PRINTED: 01/31/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATIO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345558	B. WNG_		C 01/16/2014
	ROVIDER OR SUPPLIER E VETERANS HOME-BL	ACK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 323 SS=E	environment remains as is possible; and e		F3	What Corrective action accomplished for the refound to have been affer the deficient practice?	esidents esidents
	by: Based on resident, and record reviews to environment free of heaters in resident controls.	T is not met as evidenced family and staff interviews he facility failed to have an nazards by utilizing space are areas for 5 of 6 sampled is #1, #3, #4, #5 and #6).		All space heaters re from resident areas	
	Resident #4 dated 1: resident as cognitive others and being abl Resident #4 was included of the control of the	//inimum Data Set (MDS) for 2/05/13 assessed the ly intact, able to understand e make himself understood. luded on the facility's viewable residents. AM Resident #4 was the interview Resident #4		Received Washington by:	
LABORATO F	heater in his room the three prong electrical heater away from the objects. The residen	ey plugged it directly into a lively lively and the wall outlet and placed the wall and away from any talso explained that the staff	RE	TITLE	(Xey date

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

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			*************************************		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '		DINSTRUCTION	(X3) DATE COMF	SURVEY PLETED
AND PLAN OF CORRECTION IDENTIF		IDENTIFICATION NUMBER:	A. BUILD	ING	<u></u> ·		С
			B. WING				/16/2014
		345558	B. Willed	етрь	EET ADDRESS, CITY, STATE, ZIP CODE		10/2014
NAME OF PI	ROVIDER OR SUPPLIER				AKE EDEN ROAD		
NC STATE	VETERANS HOME-BL	ACK MOUNTAIN			CK MOUNTAIN, NC 28711		
			1 ,,		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLÉTION DATE
	0	- 1		323			
F 323	, -		'	323			
ı	performed frequent of	checks of his room to ensure nained positioned properly.					
	The resident stated t	that the space heater was			How will you identify other		
	utilized in his room for	or a day or two before being			residents having the potentia	1	
ļ	removed by staff.	•			to be affected by the same		
					deficient practice and what		
	On 01/16/14 at 9:10	AM an interview was			corrective action will be		ł.
•	conducted with the to	acility's Maintenance interview the Maintenance			taken?		
	Director stated the fa	acility placed portable space					
	heaters in resident re	ooms because the facility's					
	heating system had	difficulty keeping the facility		1			
	environment warm e	enough when extremely cold			Nursing staff to notify		
		enced during the week of			Maintenance Departmen	it	
	January 06, 2014.				immediately if resident		
	On 01/16/14 at 11:1	0 AM an interview was			•		
		facility's Environmental			room temperatures drop		
	Service Director/Saf	fety Officer. During the			below levels comfortable	:	
	interview the Enviro	nmental Service			to resident and staff is		
	Director/Safety Office	cer stated that on January 06,			unable to bring the room	ı	
	2014 the facility pur	chased and placed small ters in resident rooms for a		İ	_		
	couple days when the	he facility experienced			temperature up by		
	extremely cold weat	ther conditions. The staff			adjusting the thermostat	i	Feb. 10
	member specified th	nat he oversaw the process of			in the resident room. Sta	ff	2014
	placing the small sp	pace heaters in resident rooms			to be educated on		
	by ensuring that the	y were plugged into a three					
	prong outlet, were p	placed a minimum of three feet d any objects and informed			procedure.		
	residents to not mor	ve the heaters or place any					
		In addition, staff were					
	instructed on prope	r safety precautions, when the					
	space heaters were	utilized in resident rooms for					
	two days, which inc	cluded conducting fifteen			•		
		nds to observe for any					
	potential problems.				•		
	On 04/46/44 of 2:00	n DM an interview was					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		345558	B. WING		0	C 1/16/2014
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		110,2014
NC STATE	E VETERANS HOME-BLA	CK MOJINTAIN		62 LAKE EDEN ROAD		
NO SIAIS	TYPICAMO (TOME-BEA	CK BOOKIAM		BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 323	conducted with the farm Administrator confirm utilized portable space during the week of Jar facility experienced exconditions. The Administrator was aware the use of prohibited in resident facility's heating system comfortable and safe resident population shand use of space heat short term solution what to forty eight hours. The explained that the fact to ensure resident samplacement of the space the manufacturer institution of the resident portable and the manufacturer institution of the resident samplacement of the space the manufacturer institution of the resident samplacement of the resident samplacement of the space the manufacturer institution of the resident samplacement of the resident samplacement of the space the manufacturer institution of the resident samplacement samplaceme	cility's Administrator. The ed that the facility had e heaters in resident rooms nuary 06, 2014 when the extremely cold weather nistrator specified that she space heaters were care areas, but when the em failed to maintain a interior temperature for the ne approved the purchase ters in resident rooms as a nich was to last twenty-four he Administrator further ility implemented measures fety which included ce heaters as directed by ructions and periodic staff dent care areas where the	F	What measures will be place or what system changes will be made that the deficient pranot reoccur? 1. The cell number the Maintenance staff on-call we posted at each nursing station at the front deficient or whether the staff on the staff	ic to ensure actice will ers of nce ill be n and	Feb. 10 2014
	Resident #5 dated 12 resident as cognitively understand others an understood. Resident facility's 01/16/14 list An Interview was con 01/16/14 at 2:45 PM. Resident #5 stated th placed a space heate days and nights when was having problems The resident stated si heater into a three pro	inimum Data Set (MDS) for /27/13 assessed the /intact, usually able to d being able make himself #5 was included on the of interviewable residents.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
-		345558	B WING	B. WING		C
	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP COR 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	DE	01/16/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 323	On 01/16/14 at 9:10 conducted with the far Director. During the indirector stated the far heaters in resident or heating system had denvironment warm exerting system had denvironment warm exerting weather was experied January 06, 2014. On 01/16/14 at 11:10 conducted with the far Service Director/Safety Office 2014 the facility pure portable space heater couple days when the extremely cold weath member specified the placing the small space by ensuring that they prong outlet, were plaway from walls and residents to not move objects near them. In instructed on proper space heaters were two days, which incluminute walking round potential problems.	AM an interview was acility's Maintenance interview the Maintenance interview the Maintenance interview the Maintenance interview the Maintenance interview because the facility's difficulty keeping the facility inough when extremely cold inced during the week of a AM an interview was acility's Environmental ety Officer. During the interview in the process of a stated that on January 06, whased and placed small ers in resident rooms for a se facility experienced in an experienced in the oversaw the process of ace heaters in resident rooms of were plugged into a three aced a minimum of three feet any objects and informed in the heaters or place any in addition, staff were safety precautions, when the putilized in resident rooms for used conducting fifteen disto observe for any	F3	2. A temporary back heating system for areas that is accept DHSR Life Safety winstalled and opera This system will be outside the building heat piped into the on each of the four solariums via a non door. The systems on diesel fuel and wigenerator located of the building as well	resident table to ill be ational. located g with the dayroom resident a-exit will run will have a outside	Jan. 22 2014
	conducted with the far Administrator confirm utilized portable space during the week of Ja facility experienced of	PM an interview was acility's Administrator. The ned that the facility had be heaters in resident rooms anuary 06, 2014 when the extremely cold weather inistrator specified that she				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345558	B. WING		 01	C //16/2014
NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-BLACK MOUNTAIN				STREET ADDRESS, CITY, STATE, ZIP COD 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		SHOULD BE	(X5) COMPLETION DATE
F 323	was aware the use of prohibited in resident facility's heating syste comfortable and safe resident population shand use of space hea short term solution who forty eight hours. The explained that the fact to ensure resident satisfactory and the manufacturer institution of the space heaters were used. 3. The most recent Michigan Resident #6 dated 10 resident as cognitively	space heaters were care areas, but when the of failed to maintain a interior temperature for the ne approved the purchase ters in resident rooms as a nich was to last twenty-four the Administrator further illity implemented measures fety which included the heaters as directed by ructions and periodic staff dent care areas where the tillized. In immum Data Set (MDS) for 1/17/13 assessed the y intact, able to understand the make himself understood.	F	3. The facility's owner (North Carolina Division of Veterans Affairs) wi meet with the State Construction Engineers to devise permanent back-up heating system.		Jan. 31 2014
	stated that staff place his room for a couple of very cold weather. when staff placed the they plugged it into a	te interview Resident #6 d a small space heater in days during a recent period The resident explained that space heater into his room three prong outlet and ly three feet away from his ocessions.				
	conducted with the far Director. During the in Director stated the far heaters in resident ro heating system had d					

		(X1) PROVIDER/SUPPLIÈR/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			-			С	
	,	345558	B. WNG_			01/16/2014	
	ROVIDER OR SUPPLIER	I ACK MOUNTAIN	,	STREET ADDRESS, CITY, STAT 62 LAKE EDEN ROAD	FE, ZIP CODE	-	
NOUNT	. VETERORIO MONIE-D	LACK MODITAIN		BLACK MOUNTAIN, NC 2	8711		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 323	, • • · · · · · · · · · · · · · · · · ·	ge 5 enced during the week of	F3	23			
	January 06, 2014.	enced during the week of			orrective action		
-	On 01/16/14 at 11:1	I0 AM an interview was		be monitored the deficient p	to assure that ractice will not		
		facility's Environmental fety Officer. During the		reoccur, i.e., w	hat quality		
	interview the Enviro	nmental Service		assurance proj in place for me	gram will be put		
	2014 the facility pur	cer stated that on January 06, chased and placed small			ed compliance.		
		ters in resident rooms for a he facility experienced		1. Monit	toring of		
		ther conditions. The staff hat he oversaw the process of		reside	ent rooms for		
	placing the small sp	pace heaters in resident rooms		•	erature,		
	prong outlet, were p	ey were plugged into a three placed a minimum of three feet		•	nce of space		
		d any objects and informed ve the heaters or place any			rs and others ds will be		
		In addition, staff were r safety precautions, when the			ded by		
	space heaters were	utilized in resident rooms for		Direct			
	minute walking rour	luded conducting fifteen nds to observe for any		Maint	enance or		
	potential problems.			appoi	ntee twice		
		PM an interview was		weekl	y for 6 weeks		
-	Administrator confir	facility's Administrator. The med that the facility had			nce weekly	Feb. 10 2014	
٠	during the week of	ace heaters in resident rooms January 06, 2014 when the extremely cold weather		for 6 v	weeks.		
	conditions. The Adr	ninistrator specified that she of space heaters were					
	l '	nt care areas, but when the stem failed to maintain a					
	comfortable and sa	fe interior temperature for the	1				
	and use of space h	she approved the purchase eaters in resident rooms as a which was to last twenty-four					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A, BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	,	345558	B. WING	·	C 01/16/2014
	ROVIDER OR SUPPLIER	BLACK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	1 01/10/2014
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	· ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 323	explained that the to ensure resident placement of the sthe manufacturer monitoring of their space heaters were 4. Resident #1, who secured unit, was 11/25/13 with diag disease, macular reactive confusion Data Set (MDS) distribution was to make daily decident make daily decident make distribution was to make daily decident make daily da	s. The Administrator further facility implemented measures safety which included space heaters as directed by instructions and periodic staff resident care areas where the	F 32	2. Maintenance Department wi report tempera readings and ar requests from staff, residents, families regardi uncomfortable temperatures in building to QAP committee monthly.	or ng Feb. 10 2014
	On 01/16/14 at 10 member was inter stated the residen 01/06/14 and the 1 Resident #1's roor On 01/16/14 at 9: conducted with the Director. During the Director stated the heaters in residen heating system has environment warm weather was experiently January 06, 2014. On 01/16/14 at 11 conducted with the	10 AM an interview was e facility's Maintenance e interview the Maintenance facility placed portable space trooms because the facility's d difficulty keeping the facility in enough when extremely cold rienced during the week of		3. Newly hired staf will be educated heating system a back-up plans during orientation	on Feb. 7 and 2014

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIÀ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 -	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345558	B. WING	-		1 .	16/2014
NAME OF P	ROVIDER OR SUPPLIER	When the state of	·	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	E VETERANS HOME-BLA	CK MOUNTAIN			AKE EDEN ROAD	•	
NC SIAII	L VETERAIS HOME-DEA	TO THE TAIN		BLA	CK MOUNTAIN, NC 28711		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From page	• 7	· F:	323			
	2014 the facility purch portable space heater couple days when the extremely cold weath member specified that placing the small space by ensuring that they prong outlet, were plate away from walls and residents to not move objects near them. In instructed on proper space heaters were uportable space heaters were uportable.	r stated that on January 06, nased and placed small rs in resident rooms for a pacifity experienced er conditions. The staff the oversaw the process of the heaters in resident rooms were plugged into a three faced a minimum of three feet any objects and informed the heaters or place any addition, staff were pafety precautions, when the tilized in resident rooms for ded conducting fifteen					
	on the facility's secure Nurse #1 stated durin residents on the secu sleeve shirts, blankets covering their legs, ar placed in some residents warm. Nurs check the residents roof for temperature chang the residents. She incominutes rounds the st heaters were operating monitoring that the sp positioned on the floor On 01/16/14 at 3:00 F conducted with the face.	ace heaters were r of the resident's room.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345558	B, WING	· · ·	C 01/16/2014	
NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-BLACK MOUNTAIN				STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	,	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 323	facility experience conditions. The A was aware the us prohibited in resic facility's heating s comfortable and s resident population and use of space short term solution to forty eight hour explained that the to ensure resident placement of the the manufacturer	of January 06, 2014 when the ad extremely cold weather diministrator specified that she e of space heaters were lent care areas, but when the system failed to maintain a safe interior temperature for the enshe approved the purchase heaters in resident rooms as an which was to last twenty-four so. The Administrator further a facility implemented measures to safety which included space heaters as directed by instructions and periodic staff resident care areas where the	F 32	3		
	was admitted to the diagnoses of paratype), and Parkins Minimum Data Serevealed Resident impaired and una Further review of required maximum daily living (ADL), On 01/16/14 at 95 member was inte 01/06/14 a space Resident #3's root type).	ho resided on the secured unit, the facility on 08/29/13 with alysis, dementia (Alzheimer's son's disease. The most recent set (MDS) dated 12/05/13 tr #3's cognition was severely ble to make daily decisions. The MDS indicated Resident #3 and assistance with activities of transfers, and/or ambulation. 45 AM Resident #3's family reviewed. She stated the week of heater was brought into mand the space heater was ening and remained in the or two days.				
	conducted with th	10 AM an interview was e facility's Maintenance he interview the Maintenance				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345558	B. WING_			C
NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-BLACK MOUNTAIN				STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		I/16/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 323	heaters in resident ro heating system had d environment warm en	e 9 cility placed portable space oms because the facility's ifficulty keeping the facility ough when extremely cold aced during the week of	F	323		
-	2014 the facility purch portable space heater couple days when the extremely cold weather member specified that placing the small space by ensuring that they prong outlet, were plate away from walls and a residents to not move objects near them. In instructed on proper s	cility's Environmental ty officer. During the mental Service r stated that on January 06, mased and placed small rs in resident rooms for a r facility experienced er conditions. The staff the oversaw the process of the heaters in resident rooms were plugged into a three ced a minimum of three feet any objects and informed the heaters or place any				
	two days, which incluminate walking round potential problems. On 01/16/14 at 11:15 on the facility's secure Nurse #1 stated durin residents on the secu sleeve shirts, blankets covering their legs, ar placed in some resideresidents warm. Nursicheck the resident rock	ded conducting fifteen				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	•	345558	B. WNG	•	01/16/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NO STATE	E VETERANS HOME-BLA	OK HOUSETAN		62 LAKE EDEN ROAD	
NCSIAII	E VETERANS HUIVIE-BLA	CK MODNIAIN		BLACK MOUNTAIN, NC 28711	
(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 APPROVIDERICIENCY)	D BE COMPLETION
F 323	Continued From page	± 10	F 32	23	
· ·	the residents. She inc minutes rounds the st heaters were operatin monitoring that the sp	licated during the fifteen aff was ensuring the space ng properly as well as			
	Administrator confirmed utilized portable space during the week of Ja facility experienced exconditions. The Admir was aware the use of prohibited in resident facility's heating syste comfortable and safe resident population shand use of space heat short term solution what to forty eight hours. The explained that the facilitized portable and safe resident population shand use of space heat short term solution what the facility is shadown.	cility's Administrator. The ed that the facility had e heaters in resident rooms nuary 06, 2014 when the dremely cold weather nistrator specified that she space heaters were care areas, but when the m failed to maintain a interior temperature for the le approved the purchase ters in resident rooms as a lich was to last twenty-four ne Administrator further lility implemented measures			
	the manufacturer instr	e heaters as directed by ructions and periodic staff dent care areas where the			