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	255315	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR SPRINGS NURSING CTR, LLC	6615 P0PLAR SPRINGS DR MERIDIAN, MS 39305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency conducted an annual recertification survey, from 12/2/19 to 12/5/19. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA cited F550, F623, F641, F656, and F679. The census at the time of the survey was 88, and the facility was certified for 91 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		1/9/20

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

Electronically Signed | 01/03/2020

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 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and facility policy review, the facility failed to ensure a resident's right to dignity for one (1) of 18 residents observed. (Resident #59) Findings Include: Review of the facility's "Resident Rights" policy, revealed that employees shall treat all residents with kindness, respect, and dignity. The facility policy stated that the facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. The facility's policy was revised in April 2012. During the State Agency's (SA) initial tour observation of the facility, on 12/3/2019 at 9:52 AM, it was observed that the door to Resident #59's room was completely wide open. The SA observed that from the hallway Resident #59 was seen in her room, totally nude from the waist	F 550	F 550: The facility failed to protect the resident rights of Resident #59 by not providing adequate privacy for this resident when toileting. The facility failed to properly document in the medical record, implement care plan related to, and record behavior on the Minimum Data Set regarding preferences of nudity and preference of keeping her door open at all times. On December 20, 2019, the resident□s care plan was updated to reflect the preference she has for her room door to remain opened at all times. On January 2, 2020, the resident□s care plan was updated to reflect her preferences of nudity and interventions to address this preference. On December 04, 2019, privacy curtains were installed to provide privacy for Resident #59 while toileting.	

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F 550	Continued From page 2 down, standing at her sink wiping her buttocks area. Further observation revealed there were no staff or other residents in the area at that time. It was observed after 4 minutes, Certified Nursing Assistant (CNA) #1/ Restorative CNA appeared on the adjacent hall, at that time CNA #1 was notified that Resident #59 needed assistance. CNA #1 was observed entering Resident #59's room and closing the door to assist Resident #59. During an interview, on 12/3/2019 at 10:10 AM, Certified Nursing Assistant (CNA) #1 confirmed Resident #59 was disrobed from the waist down, standing at her sink attempting to clean herself. CNA #1 stated that she did not know if the resident had ever done this before. CNA #1 stated that she had not heard anything about this type of behavior regarding this resident. During an interview, on 12/4/2019 at 4:05 PM, Licensed Practical Nurse (LPN) #2 stated Resident #59 has a history of episodes of ambulating across the room to use the Bed Side Commode (BSC) and not wearing any clothing below the waist. LPN #2 stated that the facility staff offers reminders to the resident to use the call light when she needs assistance to go to the bathroom, but the resident still does not use her call light. LPN #2 stated that Resident #59, also does not like to sleep or take a nap with her pajama bottoms on. LPN #2 stated she has documented Resident #59's behaviors in the past, although she could not remember the last time she documented about them, even though the behaviors have continued. LPN #2 stated Resident #59 has had these behaviors going on since the time she was admitted. LPN #2 stated that right after Resident #59 was admitted, that	F 550	II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. All residents in the facility are at risk for the alleged deficient practice. III. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? A directed in-service, by a Certified Therapeutic Recreation Specialist will be held on January 09, 2020 with all clinical staff of the facility to address Resident Rights/Exercise of Resident Rights. The Director of Nursing and Assessment Coordinator Nurse will audit care plans monthly to ensure interventions are appropriate and obtainable. Minimum Data Set will be monitored by the Assessment Coordinator to ensure all documented behaviors are recorded. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. The Director of Nursing and Assessment Coordinator Nurse will audit care plans monthly to ensure interventions are appropriate and obtainable. The Assessment Coordinator will ensure Minimum Data Sets are submitted with accuracy. Staff will continue to be inserviced, in-house, on a quarterly basis on maintain residents□ rights for all	

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F 550	Continued From page 3 she could recall Resident #59 having rolled herself up to the Nurse's station in her wheelchair and Resident #59 was completely nude. LPN #2 stated that she was sure that she documented about this episode. During a follow-up observation, on 12/4/2019 at 4:10 PM, it was revealed the door to Resident #59's room was fully open and Resident #59 was sitting on the side of her bed, with no clothes on from the waist down. It was observed that Resident #59 could be seen from the hallway. During an interview, on 12/4/2019 at 4:15 PM, Certified Nursing Assistant (CNA) #2 revealed Resident #59 does not wear clothing on the lower part of her body when she ambulates in her room, or when she is in bed. CNA#2 stated the CNAs try to check on the resident often, but Resident #59 gets up and uses the BSC without calling for help. CNA #2 stated that the resident does this on morning and evening shifts. CNA #2 stated, "She does that a lot, and she's been doing it since she came." During a subsequent observation, on 12/5/2019 at 9:35 AM, it was observed that the door to Resident #59's room was opened all the way and Resident #59 was sitting on her BSC with her pants pulled down to her ankles. It was observed that no staff were in the area for four (4) and a half (½) minutes During an interview, on 12/5/2019 at 9:40 AM, CNA #3 stated she had learned about Resident #59's behavior from actually seeing Resident #59 expose herself multiple times. CNA #3 stated she has been aware of Resident#59's behavior for at least two to three (2-3) months. CNA #3 stated,	F 550	residents. All findings will be reported monthly to the Quality Assurance Committee for three months or until compliance is achieved. The Quality Assurance Committee will make recommendations as needed.	

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F 550	Continued From page 4	F 550		

"The staff just kinda watches out for the resident."

During an interview, on 12/5/2019 at 11:01 AM, the Director of Nursing (DON) stated she was not aware of Resident #59 having a behavior of disrobing, and/or being exposed to the hallway when toileting. The DON stated Resident #59 has been recently treated for a Urinary Tract Infection (UTI), which could have possibly contributed to this behavior.

During an interview, on 12/5/2019 at 11:05 AM, the facility's Licensed Social Services (LSS) staff stated she thought if nothing was documented, then the behaviors were not present, and you could put that they were not present on the MDS. The LSS staff stated she does not interview anyone concerning the resident during the look back period to ask about behaviors or anything else, she only looks for what has been documented. The LSS staff confirmed there was nothing on the care plan to indicate the resident had a behavior problem. The LSS staff confirmed she had indicated no behaviors on the Admission MDS dated 7/19/2019 and the Quarterly MDS dated 10/17/2019.

Review of Resident #59's most recent Comprehensive "Admission" Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/19/2019, revealed the resident had been assessed as not having exhibited the behavior of disrobing in public during the assessment look-back period.

Review of Resident #59's most recent Quarterly MDS with an ARD of 10/17/2019 revealed that the resident had been assessed to not having exhibited the behavior of disrobing in public

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F 550	Continued From page 5 during the assessment look back period. Review of the Face Sheet revealed the facility admitted Resident #59, on 7/11/2019, with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD) and Other Symptoms and Signs involving Cognitive Functions and Awareness Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/17/2019, revealed Resident #59 had a Brief Interview of Mental Status (BIMS) score of seven (7), indicating severely impaired cognition.	F 550		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		1/9/20

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F 623	Continued From page 6 made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related	F 623		

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F 623	Continued From page 7 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a written notification of transfer to an acute care hospital to the resident and/or the Responsible Party (RP) for two (2) of four (4) hospitalizations reviewed for Resident	F 623	F 623: The facility failed to provide written notification of transfer to an acute care hospital to the resident and/or responsible	

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F 623	Continued From page 8 #52. Findings Include Review of Resident #52's Medical Records, revealed the absence of a written letter of Notification of Transfer to an acute care hospital for the following dates of hospitalization: 9/9/2019 and 9/29/2019. Review of the facility document titled, "Transfer Form," with an effective date of 9/9/2019, revealed the facility sent Resident #52 to an acute care hospital to be evaluated for a decrease in urinary output. Review of the facility document titled, "Transfer Form," with an effective date of 9/29/2019, revealed the facility sent Resident #52 to an acute care hospital per Resident #52's request. During an interview, on 12/4/2019 at 11:36 AM, the facility's Admissions Coordinator stated she was not familiar with the Written Letter of Notification for transfer/discharge. The Admissions Coordinator stated that she had only recently been given the responsibility for issuing the Bed Hold Letter. During an interview, on 12/4/2019 at 1:34 PM, the facility's Administrator, confirmed that the facility does not have a letter stating the reason a resident is being sent out to the hospital. The Administrator stated that the "Bed Hold" letter that is sent out to the Resident/Resident's Representative, includes all the information except the reason for the transfer/discharge. The Administrator stated that he was not sure if the facility had a policy addressing the written notice	F 623	party for two of four hospitalizations reviewed. Residents and/or responsible representitives are now notified in writing of all non-resident-initiated transfers. II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. All residents of the facility are at risk for the alleged deficient practice. III. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? A directed in-service, by the Registered Nurse Corporate Consultant, was held on December 05, 2019 with the facility Social Worker and Administrator to address the facility policy on providing a written notification of transfer for all non-resident initiated transfers out of the facility. On December 16, 2019, a log was formed to record all non-resident-initiated transfers, which will be sent to the State Ombudsman□s office no later than the 10th of the following month. The Administrator will audit the transfer log on a monthly basis ensuring the log is being maintained and reported. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. The Administrator and Social Worker will	

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F 623	Continued From page 9 of transfer. Review of the Face Sheet revealed the facility admitted Resident #52, on 3/13/2017, and re-admitted on 10/29/2018 with diagnoses to include Cholecystitis and Chronic Obstructive Pulmonary Disease (COPD)	F 623	audit the transfer log on a monthly basis ensuring all non-resident-initiated transfers are receiving written notice and being logged. All findings will be reported monthly to the Quality Assurance Committee for three months or until compliance is achieved. The Quality Assurance Committee will make recommendations as needed.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to accurately reflect the resident's mental illness status on the Minimum Data Set (MDS) for one (1) out of 18 Resident Minimum Data Sets reviewed. (Resident #12) Findings Include: Review of a letter on the facility's letterhead, dated 12/5/2019, revealed that it is the facility's policy that the Resident Assessment Instrument (RAI) manual be used for Minimum Data Set coding. The letter was signed by the Director of Nursing. Review of Resident #12's "Diagnosis Report", dated 12/5/2019, revealed Resident #12's Primary Diagnosis upon Admission was Paranoid Schizophrenia. Resident #12's Diagnosis report also indicated that Bipolar Disorder was a	F 641	F 641: The facility failed to accurately reflect the resident□s mental illness status on the Minimum Data Set. Upon admission, a Level II pre-admission screening was done identifying resident to have mental illness. The Assessment Coordinator will correctly identify all existing diagnosis of each resident and properly report them on the Minimum Data Set. II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. All residents in the facility are at risk for the alleged deficient practice. III. What measures will be put into place or systemic changes made to ensure that	1/9/20

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F 641	Continued From page 10 secondary diagnosis upon admission. Review of Resident #12's Medical Records revealed a Pre-Admission Screening (PAS) dated for 3/27/2018. Resident #12's PAS indicated under the section titled, "Selected Active Medical Conditions", that both Schizophrenia/other psychosis and Bipolar Disorder were listed. Resident #12's PAS also indicated under the section titled, "Federal Pre-Admission Screening and Resident Review (PASRR)- For Nursing Facility Admissions", "Part B- Level II Referral Criteria", that the following questions were asked: "Person has a diagnosis of a major mental illness?" and "Person has a recent history of a major mental illness?". Resident #12's PASRR indicated the answer to both of the questions was Yes. Review of the Resident # 12's Significant Change MDS, with an Assessment Reference Date (ARD) of 9/2/2019, revealed Section A1500 was coded "0" as to indicate that No Level II PASRR had been addressed and that Section A1510 was left blank as to indicate that Resident #12 had No Serious Mental Illness. Resident#12's Significant Change MDS with an ARD of 9/2/2019 Section I is coded to indicate the following Diagnoses were Active: Manic Depressive Disorder (bipolar disease), Schizophrenia (e.g., schizoaffective and schizophreniform disorders), and Paranoid Schizophrenia. During an interview, on 12/4/2019 at 2:50 PM, the facility's Admissions Coordinator (AC), confirmed Resident #12 had a Level II screening on 3/26/2018, and a letter of approval for admission on 3/27/2018. The AC confirmed Resident #12 had the diagnoses that included Schizophrenia,	F 641	the deficient practice will not recur? A directed in-service, by the Corporate Assessment Compliance Nurse, will be held on January 08, 2020 with all licensed nurses of the facility to address ensuring correct information is being pulled from the resident□s medical record and entered on the Minimum Data Set. The Director of Nursing and Assessment Coordinator Nurse will review the Minimum Data Set prior to submission to ensure proper diagnosis are entered into Section A of the Minimum Date Set. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. The Director of Nursing and Assessment Coordinator Nurse will review the Minimum Data Set prior to submission to ensure proper diagnosis are entered into Section A of the Minimum Date Set. All findings will be reported monthly to the Quality Assurance Committee for three months or until compliance is achieved. The Quality Assurance Committee will make recommendations as needed.	

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F 641	Continued From page 11 Manic Depression (bipolar disease), and the additional diagnosis of Paranoid Schizophrenia on admission. During an interview, on 12/4/2019 at 3:00 PM, Licensed Practical Nurse (LPN) #1/ MDS Coordinator confirmed Resident #12's Significant Change MDS with an Assessment Reference Date (ARD) of 9/2/2019, was marked no in the A1500 section. LPN #1 also confirmed the MDS, Section I did indicate Resident #12 has diagnoses that include Schizophrenia, Manic Depression (bipolar disease), and the additional diagnosis of Paranoid Schizophrenia. LPN#1 confirmed that sections A1500 and A1510 were incorrectly coded on Resident #12's Significant Change MDS with an ARD of 9/2/2019. Review of the Face Sheet revealed the facility admitted Resident #12, on 3/26/2018, with diagnoses to Paranoid Schizophrenia, Major Depressive Disorder, Bipolar Disorder, and Chronic Obstructive Pulmonary Disease (COPD)	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		1/9/20

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F 656	Continued From page 12 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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interviews, the facility failed to develop a Care Plan for three (3) of 18 resident care plans reviewed. (Resident #11, Resident #59, Resident #84) Findings include: The facility's "Care Plan-Comprehensive" policy	F 656	F 656: The facility failed to develop a care plan for 3 of 18 resident care plans reviewed. The facility holds a morning meeting each day reviewing new resident occurrences and treatments. The Assessment Coordinator attends this meeting each day, and will care plan all new resident	

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F 656	Continued From page 13 stated it is the policy of this facility that an individual (person centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs, shall be developed for each resident. The facility policy also stated the facility's care planning team/ Interdisciplinary Team (IDT), in coordination with the resident, his/ her family or representative, develops and maintain a comprehensive care plan for each elder resident, and that care plan is based on a thorough assessment that includes, but is not limited to the MDS (Minimum Data Set). This facility policy was revised in October 2016. Resident #59 Review of Resident #59's "Care Plan" revealed there was no mention of Resident #59 exhibiting the behavior of disrobing in public or exposing herself from the waist down when toileting. During the State Agency's (SA) initial tour observation of the facility, on 12/3/2019 at 9:52 AM, it was observed the door to Resident #59's room was completely wide open. The SA observed that from the hallway Resident #59 was seen in her room, totally nude from the waist down, standing at her sink wiping her buttocks area. It was observed there were no staff or other residents in the area at that time. After four (4) minutes, Certified Nursing Assistant (CNA) #1/ Restorative CNA appeared on the adjacent hall, at that time CNA #1 was notified that Resident # 59 needed assistance. CNA #1 was observed entering Resident #59's room and closing the door to assist Resident #59. During an interview, on 12/3/2019 at 10:10 AM,	F 656	information that is addressed. Care Plans as it relates to deficient survey individuals. On 12/20/19 the Director of Nursing developed a Care Plan for resident #59 stating resident prefers that door stays open. On 1/2/20 the Assessment Coordinator Nurse updated resident #59 Care Plan indicating resident walks around nude. On 1/8/20 the Assessment Coordinator Nurse documented a Care Plan revision for resident #11 indicating the resident is a wanderer. II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. All residents of the facility are at risk for the alleged deficient practice. III. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? A directed in-service, by the Corporate Assessment Compliance Nurse, will be held on January 08, 2020 with all licensed staff of the facility to address development and implementation of care plans. The Director of Nursing and Assessment Coordinator Nurse began 12/30/19 reviewing care plans monthly to ensure interventions are appropriate and obtainable on all new occurrences	

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F 656	Continued From page 14 Certified Nursing Assistant (CNA) #1 confirmed Resident #59 was disrobed from the waist down, standing at her sink attempting to clean herself. CNA #1 stated she did not know if the resident had ever done this before. CNA #1 stated she had not heard anything about this type of behavior from this resident. During an interview, on 12/4/2019 at 4:05 PM, Licensed Practical Nurse (LPN) #2 stated Resident #59 had a history of episodes of ambulating across the room to use the Bed Side Commode (BSC) and not be wearing any clothing below the waist. LPN #2 stated the facility staff offers reminders to the resident to use the call light when she needs assistance to go to the bathroom, but the resident still does not use her call light. LPN #2 stated Resident #59 also does not like to sleep or take a naps with her pajama bottoms on. LPN #2 stated she has documented Resident #59's behaviors in the past, although she could not remember the last time she documented them, even though the behaviors have continued. LPN #2 stated Resident #59 has had these behaviors going on since the time she was admitted. LPN #2 stated right after Resident #59 was admitted, she could recall Resident #59 having rolled herself up to the Nurse's station in her wheelchair and Resident #59 was completely nude. LPN #2 stated she was sure she documented this episode. During a follow-up observation, on 12/4/2019 at 4:10 PM, it was observed that the door to Resident #59's room was fully open and Resident #59 was sitting on the side of her bed, with no clothes on from the waist down. It was observed that Resident #59 could be seen from the hallway.	F 656	addressed. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. The Director of Nursing and Assessment Coordinator Nurse will review care plans monthly to ensure interventions are appropriate and obtainable on all new occurrences addressed. All findings will be reported monthly to the Quality Assurance Committee for three months or until compliance is achieved. The Quality Assurance Committee will make recommendations as needed. 01-09-2020	

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F 656	Continued From page 15 During an interview, on 12/4/2019 at 4:15 PM, Certified Nursing Assistant (CNA) #2 revealed Resident #59 does not wear clothing on the lower part of her body when she ambulates in her room or when she is in bed. CNA#2 stated the CNAs try to check on the resident often, but Resident #59 gets up and uses the BSC without calling for help. CNA #2 stated the resident does this on morning and evening shifts. CNA #2 stated, "She does that a lot, and she's been doing it since she came." During a subsequent observation, on 12/5/2019 at 9:35 AM, it was observed that the door to Resident #59's room was opened all the way and Resident #59 was sitting on her BSC with her pants pulled down to her ankles. It was observed that no staff were in the area for four (4) and a half (½) minutes. During an interview, on 12/5/2019 at 9:40 AM, CNA #3 stated she had learned about Resident #59's behavior from actually seeing Resident #59 expose herself multiple times. CNA#3 stated she has been aware of Resident#59's behavior for at least two to three (2-3) months. CNA #3 stated, "The staff just kinda watches out for the resident." During an interview, on 12/5/2019 at 11:01 AM, the Director of Nursing (DON) stated she was not aware of Resident #59 having a behavior of disrobing, and/ or being exposed to the hallway when toileting. The DON stated Resident #59 has been recently treated for a Urinary Tract Infection (UTI), which could have possibly caused or contributed to this situation. The DON stated Resident #59's behaviors should have been noted in the Resident #59's Progress Notes, on	F 656		

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F 656	Continued From page 16 her MDS, and most certainly on her care plan. During an interview, on 12/5/2019 at 11:05 AM, the facility's Licensed Social Services staff (LSS) stated she thought if nothing was documented, then the behaviors were not present, and you could put that they were not present on the MDS. The LSS stated she does not interview anyone concerning the resident during the look back period to ask about behaviors or anything else, she only looks for what has been documented. The LSS confirmed there was nothing on the care plan to indicate that Resident #59 had a behavior problem. The LSS confirmed she had indicated no behaviors on the Admission MDS dated 7/19/2019 and the Quarterly MDS dated 10/17/2019. Resident #11 Record review of Resident #11's Comprehensive Care plan revealed the facility failed to develop a Care Plan for Wandering. The Care Plan meeting is conducted weekly with the facility's interdisciplinary team, the resident and family representative. Record review of the quarterly Minimum Data Set (MDS), dated 8/30/19 revealed Section E that Resident #11 has Wandering behaviors that occurred within 4-6 days of 8/30/19. Record review of the facility's Progress Note revealed the Social Worker (SW) documented, on 11/29/19, Resident #11 had wandering behaviors three (3) days (11/24/19, 11/25/19, 11/26/19) during her MDS review period. Resident #11's wandering assessment completed on 9/6/18 was the last wandering assessment	F 656		

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F 656	Continued From page 17	F 656		

which stated a history of wandering.

An interview, on 12/4/2019 at 2:00 PM, revealed the DON confirmed the facility failed to develop a wandering care plan. The DON said they missed it because the care plan nurse resigned.

An interview, on 12/5/19 at 12:09 PM, with Registered Nurse (RN) #1 confirmed the facility failed to develop a Care Plan for Wandering. RN # 1 said he just started working at the facility and he's trying to catch up on all of the Care Plans.

Review of the Face Sheet revealed the facility admitted Resident #11, on 10/30/2015, with diagnoses which included, Dementia without Behavioral Disturbance , Alzheimer's Disease and Major Depression.

A review of Resident #11's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/30/2019, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident was cognitively impaired.

Resident #84

An observation, on 12/3/19 at 10:04 AM, revealed a sign on Resident #84's door to see the nurse at the nurse's station. Resident #84 was on Contact Isolation/Transmission Precautions.

Record review of the Care Plan revealed there was no Problem/Need, Goals, or Interventions/Approaches for contact isolation precaution.

An interview, on 12/05/19 at 12:09 PM, with RN

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F 656	Continued From page 18 #1 and the DON confirmed the facility failed to develop a Contact Isolation Care Plan. The DON said the care plan nurse resigned, so they were short and was unable to keep up with the care plans. A review of the Face Sheet revealed the facility admitted Resident #84, on 08/7/2019, with diagnoses which included Dementia without Behavioral Disturbance , Methicillin Resistant Staphylococcus Aureus (MRSA), Extended Spectrum Beta Lactamase (ESBL) and Major Depression. A review of Resident #84's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/12/2019, revealed Resident #84 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident was cognitively impaired.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and facility policy review, the facility failed to	F 679	F 679:	1/9/20

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F 679	Continued From page 19 provide activities to meet the resident's preferences and individualization for Residents #6 and #47, for three (3) of three (3) days of resident activities observed. Findings include: Review of the facility's Activity Policy titled, " Programming for Residents with Cognitive Impairments and Other Special Needs", revealed the activity programs are provided for the maintenance and enhancement of each resident's quality of life while promoting physical, cognitive and emotional health. The facility will offer meaningful programs for residents with cognitive impairments that use reality and sensory awareness techniques. The Interdisciplinary Team identifies each resident's physical, emotional, or mental challenge and needs (wheelchair, ambulatory, visual or hearing impairment, happy or sad affect, evidence or dementia) during the resident assessment process. Special needs may include dietary (fluid restriction, thicken liquids, salt or sugar restriction), religion affiliation (special holidays, foods) visual/auditory/speech, language, physical impairments and aids. General Activity Programs may be modified by simplifying steps, adapting approaches, and modifying instructions to accommodate residents with cognitive impairments. Activity staff observes each resident to identify those residents who might benefit from a reality and sensory awareness program. Reality and sensory awareness focuses on orienting the resident to the current time and place, while providing intervention to stimulate the five senses. Group activities are available in the facility and an activities calendar is completed to inform resident, families and staff of the activity	F 679	The facility failed to to provide activities to meet the resident□s preferences and individualization for resident s # 6 and #47 for three of three days. The Activities Director will ensure an assessment will be done upon admission to discover interest and preferences of the residents admitted to this facility. On 1/9/20 the Activity Director documented an individualized Care Plan for the following residents. Resident #47 focus indicates anxiety along with over stimulation within some group activities. Staff goals are to provide 1on 1 in room activities of her preference and have resident show signs of enjoyment by uncovering her head and smiling by next review date of 1/16/20. Resident #6 focus indicates group programs often offend or affects others enjoyment from activities. Staff goals are to provide 1on 1 in room activities of her preference and have resident express satisfaction by not yelling or hitting by next review date of 2/28/20. II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. All residents of the facility are at risk for the alleged deficient practice. III. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	

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F 679	Continued From page 20 opportunities available. Individual activities will be provided for those resident's whose situation or condition prevents participation in other types of activities, and for those residents who do not wish to attend group activities. Residents who are able maintain an independent program will have supplies available to them. Record review of the Activities Attendance policy revealed the Activity Department records activities and attendance of participation of all residents. The attendance and participation is recorded for every resident in group and individual activities on a daily basis. Records are reviewed on a regular basis to determine any changes in resident participation that might indicate a change in condition and lead to reassessment and care plan review. Attendance records are filed for a minimum of three years. Attendance records are used when completing residents progress notes to determine their participation as it relates to their activity plan. Record review of the facility's Activity Program revealed an ongoing program of activities is designed to meet the needs of each resident. Our activity program consists of individual, and small and large group activities which are designed to meet the needs and interest of each resident and includes at a minimum: Social activities, Indoor and outdoor activities, Activities away from the facility, religious programs, Creative activities, Exercise activities, Individualize Activities, Community Activities. Activity programs are approved by the attending physician in coordination with the resident's comprehensive assessment, Scheduled activities are posted on the residents bulletin board, Individualized and group activities are provided that reflect the	F 679	A directed in-service, by the Certified Therapeutic Recreation Specialist, will be held on January 09, 2020 with all staff from the Activities Department to address ensuring that all activities meet the interest/needs of each resident. Activity staff will be re-in serviced on the activity assessment that is done upon each admission ensuring residents interest and preferences are identified. The Administrator will monitor activities randomly each week, ensuring the individual interest and preferences of each resident is being addressed. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. Starting 12/30/19 the Administrator will begin monitoring activities randomly each week, ensuring the individual interest and preferences of each resident is being addressed. All findings will be reported monthly to the Quality Assurance Committee for three months or until compliance is achieved. The Quality Assurance Committee will make recommendations as needed. 01-09-2020	

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F 679	Continued From page 21 schedules, choices, and rights of the residents, including evenings, holidays and weekends: reflect the cultural and religious interest of the resident and appeal to both men and women as all age groups of residents residing in the facility. Residents are encouraged, but not forced to participate in scheduled activities. Adequate space and equipment are provided to ensure that needed services identified in the resident's plan of care are met. Resident #6 Observations, on 12/03/19 at 10:28 AM, 12/3/19 at 1:00 PM, 12/4/19 at 9:29 AM, 12/5/19 at 8:31 AM, and 12/5/19 at 12:32 PM, revealed Resident #6 was sitting in the day room with her head down on the laptray. Record Review of The Monthly Activity Attendance Record for December reveal Resident #6 did not receive Activity Therapy to meet her needs. Review of the Care Plan revealed Resident #6 had the potential for impaired cognition or inappropriate behaviors related to the diagnosis of Dementia, Depressive and Anxiety Disorder. Listed interventions included to involve the resident in spiritual games, and social activities, provide calm quiet, rush free environment during periods of inappropriate behavior, psych consult as needed, staff to introduce self when providing care, staff to sit down and converse with resident for social interaction, wait and reattempt when care or treatment is refused. Resident #6 is dependent of staff for activities, cognitive stimulation and social interaction. Listed interventions included to encourage the resident	F 679		

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F 679	Continued From page 22 to come to activity, increase lighting, large printed material, audio books, invite family to attend activity with resident, invite resident to activity such as pet therapy, parties, exercise, food or snacks, story telling arts and crafts and music, provide calm, non hurried environment, provide activity calendar monthly in room. An interview, on 12/05/19 at 2:33 PM, the Activities Director and the Administrator confirmed Resident #6 was not taken to activities during the three (3) days of observations, the days the State Agency (SA) was in the building. The Administrator said he's trying to improve the activities in the building and looking to hire more staff. The Activity Director said she just started working at the facility. The Activity Director also said she's trying to change the activity program and has not had a chance to get to all of the one on one residents. A review of the Face Sheet revealed the facility admitted Resident #6, on 04/30/2012 with diagnoses, which included Dementia without Behavioral Disturbance , Anxiety and Depression. A review of Resident #6's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/22/2019, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident was cognitively impaired. Resident #47 Observations on 12/03/19 at 10:17 AM, 12/04/19 at 02:39 PM, 12/05/19 at 10:36 AM, and 12/05/19 at 2:40 PM, revealed Resident #47 was sitting in	F 679		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 23 the dayroom with the cover over her head. Review of The Monthly Activity Attendance Record for December 2019 revealed Resident #47 did not receive Activity Therapy to meet her needs. Review of the Care Plan revealed Resident #47 was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits. Resident #47's goals included Resident #47 will attend/participate in activities of choice 3-5 times a week. Listed interventions are all staff to converse with resident while providing care, encourage ongoing family involvement invite the resident's family to attend special events activities, meals, invite the resident to scheduled activities, activity calendar, resident needs assistance /escort activity function. An interview, on 12/05/19 at 2:41 PM, with the Administrator and the Activities Director confirmed the resident prefers to keep her head covered. Resident #47 did not receive Activity Therapy during the three days the survey team was in the building. The Administrator said he's trying to improve his activities in the building and looking to hire more staff. A review of the Face Sheet revealed the facility admitted Resident #47, on 01/12/2011, with diagnoses which included Dementia with behavioral Disturbance, Anxiety and Major Depression Disorder. A review of Resident #47's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/22/2019, revealed Resident #47 had a Brief Interview for Mental Status (BIMS)	F 679		

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 _____	12/05/2019

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F 679	Continued From page 24 score of 6, which indicated the resident was cognitively impaired.	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255315	A. BUILDING **01 - POPLAR SPRINGS BLDG. 1** B. WING _____	**12/09/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR SPRINGS NURSING CTR, LLC	**6615 P0PLAR SPRINGS DR** **MERIDIAN, MS 39305**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255315	A. BUILDING **02 - POPLAR SPRINGS NURSING CENTER** B. WING _____	**12/09/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR SPRINGS NURSING CTR, LLC	**6615 P0PLAR SPRINGS DR** **MERIDIAN, MS 39305**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

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.

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 _____	12/09/2019

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E 000	Initial Comments ********** Survey conducted on 12/09/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

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.