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 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

(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 (SA) conducted two Complaint Investigations (CIs), MS #28191 and 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 requirements for participation in Medicare and Medicaid. CI MS#28191 was investigated for physical environment and there were no deficiencies related to the investigation. CI MS #28280 was investigated for abuse, neglect, and resident rights and F550 and F610 were cited. The facility held a license for 89 beds and had a census of 85 at the time of the survey.	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	F 550		4/30/25

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

Electronically Signed | 04/25/2025

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 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

(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 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. 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 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) 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	F 550	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. 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.	

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 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

(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 550	Continued From page 2 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 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	F 550	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.	

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 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

(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 550	Continued From page 3	F 550		

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 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

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 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

(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 550	Continued From page 4	F 550		

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 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

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 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

(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 550	Continued From page 5 #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.	F 550		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 610		4/30/25

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 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

(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 610	Continued From page 6 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to thoroughly investigate an allegation of abuse for one (1) of three (3) residents reviewed for abuse (Resident #1). Specifically, the facility failed to interview other cognitively intact residents who received care from the alleged perpetrator (CNA #1) to determine whether a pattern of verbal abuse or neglect existed. Findings include: A review of the facility's "Abuse Policy and Procedure," dated 3/21/2022, revealed, " ...Abuse Investigation Process ...The investigation will include the following ...e. Resident's statements regarding the incident, if appropriate ..." A record review of the facility's investigation revealed that on 3/14/2025 at 2:00 PM, the Activities Director found Resident #1 in her room crying. Resident #1 alleged verbal abuse and neglect by CNA #1. She stated she had returned to her room at approximately 12:30 PM, pressed her call light for assistance, and CNA #1 turned off the call light but did not assist. The resident alleged CNA #1 returned two (2) hours later and said, "We have other things to do, we're short staffed, and I haven't had my break." There were no interviews in the written investigation to determine or identify if other residents were affected by CNA #1's behavior.	F 610	1. On 03/14/2025, Certified Nursing Assistant #1 was asked to clock out and was terminated 03/17/2025, per the facility's policy. 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. 2. All residents have the potential to be affected by this deficient practice. 3. An in-service was conducted on 04/10/2025 by the Corporate Nursing Staff with the Director of Nursing and the Administrator reviewing the Abuse Policy and Procedure with emphasis on the investigation process. 4. Beginning 04/10/2025, the Administrator or Director of Nursing will perform random audits, in the form of resident interviews on two residents with a BIMS of 13 or above, weekly for 4 weeks, every other week for 2 weeks, and monthly for 1 month to ensure ongoing and sustained compliance with this alleged deficient practice. Any adverse findings will be immediately reported to the administrator, investigated, and reported to the State Agency as deemed necessary. Findings of audits will be brought the quality assurance committee monthly for three months beginning 4/17/25.	

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 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

(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 610	Continued From page 7 On 4/10/2025 at 9:45 AM, during an interview with the Administrator, he confirmed that during the investigation, he did not review the surveillance video. He reviewed the video after the State Agency (SA) entrance on 4/9/25, which revealed Resident #1's call light was activated at 12:40 PM and again at 1:04 PM, and the mechanical lift was used at 1:42 PM. He stated the facility conducted a detailed investigation but acknowledged that the facility failed to interview other residents assigned to CNA #1 during the shift. Specifically, those with a Brief Interview for Mental Status (BIMS) score of 13 or higher, who may have provided additional insight into the CNA's behavior. On 4/10/2025 at 10:00 AM, during an interview with the Director of Nursing (DON), she stated that the facility performed a thorough investigation, but they failed to interview other residents with a BIMS score greater than 13, to ascertain if they felt they were abused or neglected by CNA #1. On 4/10/2025 at 10:30 AM, during an interview with the Social Services Director, she stated that following the event with Resident #1, she failed to interview other residents that were assigned to CNA #1 with a BIMS score greater than 13, to determine if others had any issues with the CNA. 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	F 610	5. Findings will be reviewed and discussed during the 4/30/25 QA meeting.	

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 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

(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 610	Continued From page 8 (ARD) of 2/12/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 610		