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 11/02/2022

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

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #18529 at the facility from 11/01/22 through 11/02/22. The SA determined that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA substantiated MS CI #18529 for abuse and cited M500.	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 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	M 500		11/28/22

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M 500	Continued From page 1	M 500		

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 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

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M 500	Continued From page 2	M 500		

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 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

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M 500	Continued From page 3 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: Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents were protected from staff physical abuse for one (1) of three (3) residents reviewed for abuse. Resident #1 Finding include:	M 500	#1 Licensed Practical Nurse #1 was suspended and removed from the work schedule effective approximately 6:30 P.M. on 2/17/22 pending the outcome of the investigation. Subsequently, Licensed Practical Nurse #1 was terminated 2/18/22 for their actions in this case.	

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M 500	Continued From page 4 Record review of the facility policy titled "Abuse Policy and Procedure", dated 10/2016, revealed, "Each resident of this facility has the right to be from verbal, sexual, physical, and mental abuse, involuntary seclusion, corporal punishment, neglect and/or misappropriation of resident property. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish ... "Physical abuse" includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment ...." Record review of the facility's "Investigation" revealed, on 2/17/22, the Administrator notified the Director of Nursing (DON) of an incident reported to him in which Resident #1 had possibly been physically abused by Licensed Practical Nurse (LPN) #1 on 2/13/22. Upon review of the video recorded during that timeframe, Administration was able to determine that at approximately 3:31 PM on 2/13/21, following what appeared to be a verbal altercation, LPN #1 very aggressively got behind the resident and placed his arms under the resident's axilla (arm pits) of both arms and aggressively dragged the resident approximately 21 feet to a nearby dining room chair while the resident still had his walker in his left hand. At that time, the nurse was observed aggressively placing the resident in the chair and pulling him up into a sitting position. The nurse was observed walking away and then walking back over to the resident and grabbed his walker and threw it toward the sink located in the B hall dining area. LPN #1 was then seen on video walking away again from the resident and texting on his phone. After the incident, the resident was observed using his rolling walker and walking down B hall toward his room. A family member of	M 500	Certified Nursing Assistant #1 was suspended and removed from the work schedule effective approximately 6:30 P.M. on 2/17/22 pending the outcome of the investigation. Subsequently, Certified Nursing Assistant #1 was terminated 2/19/22 for their actions in this case. #2 All residents have the potential to be affected by 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 to their understanding. All other staff were scheduled In-Services on Abuse and Neglect and procedures on reporting Abuse and Neglect. Current employees are educated / In-Serviced quarterly on Abuse and Neglect and policy and procedure of reporting any suspicion of Abuse and Neglect timely. The Licensed Nursing Home Administrator, Director of Nursing and Assistant Director of Nursing conducted a Mandatory Resident Abuse In-Service on 2/18/2022. The area Ombudsman conducted a Mandatory Resident Abuse In-Service on 3/2/22 and 3/4/22. The Assistant Director of Nursing conducted a Resident Rights In-Service on 5/2/2022. The Assistant Director of Nursing conducted a dementia resident behaviors/dealing with difficult behaviors	

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M 500	Continued From page 5 another resident was observed on video witnessing Resident #1 being roughly placed in a chair. In the investigation, the family member had stated that he heard raised voices and stepped out of the room and witnessed Resident #1 being very roughly placed in the chair. During the entire incident, Certified Nurse Aide (CNA) #1 was seen in the video witnessing the verbal, as well as physical exchange between Resident #1 and LPN #1. The investigation reveals that upon notification of the incident on 2/17/22, at approximately 5:00 PM, the Administrator began investigating the allegation of abuse and notified the DON. The notes reveal at 6:25 PM, the facility began reporting the incident to the local police department, the Medicaid Fraud Control Unit (MFCF) of the Attorney General's Office via web, the Resident's Representative (RR), and the Department of Health. The DON wrote in the investigative notes that Resident #1 had been transferred on 2/15/22, to a Geriatric Psychiatric facility in which he had recently been treated for further evaluation. The resident reportedly acquired no physical injuries from the 2/13/22 incident. The investigation confirms that both employees were terminated from the facility. LPN #1 was terminated for his actions and CNA #1 was terminated for not reporting the incident that she witnessed. On 11/1/22 at 3:45 PM, in an interview the Administrator confirmed, the information as written in the "Investigation" was obtained through interview and observation of the incident recorded on the facility's video camera. The Administrator explained that the facility determined that the physical abuse occurred and took corrective actions. He stated that the appropriate authorities were notified, and both the LPN and CNA were terminated from employment.	M 500	on 7/11/2022. Furthermore, Elder Justice Act/Accident-incident Resident Rights Vulnerable Adult Act was covered during the same In-Service. The Assistant Director of Nursing conducted a Resident Rights/Vulnerable Adult Act In-Service on 10/17/2022. #4 The first new hire orientation was 2/25/22, the Staff Development Nurse gave the Director of Nursing and Licensed Nursing Home Administrator a copy of the new employees signed acknowledgement of Abuse and Neglect policy/procedure and procedure of immediate reporting Abuse and Neglect. The facility had other new hire orientees 3/7/22, 3/11/22, 3/24/22, etc.& which both Director of Nursing and Licensed Nursing Home Administrator continue to receive the signed acknowledgements. The Licensed Nursing Home Administrator, Director of Nursing and Social Services Director will interview 4 residents times 3 weeks for a total of 12 residents beginning 11/3/22 and completing by 11/28/22. The interview audit tool will reiterate the importance of Resident Abuse and Neglect reporting. The desired outcome is prevention of any future reoccurrence. Furthermore, have residents more likely voicing Abuse and Neglect concerns to Poplar Springs Nursing Center, LLC staff. The Director of Nursing and Licensed Nursing Home Administrator will report any findings that may occur to the Quality Assurance Committee on 11/23/22 and the final audit tools discussed 11/28/22	

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M 500	Continued From page 6 On 11/02/22 at 11:59 AM, during an interview with LPN #2, she confirmed that on 2/17/22, while working at the facility, she heard that Resident #1 had been physically abused by LPN #1 and she immediately reported the information to the Administrator. On 11/2/22 at 1:00 PM, the State Agency (SA) observed the video recording of the 2/13/22 incident. The video confirmed that the information, as written in the facility's "Investigation", accurately depicted the physical abuse of Resident #1 by LPN #1. CNA #1 was also seen in the video at the nurses' station of B hall during the time of the incident. Record review of the "Admission Record" of Resident #1 revealed, the resident was admitted by the facility on 6/30/21, and currently has diagnoses including Dementia with Behavioral Disturbance, Generalized Anxiety Disorder, and Cognitive Communication Deficit. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/8/22, revealed at the time of the incident, Resident #1 had a Brief Interview for Mental Status (BIMS) score of nine (9), indicating the resident had moderate cognitive impairment.	M 500	concluding the last of the resident interviews. The Quality Assurance Committee will discuss and make recommendations as needed. The Director of Nursing and Licensed Nursing Home Administrator have decided to conducted these resident interviews/audit tools December 2022, January 2023 and February 2023. The findings will be brought to the Quality Assurance Committee on 12/21/22, 1/18/23 and 2/15/23.	