stated they transferred Resident #1 back to the geriatric chair by pulling the resident up under the arms and lifting. CNA #9 stated they did not have a gait belt on them. CNA #9 stated they just kind of chicken-winged the resident. CNA #9 stated they did change the resident maybe two or three times during the shift. CNA #9 stated she did not notice any bruising or swelling when she changed the resident. CNA #9 stated she was just trying to get the resident up off the floor in any way they could get the resident up into the chair.</p> <p>During a telephone interview on 10/26/2023 at 2:18 PM, CNA #10 stated she did 1:1 with Resident #1, and the facility had a sheet staff initialed every 15-20 minutes on a two-hour rotation. CNA #10 stated CNA #9 came and found her because she could not find the nurse and told her Resident #1 had thrown herself out of their chair, so she went in to help CNA #9. CNA #10 stated they changed the resident and then put the resident back in the wheelchair. CNA #10 stated she did not notice any swelling, discoloration, or bruising at that time. CNA #10 stated the resident was sitting on the floor on their bottom when she entered the room. CNA #10 stated she did not see the resident fall. CNA #10 stated they kind of scooped Resident #1 up, putting one of their arms under each arm of the resident, and they grabbed the resident's pants and pulled the resident up. CNA #10 stated she did not remember if they used a gait belt but thought they did. CNA #10 stated she did remember they grabbed underneath the resident's arm. CNA #10 stated that is not how they should have transferred a resident. CNA #10 stated she had to write a statement about what her part was in the incident. CNA #10 stated the supervisor called her, she thought, and asked her about this. CNA #10 stated she thought CNA #9 changed the resident. CNA #10 stated she had 1:1 with the resident from 5:30 AM to 7:00 AM that morning, and the resident was fine and had no signs of pain.</p> <p>During a joint interview on 10/26/2023 at 2:30 PM with the Administrator and DON, the Administrator stated they talked to staff who took care of Resident #1 on Saturday (07/08/2023) and Sunday (07/09/2023), and no one noticed anything like bruising. The DON stated she asked the CNAs how they transferred the resident back into the wheelchair, but they did not get very descriptive. The DON stated the CNAs only said they lifted the resident back into the geriatric chair. The DON stated she did not press for more answers to determine how they specifically transferred the resident back into the chair.</p> <p>During a joint interview on 10/26/2023 at 4:10 PM with the Administrator and the DON, the Administrator stated she did not remember which side the CNA said the resident fell on. The DON stated she should have asked more specifically how the CNAs got the resident up. The DON stated the CNAs should not have chicken-winged the resident to get them up off the floor.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/27/2023 at 6:30 PM, the Administrator stated they investigated the incident as a fall with injury since staff reported the following day that the resident had flipped themselves out of the wheelchair.</p> <p>During an interview on 10/26/2023 at 10:50 AM, the DON stated the CNAs had a sign-out sheet for those who did 1:1 with Resident #1. The DON stated she reviewed the sign-out sheets and tried to determine who had signed out as providing 1:1 with the resident but could not make out all names.</p> <p>During a joint interview on 10/27/2012 at 2:26 PM with the DON and the Administrator, the DON stated she did not remember doing any audits officially after Resident #1 fell out of the chair. The Administrator stated that because the incident with Resident #1 was an isolated incident, they felt they did not need to do audits or retraining. The Administrator stated once they knew Resident #1 fell, they turned this into a fall investigation instead of following the injury of unknown origin pathway, reporting to the state agency, and sending the 5-day follow-up as required.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on record review, facility document review, and interviews, the facility failed to ensure proper transfer methods were used for 1 (Resident #1) of 3 residents reviewed for falls.</p> <p>Findings included:</p> <p>Review of Resident #1's Resident Face Sheet revealed the facility admitted the resident on 11/02/2022, with diagnoses that included unspecified intellectual disabilities and anxiety disorder.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/26/2023, revealed the Staff Assessment for Mental Status (SAMS) indicated the resident had a short and long term memory problem and their cognitive skills for daily decision making were severely impaired. The MDS indicated Resident #1 required extensive assistance from staff for bed mobility and transfers and was totally dependent on staff for locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing.</p> <p>Review of a facility Occurrence Report dated 07/09/2023, revealed Registered Nurse (RN) #2 indicated Certified Nursing Assistant (CNA) #9 reported to her that Resident #1 flipped themselves out of their chair. The report revealed during the three hours prior to the fall, the resident was very restless. The report revealed CNA #9 was with the resident in the dining room at 1:00 AM, rolling the resident in the hallway at 2:00 AM, in the hallway with the resident near their room at 3:00 AM, and at approximately 3:15 AM, Resident #1 flipped themselves over the side of the chair onto the floor. The report revealed CNA #9 reported Resident #1 flipped over the side of the chair when CNA #9 went to the back of the chair to pull the resident back in the seat because the resident was leaning forward in the chair.</p> <p>Review of a statement dated 07/11/2023, handwritten by CNA #9 revealed that on 07/09/2023, at 2:00 AM to 3:00 AM, she was sitting with Resident #1. The statement revealed the resident was irritated, restless, and squirmy in their chair. The statement revealed that CNA #9 went around to the back of the chair, and by that time, the resident had flipped over the arm of the chair. The statement revealed CNA #9 called for the nurse and could not find the nurse, so another CNA helped her get Resident #1 off the floor and back in their chair. The statement revealed that CNA #9 took the resident to the nurse and informed the nurse of what happened.</p> <p>During a telephone interview on 10/26/2023 at 2:18 PM, CNA #10 stated CNA #9 came and found her because she could not find the nurse and told her Resident #1 had thrown herself out of their chair, so she went in to help CNA #9. CNA #10 stated they changed the resident and then put the resident back in the wheelchair. CNA #10 stated the resident was sitting on the floor on their bottom when she entered the room. CNA #10 stated she did not see the resident fall. CNA #10 stated they kind of scooped Resident #1 up, putting one of their arms under each arm of the resident, and they grabbed the resident's pants and pulled the resident up. CNA #10 stated she did not remember if they used a gait belt but thought they did. CNA #10 stated she did remember they grabbed underneath the resident's arm. CNA #10 stated that is not how they should have transferred a resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/27/2023
NAME OF PROVIDER OR SUPPLIER Mulberry Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Strahl Street Franklin, TN 37064	

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

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a joint interview on 10/26/2023 at 2:30 PM with the Administrator and Director of Nursing (DON), the DON stated she asked the CNAs how they transferred the resident back into the wheelchair, but they did not get very descriptive. The DON stated the CNAs only said they lifted the resident back into the geriatric chair. The DON stated she did not press for more answers to determine how the CNAs specifically transferred the resident back into the chair.</p> <p>During a telephone interview on 10/26/2023 at 3:00 PM, CNA #9 stated they transferred Resident #1 back to the geriatric chair by pulling the resident up under the arms and lifting. CNA #9 stated they did not have a gait belt on them. CNA #9 stated they just kind of chicken-winged the resident. CNA #9 stated she was just trying to get the resident up off the floor in any way they could get the resident up into the chair.</p> <p>During a joint interview on 10/26/2023 at 4:10 PM with the Administrator and the DON, the DON stated she should have asked more specifically how the CNAs got the resident up. The DON stated the CNAs should not have chicken-winged the resident to get them up off the floor.</p>