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 _____	C 01/21/2015

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 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to ensure a resident ' s call light was within reach for 1 of 3 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 7/29/13 and had diagnoses that included Alzheimer ' s Disease and Cerebrovascular Accident (Stroke) with Left Hemiplegia (Paralysis). The Falls Care Area Assessment (CAA) dated 7/15/14 revealed the resident was non-ambulatory. The resident ' s Care Plan for falls dated 12/29/14 instructed staff to keep the call light within easy reach of the resident and to encourage the resident to call for assistance when items were not easily accessible to her. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 1/1/15 revealed the resident had severe cognitive impairment, required extensive assistance with transfers and	F 246	1. Call light cord for resident #1 was replaced with a longer cord on 1/21/2015. 2. 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. 3. 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 will be performed at staggered times to accommodate all shifts. 4. Results of the call light audits will be reported to the facility's Performance Improvement Committee monthly x 3 months for review and further recommendation.	2/2/15

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

Electronically Signed | 01/29/2015

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F 246	Continued From page 1 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 lying across the bed with the push button lying on the left edge of the bed. The call light was not within reach of the resident. On 1/21/15 at 9:32AM the right side of the resident ' s bed was observed against the wall and the wall plug for the call light was on the wall to the right of the bed. The call light cord was between the wall and the 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 with both feet resting on the foot pedals of the wheelchair. The resident could not reach the call light from her 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 sitting in a wheelchair near the opposite wall from the bed. The resident was asked where her call light was and the resident pointed to the bed. The 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 but the cord was pulled tight in mid-air and barely reached the wheelchair. On 1/21/15 at 11:30AM the Unit Manager stated	F 246		

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F 246	Continued From page 2 in an interview that Resident #1 was able to use her call light and did use the call light at times. The Unit Manager stated the resident was not able to self propel the wheelchair and was not able to move around the room independently. On 1/21/15 at 2:15PM a Resident #1 was observed to have an extra long call bell cord that easily reached the resident ' s wheelchair on the other side of the room. During the observation the Resident stated she pushed the call light whenever she wanted something to eat or drink or if she needed assistance and demonstrated that she could push the call light button. On 1/21/15 at 2:36PM Nurse #1 stated in an interview that Resident #1 was able to use her call light. The Director of Nursing stated in an interview on 1/21/15 at 4:35PM it was the resident ' s preference to sit in her wheelchair across the room from her bed and was where she usually sat. On 1/21/15 at 6:15PM the DON stated in an interview that the resident should have access to her call light.	F 246		