STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	C 07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

(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=G	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 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 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 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 voice concerns about his health issues. He required assistance for transfers and activities of daily living (ADLs).	F 309	**Submission of this response to the statement of deficiencies does not constitute an admission that the deficiency exists and/or was correctly cited or required correction.** 1. Corrective action for resident #3 has been accomplished by maintaining a comfortable temperature within facility via steps further described below. 2. All residents in the facility with respiratory conditions have the potential to be affected. No additional residents have been identified to have experienced respiratory distress due to increased facility temperature. Steps described below have been implemented to prevent reoccurrence. 3. All Department Heads/Charge Nurses will be in-serviced by Maintenance Director on proper functioning of fire panel to include bypassing defective smoke head to prevent complete a/c system shut down. Administrator and Maintenance Director must be notified of A/C system shutdown.	

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

Cheryl Arnold — Administrator — 8/15/13

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 1 A record review was conducted of the nurse ' s notes dated 7-14-13 from nurse #2 who identified Resident #3 was having respiratory difficulty. She reported in her notes that the resident was sweating profusely and that the resident reported he was too hot. She noted there were visible 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%. " A record review of the hospital discharge summary dated 7-17-13 revealed the following: " The resident was admitted to the hospital from the nursing home because he was having shortness of breath. It was very hot and I think it was all precipitated by the fact that it was very hot	F 309	Training will be included in hiring orientation for department heads and charge nurses. All smoke heads will be cleaned and inspected by BFPE International. Nursing staff/Department Heads in-serviced by Director of Nursing or Designee on implementing measures to include recognizing early signs and symptoms of respiratory distress during increased temperatures to include location of floor fans, hydration, use of cool compresses, and notification of administrator and maintenance director Maintenance staff was in-serviced by administrator on the on- call policy, 1 hour response times, timely administrator notification (within 1 hour). On call schedule implemented for designated maintenance staff after hours and weekends. Training will be included in hiring orientation maintenance staff. 4. Maintenance Director or designee will select random rooms for temperature checks daily for 4 weeks then weekly for 8 weeks.	8/20/13 8/19/13 8/20/13 7/15/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

(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 2 and he has possibly bronchospasm, shortness of breath. He got to the hospital, we gave him Solu-Medrol and gave him IV antibiotics." The resident had a three day hospital stay and was discharged back to the facility on 7-17-13. 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 never 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.	F 309	Results will be reviewed monthly in QA meeting times 3 months with further plans being developed based on results.	
F 465 SS=G	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465	1. Corrective action for resident #3 has been accomplished by maintaining a comfortable temperature within facility via steps further described below.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	C 07/25/2013

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UNIVERSAL HEALTH CARE LILLINGTON	1095 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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F 465	Continued From page 3 residents, staff and the public. 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 a result of malfunction of the air condition unit. Findings include: Resident #3 was admitted to the facility on 10-6-10 with the following diagnoses: Chronic Airway Obstruction Disease (COPD), Congestive Heart Failure (CHF), and Hypertension (HTN), Chronic Hypoxemia, Emphysema, and Chronic Oxygen use. During an interview with the fire chief on 7-24-13 at 1:30pm, he indicated that on 7-14-13 at 11:55 am, the fire department responded to a fire alarm at the facility. Upon their arrival, no fire or smoke was identified but a bad smoke detector head in Zone 28 was determined to be the cause of the alarm. Once this was identified, it was reported by the Fire Chief at approximately 12:30pm to the Maintenance Director, who was on-call for the weekend of 7-13-13 through 7-14-13. A review of the named resident ' s 5 day re-entry 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 transfers and activities of	F 465	2. All residents in the facility with respiratory conditions have the potential to be affected. No additional residents have been identified to have experienced respiratory distress due to increased facility temperature. Steps described below have been implemented to prevent reoccurrence. 3. All Department Heads/Charge Nurses will be in-serviced by Maintenance Director on proper functioning of fire panel to include bypassing defective smoke head to prevent complete a/c system shut down. All smoke heads will be cleaned and inspected by BFPE International. All smoke heads will be inspected and cleaned quarterly by maintenance director. Nursing staff/Department Heads in-serviced by Director of Nursing or Designee on implementing measures to include recognizing early signs and symptoms of respiratory distress during increased temperatures to include location of floor fans, hydration, use of cool compresses and notification of administrator and maintenance director.	8/20/13 8/19/13 8/20/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 4 daily living (ADLs) a review of friendly forecast.com for the date of 7-14-13 for Lillington, NC, revealed the daily temperature was a low of 72 degrees and a high of 86 degrees. The humidity for that date ranged from 59% to 99%. On 7-23-13 at 8:00 am an interview was conducted with the Maintenance Director who was on-call for the facility the weekend of 7-13-13 through 7-14-13. He indicated that he did not notify the Administrator that he would not be available in a timely manner to fix the identified smoke detector in Zone 28 of the facility on 7-14-13. He reported that the facility had a central heating and air conditioning system. The air could not be controlled in individual resident rooms. He also indicated that on 7-14-13, the reason the facility became increasingly hot was because the air handlers had shut off when the fire alarm had gone off. This is a safety mechanism to prevent the spread of fire. He reported he had spoken with the Fire Chief who has since shown him how to bypass the trouble area so that the entire fire system is not off-line until maintenance can repair any problems. The Maintenance Director stated he spoke with the Fire Marshall and the Charge Nurse on 7-14-13 and told them he would arrive at the facility within a couple of hours. In the meantime, the fire alarm system was taken off-line and a " Fire Watch " was initiated. A " Fire Watch " consists of a designated staff member making a tour around the facility every 15 minutes to determine the facility does not have any fire activity. He reported the facility thermostat readings were 76 degrees after the fire alarm was reset and the air handlers came back on around 8:00pm. He did indicate that he did not record these readings.	F 465	Maintenance staff in-serviced by administrator on the on- call policy, 1 hour response times, timely administrator notification (within 1 hour). On call schedule implemented for designated maintenance staff after hours and weekends. Training will be included in hiring orientation for maintenance staff. Administrator or designee will notify Fire Marshall and Life Safety when the fire alarm panel is out of operation for more than 4 hours in a 24 hour period. Current disaster plan amended to include procedure for temperatures below 71 degree or above 81 degree. Training will be included in new hire orientation. All Maintenance Personnel job descriptions have been reviewed, signed, and placed in personnel file 4. Maintenance Director or designees will select Random rooms for temperature checks daily for 4 weeks then weekly for 8 weeks Results of random room checks will be reviewed monthly in QA meeting	7/15/13 8/19/13 8/16/13

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 5 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 off-line for an 8 hour period of time. He reported that when he spoke to the Maintenance Director on 7-14-13 at approximately 1:15pm he had been under the impression that he would be arriving around 2:00 pm. 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	F 465	with further plans being developed based on results. Results of quarterly smoke detector inspections and cleaning will be reviewed quarterly in QA meeting times 6 months with further plans being developed based on results.	

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F 465	Continued From page 6	F 465		

worse. She reported she had spoken with the Maintenance Director at the time the fire alarm had gone off and had been told to take the fire alarm system off-line and to begin 15 minute " Fire walks. " Fire walks involve making walking rounds of the facility every 15 minutes to make sure there is no fire or smoke present in the facility. She stated she was under the impression that he was on his way. The RN stated that when the Maintenance Director had not shown up by 3:00 pm, she attempted to call him again and was told it would be another couple of hours before he could be at the facility. At that time, 3:00 pm, the RN contacted the Director of Nursing, who had a personal emergency and was unable to assist. The RN reported that she instructed the staff to give the residents extra ice and water and perform frequent checks on the residents as the facility temperature continued to rise. Nurse #1 reported she contacted the Maintenance Director again around 5:00 pm and he asked her to check the thermostat on " A " hall to see what the temperature was reading. The temperature was 80 degrees. She stated it wasn ' t the heat that was the main problem; it was the mixture of the heat and the high humidity.

During an interview on 7-23-13 at 3:30 pm with Nurse #2 (An evening nurse working 7:00pm until 7:00am) on 7-14-13 reported the facility was extremely hot when she reported to work on 7-14-13. She stated that several residents and families were complaining about the heat and some family members went out and bought fans for the resident ' s rooms. Nurse #2 stated, during her shift, four residents were identified as having respiratory issues, but was unknown if related to the heat in the facility. These residents were sent out to the local emergency rooms for evaluation.

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F 465	Continued From page 7	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 hot 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 assigned 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 quoted " 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 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 around 9:30 pm.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 8 he got really hot but did not notice the facility getting hot until in the afternoon. This resident reported he stayed in his room with the door closed and his room stayed cool until later. Once he started feeling the heat, he reported he opened his room door, got into his wheelchair and rolled around in the facility. He reported the staff passed ice water to keep every one hydrated. He stated the facility began to cool off around 11:00 pm. During an interview with the emergency medical services supervisor (EMS) on 7-24-13 at 11:45 am, he revealed he had been contacted by the paramedics who had been transporting the residents from the facility to the local emergency rooms on 7/14/13. He reported that his paramedics were concerned because there had been four residents transported from the facility throughout the day with respiratory related illnesses they thought may be related to the increased temperature in the facility. He reported he arrived at the facility around 8:30 pm and found the facility to be " Hot and humid " upon his entry. He reported that the maintenance man and his assistant as well as the Administrator were present in the facility. The EMS Supervisor stated he was present in the facility for 45 minutes and the facility had started to cool off prior to his leaving. Observation of the smoke detector head in Zone 28 that set off the fire alarm was observed to be in the Assisted Living portion of the building. The smoke detector was not replaced but cleaned and is in working order. Record review of preventative maintenance records identified that all smoke detectors	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 9	F 465		

including the smoke detector in Zone 28 that set off the fire alarm were inspected along with the manual pull stations, and control panel on 5-3-13 and deemed to be in working order a fire, safety and security company. This inspection is conducted on an annual basis.

A review of the facility ' s disaster plan did not have a policy and procedure in place for temperatures that fall below 71 degrees or rise above 81 degrees.

A review of an undated job description for the Maintenance Director stated " Able to respond to needs of facility 24 hours a day, 7 days a week. " And " Responds to emergency maintenance needs promptly. " The Maintenance Director did not have a copy of a signed job description in his employee file until 7-26-13.

A record review was conducted of the nurse ' s notes from nurse #2 who identified Resident #3 was having respiratory difficulty. She reported in her notes that the resident was sweating profusely and that the resident reported he was too hot. She noted there were visible 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.

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F 465	Continued From page 10 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%. " Record review of the hospital discharge summary dated 7-17-13 revealed the following: " The resident was admitted to the hospital from the nursing home because he was having shortness of breath. It was very hot and I think it was all precipitated by the fact that it was very hot and he has possibly bronchospasm, shortness of breath. He got to the hospital, we gave him Solu-Medrol and gave him IV antibiotics. "	F 465		