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	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

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 08/26/24 through 08/29/24. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F584, F656, F690, F695, F759, and F880. The facility held a license for 91 beds, with a census of 86.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) 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. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		9/25/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/16/2024

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.

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: 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	F 584	1. The Nursing Home Administrator will purchase concrete patch to fill and level the deficient/unsafe flooring on the Therapy room hallway. On 08/28/24 the Nursing Home Administrator and the Maintenance Supervisor assessed the Therapy room hallway flooring to see how much material is needed to correct/patch/mend the unsafe flooring. The rest of the facility flooring was also assessed. An area approximately 12inch by 12 inch or the equivalent of one tile was missing on B-Hall in the dining room area in front of the B-Hall nurses' station. The remaining floor throughout the facility is clear of any unsafe flooring/indentations. 2. All residents have the potential to be affected by this deficient practice. 3. On 9/3/24 the concrete patch, carbon wire brush and steel concrete trowel were ordered by the Nursing Home	

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F 584	Continued From page 2 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.	F 584	Administrator. 4. Beginning 9/4/24 on the Therapy room hallway the Maintenance Supervisor used the Carbon Wire Brush to clean the indented area to remove dirt, debris and wax. He then proceeded to vacuum the area to remove all loosened material. Next, he proceeded to fill the indented area with concrete patch then smooth and level it with the existing floor/tile. Lastly, the Maintenance Supervisor placed a barrier around the area in which he worked to allow proper curing time. The Maintenance Supervisor completed the Therapy room hallway on 9/4/24. After completing the Therapy room hallway, the Maintenance Supervisor began on the B-Hall dining room area in front of the nurses' station and completed the same tasks. The Maintenance Supervisor completed the B-Hall dining room area on 9/4/24. The entire facility flooring was corrected/patched/mended by 9/4/24. The Maintenance Supervisor will assess the Therapy room hallway and B-Hall dining room once a week for three weeks beginning 9/11/24 and ending 9/25/24 to ensure the areas have not cracked or become brittle. He will report the result to the QA committee on 9/25/24. Following the 9/25/24 QA meeting the Maintenance Supervisor will assess the Therapy room hallway and B-Hall dining room once a month for three months to continually ensure the repair of the deficient/unsafe flooring and report the findings during the monthly QA meeting.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		9/25/24

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F 656	Continued From page 3 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 4 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: 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 ..."	F 656	1. Resident #75's care plan was updated 08/29/24 by Minimum Data Set Nurse and now has interventions being implemented related to behaviors beginning 08/29/24. Minimum Data Set Nurse was educated on having interventions for behaviors by the Director of Nursing on 08/29/24. 2. All residents with behaviors have the potential to be affected by this deficient practice. 3. In-services began on 08/29/24 and ending 09/01/24 by the director of nursing with the nursing staff to review documentation of behavioral monitoring on the medication administration record. All residents with behaviors have had orders and care plans reviewed for interventions by the Minimum Data Set Nurse beginning 08/29/24 and completed 09/01/24. 4. The Director of Nursing or Minimum Data Set Nurse to monitor care plans and medication administration records to ensure behaviors are being documented and managed accordingly beginning 09/01/24. The Minimum Data Set Nurse or Director of Nursing will monitor three care plans and Medication Administration Records a week for three weeks, then	

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F 656	Continued From page 5 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."	F 656	twice a week for three months beginning 09/01/24 to ensure the process is being implemented. Results will be presented to the quality assurance committee by the Director of Nursing beginning 09/25/24 and then monthly for three months for any further recommendations to ensure compliance has been achieved.	

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F 656	Continued From page 6	F 656		

"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 ..."

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 May 13, 2024 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)

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F 656	Continued From page 7	F 656		

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.

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F 656	Continued From page 8 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.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		9/25/24

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F 690	Continued From page 9 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: 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	F 690	1. On 08/29/2024, the Director of nursing assessed resident #83 for signs and symptoms of urinary tract infection. There were no signs of infection noted. The Director of Nursing provided individual in-services to Certified Nursing Assistants #1 and #2, including skill pass-offs for perineal and catheter care. 2. All incontinent residents have the potential to be affected by this deficient practice. 3. Infection Prevention Nurse began in-servicing all certified nursing assistants and nurses on 8/29/2024, to be completed by 09/01/24. 4. Once a week for three weeks, beginning 08/30/24, then weekly for three months. An observation of four residents with incontinence being provided by the Infection Prevention Nurse, the Assistant Director of Nursing, or the Director of Nursing. Observations will be recorded on the weekly observation form. Observations will be reported monthly for three months beginning 09/25/24, to the	

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F 690	Continued From page 10	F 690		

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

Quality Assurance Performance Improvement Committee by the Infection Prevention Nurse. The committee will review documentation to verify that staff are demonstrating appropriate infection control practices.

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F 690	Continued From page 11 impaired. Section GG indicated that the resident was dependent on staff for toileting care.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: 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	F 695	1. On 08/29/24, resident # 18 was assessed for signs and symptoms of infection. No signs or symptoms of infection were noted. At this time, resident #18 had oxygen tubing replaced and dated. Licensed Practical Nurse #2 was in-serviced on Nebulizer and Oxygen Tubing storage policy on 08/29/24 by the Director of Nursing. 2. All residents with oxygen have the potential to be affected by the deficient practice. 3. Assistant Director of Nursing began in-servicing all Nurses on oxygen tubing storage policy, starting 08/30/24 and completed on 09/06/24, to ensure all respiratory equipment is properly stored and dated. 4. Three residents on oxygen will be monitored by the Director of Nursing or Assistant Director of Nursing two times weekly for three weeks then once weekly	9/25/24

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F 695	Continued From page 12 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	F 695	for three months to determine if respiratory equipment is being properly stored and dated beginning 08/30/24. Results will be presented to the Quality Assurance Committee by the Director of Nursing beginning on 9/25/24 then monthly for three months, to ensure compliance has been obtained.	

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F 695	Continued From page 13 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.	F 695		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: 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	F 759	On 08/27/24, the Director of Nursing in-service Licensed Practical Nurse #2 on Medication Administration policy regarding crushable and non-crushable medications. 2. All residents who received crushed medications have the potential to be affected by this deficient practice. 3. In-services began 8/27/24 and ended 8/30/24 by the Director of Nursing with the nursing staff on medication administration and crushable medications. The pharmacy consultant will hold a mandatory in-service for all licensed nursing staff on 09/24/24. 4. Beginning 09/02/24, the Director of Nursing or the Assistant Director of Nursing will monitor medication administration on three residents a week for three weeks, then once weekly for	9/25/24

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F 759	Continued From page 14 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 Report"with 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.	F 759	three months to ensure medications are administered correctly. Results will be delivered to the Quality Assurance Committee beginning 09/25/25, then monthly for three months to ensure compliance has been achieved.	

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F 759	Continued From page 15 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.	F 759		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		9/25/24

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F 880	Continued From page 16 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 17 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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)	F 880	1. On 08/29/24, resident # 69 was assessed for signs and symptoms of infection by the Director of Nursing. There were no signs of infection noted. Licensed Practical Nurse #2, Certified Nursing Assistant #3, and Certified Nursing Assistant #2 were all in-serviced on Hand Sanitizing procedures with skills pass-offs by the Director of Nursing on 08/29/24. 2. All residents have the potential to be affected by the deficient practice. 3. Assistant Director of Nursing and Infection Prevention Nurse began in-servicing all Certified Nursing Assistants and Licensed Nursing staff on Hand Sanitizing policy with skills pass-offs, starting 08/30/24 and completed on 09/01/24, to ensure all staff use proper hand hygiene/ hand sanitizing procedures 4. Three patient care staff members will be monitored by the Director of Nursing, Assistant Director of Nursing, or Infection Prevention Nurse two times weekly for three weeks then once weekly for three months to determine if proper hand sanitation is being performed beginning 08/30/24. Results will be presented to the quality assurance committee by the Director of Nursing monthly for three months, beginning on 9/25/24, to ensure compliance has been obtained.	

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F 880	Continued From page 18	F 880		

#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

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F 880	Continued From page 19	F 880		

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.

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.