	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345267	B. WING		07/16/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/10/2010
				804 SOUTH POPULAR STREET	
POPLAR I	IEIGHTS CENTER			ELIZABETHTOWN, NC 28337	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENT	S	F 000		
	survey was conduc Heights Center was applicable requirem	3.0 Focused Survey. The ted July 15-16, 2015. Poplar a not in compliance with tents of 42 C.F.R. Part 483, equirements for Long Term			
F 221 SS=D	483.13(a) RIGHT T PHYSICAL RESTR		F 221		8/14/15
	physical restraints i	e right to be free from any mposed for purposes of nience, and not required to medical symptoms.			
	by: Based on observat interviews, the facili justification for restra reviewed for restrai Findings included: Resident #2 had be 5/27/2011. His diag dysphagia, hyperter valve disease and r An annual Minimum	n Data Set (MDS) assessment		1. Restraint order for Resident #2 clarified by the DNS on 8/6/15 to includ muscle weakness and difficulty walking Resident #2 referred to Physical and Occupational therapies to determine le restrictive device or alternatives to promote independent mobility. Therap evaluations were completed on 8/4/15 8/13/15 with recommendations to continue with lap buddy as it was the le restrictive device for this resident and the	i. ast y and east o
	memory problem an The resident neede or more staff for act The assessment ind non-ambulatory, wa seated to a standing surface transfers an	ndicated Resident #2 had a nd was cognitively impaired. d extensive assistance of one ivities of daily living (ADL). dicated he was as unsteady moving from a g position or with surface to nd was only able to stabilize nce. The assessment		 continue to attempt ambulation with wa 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. 	

Electronically Signed

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.

08/07/2015

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345267 B. WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **804 SOUTH POPULAR STREET** POPLAR HEIGHTS CENTER ELIZABETHTOWN, NC 28337 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 221 Continued From page 1 F 221 indicated he had no functional limitation in range Education included situations where of motion in his arms or legs. The assessment restraints would be appropriate, need for noted the resident used a wheelchair for mobility physician's order noting the medical and a trunk restraint had been used daily while in symptom the restraint was used for, a chair and out of bed. No falls had been reported development of care plan for restraint use, during the look back period. Active diagnoses monitoring of residents with restraints to included Alzheimer 's disease, dementia, ensure care plan interventions are esophageal reflux, hypertension, benign prostatic implemented as written, and completion of hypertrophy, hypothyroidism and dysphagia. restraint evaluation assessment. 3. Newly admitted residents with The Care Area Assessment (CAA) dated restraints and current residents requiring 12/17/2014 for physical restraint use had been restraint implementation will be reviewed completed. The CAA noted the resident had by the DNS or ADNS to ensure diagnoses of Alzheimer 's dementia, appropriate documentation of medical hypertension, benign prostatic hypertrophy and symptoms for restraint use. hypothyroidism and the resident required a Documentation of these reviews will be physical restraint while up in wheelchair related to kept in a notebook in the DNS office. Alzheimer 's disease. 4. DNS will report to the Performance Improvement Committee monthly x 3 months any newly implemented restraints The Kardex (a care guide for the nurse assistants) had been last updated on 3/18/2015. and medical justification for use. 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 guarterly MDS assessment was dated 6/18/2015 and indicated Resident #2 diagnoses included Alzheimer 's disease, benign prostatic hypertrophy, Esophageal reflux and hypothyroidism.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 2 of 15

PRINTED: 09/02/2015

	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM): 09/02/2015 // APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	
		345267	B. WING			_	07/	16/2015
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
POPLAR	HEIGHTS CENTER				804 SOUTH POPULAR STR			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 221	The care plan had be on 6/24/2015 and indi following problem: the complications of restra wheelchair due to ina position due to Alzhei tendency to lean forw items. Goal included: any adverse effect of Interventions included of restrain use such a breakdown, decrease confusion and consult restraint assessment/ protocol. Monitor for c and changes in functi as indicated. Promote prevent decline. The July 2015 medica (MAR) indicated: Lap up due to inability to r related to Alzheimer ' lean forward and pick floor, every shift for m atrophy. On 7/15/2015 at 5:45 observed in the dining asked if he could rem resident grunted, held buddy and shook it, u An interview with nurs at 10:30 AM was cond resident was unable to On 7/16/2015 at 12:04	en reviewed by facility staff icated the resident had the e resident is at risk for aint use. Lap buddy to bility to maintain an upright imer 's disease and vard and pick up imaginary resident will not experience restraint use times 90 days. d: Assess for adverse effects as incontinence, skin e functional ability and t with physician. Complete freduction review per changes in mental status ional level and report to MD e physical/motor activities to ation administration record buddy to wheelchair while maintain upright position s disease and tendency to a up imaginary items from nuscular wasting and disuse	F	221				

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		D HUMAN SERVICES			,	FORM APPROVE	
						OMB NO. 0938-039	11
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345267	B. WING			07/16/2015	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
	IEIGHTS CENTER			804 SOUTH POPULAR STREET			
				ELIZABETHTOWN, NC 28337	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE		1
F 221 F 272 SS=D	could remove the lap eye contact but did no remove the lap buddy An interview with Nurs 7/16/15 at 2:08 PM. T buddy was necessary safety because the re- had no safety awaren resident had been abl but had not seen him recently. An interview with NA s was conducted. The N unable to remove the An interview with Nurs PM was conducted. T had a diagnosis of Alz stated the lap buddy of resident was in the wild did not fall forward. An interview with the PM was conducted. T #2 needed the lap bud was unable sit up in a stretch out and be full and tumble straight of assumed it was becau Alzheimer 's disease resident was unable to 483.20(b)(1) COMPR ASSESSMENTS	. When he was asked if he buddy, Resident #2 made of respond to the request to 2. se #2 was conducted on the nurse stated the lap of for this resident for his sident had dementia and ess. The nurse stated the le to remove the lap buddy remove the lap buddy #2 on 7/16/2015 at 4:25 PM VA stated Resident #2 was lap buddy. se #3 on 7/16/2015 at 4:33 the nurse stated the resident cheimer ' s. The nurse also would be used when the heelchair to make sure he DON on 7/16/2015 at 5:16 the DON indicated Resident ddy restraint because he or chair because he would y extended or bend over ut. The DON stated she use of a progression of his . The DON also stated the o remove the lap buddy. EHENSIVE	F 2			8/14/15	
	resident was unable t 483.20(b)(1) COMPR ASSESSMENTS	o remove the lap buddy.	F 2	72		8/14/15	

Facility ID: 943301

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PRINTED: 09/02/2015 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 09/02/2015 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345267	B. WING		07	/16/2015
NAME OF PI	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZI	IP CODE	
POPLAR I	HEIGHTS CENTER			04 SOUTH POPULAR STREET LIZABETHTOWN, NC 28337	,	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	TO THE APPROPRIATE	COMPLETION DATE
F 272	Continued From page	e 4	F 272			
	a comprehensive, ac					
		nent of each resident's				
	A facility must make a	comprohonsivo				
	-	dent's needs, using the				
		instrument (RAI) specified				
	by the State. The ass least the following:	sessment must include at				
		nographic information;				
	Customary routine;					
	Cognitive patterns; Communication;					
	Vision;					
	Mood and behavior p Psychosocial well-bei					
		and structural problems;				
	Continence;					
	Disease diagnosis an Dental and nutritional					
	Skin conditions;					
	Activity pursuit;					
	Medications; Special treatments ar	nd procedures;				
	Discharge potential;	-				
		mmary information regarding ment performed on the care				
		e completion of the Minimum				
	Data Set (MDS); and					
	Documentation of pai	rticipation in assessment.				
		is not met as evidenced				
	by:					

If continuation sheet Page 5 of 15

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345267 B. WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **804 SOUTH POPULAR STREET** POPLAR HEIGHTS CENTER ELIZABETHTOWN, NC 28337 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 272 | Continued From page 5 F 272 Based on record review and staff interviews, the 1. Care Area Assessment (CAA) was facility failed to accurately complete a Care Area completed for Resident #2 by MDS nurse Assessment (CAA) for 1 of 10 residents whose on 8/10/15 to include current restraint use, assessment was reviewed (Resident #2). medical condition that may lead to Findings include: restraint use, and diagnosis documented Resident #2 had been admitted to the facility on in CAA summarv. 5/27/2011. His diagnoses included dementia, 2. No other current residents identified dysphagia, hypertension, urethral stricture, aortic with restraint use. RN completing CAAs valve disease and malnutrition. was educated by the Clinical Reimbursement Manager regarding A Care Area Assessment (CAA) dated accuracy of CAA completion on 8/4/15. 12/17/2014 for physical restraint use had been 3. Newly admitted residents with completed. The triggering condition for this CAA restraints and current residents requiring was trunk restraint used in chair or out of bed, restraint implementation will have CAAs trunk restraint used daily. reviewed by the DNS or ADNS prior to submission to ensure appropriate The CAA summary indicated Resident #2 had documentation of current restraint use, diagnoses of Alzheimer 's dementia, medical condition that may lead to hypertension, benign prostatic hypertrophy and restraint use, and diagnosis for restraint hypothyroidism. The summary further indicated use. Documentation of these reviews will the resident required a physical restraint while up be kept in a notebook in the DNS office. in wheelchair related to Alzheimer 's disease. 4. DNS will report to the Performance Improvement Committee monthly x 3 The CAA analysis did not include an evaluation of months results of CAA reviews completed current restraint use, medical for restraint use. 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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 09/02/2015

		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVE NO. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
		345267	B. WING			07/16/2015
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				804 SOUTH POPULAR STREET		
PUPLAR	IEIGHTS CENTER			ELIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 278	Continued From page	- 6	F 27	28		
F 278	483.20(g) - (j) ASSES		F 27			8/14/15
SS=D		DINATION/CERTIFIED		0		0/14/13
	The assessment mus resident's status.	st accurately reflect the				
	A registered nurse m each assessment wit participation of health					
	A registered nurse m assessment is compl	ust sign and certify that the eted.				
		completes a portion of the n and certify the accuracy of sessment.				
	willfully and knowingl false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingl to certify a material a	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each				
	Clinical disagreemen material and false sta	t does not constitute a atement.				
	by: Based on record rev facility failed to accur	└ is not met as evidenced iew and staff interviews, the ately code a diagnosis of (UTI) on the Minimum Data		 Significant Correction Asses completed by MDS nurse on 8/1 resident #1 with urinary tract inference 	2/15 for	
	-) residents reviewed for UTI		coded. 2. Residents treated for urinary		

Facility ID: 943301

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PRINTED: 09/02/2015 FORM APPROVED

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345267	B. WING		07/	16/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				804 SOUTH POPULAR STREET			
POPLAR	HEIGHTS CENTER			ELIZABETHTOWN, NC 28337			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 278	Continued From page	e 7	F 27	3			
	 9/30/2011. Diagnose C5-C7 complete, neu- hypertension, general and disuse atrophy, of anxiety, paraplegia, of diabetes, constipation infection. The Nurse Practition 5/11/2015 indicated F over the last 3 days h feels ill like she is get infection (UTI). She of low grade temperatur feeling chills and son upset. " A urinalysis test were ordered to The nurse progress r indicated the NP had orders had been rece and a culture and set The Physician progres noted the resident had and the urinalysis pre- had abnormal results a UTI. The physician resident to receive Ke one capsule three tim antibiotic to treat UTI The nurse progress r indicated the physician 	Alized pain, muscle wasting dysuria, esophageal reflux, depressive disorder, n, vaginitis and urinary tract er (NP) progress note dated Resident #1 had reported " has not been feeling well and thing another urinary tract does report that she had a re over the weekend and is ne GI (gastrointestinal) and a culture and sensitivity rule out UTI. note dated 5/11/2015 evaluated Resident #1 and eived to perform a urinalysis nsitivity test. ess note dated 5/14/2015 ad complained of symptoms eformed earlier in the week a indicating the resident had then wrote an order for the eflex 500 milligrams (mg) nes a day for 7 days (an) for UTI.		infection within the past 90 days we reviewed by the Manager of Clinical Operations on 8/6/15 to ensure acc coding of urinary tract infection. Our resident identified with inaccurate of of urinary tract infection. Significan correction completed for identified resident on 8/10/15 by the MDS nu Licensed nurses completing MDS assessments were educated on 8/4 the Manager of Clinical Reimburser regarding accurate coding of urinar infections within the assessment lo back period. 3. Newly admitted residents and/or current residents with diagnosis of tract infection will be reviewed by th or ADNS to validate criteria is met f MDS coding within the look back per Results of these reviews will be kep notebook in the DNS office. 4. DNS will report number of UTIs on the MDS monthly x 3 months to Performance Improvement Commit	Il curate ne soding t rse. I/15 by ment y tract ok r urinary ne DNS for eriod. ot in a coded the		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/02/2015 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE	
		345267	B. WING			07/	16/2015
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
POPLAR H	HEIGHTS CENTER				04 SOUTH POPULAR STREET LIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	8	F	278			
		ent dated 5/19/2015 had received an antibiotic of UTI within the past 30					
	dated 5/22/15 and ind cognately intact. Her of included gastro-esoph bladder, diabetes, par depression, generaliz and constipation. The	ed pain, hypopotassemia assessment also indicated ived 6 days of antibiotic					
	1:45 PM was conduct had not seen the sym	S nurse #1 on 7/16/2015 at ted. The nurse indicated she ptoms documented and nt UTI as a diagnosis on the					
F 282 SS=D	PM was conducted. T expectation the MDS coded correctly. 483.20(k)(3)(ii) SERV		F	282			8/14/15
	must be provided by o	d or arranged by the facility qualified persons in n resident's written plan of					
	by:	is not met as evidenced ns, record review and staff			1. Care plan for resident #2 reviewed		

Facility ID: 943301

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	S FOR MEDICARE &				OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345267	B. WING		07/16/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE
POPLAR	HEIGHTS CENTER			804 SOUTH POPULAR STREET ELIZABETHTOWN, NC 28337	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 282	Continued From page	e 9	F 28	2	
	interviews, the facility established care plan residents whose care (Resident #2). Findings include: Resident #2 had bee 5/27/2011. His diagno dysphagia, hypertens valve disease and ma An annual Minimum I dated 12/16/2014 had included a Care Area physical restraint use findings indicated: 1. impairment/behaviora restraint use which in Alzheimer 's disease falls that may lead to incontinence of bowe problem and need for Adverse reactions the use were noted to be of the restraint, falls a increased incontinence considerations overal risks. It noted the res Alzheimer 's dement prostatic hypertrophy considerations also n physical restraint (lap wheelchair due to ina position related to Alz The Kardex (a care g assistants) had been	 a failed to follow the for 1 of 10 sampled a plan was reviewed an admitted to the facility on oses included dementia, sion, urethral stricture, aortic alnutrition. Data Set (MDS) assessment d been completed and Assessment (CAA) for a. The CAA analysis of the resident had cognitive al symptoms that may lead to reluded wandering and b. 2. The resident 's risk for restraint use included and/or bladder, balance r assistance with mobility. 3. b. resident had to restraint frequent attempts to get out and incontinence or ce. 4. The care plan Il objective was to minimize ident had diagnoses of ia, hypertension, benign and hypothyroidism. The toted the resident required a buddy) while up in ability to maintain an upright theimer 's disease. 		 and updated on 8/6/15 by the reflect current status and in restraint use. No other current resider with restraint use. Staff edu 8/10/15-8/13/15 by the Nurre Educator on implementation interventions, use of CNA kerestraint management. Speprovided on current resider and care plan interventions restraint in use, when restrate released, current intervention ambulating to dining room vassistance, and monitoring effects of restraint use). Nurse Practice Educator or restraints may be used for estraints may be used for estraints is released with new restraint the restraint is released with new restraint in released with new restraint in restraint is released with new restraint is released with Activity staff were educated on 8/10/15-10/17-	terventions for this identified ucated se Practice n of care plan Kardex, and ecific education nt's restraint (type of aint is to be on of with staff for adverse ursing staff 8/13/15 by the n when emergency straint en restraints ementation of t use to ensure en appropriate. 4 by the Nurse 15-8/13/15 on dents during as and/or aint use will be ek, 2 x week x then monthly x or ADNS to ons are esults of these

Facility ID: 943301

							D. 0938-039	
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			· · ·	E SURVEY PLETED	
		345267	B. WING			07	/16/2015	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE			
POPLAR	HEIGHTS CENTER		804 SOUTH POPULAR STREET ELIZABETHTOWN, NC 28337					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 282	Continued From page 10		F 2	282				
	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.				by the DNS monthly x 3 months.			
	dated 6/18/2015 and memory problem, wa had psychomotor reta continuously present assessment indicated extensive assistance assist with activities of assessment indicated ambulatory with exten more staff, was not st seated to a standing surface transfers and with human assistance	and did not fluctuate. The d the resident needed of one or more staff to of daily living (ADL). The d the resident was nsive assistance of two or teady when moving from a position or with surface to I was only able to stabilize ce. The assessment also functional limitation in his s arms or legs. The						

Facility ID: 943301

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	MENT OF HEALTH AN						FORM): 09/02/2015 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345267	B. WING				07/	16/2015
NAME OF P	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE			
POPLAR	HEIGHTS CENTER				804 SOUTH POPULAR STREET ELIZABETHTOWN, NC 28337			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 282	Continued From page	11	F	282	2			
	on 6/24/2015 and ind following problems: 1 complications of restr wheelchair due to ina position due to Alzhei tendency to lean forw items. Goal included: any adverse effect of Interventions included mental status and cha report to MD as indica physical/motor activiti and release restraint resident is at risk for f of safety awareness. aggressive behaviors should have no fall re Interventions included ambulation providing light within reach at a following safety preca wheelchair. The July 2015 medica (MAR) indicated: 1. L while up due to inabili position related to Alz tendency to lean forw items from floor. Devi meals, personal care Nursing to assist resid dining room with at le tolerated for breakfas	ard and pick up imaginary resident will not experience restraint use times 90 days. 4: Monitor for changes in anges in functional level and ated. Promote es to prevent decline. Utilize per physician order. 2. The alls, cognitive loss, and lack History of falls and . Goal included: Resident lated injury times 90 days. 4: Assist resident with two assistance, place call I times, implement the outions: lap buddy in ation administration record ap buddy to wheelchair ty to maintain upright heimer 's disease and ard and pick up imaginary ce to be removed during and supervised activities. 2. dent with ambulation to ast two meals a day and as t, lunch and dinner. These id to have been signed by						

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		D HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 09/02/2015 MAPPROVED O. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345267	B. WING			0.	7/16/2015
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
POPLAR H	IEIGHTS CENTER						
					ELIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	bed, eyes closed. 7/15/2015 at 5:15 PM in bed, eyes closed. 7/15/2015 at 5:40 PM lap buddy applied bei aide (NA) to the dining 7/15/2015 at 5:45 PM the surveyor if he cou Resident responded v front center of the lap remove the device. 7/15/2015 at 6:17 PM lap buddy was on the observed holding onto 7/15/2015 at 6:28 PM wheelchair, being fed 7/16/15 at 8:15 AM of dining room with the law wheelchair, being fed 7/16/2015 at 9:55 AM WC with lap buddy ap a position unable to v laying on the bed, not An interview with NA as was conducted. The N unable to remove the applied, the lap buddy the resident was walk The NA also stated th short distances with a was only walked wheat the resident does not meals.	served lying on his back in observed lying on his back observed in wheelchair with ng transported by the nurse g room. Resident #2 was asked by ld remove the lap buddy. with grunts, holding onto the buddy shaking it, unable to received his dinner tray, the wheelchair. Resident was o the lap buddy, wiggling it. observed lap buddy on dinner by NA. Deserved Resident #2 in the ap buddy applied to his breakfast by NA. sitting in his room in his oplied, TV on but resident in iew, lights out, and call bell in reach. #1 on 7/16/15 at 10:30 AM NA stated Resident #2 was lap buddy restraint when y was only removed when ing or had returned to bed. e resident was able to walk ssistance but the resident in his son visits and indicated walk to the dining room for	F	282	2		
	the resident does not meals. On 7/16/2015 at 12:0 observed sitting in his	walk to the dining room for					

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM): 09/02/2015 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345267	B. WING		_	07/	16/2015
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
POPLAR I	HEIGHTS CENTER			04 SOUTH POPULAR ST LIZABETHTOWN, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	unable to view, lights the bed, not in reach. resident if he was able The resident made ey his hands or verbally in On 7/16/2015 at 2:00 observed lying on his closed. An interview with nurs 7/16/15 at 2:08 PM. T buddy intervention list every shift to acknowl on the resident while if other interventions list for as needed use. Th had been able to reme indicated the lap budd resident for his safety dementia and had no nurse indicated the re distances when his so An interview with NA a was conducted. The N walks with his son wh staff do not walk Resider resident was unable to indicated the lap budd the resident was out of An interview with Nurs PM was conducted. The buddy should be releat The nurse also stated	out, and call bell laying on The surveyor asked the e to remove the lap buddy. ve contact but did not move respond. PM Resident #2 had been back in bed with eyes as #2 was conducted on the nurse stated the lap ted on the MAR was signed ledge that the lap buddy was in the wheelchair and the ted on the MAR were there he nurse stated the resident ove the lap buddy and dy was necessary for this because the resident had safety awareness. The esident would walk short on visits. #2 on 7/16/2015 at 4:25 PM NA stated Resident #2 only en visiting and indicated dent #2. The NA stated the o remove the lap buddy and dy was only removed when of the wheelchair. se #3 on 7/16/2015 at 4:33 the nurse stated the lap ased as the MAR indicated. It he resident was walked to pom for two meals a day	F 282				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 09/02/2015 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
345267		345267	B. WING		07/16/2015		
NAME OF PROVIDER OR SUPPLIER				TREET 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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 282	On 7/16/2015 at 5:00 observed lying on his closed. An interview with the PM was conducted. T was unable to remove her expectation was t removed for meals, d activities. The DON in be walked by staff bu enough strength to w	PM Resident #2 had been back in bed with eyes DON on 7/16/2015 at 5:16 The DON stated Resident #2 the lap buddy device and he lap buddy should be uring personal care and in indicated the resident used to t the resident does not have alk or attempt to walk lso indicated the care plan	F 282				

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