DEPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0								
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			X3) DATE SURVEY COMPLETED		
		345267	B. WING		•	C 01/21/2015		
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
	HEIGHTS CENTER			8	304 SOUTH POPULAR STREET			
				E	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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	BE COMPLETION		
F 246 SS=D			F 2	246		2/2/15		
	preferences, excep	t when the health or safety of er residents would be						
	by: Based on observat and resident intervie ensure a resident ' 1 of 3 sampled resi findings included: Resident #1 was ac 7/29/13 and had dia Alzheimer 's Disea Accident (Stroke) w (Paralysis). The Falls Care Area 7/15/14 revealed th non-ambulatory. The resident 's Car instructed staff to k reach of the resider resident to call for a not easily accessibl The most recent Mi	a Assessment (CAA) dated e resident was re Plan for falls dated 12/29/14 eep the call light within easy nt and to encourage the assistance when items were			 Call light cord for resident #1 was replaced with a longer cord on 1/21/2015 Residents residing in the facility have the potential to be affected. An audit of current residents' call lights was completed on 1/29/2015 to validate appropriate cord length and accessibility of call lights. Staff were in-serviced by the Director of Nursing on 1/28/15, 1/29/15, and 1/30/2015 on ensuring call lights are within residents' reach at all times. Call light audits will be conducted by department head staff daily x 1 week, 3 x week x 1 week, weekly x 2 weeks, then monthly x 2 months to validate call lights are accessible to the residents. Audits w be performed at staggered times to accommodate all shifts. Results of the call light audits will be reported to the facility's Performance Improvement Committee monthly x 3 	e		
	the resident had se required extensive	vere cognitive impairment, assistance with transfers and			months for review and further recommendation.			
ABORATORY	URECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	TITLE	(X6) DATE				

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

01/29/2015

PRINTED: 01/29/2015

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.

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X) PROVIDERSUPPLERERULA IDENTIFICATION NUMBER (X) MULTIPLE CONSTRUCTION A BUILDING (X) DATE SUPPLY COMPLETE NAME OF PROVIDER OR SUPPLER 345267 III WING (X) DATE SUPPLY III WING WING WING WING WING WING WING WING WING WING WING WING WING WING			AND HUMAN SERVICES				FORM	01/29/2015 APPROVED 0938-0391	
345267 B: WING 01/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, UP CODE and SOUTH POPULAR STREET ELZABETHTOWN, NC 20337 01/21/2015 VAID OF PROVIDER OF DEFICIENCY MISTER FRECEDED BY FULL RECULATORY OR LSC DENTFYING INFORMATION) IP PREX (EACH OPERCIFICATION NOT DEFICIENCIES) 01/21/2015 F2460 Continued From page 1 was not ambulatory. The MDS revealed the resident id not move between locations in her room. F 246 F 246 F 246 Continued From page 1 was not ambulatory. The MDS revealed the resident id not move between locations in her room. F 246 F 246 F 246 During the initial tour of the facility on 1/20/15 at 2.58PM, Resident #1 was observed ing in her room in a wheelchair. The resident was observed to be sitting near the opposite wall from the bed. The rail light was not within reach of the resident. F 246 F 246 On 1/21/15 at 9.32AM the right side of the was not visible. The resident was observed to be sitting in a wheelchair. The resident was observed to be sitting nor the ledge of the bed. The call light or the call light was on the wall to the right of the bed. The resident on the wall to the right of the bed. The resident is call light was observed to be sitting in a wheelchair. On 1/21/15 at 11:15AM the resident 's call light was observed to be sitting in a wheelchair. On 1/21/15 at 11:15AM the resident 's call light was observed to be sitting in a wheelchair. On 1/21/15 at 11:15AM the resident 's call light was observed to be sitting in a			(X2) MULTIPLE CONSTRUCTION			COMPLETED			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP CODE POPLAR HEIGHTS CENTER BUMMARY STATEMENT OF DEFICIENCIES Bed SOUTH POPULAR STREET IMAID SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PUPULAR STREET PREFIX REGULATORY OR LSC DENTIFYING INFORMATION) PREFX PROVIDERS PUPULAR STREET TAG SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PUPULAR STREET COMPLETO PREFX REGULATORY OR LSC DENTIFYING INFORMATION) PREFX PROVIDERS CITY, STATE ZIP CODE Was not ambulatory. The MDS revealed the resident did not move between locations in her room. F 246 F 246 During the initial tour of the facility on 1/20/15 at 2:58PM, Resident #1 was observed sitting in her room in a wheelchair. The resident was observed to the sitting near the opposite wall from the bed. The right side of the bed was against the wall and the call light was not within reach of the resident. F 246 On 1/2/1/5 at 9:32AM the right side of the let edge of the bed. The call light was not was beleved to be sitting in a wheelchair. The resident was observed to be sitting in a wheelchair. F 241 On 1/2/1/5 at 11:15AM the resident 's call light was not within the ded and the push button was observed to be sitting in a wheelchair. F 241 On 1/2/1/5 at 11:15AM the resident 's call light was not within the resident. On 1/2/1/15 at 11:15AM the resident 's call light was not within the resident 's wheelchair. <td></td> <td></td> <td>345267</td> <td>B. WING</td> <td></td> <td></td> <td colspan="2"></td>			345267	B. WING					
POPLAR HEIGHTS CENTER ELIZABETHTOWN, NC 28337 [04] JD TAG SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE PRECEDED BY FULL REQUEATORY OR LSC DENTIFYING INFORMATION) ID TAG PROVIDER'S IAN OF CORRECTIVE (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCET OT THE APPROPRIATE DEFICIENCY) COMMENTION DEFICIENCY) F 246 Continued From page 1 was not ambulatory. The MDS revealed the resident did not move between locations in her room. F 246 F 246 During the initial tour of the facility on 1/20/15 at 2:58PM, Resident #1 was observed sitting in her room in a wheelchair with both feet resting on the foot pedals of the wheelchair. The resident was observed to be sitting near the opposite wall from the bed. The right side of the resident. F 246 On 1/21/15 at 9:32AM the right side of the resident 's bed and the push button was not visible. The resident was observed to be sitting in a wheelchair near the opposite wall from the bed. The right of the bed. The resident from was not visible. The resident was observed to be sitting in a wheelchair near the opposite wall from the bed with both feet resting on the foot pedals of the wheelchair. The resident was observed to be sitting in a wheelchair near the opposite wall from the bed. The resident was observed to be sitting in a wheelchair. On 1/21/15 at 11:15AM the resident 's call light was observed to be sitting in a wheelchair. On 1/21/15 at 11:15AM the resident 's call light was observed to be sitting in a wheelchair. On 1/21/15 at 11:15AM the resident 's call light was observed to be sitting in a wheelchair. Deficiency is reach. NA #1 entered the room during the observation and attempted to pull the call light to the resident 's wheelchair but the cord w	NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
Pričejki TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉPIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE COMPÉTIO DEFICENCY) F 246 Continued From page 1 was not ambulatory. The MDS revealed the resident did not move between locations in her room. F 246 F 246 During the initial tour of the facility on 1/20/15 at 2:58PM, Resident #1 was observed sitting in her room in a wheelchair. The resident was observed to be sitting near the opposite wall from the bed. The right side of the bed was against the wall and the call light was not within reach of the resident. F 246 On 1/21/15 at 9:32AM the right side of the resident. The resident the wall and the wall pug for the call light was on the wall to the right of the bed. The call light was on the wall to the right of the bed. The call light or was between the wall and the bed and the push button was not visible. The resident was observed to be sitting in a wheelchair. The resident 's call light was observed to be sitting in a wheelchair near the opposite wall from the bed. The call light tore reading the othe set. The resident was asked where her call light was and the resident was observed to be sitting in a wheelchair. On 1/21/15 at 11:15AM the resident 's call light was observed to be sitting in a wheelchair near the opposite wall from the bed. The resident was asked where her call light was and the resident was observed to be sitting in a wheelchair near the opposite wall from the bed. The resident was asked where her call light was and the resident was observed to be sitting in a wheelchair near the opposite wall from the bed. The resident was appled tight to meresident 's wheelchair buthe cord was pulle	POPLAR	HEIGHTS CENTER							
 was not ambulatory. The MDS revealed the resident did not move between locations in her room. During the initial tour of the facility on 1/20/15 at 2:58PM, Resident #1 was observed sitting in her room in a wheelchair with both feet resting on the foot pedals of the wheelchair. The resident was observed to be sitting near the opposite wall from the bed. The right side of the bed was against the wall and the call light was not within reach of the resident. On 1/21/15 at 9:32AM the right side of the resident was observed to be sitting in a wheelchair near the opposite wall from the bed. The resident was observed to be sitting on the left of the gainst the wall and the call light was not within reach of the resident. On 1/21/15 at 9:32AM the right side of the resident was observed to be bed. The call light was on the wall to the right of the bed. The call light was on the wall to the right of the bed. The resident was observed to be sitting in a wheelchair. The resident was observed to be sitting in a wheelchair. On 1/21/15 at 11:15AM the resident 's call light was observed to be lying on the bed. The resident was observed to be lying on the bed. The resident was abserved to be lying on the bed. The resident was observed to be lying on the bed. The resident was abserved to be lying on the bed. The resident was abserved to be lying on the bed. The resident was abserved to be lying on the bed. The resident was abserved to be lying on the bed. The resident was abserved to be lying in a wheelchair. On 1/21/15 at 11:15AM the resident 's call light was not within the resident 's reach. NA# 1 entered the room during the observation and attempted to pull the call light to the resident 's wheelchair her room during the observation and attempted to pull the call light to the resident 's wheelchair be cord was pulled tight in mid-air and barely reached the 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF) BE	COMPLETION	
On 1/21/15 at 11:30AM the Unit Manager stated	F 246	was not ambulatory resident did not mo room. During the initial tou 2:58PM, Resident # room in a wheelchat foot pedals of the w observed to be sittlin the bed. The right s wall and the call light with the push buttor bed. The call light w resident. On 1/21/15 at 9:32/ resident ' s bed was and the wall plug fo to the right of the be between the wall ar was not visible. The sitting in a wheelchair. T the call light from he On 1/21/15 at 11:15 was observed to be the opposite wall fro asked where her ca pointed to the bed. the resident ' s read during the observat call light to the reside was pulled tight in r wheelchair.	A. The MDS revealed the ve between locations in her ar of the facility on 1/20/15 at #1 was observed sitting in her air with both feet resting on the vheelchair. The resident was ng near the opposite wall from side of the bed was against the ht was lying across the bed in lying on the left edge of the vas not within reach of the s observed against the wall or the call light was on the wall ed. The call light cord was nd the bed and the push button e resident was observed to be air near the opposite wall from eet resting on the foot pedals The resident could not reach er wheelchair. 55AM the resident ' s call light e lying on the bed. The resident e sitting in a wheelchair near om the bed. The resident the call light was not within ch. NA #1 entered the room tion and attempted to pull the dent ' s wheelchair but the cord mid-air and barely reached the	F 2	246				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345267	B. WING			C 01/21/2015		
NAME OF F	PROVIDER OR SUPPLIER		4		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
POPLAR	HEIGHTS CENTER				804 SOUTH POPULAR STREET ELIZABETHTOWN, NC 28337			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 246	in an interview that her call light and did The Unit Manager s able to self propel the able to move aroun On 1/21/15 at 2:15F observed to have an easily reached the roor Resident stated she whenever she want or if she needed as that she could push On 1/21/15 at 2:36F interview that Resid call light. The Director of Nur 1/21/15 at 4:35PM if preference to sit in	nge 2 Resident #1 was able to use d use the call light at times. stated the resident was not he wheelchair and was not ad the room independently. PM a Resident #1 was n extra long call bell cord that resident ' s wheelchair on the om. During the observation the e pushed the call light ted something to eat or drink sistance and demonstrated in the call light button. PM Nurse #1 stated in an dent #1 was able to use her rsing stated in an interview on it was the resident ' s her wheelchair across the and was where she usually	F 2	246				
		PM the DON stated in an esident should have access to						

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