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 03/11/2020

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 (SA) conducted Complaint Investigation (CI) MS #16605, at the facility, from 03/09/2020 through 03/11/2020. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated CI MS #16605 for Abuse and Neglect and cited the regulatory deficiencies at F600 and F609. At the time of survey, the facility had a census of 88, and held a license for 91 beds.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to ensure residents were free from abuse and neglect, for three (3) of six (6) sampled residents, Resident #1 Resident #2, and Resident #3.	F 600	#1 The facility failed to ensure Resident□s #1, #2 and #3 were free from abuse and neglect as evident by verbal and written allegations of two employees abusing resident #1 and #2.	4/22/20

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

Electronically Signed | 04/22/2020

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F 600	Continued From page 1 Findings include: Review of the facility's "Resident Rights" policy, dated 03/2019, revealed employees shall treat all residents with kindness. The policy revealed, the facility would 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. Review of the facility's "Preventing Resident Abuse" policy, dated 08/16/2016, revealed, the facility would not condone any form of resident abuse and would continually monitor the facility's policies, procedures, training programs, to assist preventing resident abuse. "Residents have the right to be free from all forms of abuse. Abuse includes conduct that causes or has the potential to cause the resident to experience humiliation, fear, shame, agitation, or degradation." A review of the facility's "Types of Abuse" policy, dated 10/2016, revealed: Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to threats of harm or saying things to frighten a resident. The policy revealed the definition of Physical Abuse as hitting, slapping, pinching and kicking. The policy further revealed the definition of Neglect as failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. "Intentionally or unintentionally not providing basic needs such as food, fluids, hygiene, dignity, and medical needs."	F 600	On January 30, 2020, the alleged employees were immediately placed on administrative leave, sent home and removed from their rotations pending the outcome of the investigation. Residents #1 and #2 were immediately assessed on January 30, 2020. The nurse practitioner was notified of both alleged incidents. Resident #2 who acquired the alleged physical abuse to the hand received an x-ray of bilateral hands to rule out any internal injuries. Family members for resident #1 an #2 were notified of the alleged incidents on January 30, 2020. The Mississippi State Department of Health was notified on January 30, 2020 at approximately 17:23. On January 31, 2020, individual In-Services were conducted with all 3 employees who reported the allegations of abuse. The In-Service was as followed: It is the policy of Poplar Springs Nursing Center to comply with state and federal laws about reporting reasonable suspicion of any crime including the abuse (physical, mental, sexual, neglect) of any vulnerable adult. If any staff member becomes aware or suspects abuse, he/she is to firstly, ensure the safety of the resident. Secondly, he/she is to immediately report the suspected abuse to his/her immediate supervisor and escalate as necessary the concerns are reported timely to the Director of Nursing and Administrator of the facility. On January 31, 2020, the alleged incidents were reported to the Sheriff□s Department and Medicaid Fraud Criminal	

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F 600	Continued From page 2 Review of the facility's investigation report, submitted via fax to the State Agency (SA) on 02/03/2020, revealed, on 01/30/2020, Certified Nursing Assistant (CNA) and CNA #4 reported to the Assistant Director of Nursing (ADON)/Registered Nurse (RN) #2 that CNA #1 and CNA #2 were treating some of the resident inappropriately. The residents were identified as Resident #1, Resident #2 and Resident #3. The facility's investigation report revealed, CNA #3 reported that CNA #1 had gotten mad with Resident #1 because he was licking his fingers, and CNA #1 slammed the resident's tray down, and told him that she wasn ' t feeding him anymore. The incident was confirmed by CNA #4. The report revealed CNA #3 witnessed CNA #2 popped Resident #2 "real hard" when the resident kept reaching for her tray. CNA #3 stated Resident #2 was hit hard enough for neighboring tables to hear and notice. This incident was also confirmed by CNA #4. The report revealed that CNA #5 reported to the ADON, an incident which occurred on 01/28/2020, where CNA #2 got in Resident #3 ' s face and told the resident that she would choke the life out of her. CNA #5 stated Resident #3 started to cry and CNA #2 took the resident ' s call light and placed it out of her reach. A review of the "Medicaid Fraud Crime Unit (MFCU) Crime Web Submission" document, dated 01/31/2020 at 2:24 PM, revealed the Attorney General's Office (AGO) received a report, which alleged abuse had occurred on 01/29/2020 with Resident #2 named as the victim, and CNA #2 as the suspect. Review of the "MFCU Crime Web Submission" document, dated 01/31/2020 at 2:44 PM,	F 600	Unit for Alleged Abuse / Attorney General□s Office pertaining to resident #1 and #2. On February 3, 2020, another employee submitted a written and verbal allegation of alleged abuse against resident #3 by the same employee who allegedly abused resident #2. On this date the Sheriff□s Office and Medicaid Fraud Criminal Unit for Alleged Abuse / Attorney General□s Office were notified of the alleged incident pertaining to resident #3. On February 4, 2020, the Attorney General□s Office was notified of the finalization of the investigations pertaining to the alleged abuse against resident #1, #2 and #3. On February 10, 2020, the local Ombudsman conducted an In-Service pertaining to Resident Abuse and Neglect. On March 9, 2020, a state investigator from the Attorney General□s Office conducted an In-Service pertaining to Resident Rights and Abuse / Neglect. #2 All residents in the facility are at risk for the alleged deficient practice. #3 All new employees are educated and In-Serviced upon hire regarding Resident Abuse and Neglect and the policy and procedures of reporting abuse and neglect. Furthermore, the new employees sign an acknowledgment form showing it has been explained and they understand. All other staff were scheduled In-Services on Abuse and Neglect and procedures on reporting Abuse and Neglect. The Staff Development Nurse will ensure	

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F 600	Continued From page 3 revealed the Attorney General's Office (AGO) received a report, which alleged abuse had occurred on 01/29/2020 with Resident #1 as the victim, and CNA #1 as the suspect. A review of the "MFCU Crime Web Submission" document, dated 02/03/2020 at 12:53 PM, revealed the Attorney General's Office (AGO) received a report, which alleged Resident #3 was the victim of abuse, that occurred on 01/28/2020, and CNA #2 was named as the suspect. Review of a typed statement by the Assistant Director of Nursing (ADON), dated 01/30/2020, revealed, CNA #3 and CNA #4 informed her, on 01/30/2020 at 4:30 PM, that CNA #1 and CNA #2 were treating some of the residents inappropriately. The statement revealed both CNA #3 and CNA #4 witnessed CNA #2 hitting a resident hard enough for it to be heard and noticed. The statement further revealed that CNA #1 was witnessed, by CNA #3 and CNA #4, talking harshly to a resident about licking his fingers, and when he continued to do so, CNA #1 took his tray away and refused to further feed him. Review of Certified Nursing Assistant (CNA) #2's written statement, signed and dated 01/31/2020, revealed she did "tap" Resident #2 on the back of her hand to keep her from getting another resident's tray or knocking it on the floor. During an interview, on 03/09/2020 at 10:00 AM, the facility's Administrator revealed, the facility had self-reported the allegations of abuse, perpetrated by two facility staff members on 01/30/2020. The Administrator stated the facility had investigated the allegations, notified all	F 600	all new employees are educated upon hire. Current employees are educated / In-Serviced quarterly on Abuse and Neglect and policy and procedure of reporting any suspicion of Abuse and Neglect timely. Weekly, the Staff Development Nurse will give the Director of Nursing and Administrator copies of the new employees signed acknowledgement of the Abuse and Neglect policy and procedure and a copy of In-Services on Abuse and Neglect and policy and procedure of immediate reporting. A monthly summary of all new hires and any In-Services pertaining to Abuse and Neglect / Timely Reporting of Abuse and Neglect will be submitted to the Director of Nursing and Administrator. #4 The Director of Nursing and Administrator will report any findings that may occur to the Quality Assurance Committee on a monthly basis. The Quality Assurance Committee will discuss and make recommendations as needed. All of the In-Services were completed by 3/10/2020.	

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F 600	Continued From page 4	F 600		

required entities, and terminated the employees involved.

During an interview, on 03/09/2020 at 3:30 PM, CNA #3 revealed she had witnessed CNA #2 slap Resident #2 on the back of the hand while assisting Resident #2 with her meal. CNA #3 also stated she heard CNA #1 speaking to Resident #1 in an aggressive tone of voice, fussing at him for licking his fingers and spilling his food. CNA #3 stated she then witnessed CNA #1 take Resident #1's tray away and say to Resident #1 that she wasn't going feed him anymore.

During a telephone interview, on 03/10/2020 at 9:00 AM, CNA #1 confirmed she had removed Resident #1's food tray and fussed at him for licking his fingers and spilling his food. CNA #1 stated she removed the tray because Resident #1 was playing in his plate, getting food on the floor, and on his clothes. CNA #1 stated that Resident #1 was also licking his fingers and she had told him to stop.

During a telephone interview, on 03/10/2020 at 9:10 AM, CNA #5 revealed that on 01/28/2020, she had witnessed CNA #2 speaking to Resident #3 disrespectfully and telling Resident #3 to stay off the call light. CNA #5 stated CNA#2 sounded like she was threatening to harm Resident #3. CNA #5 stated CNA #2 moved Resident #3's call light out of the resident's reach and left the room.

A review of CNA #5's written statement, dated 02/01/2020, revealed, on the evening of 01/28/2020 around 7:30 PM - 8:30 PM, CNA #2 pulled her into Resident #3's room to her a cup of water that had overturned on the floor. CNA #5 revealed that CNA #2 told her to "clean it up

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F 600	Continued From page 5	F 600		

now." CNA #5 revealed that CNA #2 approached Resident #3, got in her face and stated, "We are not doing this tonight. I have had it with you. You will not make a sound or I will choke the life out of you, do you understand?" CNA #5 revealed Resident #3 started crying and CNA #2 took the resident's call light and placed it out of reach. CNA #5 further revealed CNA #2 stated to Resident #3, "Do you understand me? Not a damn sound!"

During a telephone interview, on 03/10/2020 at 11:25 AM, RN #2/ADON stated that on 01/30/2020, at around 4:30 PM, CNA #3 and CNA #4 had approached her to report CNA #1's abuse of Resident #1 and CNA #2's abuse of Resident #2. RN #2 stated that she then accompanied CNA #3 and CNA #4 to the Director of Nursing ' s (DON) office, so they could immediately report the abuse together.

During an interview, on 03/11/2020 at 9:20 AM, the DON confirmed CNA #3 and CNA #4 came to her office with RN #2 and reported they had witnessed CNA #1 and CNA #2 abuse two (2) residents. The DON stated that each of the witnesses gave her a signed written statement regarding the witnessed abuse by CNA #1 and CNA #2, towards Resident #1 and Resident #2. The DON stated that on 02/01/2020 at 10:35 AM, CNA #5 came to her office and reported that she had witnessed CNA #2 verbally abuse Resident # 3, and well as taking Resident #3's call light away and putting it out of reach. The DON stated CNA #5 gave her a written and signed statement as to what she allegedly saw and heard when the incident occurred on 01/28/2020.

Review of the facility's Admission Record,

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F 600	Continued From page 6 revealed Resident #1 was admitted by the facility on 08/19/2016 with diagnoses which included Alzheimer's Disease and Benign Prostatic Hyperplasia. Resident #1 had a Brief Interview of Mental Status (BIMS) score was 00, which indicated severe cognitive impairment, during an assessment on 12/05/2019. A review of the facility's Admission Record for Resident #2, revealed she was admitted by the facility on 05/03/2013, with diagnoses which included Dementia with Behavioral Disturbance, Major Depressive Disorder, and Alzheimer's Disease. Resident #2 had a BIMS score of 00, as of 12/10/2019, which indicated severe cognitive impairment. Review of the facility's Admission Record for Resident #3, revealed she was admitted by the facility on 12/12/2019, with diagnoses which included Type II Diabetes Mellitus, Heart Failure and Hyperlipidemia. Resident #3 had a BIMS score of 9, which indicated moderately impaired cognitive skills, as of 02/03/2020.	F 600		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		4/22/20

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F 609	Continued From page 7 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her 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 interview, record review and facility policy review, the facility failed to report staff to resident abuse and neglect to the appropriate agencies within the required two (2) hour timeframe, for three (3) of six (6) residents reviewed, Resident #1, Resident #2, and Resident #3. Findings include: Review of the facility's "Reporting Resident Abuse" policy, dated 03/2019, revealed: "All employees of this facility must immediately report any incident or suspected incident of resident neglect, abuse, or misappropriation of resident property." The facility policy revealed, that an employee of the facility shall not knowingly fail to report an incident or suspected incident of abuse, and any employee who has knowledge or reason to believe that a resident has been a victim of	F 609	#1 The facility failed to report Staff to Resident abuse and neglect to the appropriate agencies within the required 2-hour time frame for Residents #1, #2 and #3. On January 31, 2020, individual In-Services were conducted with all 3 employees who reported the allegations of abuse in an untimely manner. The In-Service was as followed: It is the policy of Poplar Springs Nursing Center to comply with state and federal laws about reporting reasonable suspicion of any crime including the abuse (physical, mental, sexual, neglect) of any vulnerable adult. If any staff member becomes aware or suspects abuse, he/she is to firstly, ensure the safety of the resident. Secondly, he/she is to immediately report	

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F 609	Continued From page 8 abuse is under a duty to immediately report such incident or suspicion to the nurse supervisor. Review of the facility's investigation, submitted via fax to the State Agency (SA) on 02/03/2020, revealed, on 01/30/2020, Certified Nursing Assistant (CNA) and CNA #4 reported to the Assistant Director of Nursing (ADON)/Registered Nurse (RN) #2 that CNA #1 and CNA #2 were treating some of the resident inappropriately. The residents were identified as Resident #1, Resident #2 and Resident #3. The facility ' s investigation report revealed, CNA #3 reported that CNA #1 had gotten mad with Resident #1 because he was licking his fingers, and CNA #1 slammed the resident ' s tray down, and told him that she wasn ' t feeding him anymore. The incident was confirmed by CNA #4. The report revealed CNA #3 witnessed CNA #2 popped Resident #2 "real hard" when the resident kept reaching for her tray. CNA #3 stated Resident #2 was hit hard enough for neighboring tables to hear and notice. This incident was also confirmed by CNA #4. The report revealed that CNA #5 reported to the ADON, an incident which occurred on 01/28/2020, where CNA #2 got in Resident #3 ' s face and told the resident that she would choke the life out of her. CNA #5 stated Resident #3 started to cry and CNA #2 took the resident ' s call light and placed it out of her reach. Review of a typed statement by RN #2/ADON, dated 01/30/2020, revealed, CNA #3 and CNA #4 informed her, on 01/30/2020 at 4:30 PM, that CNA #1 and CNA #2 were treating some of the residents inappropriately. The statement revealed both CNA #3 and CNA #4 witnessed CNA #2 hitting a resident hard enough for it to be	F 609	the suspected abuse to his/her immediate supervisor and escalate as necessary the concerns are reported timely to the Director of Nursing and Administrator of the facility. On February 10, 2020, the local Ombudsman conducted an In-Service pertaining to Resident Abuse and Neglect. On March 9, 2020, a state investigator from the Attorney General□s Office conducted an In-Service pertaining to Resident Rights and Abuse / Neglect. New hires are educated upon hire and current employees In-Serviced as scheduled regarding immediately reporting Abuse and Neglect. #2 All residents in the facility are at risk for this deficient practice. #3 All new employees are educated and In-Serviced upon hire regarding Resident Abuse and Neglect and the policy and procedures of reporting abuse and neglect. Furthermore, the new employees sign an acknowledgment form showing it has been explained and they understand. All other staff were scheduled In-Services on Abuse and Neglect and procedures on reporting Abuse and Neglect. The Staff Development Nurse will ensure all new employees are educated upon hire. Current employees are educated / In-Serviced quarterly on Abuse and Neglect and policy and procedure of reporting any suspicion of Abuse and Neglect timely. Weekly, the Staff Development Nurse will give the Director of Nursing and Administrator copies of the	

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F 609	Continued From page 9 heard and noticed. The statement further revealed that CNA #1 was witnessed, by CNA #3 and CNA #4, talking harshly to a resident about licking his fingers, and when he continued to do so, CNA #1 took his tray away and refused to further feed him. A review of the "Medicaid Fraud Crime Unit (MFCU) Crime Web Submission" document, dated 01/31/2020 at 2:24 PM, revealed the Attorney General ' s Office (AGO) received a report, which alleged abuse had occurred on 01/29/2020 with Resident #2 named as the victim, and CNA #2 as the suspect. Review of the "MFCU Crime Web Submission" document, dated 01/31/2020 at 2:44 PM, revealed the Attorney General ' s Office (AGO) received a report, which alleged abuse had occurred on 01/29/2020 with Resident #1 as the victim, and CNA #1 as the suspect. A review of the "MFCU Crime Web Submission" document, dated 02/03/2020 at 12:53 PM, revealed the Attorney General ' s Office (AGO) received a report, which alleged Resident #3 was the victim of abuse, that occurred on 01/28/2020, and CNA #2 was named as the suspect. A review of the (Name of the County) Sheriff Department's report, dated 01/31/2020 at 10:23 AM, revealed the DON called to report an incident involving CNA #1 and CNA #2, listed as the offenders, and Resident #1 and Resident #2 as the victims. A review of the (Name of the County) Sheriff Department's report, dated 02/03/2020 at 9:55 AM, revealed, an allegation of abuse was reported, indicating CNA #2 as the offender, and Resident #3 as the victim.	F 609	new employees signed acknowledgement of the Abuse and Neglect policy and procedure and a copy of In-Services on Abuse and Neglect and policy and procedure of immediate reporting. A monthly summary of all new hires and any In-Services pertaining to Abuse and Neglect / Timely Reporting of Abuse and Neglect will be submitted to the Director of Nursing and Administrator. #4 The Director of Nursing and Administrator will report any findings that may occur to the Quality Assurance Committee on a monthly basis. The Quality Assurance Committee will discuss and make recommendations as needed. All of the In-Services were completed by 3/10/2020.	

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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
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During an interview, on 03/09/2020 at 3:30 PM, Certified Nursing Assistant (CNA) #3 revealed that days earlier, before the incident was reported on 01/30/2020, she had witnessed CNA #2 slap Resident #2 on the back of the hand while assisting Resident #2 with her meal, but she was unsure of what day it actually occurred on. CNA #3 also stated she heard CNA #1 speaking to Resident #1 in an aggressive tone of voice, fussing at him for licking his fingers and spilling his food. CNA #3 further stated she then witnessed CNA #1 take Resident #1's tray away, and stated to Resident #1 that she wasn't going to feed him anymore. CNA #3 stated she was scared to tell anyone at first, because she had never had to report abuse or something like this before.

During an interview, on 03/09/2020 at 3:40 PM, the facility's Administrator stated that he reviewed the video recordings from 01/27/2020, 01/28/2020, 01/29/2020, and 01/30/2020, and he was unable to locate the incident on camera. The Administrator stated he was not sure why the CNAs waited to report the abuse.

During a telephone interview, on 03/10/2020 at 11:25 AM, RN #2/ADON stated that on 01/30/2020, at around 4:30 PM, CNA #3 and CNA #4 had approached her to report CNA #1's abuse of Resident #1 and CNA #2's abuse of Resident #2. RN #2 stated that she then accompanied CNA #3 and CNA #4 to the Director of Nursing's (DON) office, so they could immediately report the abuse together. RN #2 stated CNA #3 told her that what she had witnessed, happened days earlier, but she was reporting it now.