STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255315	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Poplar Springs Nursing Ctr, LLC	6615 Poplar Springs Dr Meridian, MS 39305

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48669 Based on observation, staff interview, and facility policy review, the facility failed to ensure the resident's rights for a safe and homelike environment as evidenced by broken floor tiles in two areas of the hallway for one (1) of eight (8) hallways observed. (Therapy room hallway). Findings Include: A review of the facility policy titled Safe and Homelike Environment, undated, revealed, .In accordance with resident's rights, the facility will provide a safe, clean, comfortable, and homelike environment . This includes ensuring that the resident can receive care and services safely, and that the physical layout of the facility maximizes resident independence and does not pose a safety risk . On 8/27/24 at 9:07 AM, during an observation, there were several broken floor tiles in the hallway in front of an exit door. There was also an area in which the floor tiles were missing in a straight line across the hallway, causing an indention in the hallway which was approximately six inches wide. This hallway led to the Therapy Room. On 8/27/24 at 11:01 AM, during an interview with the Rehabilitation Technician, she stated that she was aware of the broken and missing floor tiles outside of the therapy gym door. She was not aware of any residents who had fallen as a result of the broken and missing floor tiles, but acknowledged it was a hazard and someone could trip if the floors were not repaired. During an interview with the Administrator on 8/27/24 at 10:35 AM, he revealed that the facility had an area near the physical therapy gym, across the hall, with broken tile and cracks in the cement. He acknowledged that the crack was long and deep enough to potentially be a tripping hazard for both residents and staff. On 8/27/24 at 1:58 PM, during an interview with the Maintenance Director, he confirmed that the back hall near the therapy gym had a crack across the hallway in both the cement and tile that could potentially be a tripping hazard for residents going to the therapy gym.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47873 Based on staff interview, record review, and facility policy review, the facility failed to develop care plan interventions related to a resident's behaviors for one (1) of 18 care plans reviewed. (Resident #75) Findings included: A review of the facility's policy, Care Plans-Comprehensive, dated 10/2016, revealed, An individualized (person centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team .develops and maintains comprehensive care plan for each resident .2. The comprehensive care plan is based on a thorough assessment that includes .the MDS (Minimum Data Set). 3. Each resident's comprehensive care plan is designed to a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems .5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes . A record review of the comprehensive care plan for Resident #75 revealed Focus .potential for behaviors R/T (related to) Mood Disorder . revised on 8/7/2024 . Interventions Administer medications as ordered .Monitor for s/s (signs/symptoms) of behavior changes initiated on 5/3/2022. There were no interventions documented to assist staff in managing Resident #75's behaviors including sexually inappropriate behaviors, verbal aggression, and refusal of care and medications. A record review of the Admission Record revealed the facility admitted Resident #75 on 5/4/22 and he had current diagnoses including Persistent Mood Disorder and Dementia with other Behavioral Disturbance. A record review of the Psych Progress Note, dated 5/30/24, revealed Resident #75 had symptoms including Agitation, Requires frequent redirection, can be difficult to redirect, refuses care refusing meds (medications) at times, and yelling out, refuses care, yelling out, verbally aggressive at times. Current Risk Factors included Aggression: Verbal, episodes of yelling out, verbally aggressive. Case Conceptualization revealed . Staff report resident continues to have episodes of verbally aggressive behaviors, sexually inappropriate speech and behavior at times. Resident refuses care at times . A record review of the Psych Progress Note, dated 6/18/24, revealed Resident #75 had symptoms including Requires frequent redirection, can be difficult to redirect, refuses care refusing meds (medications) at times, and yelling out, verbally aggressive at times. Current Risk Factors included Aggression: Verbal, episodes of yelling out, verbally aggressive. Case Conceptualization revealed .Staff report resident continues to have episodes of verbally aggressive behaviors, sexually inappropriate speech and behavior at times, episodes of agitation, difficult to redirect at times. Resident refuses care at times, refusing to take medications at times . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Psych Progress Note, dated 7/30/24, revealed Resident #75 had symptoms including Requires frequent redirection, can be difficult to redirect, refuses care refusing meds (medications) at times, and yelling out, verbally aggressive at times. Current Risk Factors included Aggression: Verbal, episodes of yelling out, verbally aggressive. Case Conceptualization revealed .Staff report resident continues to be verbally aggressive, agitated at times, difficult to redirect. Record review of the Discharge Summary from a local geriatric psychiatric facility, dated 5/24/2024, revealed, .(Proper Name of Resident #75) was admitted on [DATE] from a nursing home after making sexual comments to staff. He touched a staff member inappropriately. He also refused care and was combative with staff. He threatened staff and would not allow them to come into his room. During the hospital stay, Patient yelled out obscene and inappropriate comments and made inappropriate advances . A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/7/2024 revealed Resident #75 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated his cognition was severely impaired. Further review revealed that Resident #75 had verbal behavioral symptoms directed toward others, other behavioral symptoms that were not directed toward others that significantly interfered with the resident's care. The MDS indicated Resident #75 had behaviors that including rejecting care that was necessary to achieve the resident's goals for health and well-being for four (4) to six (6) days of the lookback period. During an interview with Licensed Practical Nurse (LPN) #2 on 08/27/24 at 11:10 AM, she explained she works on the Alzheimer's Unit and is assigned to care for Resident #75. She stated that Resident #75 refused medication and care, and he had inappropriately touched and had swung at her. She confirmed Resident #75 was transferred to a geriatric psychiatric unit in May (2024), but there were no real changes in his behaviors as he continued to refuse care and medications and continued to be verbally aggressive and sexually inappropriate. LPN #2 said there had been no special additions or interventions related to his care and if he had any changes in behavior, she reported it to the provider and to Nursing Services. During an interview with the Director of Nursing (DON) on 08/28/2024 at 12:00 PM, she revealed Resident #75 had shown signs of aggression and sexual inappropriateness and had been transferred to a geriatric psychiatric facility for treatment and evaluation. She confirmed the resident has had encounters with nursing staff with sexual inappropriateness and no special consideration or interventions had been developed. On 08/28/2024 at 12:15 PM, during an interview with the Psychiatric Nurse Practitioner (NP), he stated that Resident #75 was on caseload to manage his medications. The NP confirmed Resident #75 had a history of sexual inappropriateness and aggressive conversation which medication management was currently ineffective. The NP stated he was aware Resident #75 continued to refuse care and medications but deferred to nursing services for behavioral monitoring and documentation related to moods and behaviors exhibited by the resident.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41680 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure perineal care was provided in a manner to prevent complications for one (1) of two (2) residents reviewed for care catheter/bowel and bladder care. (Resident #83) Findings Include: A review of the facility's Perineal Care Policy, revised 1/2010, revealed: .It is the policy of this facility to provide perineal cleanliness and comfort to the resident, to prevent infections and skin irritation, and observe the resident's skin condition .Procedure .For a male resident .b. Wash perineal area starting with urethra and working outward .(3) Continue to wash the perineal area including the penis, scrotum, and inner thighs . On 08/28/24 at 10:05 AM, during an observation of catheter and perineal care, Certified Nursing Assistant (CNA) #1, with the assistance of CNA #2, used pre-moistened disposable wipes to clean Resident #83's penis, catheter tubing, and buttocks. After stating that perineal care was completed, CNA #1 prepared to apply a clean brief to the resident. When asked by the State Agency (SA) to check below the resident's anus for feces, CNA #1 wiped the area a total of nine (9) additional times, each time revealing a moderate amount of feces. The resident was turned over, and when the SA asked CNA #1 to check underneath his scrotum, it was found that feces were present in that area as well. An additional six (6) wipes were used to clean the scrotal area, again revealing a moderate amount of feces. On 08/28/24 at 10:37 AM, during an interview, CNA #1 stated that she should have ensured the resident was completely clean before applying a clean brief. She admitted , I thought he was clean. I did not think to check under his scrotum. She acknowledged that improper cleaning could lead to skin breakdown and infection. On 08/28/24 at 4:04 PM, in an interview, the Director of Nursing (DON) stated that CNA #1 should have ensured the resident was completely clean and emphasized that the CNA's actions could result in infection and cause skin breakdown. A record review of Admission Record revealed that the facility admitted Resident #83 on 2/3/23 with current diagnoses including Pressure Ulcer in the sacral region. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/17/24 revealed Resident #83 had a Brief Interview for Mental Status (BIMS) score of nine (9), indicating that the resident was moderately impaired. Section GG indicated that the resident was dependent on staff for toileting care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 47873 Based on observation, staff interview, record review, and facility policy review, the facility failed to provide respiratory care in a manner to prevent the possibility of complications as evidenced by oxygen tubing that was not dated to indicate weekly oxygen tubing/nasal cannula changes for one (1) of one (1) resident reviewed for respiratory care. Resident #18. Findings Include: A review of the facility's Nebulizer and Oxygen Tubing Storage Policy, dated 4/2007, revealed, .It is the policy of the facility to reduce the risk of potential and/or direct exposure to infectious diseases, air contaminants, and bacterial exposure. We will provide our residents with the proper storage and cleaning of respirator equipment. Procedure .The facility will replace all respiratory tubings weekly. These tubings will be dated .Documentation will be placed on the residents treatment record (TAR) of the weekly changing of tubing A record review of the Admission Record revealed that the facility admitted Resident #18 on 2/7/24 with current diagnoses including Chronic Obstructive Pulmonary Disease (COPD). A record review of the Order Summary Report revealed Resident #18 had a Physician's Order, dated 7/11/2024, for oxygen therapy at 2 liters per minute (LPM) per nasal cannula as needed. On 08/26/24 at 10:30 AM, during an observation, Resident #18 was in the day room and was wearing a nasal cannula connected to oxygen. The oxygen tubing was not dated to indicate when the nasal cannula and tubing was last changed. On 08/27/24 at 11:10 AM, during an observation, Resident #18 was wearing oxygen per a nasal cannula while in the day room. The tubing of the nasal cannula was not dated to indicate the last tubing change. On 08/27/24 at 11:10 AM, during an interview, Licensed Practical Nurse (LPN) #2, who was responsible for Resident #18's care, confirmed the oxygen tubing was not dated. LPN #2 stated that she was unaware that the oxygen tubing needed to be dated but assured that she would label it moving forward. LPN #2 acknowledged that the facility's policy indicated that oxygen tubing should be dated. On 08/28/24 at 09:10 AM, during an interview with the Director of Nursing (DON), she confirmed that the facility's policy required replacing oxygen tubing weekly and dating the tubing to indicate the date it was last changed. She explained the oxygen tubing is usually changed on Sunday night by the night shift. She stated that the policy was reviewed with all staff during orientation, and she emphasized the importance of adhering to the policy to reduce the risk of infectious diseases and bacterial exposure.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47873 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the medication error rate was less than five percent (5%) as evidenced by four (4) errors were observed out of 39 medication administration opportunities. This affected one (1) of three (3) residents observed during medication pass, resulting in a medication error rate of 10.26%. (Resident #27) Findings Include: A review of the facility's policy, Medication Administration, dated 09/01/2022, revealed: Medications are administered .in accordance with professional standards of practice .Policy Explanation and Compliance Guidelines .11 .c. Crush medications as ordered. Do not crush medications with do not crush instructions . Example Guidelines for Medication Administration .Do Not Crush Medications: Slow release, enteric coated . A record review of the Admission Record revealed the facility admitted Resident #27 on 1/25/2023 with current diagnoses including Unspecified Atrial Fibrillation, Acute Systolic Congestive Heart Failure, Bradycardia, and Hypertensive Heart Disease with Heart Failure. A record review of the Order Summary Reportwith active orders as of 8/29/24 revealed Resident #27 had a Physician's Order for Diltiazem Hydrochloride Extended-Release (ER) 24-hour 120 milligram (mg) capsule (Order date: 1/25/2023), Metoprolol Succinate ER 24-hour Sprinkle 100 mg capsule (Order date: 1/25/23), Pantoprazole Sodium Delayed-Release 40 mg tablet (Order date 1/25/23), and Potassium Chloride ER 20 milliequivalent (mEq) tablet (Order date 2/14/23). There were no instructions that indicated the medications should be crushed. On 08/27/24 at 08:42 AM, during an observation and interview, Licensed Practical Nurse (LPN) #2 prepared Resident #27's medications by crushing them together, including Metoprolol ER 24-hour Sprinkle 100 mg, Pantoprazole Delayed-Release 40 mg, Potassium Chloride ER 20 mEq, and Diltiazem Hydrochloride ER 24-hour 120 mg. LPN #2 administered the crushed medications to Resident #27. During an interview, LPN #3 stated that she crushed the medications because she thought Resident #27 had difficulty swallowing. She acknowledged that extended-release and delayed-release medications should not be crushed unless there were specific instructions by a physician indicating the medications could be crushed. There were no instructions on the physician's orders for the ER medications to be crushed before administering to the resident. During an interview with the Director of Nursing (DON) on 08/27/24 at 10:00 AM, she confirmed that extended-release and delayed-release medications should never be crushed unless specified by a physician. She explained that crushing these medications changes the way they are meant to be delivered, potentially compromising the medication's effectiveness.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

41680

Based on observation, staff interview, record review, and policy review, the facility failed to ensure hands were cleaned with soap or hand sanitizer before, during, and after providing perineal care for one (1) of two (2) residents observed for catheter/perineal care. (Resident #69)

Findings Include:

A review of the facility's Hand Sanitizing Procedure, revised 4/2015, revealed: .It is the policy of this facility to use hand sanitizer .between handwashing when hands are not visibly soiled or dirty. Procedure .use an alcohol-based hand rub .for all the following situations: 1. Before and after direct contact with residents .10. After removing gloves.

A review of the facility's Procedure for Handwashing, revised 4/2015, revealed, .2. Apply one squirt of soap .

On 08/28/24 at 10:45 AM, during an observation of perineal care, Certified Nursing Assistant (CNA) #3, assisted by CNA #4, was observed preparing to provide perineal care for Resident #69. CNA #3 turned on the water and attempted to use the soap dispenser but found it empty. CNA #4 suggested using a bottle of soap from the resident's counter, but CNA #3 declined, stating, I cannot use resident soap. CNA #3 and CNA #4 proceeded to wash their hands without soap before starting perineal care. CNA #4 left the room to get Licensed Practical Nurse (LPN) #2 to pause the feeding pump, but did not perform hand hygiene after removing gloves or before applying new gloves. LPN #2 entered the room wearing gloves, paused the feeding pump, and exited the room wearing the same gloves. During perineal care, CNA #3 removed and reapplied her right glove multiple times due to contamination with feces but failed to remove both gloves and perform hand hygiene between glove changes. CNA #3 stated, I should have brought my own hand sanitizer to use. Both CNAs removed their gloves at the end of care and washed their hands without soap.

On 08/28/24 at 2:25 PM, during an interview, CNA #4 confirmed that there was no soap in the room and acknowledged that they should not have used the resident's liquid soap. She admitted that not using soap during handwashing could allow bacteria to remain on their hands and pose a risk of infection to the resident.

On 08/28/24 at 2:35 PM, CNA #3 admitted that she should have used soap during handwashing, noting that washing hands without soap would not remove germs. She acknowledged that she should have sanitized her hands between glove changes to prevent exposing the resident to bacteria.

On 08/28/24 at 2:43 PM, LPN #2 admitted that she should have washed her hands and should have removed her gloves before exiting the room. She stated that failing to do so could spread infection and pose a risk to the resident.

On 08/28/24 at 3:07 PM, during an interview, the Infection Preventionist (LPN #1) confirmed that LPN #2 should not have entered the room wearing gloves and should have performed hand hygiene upon entering and exiting the room. She stated that improper hand hygiene and glove changes could increase the resident's risk of infection.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/24 at 3:32 PM, the Assistant Director of Nursing (ADON) confirmed that LPN #2 should not have entered the room wearing gloves and should have performed hand hygiene. The ADON emphasized that CNA #3 should have removed both gloves, washed her hands, and applied new gloves, as improper glove handling could lead to contamination and infection. On 08/28/24 at 4:15 PM, the Director of Nursing (DON) acknowledged that LPN #2 and CNA #3 failed to follow infection control protocols. She confirmed that their actions could lead to cross-contamination, posing risks of infection and skin breakdown. A record review of the Admission Record revealed the facility admitted Resident #69 on 07/11/24 with current diagnoses including Hemiplegia and Unspecified Hemiparesis following a cerebral infarction. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/17/24 revealed Resident #69 was severely cognitively impaired, and she was dependent on staff for toileting hygiene.