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 _____	C 07/19/2021

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 Survey Agency (SSA) conducted a three (3) complaint investigations (CI) survey at the facility from 07/13/2021 to 07/19/2020 for CI #17155, CI #17480 and CI # 17548. CI #17155 was regarding Resident/Patient/Client Neglect, Quality of Care/Treatment and Dental Services involving client not being monitored or assessed accurately, services not performed for a dentist referral and improper infection control due to poor oral care. CI# 17480 was regarding Resident/Patient/Client Neglect due to client not being assessed or monitored accurately and pressure wounds, the complaint of client not being cared for well. CI # 17548 was regarding Resident/Patient/Client Neglect related to pressure ulcers due to complaint client became septic from neglect. During the investigations, the SSA determined the facility was in compliance with the requirements of participation in Medicare and Medicaid. The SSA did not substantiate CI #17155, CI #17480, and CI #17548 because there is lack of evidence to prove the facility was negligent of quality of care/treatment in pressure wounds, infection control, monitoring or assessing clients. The facility provided consistent documentation of residents' and wound care status, and the residents' overall health declined. No deficiencies cited. The facility had a census of 76 and is licensed for 91.	F 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.