STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(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 309 SS=J	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 psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on family, EMT, staff interviews, and record review, the facility failed to assess change in condition timely and intervene for 1 of 1 (Resident #1) sampled residents experiencing hypothermia. The facility failed to ensure a functioning heating unit in the room of Resident #1 (room 107). Immediate jeopardy began on 10/22/11. The facility was notified of immediate jeopardy on 10/31/11 at 3:59 pm. Immediate jeopardy was removed at 11/2/11 at 4:50 pm when the facility provided a credible allegation of compliance. The facility remained out of compliance at scope/severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and implement monitoring. Findings include: Resident #1 was admitted to the facility on 9/30/11. His diagnoses included pneumonia, rib fractures, dementia, anemia, blindness and insomnia. Resident #1 resided in room 107.	F 309	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F309 A. The facility began in-servicing all staff, on 11/1/11, on hypothermia and on what to do when a heating unit is unplugged for any reason. B. The Clinical Competency Coordinator, began in-servicing all staff, on 11/1/11, on hypothermia including signs and symptoms of hypothermia which include cold extremities, confusion, lethargy, and shivering. Treatments for hypothermia to include remove person from environment, communicate with the resident if room is at desired temperature, apply blankets and cover head, warm fluids to drink, monitor vital signs, complete a skin assessment to assess extremities and call 911 if indicated. All staff will be in-serviced by 11/2/11. Staff that has not had the hypothermia in-service will not be permitted to work until in-service is completed. The Clinical Competency Coordinator began in-servicing all staff, on 11/1/11, on what to do if they observe a resident tampering	11-18-11

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

Administrator — 11/23/2011

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(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 309	Continued From page 1 Room 107 was a private room. His 10/05/11 admission minimum data set assessment indicated he had severe cognitive impairment. He was non-ambulatory and required extensive assistance with transfers and mobility. He used a wheelchair for locomotion in the facility. His 10/7/11 care plan for " poor safety awareness secondary to diagnosis of dementia, history of falls, muscle weakness, unsteady gait, difficulty walking and blindness " had approaches: " assist resident with one staff member for all ambulation, resident prefers wearing tennis shoes, monitor for changes in resident ' s condition that may warrant increased supervision/assistance and notify the physician, resident uses a wheelchair for long distance mobility. " His 10/7/11 care plan for " potential for side effects and/or adverse reaction to psychotropic drug use secondary to diagnosis of dementia as evidenced by daily use of Risperdal " had approaches " monitor mood/behavior on an ongoing basis, administer medication as ordered, hold medication if resident is lethargic and notify physician. " His temperature ranged from 96.9 and 97.4 on 10/21/11. No temperature was documented for 10/20/11. From 10/13/11 to 10/19/11 his daily temperature ranged from 96.4 to 98.1 degrees. Weather.com indicated 10/20/11 outdoor temperature high was 60 with a low of 46 with wind. On 10/21/11 the high temperature was 66	F 309	with the heating unit (i.e. removing the cover from the unit, playing with knobs, kicking at the units and/or unplugging the unit). If staff observed the behavior they are to remove the resident immediately and the following will be preformed: a behavior screen completed and screen forwarded to the Social Worker, the nursing supervisor notified for appropriate intervention, corrected with the unit. Behavioral screens will be reviewed by the Social Services Director for placement on the behavioral management program. In-service also included what to do if the unit needs to be unplugged (i.e. apply extra blankets to the bed, move resident to a different room, and notifying the Maintenance Director and the Administrator and/or Director of Health services). All staff will be in-serviced by 11/2/11. Staff that has not had the heating units in-service will not be permitted to work until in-service is completed. In-servicing on what to do when a heating unit is unplugged will be added to our general orientation. C. The Social Services Director began conducting behavioral screens on 11/1/11, to identify behaviors that interfere with the functional capacity and maximum quality of life, on all residents to assess the potential behavior of tampering with the heating units. Any residents with identified behavior such as removing cover	

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F 309	Continued From page 2 with a low of 42. On 10/22/11 the high temperature was 67 with a low of 44. On 10/27/11 at 4:49 pm, the Maintenance Director #1 stated the corridor temperatures were maintained at 73 degrees. The heat in individual rooms was individually controlled. MD #1 stated he did not routinely check the temperatures in individual resident rooms. During an interview, on 10/27/11 at 4:24 pm, Nurse #1 (evening nurse 10/19/11 and 10/21/11) stated Resident #1 was blind and confused. Nurse #1 stated he would frequently attempt to stand from his wheelchair. She stated Resident #1 was kept at nursing station until 8-10 pm to provide close supervision. On 10/28/11 at 7:30 am, Nurse #2 (evening nurse for 10/20/11) stated Resident #1 had dementia and was blind. Nurse #2 stated Resident #1 would be agitated and reach with his hand and attempt to get out of his wheelchair. He stated Resident #1 ' s speech was difficult to understand. During an interview, on 10/27/11 at 1:33 pm, a family member of Resident #1 stated room 107 felt cold when he visited on 10/21/11 in the afternoon. The family member stated the heating unit was not working and was unplugged. The family member stated concerns about the heating unit not working was reported to nursing staff on two occasions. On 10/27/11 at 4:17 pm, NA #1 (evening NA for 10/21/11) stated Resident #1 would sit in his wheelchair with a seatbelt. Resident #1 would try	F 309	from heating unit, tampering with the knobs, or attempting to unplug the unit will be placed on the behavioral management program, and monitored weekly by the interdisciplinary team. Interventions, one on one activity, placing resident in common areas when behaviors are observed, check unit when resident is tampering with unit to ensure proper function, will be put in place for any identified behaviors and communicated to the direct care staff via Behavior Management Communication sheet that is placed in front of the CNA ADL care plan. Behavior screens will be completed on all residents by 11/2/11. As a result of the behavioral screen, 2 out of 105 residents (these residents are in the same room) were identified at risk of tampering with the heating unit. These residents were placed on the behavioral management program, interventions were put in place, communication added to the ADL Care plans book and care plan was updated. These residents will be reviewed weekly by the interdisciplinary team. The Clinical Competency Coordinator, began in-servicing, on 10/24/11, nursing staff (licensed and unlicensed) on acute change of condition including indication and assessing change of condition, who to report change of condition to, and documentation of change of	

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UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 309	Continued From page 3 to pick up things from the floor. She stated Resident #1 could not see and required assistance to get in bed. She stated Resident #1 was placed in bed at 10:00 pm. During an interview, on 10/28/11 at 8:09 am, Nurse #4 (night nurse for 10/20/11 and 10/21/11) stated Resident #1 had attempted to pull heating unit off the wall in room 107. She did not recall the date. Nurse #4 stated the heating unit was left off all the time she cared for him. Nurse #4 indicated she routinely cared for Resident #1. Resident #1 was at the nursing station on the night of 10/21/11 from 2 am until 4 am. Nurse #4 indicated Resident #1 was placed at nursing station so staff could observe him directly. On 10/28/11 at 8:30 am, NA #2 (night NA for 10/20/11 and 10/21/11) stated Resident #1 did not sleep at night. Resident #1 would be restless and agitated. On 10/21/11 at 1:00 am she placed Resident #1 in his wheelchair by the nursing station. Resident #1 was wearing a tee shirt, pajama bottoms and a pair of non-skid socks. Resident #1 was placed back in bed at 3:30 am. NA#2 stated the heater was not plugged in. NA #1 stated Resident #1 had attempted to pull the cover off the heating unit. NA #1 did not know the specific date. NA #2 stated when Resident #1 did attempt to pull heating unit cover off, the unit was unplugged because if was a fire hazard. During an interview, on 10/28/11 at 12:17 pm, NA #3 (day NA for 10/22/11) stated Resident #1 was restless and agitated at 6:30 am. NA #3 indicated Resident #1 would routinely have episodes of agitation. NA #3 stated she got the resident dressed and out of bed at 6:45 am.	F 309	condition. All staff will be in-services by 11/2/11. Staff that has not had the change in acute condition in-service will not be permitted to work until in-service is completed. The Social Services Director will review findings from the behavioral screens with the Administrator and/or Director of Health services in the daily interdisciplinary team meetings. D. Monitoring of the Behavioral screens and behavioral management plans will be conducted by the Director of Health Services and/or Administrator weekly for four weeks then monthly for twelve months. Non-compliance will be corrected at the time of discovery by the Director of Health Services and/or Administrator. Findings of the monitoring will be brought forth to the facilities monthly Performance Improvement Committee for patterns, trends and further interventions will be developed as necessary to ensure continued compliance.	

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UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 309	Continued From page 4 Resident was wearing sweat pants, tee shirt and flannel sweater. Resident was placed at the nursing station in his wheelchair. After breakfast he was sleepy and was placed back in bed. NA #3 stated she called Nurse #3 to the room because she could not get a BP on Resident #1. NA #3 thought that something was wrong with Resident #1 due to his sleepiness. NA #4 assisted in getting him back in bed. On 10/28/11 at 12:48 pm, NA #4 (day NA for 10/22/11) stated she assisted NA #3 to get Resident #1 in bed. NA #4 stated she took his shoes off and found his feet were cold. He was placed on his bedspread and two blankets to cover him. During an interview, on 10/28/11 at 12:28 pm, Nurse #3 (day shift nurse on 10/22/11) stated she responded to Resident #1 ' s room at 9:30 am. Resident #1 was lethargic and Nurse #3 stated she was unable to obtain a BP or pulse oximetry (device measures oxygen in the blood). Nurse #3 stated she was unable to obtain an oral or tympanic (ear) temperature. Nurse #3 stated she did not put any oxygen on Resident #1. Nurse #3 stated Resident #1 had 2-3 blankets on. Nurse #3 stated she did not put any more blankets on him. Nurse #3 stated she was assisted by Nurse #5 in assessing Resident #1. On 10/28/11 at 8:57 am, Nurse #5 (day shift nurse on 10/22/11) stated she went to Resident #1 ' s room at 9:45 am with Nurse #3. Nurse #5 stated Resident #1 had socks on his feet which were dangling off the bed. Resident #1 had two blankets covering him. Nurse #5 stated his feet were cold to touch. Nurse #5 stated the heating	F 309		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	6935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 309	Continued From page 5 unit was unplugged. Nurse #5 stated she plugged it in, put in heat mode but the unit kept blowing cold air. Nurse #5 stated she unplugged the unit. Nurse #5 stated Resident #1 had a HR of 44 but she was unable to obtain a BP. Nurse #5 stated she did not put any other blankets on Resident #1 until EMS arrived. During an interview, on 10/28/11 at 12:59 pm, Nurse #6 (day supervisor on 10/22/11) stated she had been called to Resident #1 ' s room by Nurse #5. Nurse #6 stated Resident #1 was lethargic and cold. Nurse #6 stated she was able to obtain a BP of 70/palpable. Nurse #6 indicated the heating unit was not on or plugged in. Nurse #6 stated she did not place any more blankets on Resident #1. Nurse #6 stated she was not in the room when EMS arrived. A 10/22/11 at 9:45 am nursing note stated " The CNA asked us to check resident as he did not seem himself. We went into the resident ' s room, he was found on his back. Resident was responsive to stimuli. Myself and the other nurse began to assess resident. I noticed his feet were cold; the other nurse was at the head of the bed checking for pulses. We took resident vitals and began to stimulate him and stabilize him. Resident began to move to stimuli, touching chest and attempting to move our hands from his body as were palpating for pulses and taking blood pressures (BP). We received consent to send him to ER for further evaluation. " The recorded vitals were heart rate (HR) 44 and respiratory rate (RR) of 16. EMS record revealed they arrived on the scene at 10:30 am. EMS record indicated call to 911 was	F 309		

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UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 309	Continued From page 6 placed at 10:18 am. Resident #1 ' s BP was 70/40, HR was 88 weak and irregular and his rectal temperature was 85.1 degrees Fahrenheit. The EMS report stated " Facility staff person stated that she had come in to find the room cold and patient ' s heater unplugged. Facility staff stated that when they plugged it in the found it blowing cold air. Facility staff person stated that this was her first day and that she was not sure how long the heat in patient ' s room had been off. Room temperature noted to be approximately 40-50 degrees. " The report indicated that EMS staff instructed staff to get warm blankets and wrapped the patient in blankets and a comforter. On 11/1/11 at 11:00 am, EMT #1 stated EMS responded to facility for Resident #1 at 10:30 am. EMT #1 stated the room felt cold. She stated the heating unit was not on when they arrived. EMT #1 stated she was wearing a jacket and the room felt cold to her. She stated Resident #1 was hypotensive, confused and agitated. Resident #1 ' s skin was cold and dry. The rectal temperature was 85.1. EMT #1 stated staff was instructed to place warm blankets on Resident #1. The 10/22/11 ER records stated " staff found patient with cold air blowing from heating, unsure as to how long this had been a problem. Check patient ' s vital signs and found to be hypotensive 70/palpable and unable to obtain a temperature, found with cold skin. " The ER note indicated a rectal temp of 85.5 degrees with a BP of 90/51. His skin was cold, dry and slightly pale. The 10/25/11 hospital discharge summary	F 309		

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F 309	Continued From page 7 primary diagnosis was hypothermia due to exposure. Secondary diagnoses were shock, cardiogenic versus septic, dementia and coronary artery disease. Resident #1 was discharged back to the facility under comfort care. Comfort measures were put in place during his hospitalization due to hypothermia. The clinical record indicated Resident #1 died in the facility on 10/26/11. On 10/28/11 at 1:30 pm, the administrator stated on 10/22/11 staff notified her of the hospitalization of Resident #1. The administrator had MD#1 to check the heater in room 107. The MD #1 found the unit unplugged and a black mark on the outlet cover. The Mode knob was not functioning properly. The heating unit was replaced on 10/22/11. During an interview, on 10/28/11 at 8:43 am, Maintenance Director (MD) #1 stated on 10/22/11 (after the incident with Resident #1) he received a call that the heating unit in room 107 was not working. MD #1 stated no pieces of the unit were off. The unit was unplugged. When the unit was turned on the mode knob was stuck and had to be fixed. MD #1 stated on 2 other occasions he had to put the cover back on the unit. MD #1 could not recall the dates of these occurrences. On 10/28/11 at 1:30 pm, the Director of Nursing (DON) stated the heating unit in room 107 had been unplugged for safety reasons. The DON was unable to explain any measures put in place to keep Resident #1 warm when in his room. The DON was unable to explain how long the heating	F 309		

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F 309	Continued From page 8 unit had been unplugged. The administrator was notified of Immediate Jeopardy on 10/31/11 at 3:59 pm. The facility provided a credible allegation of compliance on 11/2/11 at 4:50 pm. The allegation of compliance stated: After the notice of the immediate jeopardy the facility started in-servicing all staff, on 11/1/11, on hypothermia and on what to do when a heating unit is unplugged for any reason. The Clinical Competency Coordinator, began in-servicing all staff, on 11/1/11, on hypothermia including signs and symptoms of hypothermia which include cold extremities, confusion, lethargy, and shivering. Treatments for hypothermia to include remove person from environment, communicate with the resident if room is at desired temperature, apply blankets and cover head, warm fluids to drink, monitor vital signs, complete a skin assessment to assess extremities and call 911 if indicated. All staff will be in-serviced by 11/2/11. Staff that has not had the hypothermia in-service will not be permitted to work until in-service is completed. The Clinical Competency Coordinator began in-servicing all staff, on 11/1/11, on what to do if they observe a resident tampering with the heating unit (i.e. removing the cover from the unit, playing with knobs, kicking at the units and/or unplugging the unit). If staff observed the behavior they are to remove the resident immediately and the following will be preformed: a behavior screen completed and screen forwarded to the Social Worker, the nursing supervisor notified for appropriate intervention, Maintenance Director will be notified if items need	F 309		

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F 309	Continued From page 9 corrected with the unit. Behavioral screens will be reviewed by the Social Services Director for placement on the behavioral management program. In-service also included what to do if the unit needs to be unplugged (i.e. apply extra blankets to the bed, move resident to a different room, and notifying the Maintenance Director and the Administrator and/or Director of Health services). All staff will be in-serviced by 11/2/11. Staff that has not had the heating units in-service will not be permitted to work until in-service is completed. In-servicing on what to do when a heating unit is unplugged will be added to our general orientation. The Social Services Director began conducting behavioral screens on 11/1/11, to identify behaviors that interfere with the functional capacity and maximum quality of life, on all residents to assess the potential behavior of tampering with the heating units. Any residents with identified behavior such as removing cover from heating unit, tampering with the knobs, or attempting to unplug the unit will be placed on the behavioral management program, and monitored weekly by the interdisciplinary team. Interventions, one on one activity, placing resident in common areas when behaviors are observed, check unit when resident is tampering with unit to ensure proper function, will be put in place for any identified behaviors and communicated to the direct care staff via Behavior Management Communication sheet that is placed in front of the CNA ADL care plan. Behavior screens will be completed on all residents by 11/2/11. As a result of the behavioral screen, 2 out of 105 residents (these residents are in the same room) were identified at risk of tampering with the	F 309		

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F 309	Continued From page 10	F 309		

heating unit. These residents were placed on the behavioral management program, interventions were put in place, communication added to the ADL Care plans book and care plan was updated. These residents will be reviewed weekly by the interdisciplinary team.
The Clinical Competency Coordinator, began in-servicing, on 10/24/11, nursing staff (licensed and unlicensed) on acute change of condition including indication and assessing change of condition, who to report change of condition to, and documentation of change of condition. All staff will be in-services by 11/2/11. Staff that has not had the change in acute condition in-service will not be permitted to work until in-service is completed.
The Social Services Director will review findings from the behavioral screens with the Administrator and/or Director of Health services in the daily interdisciplinary team meetings.

The credible allegation was verified 11/2/11 at 5:00 pm, as evidenced by staff interviews on identifying hypothermia, interventions to treat hypothermia, change in condition, and documentation of change in condition and reporting of malfunctioning heating units. Staff interviews included identifying residents with potential for tampering with heating units and response to behavior.

Review of behavioral screening sheet was completed on each resident. Two residents were identified and placed in behavioral management program.

Review of in-service records for hypothermia and air/heating units indicated nursing and

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UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(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 309	Continued From page 11 maintenance and housekeeping staff were inserviced on identifying risk of hypothermia, treatment of hypothermia and reporting maintenance concerns for heating/air units.	F 309	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.	
F 456 SS=J	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on family, EMS and staff interviews and record review, the facility failed to ensure 1 of 89 resident heating units was functioning properly (room 107) resulting in Resident #1 becoming hypothermic. Immediate jeopardy began on 10/22/11. The facility was notified of immediate jeopardy on 10/31/11 at 3:59 pm. Immediate jeopardy was removed at 11/2/11 at 4:50 pm when the facility provided a credible allegation of compliance. The facility remained out of compliance at scope/severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and implement monitoring. Findings are: During an interview, on 10/27/11 at 1:33 pm, a family member of Resident #1 stated room 107 felt cold when he visited on 10/21/11 in the afternoon. The family member stated the heating unit was not working and was unplugged. The	F 456	F456 A. The Maintenance Director conducted a 100% audit of the 89 heating units to ensure proper functioning. In-servicing by the Maintenance Director on reporting units not working and use of maintenance work orders and maintenance log began for all staff. B. Work orders and maintenance logs is currently part of general Orientation. On October 22, 2011 the Maintenance Director completed a 100% audit of the 89 heating units in the building. The results revealed the following: Two units changed out , six control knobs fixed, two units cleaned and one unit fixed. These items where corrected as of 11/2/11. The facility completed a second audit of the heating/cooling units from 10/31/11 through 11/1/11 which identified one unit that required changing out. C. Monitoring of the 89 heating units will be completed by the Maintenance Director daily times four weeks, weekly times four weeks and then monthly there after. Monitoring of units to include	11/18/11

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F 456	Continued From page 12 family member stated concerns about the heating unit not working was reported to nursing staff on 2 occasions. On 10/27/11 at 4:49 pm, the Maintenance Director (MD)#1 stated the corridor temperatures were maintained at 73 degrees. The heat in individual rooms was individually controlled. MD #1 stated he did not routinely check the temperatures in individual resident rooms. He does not routinely check the heating units in the rooms. During an interview, on 10/28/11 at 8:09 am, Nurse #4 (night nurse for 10/20/11 and 10/21/11) stated Resident #1 had attempted to pull heating unit off the wall in room 107. She did not recall the date. Nurse #4 stated the heating unit was left off all the time she cared for him. On 10/28/11 at 8:30 am, NA #2 (night NA for 10/20/11 and 10/21/11) stated the heater was not plugged in room 107. NA #1 stated Resident #1 had attempted to pull the cover off the heating unit. NA #1 did not know the specific date. NA #2 stated when Resident #1 did attempt to pull heating unit cover off the heating unit. NA #1 did not know the specific date. NA #2 stated when Resident #1 did attempt to pull heating unit cover off, the unit was unplugged because if was a fire hazard. On 10/28/11 at 8:57 am, Nurse #5 (day shift nurse on 10/22/11) stated the heating unit was unplugged in room 107. Nurse #5 stated she plugged it in, put in heat mode but the unit kept blowing cold air. Nurse #5 stated she unplugged the unit.	F 456	proper functioning, to include proper functioning of the switches, the unit distributes warm and cool air, the filters are clean, and that the units are plugged into the outlets. Audit will be conducted by Maintenance Director and/or week-end supervisor. Any issues identified will be corrected immediately including the temperature of room at the time of discovery and temperature after the issues is corrected. Work orders and Maintenance logs are currently part of general orientation. D. Results from the monitoring will be reviewed with the Administrator and /or Director of Health Services. Monitoring of the maintenance logs accuracy will be verified during preventive maintenance completed by Maintenance Director per policy. Identified areas will be corrected immediately and the Administrator and/or Director of Health Services will be notified of any inaccuracies between the identified items and the maintenance logs. The findings of the maintenance monitoring will be brought forth to the facilities Performance Improvement Committee for patterns and trends, and further interventions will be developed as necessary to ensure continued compliance.	

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F 456	Continued From page 13 The EMS report stated " Facility staff person stated that she had come in to find the room cold and patient ' s heater unplugged. Facility staff stated that when they plugged it in the found it blowing cold air. Facility staff person stated that this was her first day and that she was not sure how long the heat in patient ' s room had been off.. Room temperature noted to be approximately 40-50 degrees. " On 11/1/11 at 11:00 am, EMT #1 stated EMS responded to facility for Resident #1 at 10:30 am. EMT #1 stated the room felt cold. She stated the heating unit was not on when they arrived. EMT #1 stated she was wearing a jacket and the room felt cold to her. On 10/28/11 at 1:30 pm, the administrator stated on 10/22/11 staff notified her of the hospitalization of Resident #1. The administrator had MD#1 to check the heater in room 107. The MD #1 found the unit unplugged and a black mark on the outlet cover. The Mode knob was not functioning properly. The heating unit was replaced on 10/22/11. During an interview, on 10/28/11 at 8:43 am, Maintenance Director #1 stated on 10/22/11 (after the incident with Resident #1) he received a call that the heating unit in room 107 was not working. MD #1 stated no pieces of the unit were off. The unit was unplugged. When the unit was turned on the mode knob was stuck and had to be fixed. MD #1 stated on 2 other occasions he had to put the cover back on the unit. MD #1 could not recall the dates of these occurrences.	F 456		

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F 456	Continued From page 14 The administrator was notified of Immediate Jeopardy on 10/31/11 at 3:59 pm. The facility provided a credible allegation of compliance on 11/2/11 at 4:50 pm. The allegation of compliance stated: When the facility was notified by EMS, on 10/22/11, that the resident, residing in room 107, was hypothermic the Maintenance Director conducted a 100% audit of the 89 heating units to ensure proper functioning. In-servicing by the Maintenance Director on reporting units not working and use of maintenance work orders and maintenance log began for all staff. Completing the work orders and maintenance logs is currently part of general orientation. On October 22, 2011 Maintenance Director completed a 100% audit of the 89 heating units in the building. The results revealed the following: room 107 not working (was changed out), room 110 had a loose control knob, room 118 the covering over the control knobs was removed and laying on top of the unit, room 211 not working (unit is not open at current time), room 307 old unit (noisy and needs cleaning), room 315 loose knob, room 612 needs cleaning, room 610 needs left side filter, room 608 loose lid to controls, room 604 loose knob, room 601 not blowing warm air(unit was fixed), and room 501 had different knob. The identified concerns have been corrected as of 11/2/11. After the notice of the immediate jeopardy the facility started a second audit of the 89 heating units on 10/31/11 and finished on 11/1/11 to ensure proper functioning of the unit. Results are as follows: room 115 control knobs were not working and unit was changed out immediately.	F 456		

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F 456	Continued From page 15 Monitoring of the 89 heating units will be completed daily times four weeks, weekly times four weeks and then monthly there after. Monitoring of units to include proper functioning, to include proper functioning of the switches, the unit distributes warm and cool air, the filters are clean, and that the units are plugged into the outlets. Audit will be conducted by Maintenance Director and/or week-end supervisor. Any issues identified will be corrected immediately including the temperature of room at the time of discovery and temperature after the issues is corrected. Results from the monitoring will be reviewed with the Administrator and /or Director of Health Services. Monitoring of the maintenance logs accuracy will be verified during preventive maintenance completed by Maintenance Director per policy. Identified areas will be corrected immediately and the Administrator and/or Director of Health Services will be notified of any inaccuracies between the identified items and the maintenance logs. The credible allegation was verified 11/2/11 at 5:00 pm, as evidenced by staff interviews identifying how to report and respond to heating/air unit malfunction. Review of in-service records for air/heating units indicated nursing and maintenance and housekeeping staff were inserviced on what to do if heating unit needs to be unplugged and reporting maintenance concerns for heating/air units. Review of maintenance audit indicated all heating units were functioning. The unit in 115 had been	F 456		

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F 456	Continued From page 16 replaced due to nonfunctioning control knob.	F 456		