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 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

(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 a Complaint Investigation (CI), MS #18529 at the facility from 11/01/22 through 11/02/22. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. Then SA substantiated MS #18529 for a abuse and F600 was cited. The facility had a license for 91 beds, with a census of 87.	F 000		
F 600 SS=D	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 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:	F 600	#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	11/28/22

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

Electronically Signed | 11/17/2022

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F 600	Continued From page 1 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	F 600	2/18/22 for their actions in this case. 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.	

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F 600	Continued From page 2 observed using his rolling walker and walking down B hall toward his room. A family member of 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	F 600	The Assistant Director of Nursing conducted a dementia resident behaviors/dealing with difficult behaviors 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	

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F 600	Continued From page 3 actions. He stated that the appropriate authorities were notified, and both the LPN and CNA were terminated from employment. 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.	F 600	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 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.	