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	07/24/2025

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to respect the resident's right to dignity and privacy by posting personal care instructions on the exterior of a resident's door for one (1) of 21 sampled residents, Resident #54.Findings include:A review of the facility's policy, Resident Rights, dated 4/2012, revealed, Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to .d. Privacy and confidentiality . On 7/21/25 at 12:09 PM, during an observation of Resident #54's room, a sign was observed on the exterior of the resident's door and on the wall next to her bed that read, Please get the Resident up three times per week: Monday Wednesday and Friday, prior to her bath please!! per resident and family request. Thank you, Social Services and Unit Manager. On 7/22/25 at 1:14 PM, during an interview with Licensed Practical Nurse (LPN) #1, she acknowledged the sign posted on the exterior of Resident #54's door and stated it was a privacy concern. She reported that the Unit Manager or the Social Services Director placed the sign. On 7/22/25 at 1:33 PM, during an interview with the Social Services Director, she confirmed that she created the sign for Certified Nurse Aides (CNAs) to post. She acknowledged that the sign was a violation of the resident's privacy and stated she had not noticed it before this interview. On 7/22/25 at 1:45 PM, during an interview with the Director of Nursing (DON), she acknowledged the sign posted on the exterior of the resident's door and confirmed it was a violation of the resident's privacy. On 7/24/25 at 11:40 AM, during an interview with the Administrator, he confirmed that he was aware of the sign and acknowledged that it was a privacy issue. A record review of the admission Record revealed the facility admitted Resident #54 on 2/9/22 with current diagnoses including Spastic Quadriplegic Cerebral Palsy. A record review of the Minimum Data Set with an Assessment Reference Date (ARD) of 7/1/25 revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated his cognition was intact. Further review revealed he had bilateral upper and lower extremity impairment.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, record review, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected a resident's vision status for one (1) of 21 sampled residents. Resident #8.Findings include:A review of the facility's policy, MDS Assessments, dated 5/2006, revealed, . It is the policy of this facility to follow the RAI (Resident Assessment Instrument) process as set forth by CMS (Centers for Medicare and Medicaid Services) protocol . The facility will follow directions per federal and state guidelines for resident assessment protocol and will refer to the MDS RAI manual. During an observation and interview on 7/21/25 at 12:37 PM, Resident #8's roommate stated that Resident #8 was blind. Resident #8 was leaving the room and asked for assistance to get out the door. Resident #8 bumped into the wall while attempting to leave the room. The roommate provided verbal directions to assist Resident #8 with exiting the room.During an interview on 7/22/25 at 11:20 AM, the Director of Nursing (DON) confirmed that Resident #8 was blind.During an interview on 7/23/25 at 2:13 PM, Licensed Practical Nurse (LPN) #1 confirmed that Resident #8 was blind. LPN #1 stated she had witnessed him bump into objects frequently and had placed him on the handrail to help guide him. She stated she had seen him bump into things numerous times.During an interview on 7/23/25 at 4:20 PM, Registered Nurse (RN)/MDS Coordinator #4 confirmed she was aware Resident #8 was blind. She stated his vision status should be reflected on both the MDS and the care plan.During a follow up interview with the DON on 7/23/25 at 4:25 PM, she stated the MDS should be coded correctly for vision for Resident #8. A record review of the admission Record revealed the facility admitted Resident #8 on 11/25/09 and he had current diagnoses including Parkinson's Disease and Schizophrenia.A record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 7/14/25 revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A review of Section B indicated his vision was adequate. A record review of a Fall Assessment, dated 4/21/25, revealed Resident #8 had an Inadequate vision pattern.

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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. Based on observation, interview, record review, and facility policy review, the facility failed to develop a comprehensive care plan that addressed a resident's visual impairment for one (1) of 21 sampled residents. Resident #8.Findings include: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 .2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, 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 .On 7/21/25 at 12:37 PM, during an observation, Resident #8 was leaving his room and asking for assistance to get out the door. Resident #8 bumped into the wall while attempting to leave the room and his roommate provided verbal directions to assist him with exiting the room. On 7/22/25 at 11:20 AM, during an interview with the Director of Nursing (DON), she confirmed Resident #8 was blind.On 7/23/25 at 2:13 PM, during an interview with Licensed Practical Nurse (LPN) #1, she stated she had witnessed Resident #8 bump into objects frequently and assists with placing his hand on the handrail to help guide him in the hallway. She stated she had seen him bump into things numerous times and confirmed that he was blind.On 7/23/25 at 4:05 PM, during an interview with Registered Nurse (RN)/MDS Coordinator #3, she stated she was not aware Resident #8 was blind. She confirmed that the resident's vision status should be included in the care plan and that all staff use the care plan to provide care.On 7/23/25 at 4:20 PM, during an interview with RN/MDS Coordinator #4, she confirmed she was aware Resident #8 was blind. She stated his vision status should be reflected on the care plan, as the care plan is used by all staff to guide care.On 7/23/25 at 4:25 PM, during a follow up interview with the DON, she stated the resident's vision status should be reflected in the care plan.A record review of the admission Record revealed the facility admitted Resident #8 on 11/25/09 and had current diagnoses including Parkinson's Disease and Schizophrenia.A record review of Resident #8's Comprehensive Care Plan revealed no focus area or interventions addressing blindness or visual impairment.A record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 7/14/25 revealed Resident #8 had a Brief Interview for Mental Status score of 15, which indicated he was cognitively intact. Review of Section B revealed his vision was Adequate.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident received the necessary care and services by not identifying, assessing, or addressing his visual impairment for one (1) of 21 sampled residents, Resident #8.Findings include:A record review of the facility's policy, Hearing and Vision Services, 10/24, revealed, . It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated .Policy Explanation and Compliance Guidelines: 1. The facility will utilize the comprehensive assessment process for identifying and assessing a resident's vision and hearing abilities in order to provide person-centered care. The process includes .b. MDS (Minimum Data Set) and care area assessments; c. Ongoing monitoring of sensory problems; d. Care plan development .e. Evaluation .On 7/21/25 at 12:37 PM, during an observation and interview with Resident #8's roommate, he stated Resident #8 was blind. An observation revealed Resident #8 leaving his room and asking for assistance to get out the door. Resident #8 bumped into the wall while attempting to leave the room. The roommate provided verbal directions to assist Resident #8 with exiting the room.On 7/22/25 at 11:20 AM, during an interview with the Director of Nursing (DON), she advised that Resident #8 was blind, and the staff provided provide verbal cues regarding what food was on his meal tray and where the food was located on the plate.On 7/23/25 at 2:07 PM, during an interview with Certified Nursing Assistant (CNA) #2, she confirmed Resident #8 was blind.On 7/23/25 at 2:13 PM, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that Resident #8 was blind. LPN #1 stated she had witnessed him bump into objects frequently and had placed his hands on the handrail to help guide him when walking in the hallway. She stated she had seen him bump into things numerous times.On 7/23/25 at 2:19 PM, during an observation, CNA #1 was seen leading Resident #8 to a chair by holding his hand.On 7/23/25 at 2:30 PM, during an interview with CNA #1, she confirmed Resident #8 was blind and stated she had seen him walk into walls.On 7/23/25 at 4:25 PM, during a follow up interview with the DON, she stated Resident #8's vision status should have been accurately identified and assessed. The DON stated they had contracted with a company that would come into the facility to address residents' vision, but Resident #8 had refused to be seen. The facility had also offered to set him up and transport him to an outside appointment, but he had refused that as well. A record review of the admission Record revealed the facility admitted Resident #8 on 11/25/09 and he had current diagnoses including Parkinson's Disease and Schizophrenia.A record review of the Quarterly MDS with an Assessment Reference Date of 7/14/25 revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A review of Section B revealed his vision was Adequate.A record review of a Fall Assessment, dated 4/21/25, revealed Resident #8 had an Inadequate vision pattern.A record review of a Progress Notes revealed Resident #8 had a Nurses Note dated 11/1/24 which indicated, .Resident ambulates outside .with guidance . resident has diff (difficulty) seeing when ambulating around facility running into walls .A record review of the medical record for Resident #8 revealed there was no records indicating his visual impairment was identified, assessed, or addressed by the facility.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and staff interview, the facility failed to ensure a resident was free from a significant medication error when a nurse incorrectly transcribed and administered Lasix (a diuretic) at a higher dose than prescribed for one (1) of 21 sampled residents, Resident #2.Findings included: A record review of the admission Record revealed the facility admitted Resident #2 on 10/25/24 with diagnoses including Atherosclerotic Heart Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/10/25 revealed Resident #2 had had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment.A record review of the Adult-Gerontology Nurse Practitioner (AGNP) Subjective, Objective, Assessment, Plan (SOAP) note for Resident #2, dated 11/5/24 revealed Increase Lasix to 40 mg (milligrams) by mouth daily.A record review of the encrypted text message exchange revealed Registered Nurse (RN) #2 received a text message with orders for Resident #2 to Increase lasix to 40 mg PO (by mouth) daily .A record review of the Order Details document revealed Resident #2 had a Physician's order, dated 11/7/24 with the Order Summary to give Lasix 40 mg twice a day, which was not consistent with the nurse practitioner's SOAP note plan. The order was created by RN #2.On 7/23/25 at 3:18 PM, during an interview, the AGNP explained that on 11/5/24, she signed an order to increase Resident #2's Lasix to 40 mg daily and sent the order via encrypted text to RN #2 Charge Nurse. She confirmed that the RN incorrectly entered the order as Lasix 40 mg twice a day. The NP stated she stopped the twice-daily dosage on 7/23/25 when she became aware of the error and confirmed the resident did not require the higher dose.On 7/23/25 at 5:04 PM, during an interview with the Director of Nursing (DON), she acknowledged that the Lasix order was incorrectly entered as twice daily instead of daily. She explained that the facility's current system involves the NP sending encrypted texts to the Charge Nurse, who then inputs the orders, and she does not have oversight of these communications. She stated her expectation is for all medication orders to be entered correctly.On 7/24/25 at 11:21 AM, during an interview with the Administrator, he confirmed that the Lasix order was not transcribed correctly and stated that the facility needs a better system for verifying and communicating orders, which will be addressed in team meetings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to store food and maintain food quality in accordance with professional standards for food safety related to overly ripe produce and exposed spice products for one (1) of two (2) kitchen observations.On July 21, 2025, at 10:15 AM, an initial observation and interview with the Kitchen Supervisor revealed refrigerator #1 contained 11 tomatoes exhibiting white biological growth. The spice rack in the food preparation area revealed three bottles of dry seasonings with their lids open, leaving the seasonings exposed. The Kitchen Supervisor acknowledged the presence of overly ripe produce and the opened spice bottles. The Kitchen Supervisor stated that she is responsible for maintaining safety and quality standards in the kitchen and that the staff receive regular in-service training on food safety.On July 24, 2025, at 11:31 AM, during an interview with the Administrator acknowledged the issues with overly ripe foods and the opened spice bottles. He stated that the Kitchen Supervisor is responsible for maintaining food quality and standards and that he expects the Kitchen Supervisor to perform regular checks on the food in the kitchen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection by not properly covering clean linens during transport and by placing clean linens against worn clothing for one (1) of two (2) laundry observations.A review of the facility's policy, Infection Prevention and Control Program, dated 8/2017, revealed, .It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of communicable diseases and infections. Policy Explanation and Compliance Guidelines.10. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent the spread of infection. b. Clean linen shall be delivered to resident care units on covered linen carts with the covers down.A review of the facility's policy, Laundry Handling & Processing Policy, dated 2/1/25, revealed, .(Proper Name of Contract Company) is committed to providing a safe, clean, and hygienic environment for residents, staff, and visitors in accordance with regulatory guidance and industry best practices.Policy.All soiled linens must be covered during transportation and when stored on units.Delivery.Employees should never carry clean linen against their bodies.On 7/23/25 at 7:30 AM, during an observation and interview, Laundry #1 was observed transporting a laundry cart with clean linen down A Hall with the plastic covering flipped over the cart, leaving the clothes and linens exposed. An empty disposable beverage cup was sitting on top of the cart near the linen. Laundry #1 stated he was not aware that the laundry was supposed to be covered.On 7/23/25 at 10:57 AM, during an observation and interview, Laundry #1 was transporting clean linen from one linen cart to another cart on the hall. The laundry worker picked up a blanket, rested it on his upper body, refolded the blanket, and placed it on the clean linen cart. The laundry worker stated he had just started working at this facility and did not know that placing clean linen against his worn clothes could spread infection.On 7/23/25 at 11:32 AM, during an interview with the District Manager of Housekeeping, she acknowledged the linen cart should not be uncovered during transport and confirmed that linen should not be placed against his clothing while refolding. She stated her expectation is that staff maintain infection control standards and that the laundry worker would be retrained on the infection prevention program.On 7/24/25 at 10:42 AM, during an interview with the Infection Preventionist (IP) nurse, she confirmed the laundry worker failed to prevent the possible spread of infection by placing a dirty cup on the clean linen cart, transporting clean laundry uncovered in the hallway, and placing a clean blanket against his clothing.On 7/24/25 at 11:03 AM, during an interview with the Director of Nursing (DON), she confirmed the laundry worker should not place dirty cups on the clean linen cart, transport clean linens uncovered in the hallway, and allow clean linens to come in contact with his clothes. The DON stated she expects all staff to follow the infection control policy.On 7/24/25 at 11:19 AM, during an interview the Administrator, he stated he expects all staff to follow the infection control policy.A record review of Onboarding Documents revealed Laundry #1 received training on Infection Control Overview.