STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255315	A. BUILDING _____ B. WING _____	03/11/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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. Review of the facility's investigation report, submitted via fax to the State Agency (SA) on [DATE], 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE], 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 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 0[DATE]20 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 0[DATE]20 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 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 0[DATE]20 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, revealed Resident #1 was admitted by the facility on 08/19/2016 with [DIAGNOSES REDACTED]. Resident #1 had a Brief Interview of Mental Status (BI[CONDITION]) 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

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 05/03/2013, with [DIAGNOSES REDACTED]. Resident #2 had a BI[CONDITION] score of 00, as of [DATE], 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 REDACTED]. Resident #3 had a BI[CONDITION] score of 9, which indicated moderately impaired cognitive skills, as of [DATE].
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** 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 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 [DATE], 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 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] at 9:55 AM, revealed, an allegation of abuse was reported, indicating CNA #2 as the offender, and Resident #3 as the victim. 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 0[DATE]20 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.