MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38PS	A. BUILDING: _____ B. WING _____	C 04/10/2025

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

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M 000	Initial Comments The State Agency (SA) conducted two Complaint Investigations (CI) MS #28191 and CI MS #28280, at the facility from 4/9/25 through 4/10/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement. CI MS #28191 was investigated for physical environment and there were no deficiencies related to the investigations. CI MS #28280 was investigated for resident rights, abuse and neglect and M500 was cited.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically	M 500		4/30/25

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contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is

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given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the

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M 500	Continued From page 3 facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on interview and record review, the facility failed to ensure a resident's right to be treated with respect and dignity for one (1) of three (3)	M 500	1. Resident #1 was assessed by the Social Worker on 03/14/2025 and the Nurse Practitioner on 03/17/2025; neither found any signs of psychological harm.	

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M 500	Continued From page 4 residents reviewed for resident rights, Resident #1, when a Certified Nursing Assistant (CNA) used an inappropriate tone and language when responding to the resident's request for care and failed to provide timely assistance, resulting in the resident feeling dismissed and disrespected. Findings included: A review of the facility's document "Vulnerable Adult Act," dated 3/21/2022, revealed, " ...A 'Vulnerable Adult' is any adult person unable to care for his or herself due to a physical or mental decline ... Any nursing home resident is considered to be a vulnerable adult ... Not respecting the resident's rights or confidentiality ..." A record review of the facility's investigation, dated 3/17/2025, revealed that on 3/14/2025 at 2:00 PM, the Activities Director found Resident #1 in her room crying. Resident #1 stated that earlier she had returned to her room around 12:30 PM and pressed her call light for assistance transferring to her recliner. CNA #1 entered the room, turned off the call light, and said "okay" but did not provide assistance. After another 30 minutes, the resident pressed her call light again. According to the resident, it took about two (2) hours for her to receive assistance. When CNA #1 returned, she was rude and stated, "Look, we have other things to do, we're short staffed, and I haven't had my break." The Activities Director notified Administration of the resident's allegation. LPN #1 instructed CNA #1 to clock out and report back on 3/17/2025. CNA #1 never returned to provide a written statement. The facility self-reported the incident, suspended CNA #1 pending investigation, and ultimately terminated. The facility then provided in-services to all staff	M 500	2. All residents have the potential to be affected by this deficient practice. 3. On 03/14/2025, Certified Nursing Assistant #1 was asked to clock out and was terminated 03/17/2025, per the facility's policy. In-services on Abuse and Neglect, Residents Rights, and the Vulnerable Adult Act are conducted quarterly by the Assistant Director of Nursing or the Director of Nursing. All staff were in-serviced by the Director of Nursing and the Assistance Director of nursing beginning 3/24/25 and ending 3/24/25. 4. Beginning on 04/10/2025, two residents will be interviewed by the Director of Nursing, Assistant Director of Nursing, or Social Worker two times weekly for three weeks, then once weekly for three months to determine if their rights are being upheld and they are being treated with respect and dignity. To ensure compliance is obtained, the Director of Nursing or Assistant Director of Nursing will present the results, beginning 04/17/2025, to the quality assurance committee monthly for three months. 5. Findings will be reviewed and discussed during the 4/30/25 QA meeting.	

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on verbal abuse, neglect, reporting, and the Vulnerable Adult Act.

A record review of a witness statement from CNA #2 revealed that she assisted CNA #1 in transferring Resident #1 and observed the resident to be upset, though she did not know why. She confirmed that CNA #1 complained about being short staffed in front of the resident, but she was behind in her workload and left the room to take care of her residents.

A record review of the "Admission Record" revealed the facility admitted Resident #1 on 7/12/2019 with diagnoses including Atrial Fibrillation and Anxiety Disorder.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/2025 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.

On 4/9/2025 at 1:45 PM, during an interview with the Administrator, he confirmed that on 3/14/2025 at 2:00 PM, Resident #1 alleged verbal abuse and neglect by CNA #1 after being left without assistance and told, "We have other stuff to do." CNA #1 was asked to clock out and was later terminated per facility policy.

On 4/9/2025 at 3:00 PM, during an interview with Resident #1, she stated that on 3/14/25, CNA #1 turned off her call light and told her she wasn't the only one who needed help, that she hadn't had a break, and would come back when someone could assist her. The resident stated this made her very upset and she cried.

On 4/9/2025 at 3:15 PM, during an interview with

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the Activities Director, she stated that on 3/14/25, she found Resident #1 crying in her room and was told that CNA #1 had spoken rudely and left her waiting for an extended time. She reported the concern to Administration.

On 4/9/2025 at 3:30 PM, during an interview with LPN #1, she confirmed that on 3/14/25, she told CNA #1 to clock out after being informed of the incident and instructed her to return on Monday to speak with the DON and Administrator.

On 4/9/2025 at 3:45 PM, during an interview with the Business Office Manager, she confirmed that CNA #1 was hired in October 2024 and terminated in March 2025. CNA #1 had completed training on abuse, neglect, and the Vulnerable Adult Act.

On 4/9/2025 at 4:00 PM, during an interview with RN #1/Unit Manager, she confirmed that staffing was sufficient on 3/14/225. She observed Resident #1 to be crying and upset following the incident.

On 4/10/2025 at 9:00 AM, during an interview with the Director of Nursing (DON), she stated that the facility provides regular in-services on abuse, neglect, and burnout, including one on 1/14/2025. She confirmed that the Social Worker evaluated Resident #1, and the Nurse Practitioner (NP) assessed her on 3/17/2025, and neither found any signs of psychological harm.

On 4/10/2025 at 9:20 AM, during an interview with CNA #1, she stated that Resident #1 had asked for help on 3/14/25, and she told the resident she would return with assistance. CNA #1 claimed Resident #1 understood and even told her to help others first. She denied being

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disrespectful and said she was unaware the resident was upset until later. She stated that she was told to return Monday to speak with the Administrator and DON but was instead terminated. She was never asked to make a statement or give an explanation regarding the event.

On 4/10/2025 at 9:45 AM, during an interview with the Administrator, he confirmed that surveillance showed on 3/14/25, Resident #1's call light was on at 12:40 PM, turned off by CNA #1, then again at 1:04 PM, and the lift used at 1:42 PM.

On 4/10/2025 at 10:00 AM, during an interview with the DON, she stated that the facility had sufficient staffing on 3/14/25 per the facility assessment. She felt CNA #1 was not experiencing burnout and should have had the capacity to perform her duties without delay or rudeness.

On 4/10/2025 at 10:30 AM, during an interview with the Social Services Director, she stated that following her evaluation, Resident #1 did not display signs of psychosocial harm.

On 4/10/2025 at 10:45 AM, during an interview with the Nurse Practitioner, she confirmed that she assessed Resident #1 on 3/17/2025 and found no signs of distress. She stated the resident was relieved to hear CNA #1 had been terminated.