(NG 1 6 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2013 FORM APPROVED OMB NO. 0938-0391

Final Type of the present the production of the properties of the	AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI)	ULTIPLE CONSTRUCTION LDING			SURVEY LETED
UNIVERSAL HEALTH CARE LILLINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR USO IDENTIFYING INFORMATION) F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocalal well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff, fire marshel and emergency medical services (EMS) supervisor interviews, facility policies and record reviews, the facility failed to prevent one of four residents from having respiratory distress by allowing the facility temperature to increase as the result of a system malfunction causing the air condition unit to shut off. Findings include: Resident #3 was admitted to this facility on 10-8-10 with the following diagnoses: Chronic Airway Obstruction Bioseae (COPD), Congestive Heart Failure (CHF), and Hypertonsion (HTN). Chronic Hypoxomia, Emphysema, and Chronic Oxygen use. A review of the named resident *3 5 day assessment MDS dated 7-22-13 indicated the resident that a BiMS (brief interview for mental status) score of 12, Indicating he was able to answer questions and voice concerns about his			345213 B. WIN				- 1	I
UNIVERSAL HEALTH CARE LILLINGTON, NO. 27648 COUNTY CAPACH CORRECTION MUST BE PRECISED BY FULL REGULATORY OF LSC IDENTIFYING INFORMATION) PREFIX TAG	NAME OF PR	ROVIDER OR SUPPLIER		•				
Final Type of the present the production of the properties of the	UNIVERSA	AL HEALTH CARE LILLI	NGTON			LLINGTON, NC 27546		
Each resident must receive and the facility must provide the necessary care and services to attain or meintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff, fire marshal and emergency medical services (EMS) supervisor interviews, facility policies and record reviews, the facility temperature to increase as the result of a system malfunction causing the air condition unit to shut off. Findings include: Resident #3 was admitted to the facility on 10-6-10 with the following diagnoses: Chronic Airway Obstruction Disease (COPD), Congestive Heart-Fallure (CHF), and Hypertension (HTN), Chronic Hypoxemia, Emphysema, and Chronic Oxygen use. A review of the named resident * s 5 day assessment MDS dated 7-22-13 indicated the resident thad a BIMS (brief interview for mental status) score of 12, indicating he was abbe to answer questions and volce concerns about his	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	х .	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff, fire marshal and emergency medical services (EMS) supervisor interviews, facility policies and record reviews, the facility failed to prevent one of four residents from having respiratory distress by allowing the facility temperature to increase as the result of a system mailfunction causing the air condition unit to shut off. Findings include: Resident #3 was admitted to the facility on 10-8-10 with the following diagnoses: Chronic Airway Obstruction Disease (COPD), Congestive Heart Failure (CHF), and Hypertension (HTN). Chronic Hypoxemia, Emphysema, and Chronic Oxygen use. A review of the named resident 's 5 day assessment MDS dated 7-22-13 indicated the resident had a BiMS (brief interview for mental status) score of 12, indicating he was able to answer questions and volce concerns about his		483.25 PROVIDE CA HIGHEST WELL BEI	RE/SERVICES FOR	F	309			
This REQUIREMENT is not met as evidenced by: Based on observations, staff, fire marshal and emergency medical services (EMS) supervisor interviews, facility policies and record reviews, the facility falled to prevent one of four residents from having respiratory distress by allowing the facility temperature to increase as the result of a system malfunction causing the air condition unit to shut off. Findings include: Resident #3 was admitted to the facility on 10-6-10 with the following diagnoses: Chronic Airway Obstruction Disease (COPD), Congestive Heart Fallure (CHF), and Hypertension (HTN). Chronic Hypoxemia, Emphysema, and Chronic Oxygen use. A review of the named resident * 5 5 day assessment MDS dated 7-22-13 indicated the resident had a BiMS (brief interview for mental status) score of 12, indicating he was able to answer questions and voice concerns about his		provide the necessar or maintain the highe mental, and psychos accordance with the	y care and services to attain et practicable physical, ocial well-being, in			constitute an admission that to deficiency exists and/or was correctly cited or required		
health issues. He required assistance for transfers and activities of dally living (ADLs). Maintenance Director must be notified of A/C system shutdown.		This REQUIREMENT is not met as evidenced by: Based on observations, staff, fire marshal and emergency medical services (EMS) supervisor interviews, facility policies and record reviews, the facility falled to prevent one of four residents from having respiratory distress by allowing the facility temperature to increase as the result of a system malfunction causing the air condition unit to shut off. Findings include: Resident #3 was admitted to the facility on 10-6-10 with the following diagnoses: Chronic Airway Obstruction Disease (COPD), Congestive Heart Fallure (CHF), and Hypertension (HTN), Chronic Hypoxemia, Emphysema, and Chronic Oxygen use. A review of the named resident 's 5 day assessment MDS dated 7-22-13 indicated the resident had a BIMS (brief interview for mental status) score of 12, indicating he was able to answer questions and voice concerns about his health issues. He required assistance for			-	has been accomplished by maintaining a comfortable temperature within facility v steps further described below 2. All residents in the facility respiratory conditions have t potential to be affected. No a residents have been identified experienced respiratory distributed below have been implemented to prevent reod 3. All Department Heads/Chan Nurses will be in-serviced by Maintenance Director on profunctioning of fire panel to it bypassing defective smoke by prevent complete a/c system down. Administrator and Maintenance Director must	ia	0

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguerids 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345213	B. WING			07/25/2013	
	ROVIDER OR SUPPLIER AL HEALTH CARE LIL			18	REET ADDRESS, CITY, STATE, ZIP CODE 96 EAST CORNELIUS HARNETT BOULEVARD LLINGTON, NC 27646		
(X4) ID PREFIX TAG	#ACH DEFIC!E	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X6) COMPLETION DATE
F 309	notes dated 7-14-1	age 1 as conducted of the nurse 1's 13 from nurse #2 who identified aving respiratory difficulty. She	F	F 309 Training will be included orientation for department charge nurses.			8/20/13
	reported in her not sweating profusely he was too hot. Sh	es that the resident was and that the resident reported no noted there were visible			All smoke heads will be clean inspected by BFPE Internation		8/19/13
	signs of respiratory distress which included: nasal flaring, chest retractions, shortness of breath, labored breathing and use of accessory muscles. The resident's vital signs were: Blood Pressure 140/98, and Heart Rate 87. His oxygen saturation (O2 Sat) rate was 84% on 3 liters of oxygen with a nasal cannula. The nurse requested a NA to stay with the resident while she went to get a non-rebreather mask. While she was gone from the room, the resident's O2 Sats dropped to 70%. The non-rebreather mask was placed on the resident and the O2 Sats returned to 92%. The resident continued to complain of being hot. Nurse #2 contacted the physician and was given orders to transport the resident to the hospital for evaluation. A record review was conducted of the EMS report dated 7-14-13. The scene information described the resident as: "Pt has been in the heat x 10 hr and became short of breath. Possibly 110 degrees in the resident's room, Air conditioning went out all over the home. Pt was placed on a non-rebreather and still couldn't keep O2 sats above 92%. After getting the Pt out of the heat, O2 sats came up to 97%."				Nursing staff/Department Heaserviced by Director of Nursin Designee on implementing me to include recognizing early sisymptoms of respiratory distribution during increased temperatures include location of floor fans, hydration, use of cool compre and notification of administral maintenance director	ng or easures igns and ess s to esses,	qledi3
					Maintenance staff was in-served administrator on the on- call produced the produced produced in the produc	thin 1 emented taff after g will be	
T T C T	summary dated 7 The resident was the nursing home shortness of brea	f the hospital discharge -17-13 revealed the following: " admitted to the hospital from because he was having th. It was very hot and I think it ed by the fact that it was very hot			4. Maintenance Director or designee will select random r for temperature checks daily weeks then weekly for 8 weeks	for 4	

		(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIF		IDENTIFICATION NUMBER;	A. BUILD	NG		i	'""	
						C		
		345213	B. WING			07/25	/2013	
NAME OF PR	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
		MATON			95 EAST CORNELIUS HARNETT BOULEVARD		1	
UNIVERSA	L HEALTH CARE LILI	INGTON		LII	LLINGTON, NC 27646			
WAID	SUMMARY S	STATEMENT OF DEFICIENCIES	dI.		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	3E	(X5) COMPLETION	
(X4) ID PREFIX	JEACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREP		CROSS-REFERENCED TO THE APPROPRI	ATE	DATE	
TAG	KEGOLATOR: O	3 400 1243 111			DEFICIENCY)			
					,			
F 309	Continued From pa	ge 2	F	309	Results will be reviewed mon	hly		
	and he has possibly	bronchospasm, shortness of			in QA meeting times 3 month	S		
	breath. He got to th	e hospital, we gave him		l	with further plans being devel	oped	ľ	
	Solu-Medrol and ga	aye him IV antiblotics. " The	-	1	based on results.		1	
	resident had a three	e day hospital stay and was		1				
	discharged back to	the facility on 7-17-13.						
		and unford with the					1	
	An interview was c	23-13 at 9:50 am. She					ļ	
	Administrator on re	id not contact her until 6:20 pm					Ì	
	on the evening of 7-14-13							
	to inform her there	was no air conditioning in the				1	Ì	
	facility and that it was hot. She stated she left her			:			1	
	home for the facility	v at that time, arriving at	1			1		
	approximately 7:30	pm. She Indicated she had						
	spoken with the Ma	aIntenance Director when she						
ĺ	was on her way to	the facility. The Administrator rai families had brought fans						
<u> </u>	reported that seve	on residents. She also						
]	Indicated there we	re large floor drying fans	ļ			ĺ		
	located in the mair	atenance section of the	1			1		
	Aggisted Living Sig	te of the facility that could have	ļ					
	heen utilized to co	ol off the halls. She stated she	-			1		
	felt the nurses atte	empted to take care of the						
ļ	situation independ	ently while awalting the			·			
	Maintenance Dire	ctor to arrive and were not						
ļ	aware of the available	ability of those fans; therefore, er utilized. The Administrator				į		
	tue lans were liev	pectations of the Maintenance						
·	eigff nerson on ca	Il would be for that person to						
	contact her for a c	lan of action if he/she was						
1	unavallable or he/	she should have a back up						
	person available.			m 400	1. Corrective action for resid	ent#3		
F 465	483 70/61			F 465	has been accomplished by			
SS=G	SAFE/FUNCTION	IAL/SANITARY/COMFORTABL			mas been accomprished by			
	E ENVIRON				maintaining a comfortable	i.		
	mm1 P	ravida a pota functional	-		temperature within facility v	151		
	The facility must f	provide a safe, functional, Ifortable environment for			steps further described below	٧.		
1	sanitary, and com	Intenta ditalini and in the					1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345213		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	1	LETED	
		B. WING_			25/2013	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BMINGDS	AL HEALTH CARE LILLI	IGTON		1995 EAST CORNELIUS HARNETT BOULEVARI)	
ONIVERSA	AL HEALITI OARG EIGEN	10,011		LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	BE	(X6) COMPLETION DATE
F 465	Continued From page		F 4	respiratory conditions have the	e potentia	1
•	This REQUIREMENT by: Based on observation emergency medical interviews, facility polifacility failed to preven having respiratory distemperature to increasof the air condition ur Findings include: Resident #3 was adm 10-6-10 with the folion Airway Obstruction Diest Failure (CHF), Chronic Hypoxemia, Oxygen use. During an interview was at 1:30pm, he indicated am, the fire department at the facility. Upon the was identified but a become 28-was determinated.	' is not met as evidenced ns, staff, fire marshal and vervices (EMS) supervisor licles and record reviews, the nt one of four residents from stress by allowing the facility use as a result of malfunction		to be affected. No additional relative been identified to have experienced respiratory distresincreased facility temperature described below have been implemented to prevent reoccional serviced by Maintenance Director on propresent complete also system serviced by BFPE Internations and the ads will be clean inspected by BFPE Internations smoke heads will be inspected by BFPE Internations and quarterly by maintenance director. Nursing staff/Department Heads/Designee on implementing in	esidents ss due to Steps arrence. rge er clude ad to hut down ed and hal, All l and ance	8/20/13
	Maintenance Directo weekend of 7-13-13 A review of the name MDS dated 7-22-13 BIMS (brief interview 12, indicating he was and voice concerns a	r, who was on-call for the		include recognizing early sign symptoms of respiratory distr increased temperatures to incl location of floor fans, hydrati- cool compresses and notificat administrator and maintenance	is and ess during ude on, use of ion of	8/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345213	B. WING		07/25/2013
	PROVIDER OR SUPPLIER AL HEALTH CARE LILL	INGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546	,
(X4) ID PREFIX TAG	/FACH DESIGIEN	OTATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 465	NC, revealed the day degrees and a humidity for that day on 7-23-13 at 8:00 conducted with the was on-call for the through 7-14-13. He notify the Administravellable in a timely smoke detector in 7-14-13. He reported heating and air connot be controlled in also indicated that facility became incoming an indicated that facility became incoming an indicated that facility became incoming the spread of fire. It with the Fire Chief to bypass the troub system is not off-line any problems. The he spoke with the I Nurse on 7-14-13 at the facility-within meantime, the fire off-line and a "Fire Fire Watch" consimember making a 15 minutes to deteany fire activity. He thermostat reading fire alarm was reserved.	review of friendly date of 7-14-13 for Lillington, ally temperature was a low of ligh of 86 degrees. The te ranged from 59% to 99%. am an interview was Maintenance Director who facility the weekend of 7-13-13 e indicated that he did not actor that he would not be manner to fix the identified Zone 28 of the facility on ad that the facility had a central ditioning system. The air could individual resident rooms. He casingly hot was because the facility mechanism to prevent the reported he had spoken who has since shown him how alle area so that the entire fire the until maintenance can repair Maintenance Director stated Fire Marshall and the Charge and told them he would arrive a couple of hours. In the alarm system was taken by Watch " was initiated. A " lests of a designated staff tour around the facility are were 76 degrees after the ever and the air handlers came coppm. He did indicate that he	F 46	Maintenance staff in-serviced administrator on the on-call phour response times, timely administrator notification (withour). On call schedule implet for designated maintenance st hours and weekends. Training included in hiring orientation maintenance staff. Administrator or designee will Fire Marshall and Life Safety the fire alarm panel is out of operation for more than 4 hou 24 hour period. Current disaster plan amendating include procedure for temperate below 71 degree or above 81 Training will be included in norientation. All Maintenance Personnel judgescriptions have been review signed, and placed in personnel. Maintenance Director or dewill select Random rooms for temperature checks daily for then weekly for 8 weeks Restandom room checks will be reviewed monthly in QA medical in QA medical control of the province of the previewed monthly in QA medical control of the previewed monthly in QA medi	chin 1 mented aff after a will be for Il notify when ars in a ed to atures degree. new hire bb ved, nel file esignees r 4 weeks ults of

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES AB NO. 0988/0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ C 07/26/2013 B. WNG 345213 STREET ADDRESS, CITY, STATE, ZIP GODE NAME OF PROVIDER OR SUPPLIER 1995 EAST CORNELIUS HARNETT BOULEVARD UNIVERSAL HEALTH CARE LILLINGTON LILLINGTON, NC 27546 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 465 with further plans being developed Continued From page 5 based on results. During an interview with the Deputy Fire Marshall on 7-24-13 at 10:15 am, he revealed he had not been notified the facility 's fire alarm system was Results of quarterly smoke detector off-line for an 8 hour period of time. He reported inspections and cleaning will be that when he spoke to the Maintenance Director on 7-14-13 at approximately 1:15pm he had been reviewed quarterly in QA meeting under the impression that he would be arriving times 6 months with further plans around 2:00 pm. being developed based on results. An interview was conducted with the Administrator on 7-23-13 at 9:50 am. She reported the staff did not contact her until 6:20 pm on the evening of 7-14-13 to inform her there was no air conditioning in the facility and that it was hot. She stated she left her home for the facility at that time, arriving at approximately 7:30pm. She indicated she had spoken with the Maintenance Director when she was on her way to the facility. The Administrator reported that several families had brought fans from home to use on residents. She also indicated there were large floor drying fans located in the maintenance section of the Assisted Living Side of the facility that could have been utilized to cool off the halls. She stated she felt the nurses attempted to take care of the situation independently while awaiting the Maintenance Director to arrive and were not aware of the availability of those fans; therefore, the fans were not utilized. The Administrator stated that her expectations of the Maintenance staff person on call would be for that person to contact her for a plan of action if he/she was unavailable or he/she should have a back up person available.

During an interview on 7-24-13 at 11:00 am the RN in charge (Nurse #1) on 7-14-13, stated that the facility did not start becoming hot until around 1:00 pm when the heat and humidity outside got

PRINTED: 08/07/2013

CENTER	S FOR MEDICARE &	WEDICAID SERVICES				V 110 11 X 11 X	TITLE VOL	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	II -	X2) MULTIPLE CONSTRUCTION A BUILDING			COMPLETED	
	345213		B. WING			C 07/25/2013		
NAME OF P	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP COD			
				1995 E	AST CORNELIUS HARNETT BOL	JLEVARD		
UNIVERSA	AL HEALTH CARE LILLI	NGTON		LILLIN	NGTON, NC 27546			
(X4) ID PREFIX TAQ	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				(X6) COMPLETION DATE	
F 465	Continued From pag	e 6	F	465				
, 400		she had spoken with the						
		r at the time the fire alarm						
		been told to take the fire						
		and to begin 15 minute "						
	Fire walks. " Fire wa	iks involve making walking						
	rounds of the facility	every 15 minutes to make						
	sure there is no fire of	or smoke present in the						
	facility. She stated si	ne was under the impression ay. The RN stated that when						
	the Maintenance Dire							
	3:00 pm. she attemp	ted to call him again and was		Į				
	told it would be anoth	ner couple of hours before he		į				
	could be at the facilit	y. At that time, 3:00 pm, the						
		rector of Nursing, who had a						
	personal emergency	and was unable to assist.						
		t she instructed the staff to						
		tra ice and water and ecks on the residents as the						
		continued to rise. Nurse #1						
	reported she contact	ed the Maintenance Director						
	again around 5:00 pr	n and he asked her to check						
	the thermostat on "	A " hall to see what the		}				
		ding. The temperature was						
		ted it wasn't the heat that		İ				
	heat and the high hu	m; it was the mixture of the						
	Liear and me man	maisy.						
	-During-an-interview-o	on-7-28-13-at-3:30-pm-with						
	Nurse #2 (An evenin	g nurse working 7:00pm until						
		reported the facility was						
:		she reported to work on						
		that several residents and		-				
		aining about the heat and rs went out and bought fans						
		oms. Nurse #2 stated, during						
		nts were identified as having						
		ut was unknown if related to		ļ				
	the heat in the facility	y. These residents were sent		Į				
		gency rooms for evaluation.						

PRINTED: 08/07/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. DDB8-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING C B. WING 345213 07/25/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1995 EAST CORNELIUS HARNETT BOULEVARD UNIVERSAL HEALTH CARE LILLINGTON LILLINGTON, NC 27546 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 7 F 465 F 465 She reported that one resident (Resident #3) was admitted to the hospital related to his respiratory issues which thought to be exacerbated by the heat in the facility. Nurse #2 reported that she had not made any attempts to contact any of the administrative staff because other nursing staff members were doing that while she was assisting with the sick residents. She reported the facility did start to cool off around 10:00 pm that evening. An interview was conducted on 7-24-13 at 4:20 pm with a second shift NA (NA #1) who worked on 7-14-13. She stated that the facility was not when she came to work and that families and residents were complaining of the heat. She reported that many of the residents requested that the windows be opened but the humidity was so high, it made the temperature more uncomfortable. She stated that she had been essigned Resident #3 who had been sent out to the hospital. Upon entering the resident 's room, the resident was sweating profusely, blood pressure was elevated at 140/98, oxygen saturation (O2 Sats) were in the low 80 *s and the resident was complaining of difficulty breathing. During-an-interview on-7-24-13-at 4:25-pm with NA#2 who worked on 7-14-13, the NA guoted "I don't usually sweat, but I was visibly sweating." The staff was passing extra ice water to the residents to help keep them cooler. The NA

around 9:30 pm.

stated that the rooms were so hot that it almost felt cool in the hallway when she came out of a room. She reported the facility began to cool off

During an Interview with an alert and oriented Resident #4 on 7-24-13 at 4:14 pm, he stated that

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			: SURVEY PLETED
					С	
		345213	B. WING		07/25/2013	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		,
111111111111111111111111111111111111111		UATAN		1995 EAST CORNELIUS HARNETT BOULEV	IRD	1
UNIVERSA	al Health Care Lilli	NGTON	l	LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X6) COMPLETION DATE
F 465	Continued From page	38	F 4	165		
r 465	he got really not but of getting hot until in the reported he stayed in closed and his room she started feeling the opened his room doo and rolled around in the staff passed loe water hydrated. He stated the around 11:00 pm. During an interview we services supervisor (if am, he revealed he hearded hear from the fact rooms on 7/14/13. He paramedics were combeen four residents to throughout the day will increased temperature he arrived at the facility to be his entry. He reported and his assistant as were present in the fact stated he was present minutes and the facility prior to his leaving. Observation of the small should be in working order and is in working order and is in working order.	afternoon. This resident his room with the door stayed cool until later. Once heat, he reported he r, got into his wheelchair he facility. He reported the r to keep every one he facility began to cool off with the emergency medical EMS) on 7-24-13 at 11:45 ad been contacted by the been transporting the cellity to the local emergency experted that his accrned because there had transported from the facility ith respiratory related transported to the lift around 8:30 pm and experted that his related to the lift around 8:30 pm and experted that his related to the lift and humid "upon if that the maintenance man well as the Administrator acility. The EMS Supervisor of the facility for 45 ty had started to cool off moke detector head in Zone alarm was observed to be portion of the building. The not replaced but cleaned	F			
	records identified that					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A BUILDING			E SURVEY IPLETED
	•	345213	B. WING		C 07/25/2013		
	ROVIDER OR SUPPLIER AL HEALTH CARE LILL	INGTON	J	1995	ET ADDRESS, CITY, STATE, ZIP CODE EAST CORNELIUS HARNETT BOULI INGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X6) COMPLETION DATE
F 465	off the fire alarm wer manual pull stations, and deemed to be in and security comparconducted on an and A review of the facilit have a policy and protemperatures that fall above 81 degrees. A review of an undat Maintenance Director needs of facility 24 h And "Responds to eneeds promptly." The not have a copy of a employee file until 7-A record review was notes from nurse #2 was having respirator her notes that the respiratory distress venest retractions, shoreathing and use of resident 's vital signs 140/98, and Heart R (O2 Sat) rate was 84 a nasal cannula. The stay with the residen non-rebreather mask the room, the residen 70%. The non-rebre the resident and the	detector in Zone 28 that set e inspected along with the and control panel on 5-3-13 working order a fire, safety by. This inspection is nual basis. y's disaster plan did not ocedure in place for il below 71 degrees or rise ed job description for the or stated " Able to respond to ours a day, 7 days a week. " emergency maintenance the Maintenance Director did signed job description in his 25-13. conducted of the nurse 's who identified Resident #3 rry difficulty. She reported in	F	485			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; 345213						E SURVEY PLETED
							C /25/2013
	ROVIDER OR SUPPLIER AL HEALTH CARE LILLI	NGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1995 EAST CORNELIUS HARNETT BOULEVAI LILLINGTON, NC 27546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE
F 465	orders to transport the evaluation. A record review was dated 7-14-13. The sthe resident as: "Pt and became short of degrees in the reside went out all over the non-rebreather and sabove 92%. After get O2 sats came up to 92 casts came up to 93 casts came up to 94 casts of the dated 7-17-13 reveals resident was admitted nursing home becaus of breath. It was very precipitated by the fathas possibly broncho	he physician and was given e resident to the hospital for conducted of the EMS report cene information described has been in the heat x 10 hr breath, Possibly 110 nt's room. Air conditioning home. Pt was placed on a till couldn't keep O2 sats ting the Pt out of the heat, 37%." hospital discharge summary ad the following: "The d to the hospital from the se he was having shortness hot and I think it was all of that it was very hot and he spasm, shortness of breath. I, we gave him Solu-Medrol	F	46	5		
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