| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155374 | A. Building<br>B. Wing | 04/29/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Poplar Care Strategies | 313 Poplar St<br>Loogootee, IN 47553 |

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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission for 1 of 3 newly admitted residents reviewed. A basline care plan assessment was not completed and plan of care was not in place specific to the individualized resident needs. (Resident B)Finding includes:During record review on 4/28/26 at 11:00 A.M., Resident B's diagnoses included, but was not limited to heart failure and anxiety. Resident B was admitted to the facility on [DATE].Resident B had no baseline care plan in place pertaining to the resident's care needs.Resident B's Interim Care plan assessment, dated 4/21/26, was initiated but was not completed. During an interview on 4/29/26 at 12:15 P.M., the Director of Nursing (DON) indicated the admitting nurse usually completed the Interim Care plan assessment and that would initiate an individualized interim care plan. On 4/29/26 at 12:51 P.M., the Facility Administrator supplied a facility policy titled, Care Plans - Baseline, dated 2026. The policy included, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.This citation relates to Intakes 29994502, 2738801, and 2989481. 410 IAC (Indiana Administrative Code) 16.2-3.1-30(a) |

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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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview, and record review, the facility failed to prevent accident hazards for 2 of 3 residents reviewed for accidents. A resident with supplemental oxygen was placed in a room with another resident with a documented history of non-compliance with the facility's non-smoking policy, which included the possecion of a vape pen in the resident room. The resident was alleged to be smoking in the resident's shared restroom and smoke was observed coming from the restroom while an oxygen concentrator was running in the resident's room. (Resident B, Resident C)Findings include:1. During an observation on 4/28/26 at 10:30 A.M., Resident B and Resident C were observed in the same room. Resident B was wearing supplemental oxygen received from an oxygen concentrator in the room. A sign outside the room door indicate no smoking was allowed due to the oxygen in use. During record review on 4/28/26 at 11:00 A.M., Resident B's diagnoses included, but was not limited to heart failure and anxiety. Resident B's vital signs included but were not limited to, on 4/25/26 during day shift at 9:00 A.M., and during the night shift at 9:05 P.M., the resident received supplemental oxygen via nasal cannula.Resident B's nurses notes included but were not limited to the following:4/22/26 at 2:02 A.M. - Resident is a new admission. The resident is alert and oriented but does lose track of time. The resident received two liters (L) of supplemental oxygen via nasal cannula. 4/25/26 at 12:30 A.M. - Call received from resident's spouse to report that the resident stated his roommate was smoking in the bathroom causing him to experience difficulty breathing. During an interview on 4/28/26 at 9:45 P.M., LPN 4 indicated she was the nurse on duty the night of 4/25/26 and was notified that Resident B's roommate was smoking in their bathroom. When she checked on the resident, it was obvious that the resident had been smoking, however, the resident denied smoking and staff was unable to search his belongings to remove any smoking devices. LPN 4 indicated the resident smoking in the facility had been an ongoing problem and that the facility had a no-smoking policy. During an interview on 4/29/26 at 10:30 A.M., Resident B indicated his roommate was smoking in the restroom one time. The roommate wheeled out of the restroom with a cloud of smoke behind him. Resident B indicated he could not handle the cigarette smoke and that he wears supplemental oxygen routinely. During an interview on 4/29/26 at 11:30 A.M., the Facility Administrator indicated Resident B should have been offered a room change following the smoking allegation/incident on 4/25/26. 2. During record review on 4/28/26 at 11:30 A.M., Resident C's diagnoses included, but was not limited to cannabis use, hallucinations, and delusional disorder. Resident C's most recent quarterly Minimum Data Set (MDS) assessment, dated 2/20/26, indicated the resident was cognitively intact. Resident C's care plan included, but was not limited to: Resident has brought marijuana and marijuana vape pens into the facility unwarranted. Resident C's routine psychiatry progress visit note, dated 12/30/25, included the resident had received marijuana as a Christmas gift while visiting family during the holiday and brought it back to the facility. Resident C's nurse's progress notes included but were not limited to the following:1/4/26 at 9:44 A.M. - Staff reported to this nurse that the resident's room and hall by room had the smell of marijuana vape.1/10/26 at 2:01 P.M. - This nurse was notified by CNAs that resident room smelled like marijuana again. This nurse reported complaint to the Director of Nursing (DON). 1/17/26 at 10:08 P.M. - This nurse was notified by a visitor that resident was up in the lobby area smoking marijuana. Resident was confronted by staff that he needed to quit smoking the marijuana in facility. Resident is suspected to have a marijuana vape pen. Front lobby does smell like marijuana. 4/24/26 at 12:50 A.M. - Resident was assessed following a complaint phone call from roommate's wife, reporting smoking in the bathroom. Upon assessment, the resident was found by their bedside. Initially, the resident denied the activity but later admitted to disposing of the illegal substance. The nurse reinforced safety, particularly given the roommate's oxygen therapy. During an interview on 4/29/26 at 11:50 A.M., CNA 9 indicated she had found a vape device in Resident C's room, out in the open. She notified her charge<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | nurse, DON, and the Facility Administrator. CNA 9 indicated the police came to the facility and it was confiscated.Resident C's facility admission agreement included a Tobacco/Smoking Policy, signed by the resident on 11/17/25. The policy included, [Facility Name] has been established as a smoke free/tobacco free facility .On 4/29/26 at 12:51 P.M., the Facility Administrator supplied a facility policy titled Accidents and Incidents - Investigating and Reporting, dated 2026. The policy included, .Incident/Accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.This citation relates to Intakes 2994502 and 2989481. 410 IAC (Indiana Administrative Code) 16.2.3.1-45(a)(1) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident receiving oxygen therapy had physician orders and a plan of care for the oxygen for 1 of 3 residents reviewed for oxygen therapy. A resident who routinely received supplemental oxygen had no physician's order to clarify the continuous need for oxygen therapy or for the amount of oxygen the resident required. (Resident B)Finding incudes:During an observation on 4/28/26 at 10:30 A.M., Resident B and Resident C were observed in the same room. Resident B was wearing supplemental oxygen received from an oxygen concentrator in the room and delivered via nasal cannula. During record review on 4/28/26 at 11:00 A.M., Resident B's diagnoses included, but was not limited to heart failure and anxiety. Resident B's vital signs included but were not limited to, resident received oxygen via nasal cannula daily, every shift, from the admission dated 4/21/26 through the review date 4/28/26. Resident B's physician orders did not included an order for routine supplemental oxygen and no clarification for routine supplemental oxygen levels. Resident B's physician orders did include an order to monitor temperature and oxygen levels every shift (started 4/21/26). Resident B had no plan of care that included the use of routine supplemental oxygen. During an observation and interview on 4/29/26 at 10:45 A.M., Resident B was wearing a nasal cannula and receiving oxygen from an oxygen concentrator set just above 2 liters (L). Resident B indicated he received oxygen at all times. During an interview on 4/29/26 at 10:55 A.M., LPN 7 indicated Resident B did receive routine supplemental oxygen and should have a physician's order for routine oxygen use. On 4/29/26 at 12:51 P.M., the Facility Administrator supplied a facility policy titled, Oxygen Administration, dated 2026. The policy included, Preparation . 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration .This citation relates to Intakes 29994502, 2738801, and 2989481. 410 IAC (Indiana Administrative Code) 16.2.3.1-47(a)(6) |