STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Poplar Care Strategies	313 Poplar St 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38770 Based on observation, interview, and record review, the facility failed to revise resident's plan of care for 3 of 17 resident care plans reviewed. Care plans were not revised to reflect discontinued medications, and alarms were in use without an order or care plan. (Resident 29, Resident 1, Resident 2) Findings include: 1. On 10/28/24 at 11:40 A.M., Resident 29's clinical record was reviewed. admitted was 8/22/24 after a fall from home that resulted in a fracture. Diagnosis included, but were not limited to, dementia, depression, and history of falling. The most recent Admission MDS (Minimum Data Set) Assessment, dated 9/11/24, indicated a moderate cognitive impairment and a fall prior to admission. Resident 29 required substantial to maximum assistance with bathing, bed mobility, transferring, and toileting. Discontinued orders included, but were not limited to: Bed/Chair Alarms, two times a day for fall risk, dated 8/23/24 through 9/4/24. A current risk for falls care plan, dated 8/26/24, lacked an intervention for alarms. Resident 29 was in the hospital from 8/31/24 through 9/4/24. A nurse's note, dated 8/23/24 at 3:14 A.M., indicated resident was very forgetful, so a bed alarm was placed under her and bed lowered. Resident 29's clinical record lacked a current physician's order for alarms. On 10/29/24 at 2:07 P.M., Certified Nurse Aide (CNA) 25 indicated Resident 29 currently used both bed and chair alarms, with a pull tab alarm on the wheelchair. On 10/29/24 at 2:15 P.M., Resident 29 was observed sitting in a recliner in her room on an alarm pad. At that time, the resident's family member indicated she could not remember how long an alarm had been in place. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 1:05 P.M., Registered Nurse (RN) 27 indicated alarms could be initiated by nursing staff, but an order should be placed shortly after. She indicated Resident 29 had an order for alarms prior to her hospitalization on [DATE], but since all orders were discontinued and re-entered upon admission on 9/4/24, the alarms had not been included on the admission orders in error. 46416 2. On 10/28/24 at 10:35 A.M., Resident 1 was observed laying in bed asleep with a bed alarm under her and a chair alarm on the back of her wheelchair next to her bed. On 10/28/24 at 11:56 A.M., Resident 1 was observed in the dining room sitting in her wheelchair with an alarm hanging on the back . On 10/30/24 at 9:52 A.M., Resident 1 was observed laying in bed asleep with bed alarm on. On 10/29/24 at 10:25 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to wedge compression fracture and muscle weakness. The most recent Admission MDS (Minimum Data Set) Assessment, dated 8/9/24 indicated Resident 1's cognition was cognitively impaired, partial to moderate assist for bed mobility, transfers, toileting, and no alarms were used for resident. Resident 1's clinical record lacked an order for a bed and chair alarm. A current Falls Care Plan, dated 8/13/24, lacked use of a bed and chair alarm for interventions. During an interview on 10/30/24 at 1:08 P.M., Licensed Practical Nurse (LPN) 21 indicated residents should have an order for alarm and oxygen use. The Director of Nursing (DON) or MDS Coordinator should update care plans as needed. Night shift nurses should change batteries and check functioning of the alarms and it should be documented on Treatment Administration Record (TAR). 45933 3. On 10/29/24 at 10:55 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, hyperlipidemia, and thyroid disorder. Resident 2 lacked a current UTI (Urinary Tract Infection) diagnoses. The most recent Annual MDS (Minimum Data Set) Assessment, dated 7/15/24 indicated Resident 2 was cognitively intact, and indicated she received an antibiotic. The MDS lacked documentation of a diuretic. Resident 2's Physician's Orders lacked a current order for a diuretic and antibiotic related to an UTI. Current care plans included, but was not limited to, an at risk for side effects related to diuretic therapy, revised 9/26/23, and an at risk for side effects related to antibiotic therapy for UTI, revised 9/16/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/24 at 9:57 A.M., the MDS Coordinator indicated she is responsible for care plan updates and revisions and she would revise the care plans when the order is discontinued. At that time, she indicated the diuretic and antibiotic related to UTI care plan should have been revised for Resident 2. On 10/31/24 at 1:00 P.M., the Administrator provided a current Goals and Objectives, Care Plans policy, revised April 2009 that indicated, .Goals and objectives are reviewed and/or revised: a. When there has been a significant change in the resident's condition; b. When the desired outcome has not been achieved; c. When the resident has been readmitted to the facility from a hospital/ rehabilitation stay; and d. At least quarterly . On 10/31/24 at 1:00 P.M., the Administrator provided a current Alarms policy, dated 7/18/13 that indicated, . All alarms will be used per physician's order although may be placed immediately in an emergency situation with the physician's order to be obtained in a timely manner .Alarm placement and function will be checked at change of shift using the alarm monitoring tool . 3.1-35(b) 3.1-35(b)(1) 3.1-35(d)(2)(B)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45933 Based on observation, interview, and record review, the facility failed to ensure residents received necessary respiratory care and services in accordance with professional standards of practicefor 3 of 3 residents reviewed for Respiratory Care. The facility failed to obtain a Physician's Order for oxygen, failed to follow Physician Orders for oxygenation, and failed to properly store a nebulizer mouthpiece and oxygen tubing while not in use. (Resident 6, Resident 28, Resident 133) Findings include: 1. During an observation on 10/28/24 at 2:08 P.M., Resident 133 was observed in bed with oxygen on via nasal cannula at 2 LPM (Liters per minute). During an observation on 10/29/24 at 11:58 A.M., Resident 133 was observed in the dining room with oxygen on via nasal cannula at 1.5 LPM. At that time, QMA (Qualified Medication Aide) 3 indicated she needed to verify the Physician's Order, but she thought Resident 133's oxygen should be set at 2 LPM. During an interview on 10/29/24 at 12:01 P.M., QMA 3 verified the Physician's Order and indicated Resident 133's oxygen order was for 1 LPM, and she had to go change the setting on Resident 133's oxygen. On 10/29/24 at 10:14 A.M., Resident 133's clinical record was reviewed. Diagnosis included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disorder) and hypertension. Resident 133 was admitted to the facility on [DATE] and a MDS (Minimum Data Set) Assessment had not been completed as of the review date. During an interview on 10/31/24 at 10:46 A.M., LPN (Licensed Practical Nurse) 9 indicated Resident 133 was cognitively intact. During an interview on 10/31/24 at 11:38 A.M., CNA (Certified Nurse Aide) 5 indicated Resident 133 was an extensive assist of 2 persons for bed mobility, transfers, and toileting. Current Physician's Orders included, but were not limited to, oxygen via nasal cannula at 1 LPM at all times, dated 10/17/24. A current care plan intervention for COPD included, but was not limited to, administer oxygen per Physician's Orders, dated 10/24/24. During an interview on 10/29/24 at 12:02 P.M., QMA 3 indicated Resident 133 would not adjust the oxygen level and staff should set the oxygen according to the Physicians Order. During an interview on 10/31/24 at 10:48 A.M., Resident 133 indicated she had been on oxygen prior to being admitted to the facility, but she was unsure what the oxygen was setting should have been. 46416 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 10/28/24 at 10:35 A.M., Resident 6 was observed sitting in her room in a wheelchair wearing portable oxygen at 2 LPM via nasal cannula. The nasal cannula tubing attached to the concentrator machine in her room was laying uncovered on the floor. A nebulizer machine was observed on the nightstand with the nebulizer mouthpiece uncovered and touching the nightstand. On 10/30/24 at 9:55 A.M., Resident 6's nebulizer mouthpiece was observed uncovered and touching the nightstand. On 10/30/24 at 10:50 A.M., a random wheelchair placed in the hallway was observed with oxygen nasal cannula tubing from portable oxygen stuffed in the pocket on the back of the wheelchair. On 10/30/24 at 1:14 P.M., Resident 6 was observed sitting in her room in her wheelchair wearing the nasal cannula tubing from the concentration machine in her room and the portable oxygen tubing on the back of her wheelchair was wrapped around the wheelchair handles and the nebulizer mouthpiece was uncovered and touching the nightstand. On 10/29/24 at 12:10 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbance and chronic obstructive pulmonary disease (COPD). The most recent Quarterly MDS Assessment, dated 10/11/24, indicated Resident 6 was cognitively intact, substantial to maximum assist of staff for bed mobility, toileting, transfers, and on continuous oxygen. Current Physician's Orders included, but were not limited to, the following: May have oxygen therapy via nasal cannula to keep oxygen saturation above 90% every day and night shift for COPD, ordered 10/26/2024 A current Respiratory Care Plan, revised 8/17/23, included, but was not limited to, the following intervention: Oxygen as ordered, initiated 12/21/22 During an interview on 10/30/24 at 1:08 P.M., Licensed Practical Nurse (LPN) 21 indicated oxygen tubing and nebulizer supplies that were not in use by the resident, should be placed in the bag that was provided for it for infection control purposes. 46882 3. On 10/28/24 at 10:46 A.M., Resident 28 was observed sitting up on the side of the bed wearing oxygen (O2) at 2 lpm (liters per minute) per nasal cannula. Oxygen tubing and water bottle were dated 10/27/24. Resident indicated she wore the oxygen at all times. On 10/30/24 at 10:46 A.M., Resident 28 was observed sitting up in a wheelchair in her room wearing O2 at 2 lpm per nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 9:32 A.M., Resident 28 was observed lying in bed on her side playing games on phone wearing O2 at 2 lpm per nasal cannula. On 10/29/24 at 1:36 P.M., Resident 28's clinical records were reviewed. Diagnosis included, but was not limited to chronic obstructive pulmonary disease with acute exacerbation (COPD). The most recent Quarterly MDS (Minimum Data Set) assessment, dated 9/6/24, indicated Resident 28 was cognitively intact, was independent with bed mobility, needed supervision with transfers and partial to moderate assistance with toilet use. She used oxygen. Physician orders included, but was not limited to the following: Oxygen supplies and tubing to be changed weekly on Sunday night shift, related to chronic obstructive pulmonary disease with acute exacerbation, dated 6/2/2024. HOB (head of bed) to be elevated greater than 30 degrees to prevent hypoxia r/t (related to) COPD every day and night shift for COPD, dated 10/12/2024. Bipap at HS (bedtime) and PRN (as needed) every day and night shift related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, dated 6/1/24 Physician orders lacked an order for oxygen. Care plans included, but were not limited to the following: Resident 28 has oxygen therapy (BiPap, O 2 via nasal cannula) and at risk for complications, initiated 9/17/2024. Resident 28 has a diagnosis of COPD and at risk for complications, initiated 5/31/2024. Intervention included oxygen/BiPap per physician orders. During an interview on 10/31/24 at 9:32 A.M., LPN (Licensed Practical Nurse) 9 indicated Resident 28 was supposed to wear her oxygen at all times and there should be an order. After looking at the chart, LPN 9 indicated she saw an order to change the tubing weekly and to check the skin under the tubing, but did not see an order for the oxygen. On 10/31/24 at 1:00 P.M., the Administrator provided an Oxygen Administration policy, dated October 2010, which indicated 1. Verify that there is a physician's order for this procedure .10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered . On 10/31/24 at 1:00 P.M., the Administrator provided a Respiratory Therapy-Prevention of Infection policy, dated November 2011, which indicated . Infection Control Consideration Related to Oxygen Administration: . 8. Keep the oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use .Infection Control Considerations Related to Medication Nebulizer/Continuous Aerosol: .7. Store the circuit in plastic bag, marked with date and resident's name between uses . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-47(a)(6)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 38770 Based on observation, interview, and record review, the facility failed to ensure pharmaceutical services met the needs of each resident for 2 of 4 residents observed for medication administration and 2 of 2 residents who had medication supplies disrupted without permission. Staff obtained medications for residents from other residents supplies. (Resident 22, Resident 233, Resident 27, Resident 24) Findings include: On 10/30/24 at 8:09 A.M., Registered Nurse (RN) 27 was observed to administer medications. While obtaining medications for Resident 22, RN 27 indicated the resident's Miralax could not be located. RN 27 then obtained the Miralax dose from another resident's bottle (Resident 24) to administer to Resident 22. At that time, RN 27 indicated Resident 22's Miralax was on an auto refill and should have been at the facility, but would contact the pharmacy for the medication. On 10/30/24 at 8:22 A.M., RN 27 was observed to obtain medications for Resident 233 and indicated the resident's Colace could not be located. RN 27 then obtained the dose of Colace from another resident's card (Resident 12) and administered to Resident 233. At that time, RN 27 indicated she had personally ordered Resident 233's Colace from the pharmacy the previous morning, and the medication should have been brought to the facility by the previous afternoon. On 10/30/24 at 10:54 A.M., the Director of Nursing (DON) indicated they have had issues with the current pharmacy such as them sending an abundance of medications when not needed, and not sending medications on time, such as with auto refill, or before the resident's medication runs out. She indicated there was no pharmacist available after 5 P.M., and if any questions were voiced after that time, they would have to leave a message and wait 1-2 hours for a call back. She indicated the pharmacy did not deliver medications on Sundays. The pharmacy was supposed to send medications to the facility within 4 hours of a request, but that did not happen. At that time, she indicated while nursing staff was not supposed to borrow medications from other residents, the nurses are stuck with either not administering the medications, or having to take from other residents. On 10/30/24 at 10:27 A.M., a current non-dated Medication Administration policy was provided and indicated Medications supplied for one resident are never administered to another resident 3.1-25(a)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 38770 Based on interview and record review, the facility failed to ensure residents who did not have a gradual dose reduction for psychotropic medications had a clinical contraindication documented for 1 of 5 residents reviewed for unnecessary medications. (Resident 12) Finding includes: On 10/29/24 at 10:38 A.M., Resident 12's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety and depression. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/5/24, indicated no cognitive impairment, and use of an antianxiety medication. No gradual dose reduction (GDR) information was listed. Current physician orders included, but were not limited to: Alprazolam 0.5mg (milligram) twice a day, dated 4/8/23. A nurse's note, dated 1/29/24, indicated a GDR recommendation was received to decrease alprazolam 0.5mg to 0.25mg. The GDR request was denied due to attempting this would not be in the best interest for this resident. On 10/30/24 at 1:17 P.M., the Director of Nursing (DON) indicated no other contraindication for GDR was located in Resident 12's clinical record. On 10/31/24 at 1:00 P.M., a current non-dated Medication Monitoring policy was provided and indicated In skilled nursing facilities, within 1st year after admission or after initiation, a gradual dose reduction (GDR) is attempted in 2 separate quarters, with at least one month between attempts. After 1st year, a GDR is attempted annually . GDR is clinically contraindicated if . MD has documented clinical rationale 3.1-48(b)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46416 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for 1 of 1 kitchens observed. Hairnets did not cover hair, food temperature log was not completed for all meals, measuring devices/scoops were stored inside containers of ice, oats, sugar, thickener, and bread was touched with bare hands. (Kitchen) Findings include: 1. During an observation of the kitchen on 10/28/24 at 9:43 A.M., two dietary staff members had hair outside of their hairnets at their temples and nape of the neck. During an observation of the kitchen on 10/31/24 at 11:05 A.M., two dietary staff members had hair outside of their hairnets at their temples and nape of the neck. 2. On 10/28/24 at 9:53 A.M., the food temperature log was reviewed from October 1 through October 27, 2024 and lacked food temperatures for the following meals: 10/21/24 lunch 10/22/24 dinner 10/23/24 breakfast and lunch 10/24/24 breakfast and dinner 10/25/24 breakfast, lunch, and dinner 10/26/24 breakfast, lunch, and dinner 10/27/24 breakfast, lunch, and dinner 3. During an observation of the kitchen on 10/28/24 at 10:00 A.M., the following was observed: large container of oats had a cup placed inside large container of sugar had a cup placed inside ice cooler in dry storage had the ice scoop placed inside During an observation on 10/31/24 at 10:59 A.M., cups were still in the oats and sugar containers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 10/31/24 at 11:02 A.M., during an observation of staff preparing pureed broccoli, staff used the measuring spoon that was stored in the thickener container to measure thickener. It was touched with bare hands and then put back into the thickener container and placed back on the shelf. 5. On 10/31/24 at 11:42 A.M., kitchen staff grabbed 4 slices of bread from the bread bag with bare hands to make peanut butter and jelly and grilled cheese sandwiches. The staff member held the bread with her bare hands to prepare them. During an interview on 10/28/24 at 9:54 A.M., the Dietary Manager indicated temperatures of food should be taken before serving each meal and written on this page of the log. If the temperatures were not documented, then it was understood that they were not taken. During an interview on 11/1/24 at 10:07 A.M., the Infection Preventionist indicated kitchen staff should not touch food with their bare hands, gloves should be worn. All hair should be contained in hairnets. Scoops and measuring devices should not be stored inside the container. They should be stored in a plastic bag and cleaned every night. 38770 6. On 10/28/24 at 11:55 A.M., Certified Nurse Aide (CNA) 51 was observed to obtain a resident's lunch tray from the hall cart parked on the E Hall. A cup of orange juice was observed on the tray not covered. CNA 51 walked the tray 33 steps to Room A2, passing the front offices, conference room, and restrooms. On 10/28/24 at 11:57 A.M., CNA 51 was observed to obtain a resident's lunch tray from the hall cart parked on the E Hall. A drink and a bowl with a piece of cake was observed on the tray not covered. CNA 51 walked the same distance to Room A1. On 10/28/24 at 11:58 A.M., CNA 5 was observed to obtain a resident's lunch tray from the hall cart parked by Room A8. A drink and a bowl with a piece of cake was observed on the tray not covered. CNA 5 walked the tray to the B Hall, past the nurses station and common area, to Room B1. On 10/29/24 at 11:46 A.M., Dietary Aide 47 was observed to obtain a resident's lunch tray from the hall cart on E Hall. A bowl of pudding was observed uncovered on the tray. Dietary Aide 47 walked the tray 83 steps to Room B1. On 10/31/24 at 11:27 A.M., the Dietary Manager indicated all cups and desserts should be covered when administering hall trays to residents. On 11/1/24 at 10:16 A.M., the Administrator indicated while there was no written policy, it was the policy of the facility to cover food in the halls, not to have scoops in food items, hair should be be completely covered with a hairnet, and gloves should be used when touching food. On 11/1/24 at 11:30 A.M., the Administrator provided a current Food Preparation and Service Policy, revised April 2019, which indicated . Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness . The temperatures of foods held in steam tables are monitored . bare hand contact with food is prohibited . food and nutrition services staff wear hair restraints [hair net, hat, beard restraint, etc.] so that hair does not contact food . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-21(i)(2) 3.1-21(i)(3)

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

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(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 - Some	Provide and implement an infection prevention and control program. 46882 Based on observation and interview, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 3 of 3 residents observed for incontinence care. Staff did not use hand hygiene between glove changes during care and did not change gloves after touching multiple items before starting incontinence care. (Resident 13, Resident 27, Resident 15). Findings include: 1. On 10/30/24 at 9:20 A.M., CNA (Certified Nurse Aide) 5 and CNA 7 were observed doing incontinence care for Resident 13. Both CNAs cleaned their hands with sanitizer as they entered Resident 13's room. Both CNAs put on gloves. CNA 7 pulled the curtain around the resident, pushed the bed away from the wall, went behind the bed and pulled the covers down. CNA 5 used the remote to put the head of the bed down and raise the bed. They did not change gloves before starting care. CNA 7 unfastened the brief, pushed it down between her legs and assisted Resident 13 to turn to the right side. CNA 5 removed the brief, took a wipe and cleaned the resident from front to back, removed gloves, threw them in the trash can and put clean gloves on. CNA 5 did not sanitize her hands before putting the clean gloves on. CNA 5 placed a clean brief under the resident, assisted the resident to turn to the left side. CNA 7 pulled the brief through, assisted the resident to turn to her back, and fastened the brief. Both CNAs used the lift pad to pull the resident up in bed. CNA 5 removed her gloves, put them in the trash bag, removed the trash bag from the trash can and tied it shut, put a clean trash bag in the trash can, went to the bathroom and washed her hands. CNA 7 pulled the covers up on the resident, put the call light within reach, pushed the bed against the wall, removed gloves, went to the bathroom and washed her hands. 45933 2. On 10/30/24 at 9:56 A.M., CNA 5 and CNA 7 assisted Resident 27 to the bathroom. A brown substance was observed in the toilet before Resident 27 sat down. CNA 7 used toilet paper to wipe Resident 27's buttocks, changed gloves, and failed to perform hand hygiene between glove changes. After Resident 27 was finished using the bathroom, CNA 5 and CNA 7 failed to offer Resident 27 to wash her hands. 46416 3. On 10/30/24 at 10:44 A.M., Certified Nurse Aides (CNA) 5 and CNA 7 were observed while toileting Resident 15. Both CNAs failed to perform hand hygiene prior to putting on gloves. CNA 5 wiped the resident after a bowel movement. CNA 5 removed gloves and put on new gloves without hand hygiene between. CNA 5 and CNA 7 put a new incontinence pad and shorts on Resident 15, pulled them up, assisted the resident to stand and transfer to wheelchair, and pulled down his shirt. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/1/24 at 10:07 A.M., the Infection Preventionist indicated she would expect staff to sanitize hands before putting on gloves to do resident toileting and in between dirty and clean tasks. She would expect hand sanitizer to be used between dirty and clean tasks unless gloves were soiled, then she would expect staff to wash (lather) hands for 15 seconds or say the ABCs twice. Residents should be given the opportunity to wash their hands. On 10/31/24 at 1:00 P.M., a current Handwashing/Hand Hygiene Policy, revised August 2019, was provided by the Administrator and indicated . This facility considers hand hygiene the primary means to prevent the spread of infections . all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . Wash hands with soap [antimicrobial or non-antimicrobial] and water for the following situations: when hands are visibly soiled . use an alcohol-based hand rub . before and after direct contact with residents . before moving from a contaminated body site to a clean body site during resident care . after removing gloves . the use of gloves does not replace hand washing/hand hygiene . 3.1-18(l)

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	155374	A. Building B. Wing	11/01/2024

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

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 45933 Based on interview and record review, the facility failed to ensure a qualified Infection Preventionist working at least part-time at that facility. Finding includes: On 10/28/24 9:45 A.M., the Director of Nursing (DON) indicated she was the facility's appointed Infection Preventionist (IP) and full time DON. On 4/5/24 at 10:08 A.M., the DON indicated she it varied from week to week on how many hours were spent for IP duties, but she does not spend as much time on IP duties as she would like to. At that time, she indicated she did not have any documentation of hours worked as an IP. On 11/1/24 at 10:23 A.M., the DON provided a current, undated Infection Preventionist job description that indicated, An Infection Preventionist is an individual responsible for the Infection Prevention and Control Program, developed to control the spread of infections and/or outbreaks .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 46416 Based on observation and interview, the facility failed to ensure a sanitary and home-like environment for 5 of 5 halls and 1 of 1 Dining Rooms reviewed for environment. Personal items were not labeled in shared bathrooms, vent fans were caked with dust, toilets were soiled, non-skid strips were peeling up and/or worn, paint was missing, and incontinence pads were stored uncovered in the shower rooms. (A Hall, B Hall, C Hall, E Hall, F Hall, Dining Room) Findings include: 1. On 10/28/24 at 10:35 A.M., the following was observed in Room B6 and shared bathroom (3 residents) with Room B4: the second non-skid strip by bed closest to the window was peeling up and covered in debris, non-skid strip in bathroom in front of toilet was worn, paint around door frame was peeling and missing in spots, caulk around toilet was brown and soiled and peeling, black and brown stains on the inside of the toilet bowl, a brown substance was smeared on the back of the seat, black scuff marks were along the bottom of the wall and paint was scratched off the same wall across from the toilet, vent fan was dusty, an unlabeled black comb and blue denture cup were laying on the sink, and a bedside table next to the sink was dusty. On 10/30/24 at 9:55 A.M., the same was observed except for the brown smear on the back of the toilet seat. 2. On 10/28/24 at 11:00 A.M., the following was observed in Room B3 and shared bathroom (4 residents) with Room B5: wall needs painted on side of bed closest to the door, wall needs painted behind head of bed and nightstand of bed closest to the window, caulk around the toilet was brown and soiled, paint was peeling off and black scuff marks were below on wall across from toilet, vent fan was dusty, unlabeled black comb and white brush laying on the sink, mirror had splash marks throughout and worst in right top corner, trash can was overflowing with paper debris falling out. On 10/30/24 at 10:01 A.M., the same was observed except the trash can was not full. 3. On 10/28/24 at 11:10 A.M., the paint and/or wallpaper was observed torn around the hand sanitizer canister in the hall by Room B1 and Room B3. On 10/30/24 at 10:02 A.M., the same was observed. 4. On 10/28/24 at 12:10 P.M., the dining room floor was uneven and cracked and peeling up below the beam and near the fire place, the flooring was bubbled up and discolored. On 10/30/24 at 10:55 A.M., the same was observed. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 10/28/24 at 10:38 A.M., the following was observed in the shared bathroom of Room C1 and C3 (3 residents): a brown stain on the toilet seat and inside toilet bowl, sink had brown streaks down the inside, two unlabeled denture cups were on the sink. On 10/31/24 at 1:50 P.M., the same was observed. 6. On 10/28/24 at 10:42 A.M., Room C4 was observed and had a strong smell of urine. The shared bathroom of Room C2 and Room C4 (1 resident) had a brown substance on the toilet seat. On 10/30/24 at 10:44 A.M., Room C4 still had a strong smell of urine. 7. On 10/30/24 at 10:51 A.M., the vent above the nurse's station on B Hall was observed to be caked with dust. On 10/31/24 at 10:35 A.M., the same was observed. 8. On 10/30/24 at 10:02 A.M., the following was observed in the Shower Room on the C Hall: the grout was soiled in the shower area, paint peeled off the floor by the toilet, toilet seat had brown substance on it, brown substance in the toilet bowl, caulking around the toilet was peeled off, brown, and soiled, vent fan above toilet caked with dust, vent fan in the middle of the room dusty with dust surrounding it on the ceiling, non-skid strips by shower were worn, door to bathroom was chipped, uncovered incontinence pads were laying on the table, and several random hygiene supplies including sprays, deodorants, and toothpastes, some without caps on them, were unlabeled. On 10/31/24 at 10:24 A.M., the same was observed except there was not a brown substance in the toilet bowl or on the toilet seat. 9. On 10/30/24 at 10:13 A.M., a ceiling tile above the soiled utility room of F Hall was observed to be cracked and had had brown stained on it. On 10/31/24 at 10:32 A.M., the same was observed. 10. On 10/30/24 at 10:13 A.M., sand-like debris was observed on the floor at the end of the F Hallway by the exit door. On 10/31/24 at 10:34 A.M., the same was observed. 11. On 10/30/24 at 10:14 A.M., the following was observed in the shower room on the F Hall: a package of wipes open to air laying on shower chair, blue coban gauze open to air laying on bedside commode lid, yellow spots on seat of large shower chair, non-skid strips worn, brown substance on front of toilet, a broken tile on the wall by the shower, wash rag laying on the back of toilet, soiled grout in shower, vent fan above toilet was caked with dust, uncovered incontinence pads scattered on the counter, and a stack of wash rags and towels were sitting on the table uncovered. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/31/24 at 10:31 A.M., the following was still observed: non-skid strips worn, brown substance on front of toilet, a broken tile on the wall by the shower, wash rag laying on the back of toilet, soiled grout in shower, vent fan above toilet was caked with dust, and uncovered incontinence pads were still scattered on the counter. 12. On 10/30/24 at 10:22 A.M., between Room E4 and Room E3 the light casing was cracked. On 10/31/24 at 10:35 A.M., the same was observed. 13. On 10/30/24 at 10:23 A.M., the vent in the hall by the Conference Room was caked with dust. On 10/31/24 at 10:35 A.M., the same was observed. 14. On 10/31/24 at 11:22 A.M., outside of the Activities Room, the light casing was cracked. On 11/1/24 at 9:44 A.M., the same was observed. During an interview on 10/30/24 at 1:14 P.M., Licensed Practical Nurse (LPN) 21 indicated personal items should be labeled especially in a shared bathroom otherwise staff would not know who it belongs to. During an interview on 10/31/24 at 10:11 A.M., the Housekeeping Supervisor indicated staff should clean the resident rooms everyday according to a checklist that included the bathrooms, stools, sides of stools, sinks, mirrors, sweeping, moping, and cleaning the bedside tables. The shower rooms were cleaned every day by spraying and wiping things down, cleaning the toilet, sweeping the floors, and then moping, grout was cleaned with bleach water and scrubber brush once a week, and staff should clean all vent fans with a Swiffer . If they notice a maintenance issue, staff are to write it down on a piece of paper and put it on maintenance's door. During an interview on 11/1/24 at 10:07 A.M., the Infection Preventionist indicated incontinence pads were kept in the supply room. If the incontinence pads were stored in the shower rooms, she would expect them to be stored covered and on the table. They provide shampoo in bulk container that was used for residents, but if a resident required a special shampoo, powder, cream, or lotion, those would be labeled for specific resident use. 46882 15. On 10/28/24 at 11:02 A.M., in the shared bathroom between rooms A6 and A8 a toothbrush, small tube of toothpaste, tube of denture cream, a bottle of perineal cleanser, a bottle of shampoo/body wash, and a comb were observed lying on the back of the sink unlabeled. The bathroom was used by three residents. On 10/31/24 at 2:12 P.M., a toothbrush, small tube of toothpaste, a tube of denture cream and a comb were observed lying on the back of the sink in the bathroom between rooms A6 and A8. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/31/24 at 2:12 P.M., CNA 5 indicated Resident 7 in room A6 goes into the bathroom and brushes her own teeth and combs her hair, but forgets to take her items out of the bathroom and put them in her bag. She indicated the toothbrush, toothpaste and comb belong to Resident 7. The denture cream belongs to Resident 14, her roommate. She indicated the items should all be labeled. On 10/31/24 at 10:22 A.M., the Housekeeping Supervisor indicated there was not a policy for cleaning the rooms but the staff was expected to follow the checklist for cleaning resident rooms which included, but was not limited, to the following: . take out trash, dust mop every day, mop floors every day . clean top to bottom and cleanest to dirtiest . prioritize high-touch surface areas . clean bathroom . clean the floor . On 10/31/24 at 11:20 A.M., the Administrator provided a Quality of Life-Homelike Environment policy, revised May 2017, which indicated .2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary and orderly environment . On 10/31/24 at 2:33 P.M., the Administrator provided an undated Inventory of Resident's Personal Property policy which indicated .3. Label resident's name legibly on all clothing and personal items . 3.1-19(e) 3.1-19(f)(5)