STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR HEIGHTS CENTER	804 SOUTH POPULAR STREET ELIZABETHTOWN, NC 28337

(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 This was an MDS 3.0 Focused Survey. The survey was conducted July 15-16, 2015. Poplar Heights Center was not in compliance with applicable requirements of 42 C.F.R. Part 483, Health Standard Requirements for Long Term Care Facilities.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to have medical justification for restraint use for 1 of 1 resident reviewed for restraint use (Resident #2). Findings included: Resident #2 had been admitted to the facility on 5/27/2011. His diagnoses included dementia, dysphagia, hypertension, urethral stricture, aortic valve disease and malnutrition. An annual Minimum Data Set (MDS) assessment dated 12/16/2014 indicated Resident #2 had a memory problem and was cognitively impaired. The resident needed extensive assistance of one or more staff for activities of daily living (ADL). The assessment indicated he was non-ambulatory, was unsteady moving from a seated to a standing position or with surface to surface transfers and was only able to stabilize with human assistance. The assessment	F 221	1. Restraint order for Resident #2 clarified by the DNS on 8/6/15 to include muscle weakness and difficulty walking. Resident #2 referred to Physical and Occupational therapies to determine least restrictive device or alternatives to promote independent mobility. Therapy evaluations were completed on 8/4/15 and 8/13/15 with recommendations to continue with lap buddy as it was the least restrictive device for this resident and to continue to attempt ambulation with walk to dine program as resident is able to tolerate. 2. No other current residents were identified with restraint use. Licensed staff educated 8/10/15-8/13/15 by the Nurse Practice Educator on restraint implementation and appropriate documentation of medical symptoms.	8/14/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/07/2015

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F 221	Continued From page 1 indicated he had no functional limitation in range of motion in his arms or legs. The assessment noted the resident used a wheelchair for mobility and a trunk restraint had been used daily while in a chair and out of bed. No falls had been reported during the look back period. Active diagnoses included Alzheimer ' s disease, dementia, esophageal reflux, hypertension, benign prostatic hypertrophy, hypothyroidism and dysphagia. The Care Area Assessment (CAA) dated 12/17/2014 for physical restraint use had been completed. The CAA noted the resident had diagnoses of Alzheimer ' s dementia, hypertension, benign prostatic hypertrophy and hypothyroidism and the resident required a physical restraint while up in wheelchair related to Alzheimer ' s disease. The Kardex (a care guide for the nurse assistants) had been last updated on 3/18/2015. Diagnoses listed on the Kardex included: Alzheimer ' s disease, dysphagia, dementia, urinary obstruction, osteoporosis, chronic kidney disease, and anemia. The most recent Restraint Evaluation/Reduction dated 6/04/2015 indicated the resident ' s medical symptom was the inability to maintain an upright position. The assessment indicated the resident leaned forward or stretched up reaching for imaginary items and has Alzheimer ' s disease. The most recent quarterly MDS assessment was dated 6/18/2015 and indicated Resident #2 diagnoses included Alzheimer ' s disease, benign prostatic hypertrophy, Esophageal reflux and hypothyroidism.	F 221	Education included situations where restraints would be appropriate, need for physician's order noting the medical symptom the restraint was used for, development of care plan for restraint use, monitoring of residents with restraints to ensure care plan interventions are implemented as written, and completion of restraint evaluation assessment. 3. Newly admitted residents with restraints and current residents requiring restraint implementation will be reviewed by the DNS or ADNS to ensure appropriate documentation of medical symptoms for restraint use. Documentation of these reviews will be kept in a notebook in the DNS office. 4. DNS will report to the Performance Improvement Committee monthly x 3 months any newly implemented restraints and medical justification for use.	

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F 221	Continued From page 2	F 221		

The care plan had been reviewed by facility staff on 6/24/2015 and indicated the resident had the following problem: the resident is at risk for complications of restraint use. Lap buddy to wheelchair due to inability to maintain an upright position due to Alzheimer ' s disease and tendency to lean forward and pick up imaginary items. Goal included: resident will not experience any adverse effect of restraint use times 90 days. Interventions included: Assess for adverse effects of restrain use such as incontinence, skin breakdown, decrease functional ability and confusion and consult with physician. Complete restraint assessment/reduction review per protocol. Monitor for changes in mental status and changes in functional level and report to MD as indicated. Promote physical/motor activities to prevent decline.

The July 2015 medication administration record (MAR) indicated: Lap buddy to wheelchair while up due to inability to maintain upright position related to Alzheimer ' s disease and tendency to lean forward and pick up imaginary items from floor, every shift for muscular wasting and disuse atrophy.

On 7/15/2015 at 5:45 PM Resident #2 was observed in the dining room. The resident was asked if he could remove the lap buddy. The resident grunted, held onto center of the lap buddy and shook it, unable to remove the device.

An interview with nurse aid (NA) #1 on 7/16/2015 at 10:30 AM was conducted. The NA stated the resident was unable to remove the lap buddy.

On 7/16/2015 at 12:04 PM Resident #2 was observed sitting in his room in a wheelchair with

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F 221	Continued From page 3 the lap buddy applied. When he was asked if he could remove the lap buddy, Resident #2 made eye contact but did not respond to the request to remove the lap buddy. An interview with Nurse #2 was conducted on 7/16/15 at 2:08 PM. The nurse stated the lap buddy was necessary for this resident for his safety because the resident had dementia and had no safety awareness. The nurse stated the resident had been able to remove the lap buddy but had not seen him remove the lap buddy recently. An interview with NA #2 on 7/16/2015 at 4:25 PM was conducted. The NA stated Resident #2 was unable to remove the lap buddy. An interview with Nurse #3 on 7/16/2015 at 4:33 PM was conducted. The nurse stated the resident had a diagnosis of Alzheimer ' s. The nurse also stated the lap buddy would be used when the resident was in the wheelchair to make sure he did not fall forward. An interview with the DON on 7/16/2015 at 5:16 PM was conducted. The DON indicated Resident #2 needed the lap buddy restraint because he was unable sit up in a chair because he would stretch out and be fully extended or bend over and tumble straight out. The DON stated she assumed it was because of a progression of his Alzheimer ' s disease. The DON also stated the resident was unable to remove the lap buddy.	F 221		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically	F 272		8/14/15

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F 272	Continued From page 4 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by:	F 272		

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F 272	Continued From page 5 Based on record review and staff interviews, the facility failed to accurately complete a Care Area Assessment (CAA) for 1 of 10 residents whose assessment was reviewed (Resident #2). Findings include: Resident #2 had been admitted to the facility on 5/27/2011. His diagnoses included dementia, dysphagia, hypertension, urethral stricture, aortic valve disease and malnutrition. A Care Area Assessment (CAA) dated 12/17/2014 for physical restraint use had been completed. The triggering condition for this CAA was trunk restraint used in chair or out of bed, trunk restraint used daily. The CAA summary indicated Resident #2 had diagnoses of Alzheimer ' s dementia, hypertension, benign prostatic hypertrophy and hypothyroidism. The summary further indicated the resident required a physical restraint while up in wheelchair related to Alzheimer ' s disease. The CAA analysis did not include an evaluation of current restraint use, medical conditions/treatments that may lead to restraint use and the summary did not include a diagnosis for restraint use. An interview with the MDS nurse #4 on 7/16/2015 at 4:43 PM was conducted. The nurse stated she was unsure why the CAA for physical restraint use had not been filled in more thoroughly and did not include a medical diagnosis for restraint use. An interview with the DON on 7/16/2015 at 5:16 PM was conducted. The DON indicated the CAA should be thoroughly completed.	F 272	1. Care Area Assessment (CAA) was completed for Resident #2 by MDS nurse on 8/10/15 to include current restraint use, medical condition that may lead to restraint use, and diagnosis documented in CAA summary. 2. No other current residents identified with restraint use. RN completing CAAs was educated by the Clinical Reimbursement Manager regarding accuracy of CAA completion on 8/4/15. 3. Newly admitted residents with restraints and current residents requiring restraint implementation will have CAAs reviewed by the DNS or ADNS prior to submission to ensure appropriate documentation of current restraint use, medical condition that may lead to restraint use, and diagnosis for restraint use. Documentation of these reviews will be kept in a notebook in the DNS office. 4. DNS will report to the Performance Improvement Committee monthly x 3 months results of CAA reviews completed for restraint use.	

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F 278	Continued From page 6	F 278		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code a diagnosis of urinary tract infection (UTI) on the Minimum Data Set (MDS) for 1 of 10 residents reviewed for UTI (Resident #1).	F 278	1. Significant Correction Assessment completed by MDS nurse on 8/12/15 for resident #1 with urinary tract infection coded. 2. Residents treated for urinary tract	8/14/15

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F 278	Continued From page 7 Resident #1 had been admitted to the facility on 9/30/2011. Diagnoses included quadriparesis C5-C7 complete, neurogenic bladder, hypertension, generalized pain, muscle wasting and disuse atrophy, dysuria, esophageal reflux, anxiety, paraplegia, depressive disorder, diabetes, constipation, vaginitis and urinary tract infection. The Nurse Practitioner (NP) progress note dated 5/11/2015 indicated Resident #1 had reported " over the last 3 days has not been feeling well and feels ill like she is getting another urinary tract infection (UTI). She does report that she had a low grade temperature over the weekend and is feeling chills and some GI (gastrointestinal) upset. " A urinalysis and a culture and sensitivity test were ordered to rule out UTI. The nurse progress note dated 5/11/2015 indicated the NP had evaluated Resident #1 and orders had been received to perform a urinalysis and a culture and sensitivity test. The Physician progress note dated 5/14/2015 noted the resident had complained of symptoms and the urinalysis preformed earlier in the week had abnormal results indicating the resident had a UTI. The physician then wrote an order for the resident to receive Keflex 500 milligrams (mg) one capsule three times a day for 7 days (an antibiotic to treat UTI) for UTI. The nurse progress note dated 5/14/2015 indicated the physician had evaluated Resident #1, had reviewed the laboratory work and had written an order for an antibiotic to be received for the diagnosis of UTI.	F 278	infection within the past 90 days were reviewed by the Manager of Clinical Operations on 8/6/15 to ensure accurate coding of urinary tract infection. One resident identified with inaccurate coding of urinary tract infection. Significant correction completed for identified resident on 8/10/15 by the MDS nurse. Licensed nurses completing MDS assessments were educated on 8/4/15 by the Manager of Clinical Reimbursement regarding accurate coding of urinary tract infections within the assessment look back period. 3. Newly admitted residents and/or current residents with diagnosis of urinary tract infection will be reviewed by the DNS or ADNS to validate criteria is met for MDS coding within the look back period. Results of these reviews will be kept in a notebook in the DNS office. 4. DNS will report number of UTIs coded on the MDS monthly x 3 months to the Performance Improvement Committee.	

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F 278	Continued From page 8 The nursing assessment dated 5/19/2015 indicated Resident #1 had received an antibiotic and had a diagnosis of UTI within the past 30 days. The most recent annual MDS assessment was dated 5/22/15 and indicated the resident was cognately intact. Her diagnoses on the MDS included gastro-esophageal reflux, neurogenic bladder, diabetes, paraplegia, anxiety, depression, generalized pain, hypopotassemia and constipation. The assessment also indicated the resident had received 6 days of antibiotic medication during the look back period. An interview with MDS nurse #1 on 7/16/2015 at 1:45 PM was conducted. The nurse indicated she had not seen the symptoms documented and therefore did not count UTI as a diagnosis on the MDS. An interview with the DON on 7/16/2015 at 5:17 PM was conducted. The DON stated it was her expectation the MDS assessments should be coded correctly.	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff	F 282	1. Care plan for resident #2 reviewed	8/14/15

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F 282	Continued From page 9 interviews, the facility failed to follow the established care plan for 1 of 10 sampled residents whose care plan was reviewed (Resident #2). Findings include: Resident #2 had been admitted to the facility on 5/27/2011. His diagnoses included dementia, dysphagia, hypertension, urethral stricture, aortic valve disease and malnutrition. An annual Minimum Data Set (MDS) assessment dated 12/16/2014 had been completed and included a Care Area Assessment (CAA) for physical restraint use. The CAA analysis of findings indicated: 1. the resident had cognitive impairment/behavioral symptoms that may lead to restraint use which included wandering and Alzheimer ' s disease. 2. The resident ' s risk for falls that may lead to restraint use included incontinence of bowel and/or bladder, balance problem and need for assistance with mobility. 3. Adverse reactions the resident had to restraint use were noted to be frequent attempts to get out of the restraint, falls and incontinence or increased incontinence. 4. The care plan considerations overall objective was to minimize risks. It noted the resident had diagnoses of Alzheimer ' s dementia, hypertension, benign prostatic hypertrophy and hypothyroidism. The considerations also noted the resident required a physical restraint (lap buddy) while up in wheelchair due to inability to maintain an upright position related to Alzheimer ' s disease. The Kardex (a care guide for the nurse assistants) had been last updated on 3/18/2015 and indicated the resident was to use the lap buddy when out of bed and in a chair.	F 282	and updated on 8/6/15 by the DNS to reflect current status and interventions for restraint use. 2. No other current residents identified with restraint use. Staff educated 8/10/15-8/13/15 by the Nurse Practice Educator on implementation of care plan interventions, use of CNA Kardex, and restraint management. Specific education provided on current resident's restraint and care plan interventions (type of restraint in use, when restraint is to be released, current intervention of ambulating to dining room with staff assistance, and monitoring for adverse effects of restraint use). Nursing staff were educated on 8/10/15-8/13/15 by the Nurse Practice Educator on when restraints may be used for emergency situations, completion of restraint evaluation assessment when restraints are implemented, and implementation of care plan with new restraint use to ensure the restraint is released when appropriate. Activity staff were educated by the Nurse Practice Educator on 8/10/15-8/13/15 on releasing restraints for residents during supervised activities. 3. Newly admitted residents and/or current residents with restraint use will be monitored 3 x week x 1 week, 2 x week x 1 week, weekly x 2 weeks, then monthly x 2 months by the DNS and/or ADNS to ensure care plan interventions are implemented as written. Results of these audits will be kept in a notebook in the DNS office. 4. Monitoring results will be reported to the Performance Improvement Committee	

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F 282	Continued From page 10 The most recent Restraint Evaluation/Reduction dated 6/04/2015 indicated the specific type of restraint used was a lap buddy pillow. The restraint order instructions indicated daily use with the wheelchair, release for meals, personal care and supervised activities. The most recent Nursing Assessment-Expanded was dated 6/15/2015. The assessment indicated Resident #2 was " completely immobile- does not make even slight changes in body position by self " and physical assistance is required. The assessment indicated the resident walks occasionally very short distances and spends the majority of the shift in bed/chair. The assessment also indicated the resident had functional limitations in all four extremities and noted a trunk restraint had been used daily. The most recent quarterly MDS assessment was dated 6/18/2015 and indicated Resident #2 had a memory problem, was cognately impaired and had psychomotor retardation noted to be continuously present and did not fluctuate. The assessment indicated the resident needed extensive assistance of one or more staff to assist with activities of daily living (ADL). The assessment indicated the resident was ambulatory with extensive assistance of two or more staff, was not steady when moving from a seated to a standing position or with surface to surface transfers and was only able to stabilize with human assistance. The assessment also indicated he had no functional limitation in his range of motion in his arms or legs. The assessment noted the resident used a wheelchair for mobility and a trunk restraint had been used daily while in a chair and out of bed. No falls had been reported during the look back period.	F 282	by the DNS monthly x 3 months.	

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The care plan had been reviewed by facility staff on 6/24/2015 and indicated the resident had the following problems: 1. the resident is at risk for complications of restraint use. Lap buddy to wheelchair due to inability to maintain an upright position due to Alzheimer ' s disease and tendency to lean forward and pick up imaginary items. Goal included: resident will not experience any adverse effect of restraint use times 90 days. Interventions included: Monitor for changes in mental status and changes in functional level and report to MD as indicated. Promote physical/motor activities to prevent decline. Utilize and release restraint per physician order. 2. The resident is at risk for falls, cognitive loss, and lack of safety awareness. History of falls and aggressive behaviors. Goal included: Resident should have no fall related injury times 90 days. Interventions included: Assist resident with ambulation providing two assistance, place call light within reach at all times, implement the following safety precautions: lap buddy in wheelchair.

The July 2015 medication administration record (MAR) indicated: 1. Lap buddy to wheelchair while up due to inability to maintain upright position related to Alzheimer ' s disease and tendency to lean forward and pick up imaginary items from floor. Device to be removed during meals, personal care and supervised activities. 2. Nursing to assist resident with ambulation to dining room with at least two meals a day and as tolerated for breakfast, lunch and dinner. These interventions are noted to have been signed by the nurse each shift.

Resident #2 observations included:

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7/15/2015 at 2 PM observed lying on his back in bed, eyes closed.
7/15/2015 at 5:15 PM observed lying on his back in bed, eyes closed.
7/15/2015 at 5:40 PM observed in wheelchair with lap buddy applied being transported by the nurse aide (NA) to the dining room.
7/15/2015 at 5:45 PM Resident #2 was asked by the surveyor if he could remove the lap buddy. Resident responded with grunts, holding onto the front center of the lap buddy shaking it, unable to remove the device.
7/15/2015 at 6:17 PM received his dinner tray, the lap buddy was on the wheelchair. Resident was observed holding onto the lap buddy, wiggling it.
7/15/2015 at 6:28 PM observed lap buddy on wheelchair, being fed dinner by NA.
7/16/15 at 8:15 AM observed Resident #2 in the dining room with the lap buddy applied to his wheelchair, being fed breakfast by NA.
7/16/2015 at 9:55 AM sitting in his room in his WC with lap buddy applied, TV on but resident in a position unable to view, lights out, and call bell laying on the bed, not in reach.

An interview with NA #1 on 7/16/15 at 10:30 AM was conducted. The NA stated Resident #2 was unable to remove the lap buddy restraint when applied, the lap buddy was only removed when the resident was walking or had returned to bed. The NA also stated the resident was able to walk short distances with assistance but the resident was only walked when his son visits and indicated the resident does not walk to the dining room for meals.

On 7/16/2015 at 12:04 PM Resident #2 had been observed sitting in his room in his WC with lap buddy applied, TV on but resident in a position

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR HEIGHTS CENTER	804 SOUTH POPULAR STREET ELIZABETHTOWN, NC 28337

(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 282	Continued From page 13	F 282		

unable to view, lights out, and call bell laying on the bed, not in reach. The surveyor asked the resident if he was able to remove the lap buddy. The resident made eye contact but did not move his hands or verbally respond.

On 7/16/2015 at 2:00 PM Resident #2 had been observed lying on his back in bed with eyes closed.

An interview with nurse #2 was conducted on 7/16/15 at 2:08 PM. The nurse stated the lap buddy intervention listed on the MAR was signed every shift to acknowledge that the lap buddy was on the resident while in the wheelchair and the other interventions listed on the MAR were there for as needed use. The nurse stated the resident had been able to remove the lap buddy and indicated the lap buddy was necessary for this resident for his safety because the resident had dementia and had no safety awareness. The nurse indicated the resident would walk short distances when his son visits.

An interview with NA #2 on 7/16/2015 at 4:25 PM was conducted. The NA stated Resident #2 only walks with his son when visiting and indicated staff do not walk Resident #2. The NA stated the resident was unable to remove the lap buddy and indicated the lap buddy was only removed when the resident was out of the wheelchair.

An interview with Nurse #3 on 7/16/2015 at 4:33 PM was conducted. The nurse stated the lap buddy should be released as the MAR indicated. The nurse also stated the resident was walked to and from the dining room for two meals a day when the resident allows.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 14 On 7/16/2015 at 5:00 PM Resident #2 had been observed lying on his back in bed with eyes closed. An interview with the DON on 7/16/2015 at 5:16 PM was conducted. The DON stated Resident #2 was unable to remove the lap buddy device and her expectation was the lap buddy should be removed for meals, during personal care and in activities. The DON indicated the resident used to be walked by staff but the resident does not have enough strength to walk or attempt to walk anymore. The DON also indicated the care plan should match the resident.	F 282		