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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495261	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEESBURG	122 MORVEN PARK ROAD NW LEESBURG, VA 20176

(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
K 000	INITIAL COMMENTS Surveyor: 29282 Description of structure: The facility is a one story with a construction type of II (000). Sprinkler status: The facility is a fully sprinklered building. An unannounced recertification Life Safety Code survey was conducted 6/6/19 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the 2012 Life Safety Code. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000	**Corrective Action: K: 211**	6-30-19
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain an exit. This has the possibility to affect 20% of the residents. The Findings Include:	K 211	**Corrective action taken for the Identified problem** A Nursing cart was removed from the exit door near grove during the survey process. **Address how facility will identify Similar occurrences of the problem** A 100% audit/inspection was conducted on all doors to ensure that they a clear from any obstructions. **Identify measures/systemic changes to ensure deficient practice will not recur.** The Maintenance Director in-serviced the Nursing staff on the need for the exits to be cleared of obstructions **Indicate how facility will monitor its performance** A comprehensive life safety review of the facility by the Regional Facility Advisor and the Vice President of Engineering is conducted annually. Review of egress is part of this mock survey process.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Vorpahl	Administrator	6/25/19

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.

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K 211	Continued From page 1 On 6/6/2019 at approximately 11:52 AM, it was identified by observation the exit on the grove side was obstructed.(Corrected on site)	K 211		
K 300 SS=D	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Surveyor: 29282 8-1.4 - Instructions for manually operating the fire-extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed periodically with employees by the management. Based on observations and interview it was determined a member of the health care facility kitchen staff failed to maintain knowledge of fire safety. This has the possibility to affect 30% of the residents. On 6/6/2019 at approximately 9:55 AM during the facility survey of the kitchen an interviewed employee was not able to accurately identify and/or describe the procedures to follow upon discovery of a fire on the kitchen cooking equipment.	K 300	**Corrective Action: K: 300** **Corrective action taken for the Identified problem** Staff assigned to the dietary department were in-serviced on the procedures in the case of a fire in the dietary department. Extinguishing by fire extinguishers and use of the deploying the ANSUL system were covered during this training. **Address how facility will identify Similar occurrences of the problem** All staff in the facility were in-serviced on the fire plan. **Identify measures/systemic changes to ensure deficient practice will not recur.** The education of the fire plan is done upon hire, annually, and during fire drills. This is a documented training. **Indicate how facility will monitor its performance** A comprehensive life safety review of the facility by the Regional Facility Advisor and the Vice President of Engineering is conducted annually. Review of Fire training compliance is done during this survey.	6-30-19

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K 300	Continued From page 2 An interview on 6/6/2019 at approximately 9:55 AM with the kitchen manager confirmed this evidence.	K 300	**Corrective Action: K: 353**	6-30-19
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ______ b) Who provided system test ______ c) Water system supply source ______ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observations it was determined the health care facility failed to properly maintain components of the fire suppression system. This has the possibility to affect 100% of the residents. The Findings Include: On 6/6/2019 at approximately 9:34 AM, it was identified by observation there was less then the required minimum number of spare sprinkler heads in the head box. On 6/6/2019 at approximately 9:38 AM, it was	K 353	**Corrective action taken for the Identified problem** The spare sprinklers inventory was reviewed and replenished to current code requirements. The Door to the boiler room was labeled as to containing sprinkler control valves inside. Any and all items/wires resting or attached to the sprinkler piping located in room 201, the staff coordinators office, DON's Office, Heritage Electrical Closet, Lead Unit Manager's Office, and by room 311 were removed. The sprinkler head in the lobby was cleared of dust. The missing ceiling tile was replaced in the HR restroom. **Address how facility will identify Similar occurrences of the problem** A 100% inspection /review was done on all areas above the ceiling. Any negative findings related to the items hanging over, resting on, or attached to the sprinkler piping was corrected **Identify measures/systemic changes to ensure deficient practice will not recur.** The Maintenance Director was in-serviced by the Regional Facility Advisor on meeting with vendors and maintenance staff that work above the ceiling. The focus of the review was educating vendors and workers that nothing can be attached to, resting on, or hanging over the sprinkler piping. **Indicate how facility will monitor its performance** A comprehensive life safety review of the facility by the Regional Facility Advisor and the Vice President of Engineering is conducted annually. Sprinkler compliance with noted deficiencies will be reviewed during this process.	

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K 353	Continued From page 3 identified by observation the doors to the boiler room were not labeled as to containing the sprinkler control valves. On 6/6/2019 at approximately 10:10 AM, it was identified by observation there were items resting on sprinkler piping by room 201. On 6/6/2019 at approximately 10:11 AM, it was identified by observation there were items resting on sprinkler piping by the staff coordinators office. On 6/6/2019 at approximately 10:18 AM, it was identified by observation there was a loaded sprinkler head in the lobby. On 6/6/2019 at approximately 10:21 AM, it was identified by observation there were items resting on sprinkler piping outside the DON's office. On 6/6/2019 at approximately 11:06 AM, it was identified by observation there were items attached to sprinkler piping in the heritage electrical closet. On 6/6/2019 at approximately 11:24 AM, it was identified by observation there were items resting on sprinkler piping by the lead unit manager's office. On 6/6/2019 at approximately 11:25 AM, it was identified by observation there were items attached to sprinkler piping by the lead unit manager's office. On 6/6/2019 at approximately 11:58 AM, it was identified by observation there were items attached to sprinkler piping by room 311. On 6/6/2019 at approximately 11:59 AM, it was	K 353		6-30-19

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K 353	Continued From page 4 identified by observation there were items resting on sprinkler piping by room 311. On 6/6/2019 at approximately 12:02 PM, it was identified by observation there were missing ceiling tiles in the HR restroom.	K 353	**Corrective Action: K: 355** **Corrective action taken for the Identified problem** The fire extinguisher in the chemical storage room was replaced.	6-30-19
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observations it was determined the health care facility failed to properly maintain fire extinguishers. This has the possibility to affect 65% of the residents. The Findings Include: On 6/6/2019 at approximately 9:43 AM, it was revealed by observation the fire extinguisher in chemical storage was out of date. On 6/6/2019 at approximately 10:01 AM, it was revealed by observation the fire extinguisher in activities was not mounted. On 6/6/2019 at approximately 11:08 AM, it was revealed by observation the fire extinguisher at the rehab exit was discharged. On 6/6/2019 at approximately 12:06 AM, it was revealed by observation the fire extinguisher by room 310 was missing the pin keeper.	K 355	The fire extinguisher in the activity area was mounted to the wall The Fire extinguisher at the rehab exit was replaced. The pin keeper on the fire extinguisher was replaced. **Address how facility will identify Similar occurrences of the problem** A 100% audit/inspection was conducted on all fire extinguishers to ensure compliance. No negative findings were noted. **Identify measures/systemic changes to ensure deficient practice will not recur.** The Maintenance Director was in-service by the Regional Facility Advisor on the monthly inspection of fire extinguishers and noted deficiencies. **Indicate how facility will monitor its performance** A comprehensive life safety review of the facility by the Regional Facility Advisor and the Vice President of Engineering is conducted annually.	
K 363	Corridor - Doors	K 363		

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K 363 SS=F	Continued From page 5 CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		

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K 363	Continued From page 6 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain correct operation of a resident's room door. This has the possibility to affect 60% of the residents. The Findings Include: On 6/6/2019 at approximately 10:30 AM, it was identified by observation the door to resident room 205 did not close and latch. On 6/6/2019 at approximately 10:32 AM, it was identified by observation the door to resident room 207 did not close and latch. On 6/6/2019 at approximately 11:01 AM, it was identified by observation the door to resident room 138 did not close and latch. On 6/6/2019 at approximately 11:23 AM, it was identified by observation the door to resident room 218 did not close and latch. On 6/6/2019 at approximately 11:30 AM, it was identified by observation the door to resident room 223 was obstructed by a trash can. (Corrected on site) On 6/6/2019 at approximately 11:51 AM, it was identified by observation the door to resident room 410 did not close and latch.	K 363	**Corrective Action: K: 363** **Corrective action taken for the Identified problem** The Door was realigned and adjusted so that it latches correctly to room 205, 207, 138, 218, and 410 The trash can was removed at the time of survey to room 223. **Address how facility will identify Similar occurrences of the problem** A 100% audit/inspection was conducted on all of the facility doors to ensure all doors operate as designed. Any negative findings were corrected during this review. **Identify measures/systemic changes to ensure deficient practice will not recur.** An in-service was conducted with the Maintenance Director by Regional Facility Advisor on door inspections. **Indicate how facility will monitor its performance** A comprehensive life safety review of the facility by the Regional Facility Advisor and the Vice President of Engineering is conducted annually. Door inspection is part of the compliance program in Tels. The noted deficiency will be reviewed during the Mock Survey annually.	6-30-19
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour	K 372		

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K 372	Continued From page 7 fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain rated doors. This has the possibility to affect 25% of the residents. The Findings Include: On 6/6/2019 at approximately 10:46 AM, it was identified by observation the rate doors by room 111 did not close and latch.	K 372	**Corrective Action: K: 372** **Corrective action taken for the Identified problem** The rated door by room 111 was adjusted so that it latches as designed **Address how facility will identify Similar occurrences of the problem** A 100% audit/inspection was conducted on all of the facility doors to ensure all doors operate as designed. Any negative findings were corrected during this review. **Identify measures/systemic changes to ensure deficient practice will not recur.** An in-service was conducted with the Maintenance Director by Regional Facility Advisor on door inspections. **Indicate how facility will monitor its performance** A comprehensive life safety review of the facility by the Regional Facility Advisor and the Vice President of Engineering is conducted annually. Door inspection is part of the compliance program in Tels. The noted deficiency will be reviewed during the Mock Survey annually.	6-30-19
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to prevent	K 511		

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K 511	Continued From page 8 an electrical hazard. This has the possibility to affect 30% of the residents. The Findings Include: On 6/6/2019 at approximately 12:12 PM, it was identified by observation there were exposed wires on the back of dryer #1 in the laundry room.	K 511	**Corrective Action: K: 511** **Corrective action taken for the Identified problem** The exposed wires on the back of the dryer were secured as per NFPA 70. **Address how facility will identify Similar occurrences of the problem** A review of all equipment in the laundry was conducted to identify any other electrical deficiencies. No negative findings were noted. **Identify measures/systemic changes to ensure deficient practice will not recur.** The Facility Advisor conducted an in-service with the Maintenance Director to review the electrical Safety of the facility **Indicate how facility will monitor its performance** A comprehensive life safety review of the facility by the Regional Facility Advisor and the Vice President of Engineering is conducted annually. Review of all dryers are done in this review.	6-30-19
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to control dust accumulation and combustible storage. This has the possibility to affect 40% of the residents. On 6/6/2019 at approximately 9:42 AM, it was identified by observation there were combustibles stored in the telephone room. On 6/6/2019 at approximately 10:02 AM, it was identified by observation there was excessive accumulation of dust on the vent in the activities closet.	K 521	**Corrective Action: K: 521** **Corrective action taken for the Identified problem** The combustibles were removed from the telephone room The dust was removed from the vent on the activity closet room. **Address how facility will identify Similar occurrences of the problem** A review of the facility was conducted to ensure there were no other deficiencies as noted in K-521. Any negative deficiencies were corrected.	6-30-19
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and	K 920		

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K 920	Continued From page 9 Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain control of the proper use of electrical components. This has the possibility to affect 70% of the residents. The Findings Include: On 6/6/2019 at approximately 10:06 AM, it was identified by observation there was an unapproved multi plug cord in the dining room. On 6/6/2019 at approximately 10:26 AM, it was identified by observation there was a power strip with in the patient care vicinity in room 202B.	K 920	**K521...cont.** **Identify measures/systemic changes to ensure deficient practice will not recur.** The Facility Advisor conducted an in-service with the Maintenance Director on the noted deficiency. **Indicate how facility will monitor its performance** A comprehensive life safety review of the facility by the Regional Facility Advisor and the Vice President of Engineering is conducted annually. Review of the HVAC system and mechanical rooms is part of this review.	

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K 920	Continued From page 10 On 6/6/2019 at approximately 10:27 AM, it was identified by observation there was an unapproved multi plug in room 203A. On 6/6/2019 at approximately 10:31 AM, it was identified by observation there was a power strip with in the patient care vicinity in room 207B. On 6/6/2019 at approximately 10:34 AM, it was identified by observation there was an unapproved multi plug cord at the birdcage. On 6/6/2019 at approximately 10:35 AM, it was identified by observation there was an unapproved non-grounded adapter at the birdcage. On 6/6/2019 at approximately 10:48 AM, it was identified by observation there was a power strip with in the patient care vicinity in room 109. On 6/6/2019 at approximately 11:11 AM, it was identified by observation there was an unsupported power strip in clean linen. On 6/6/2019 at approximately 11:30 AM, it was identified by observation there was an unapproved multi plug cord in room 231 B.	K 920	**Corrective Action: K: 920** **Corrective action taken for the Identified problem** The unapproved multi plug was removed from the dining room, 203A, birdcage, and 231B Power strips were removed from 202B, 207B, 109 The ungrounded adapter was removed from the birdcage The unsupported power strip was removed from the clean linen. **Address how facility will identify Similar occurrences of the problem** A 100% audit/inspection was conducted to identify any other rooms that have a non-approved power strip and/or multi-plug **Identify measures/systemic changes to ensure deficient practice will not recur.** An in-service was conducted with the Maintenance Director by the Regional Facility Advisor to review electrical safety related to the cited code. **Indicate how facility will monitor its performance** A comprehensive life safety review of the facility by the Regional Facility Advisor and the Vice President of Engineering is conducted annually. Electrical Safety related to the cited code will be a focus.	6-30-19
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or	K 923		

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
	495261	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**06/06/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEESBURG	**122 MORVEN PARK ROAD NW LEESBURG, VA 20176**

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K 923	Continued From page 11 gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain control of oxygen use and signage. This has the possibility to affect 40% of the residents. The Findings Include: On 6/6/2019 at approximately 11:28 AM, it was identified by observation there was oxygen in use in Physical Therapy without signage. On 6/6/2019 at approximately 11:34 AM, it was	K 923	**Corrective Action: K: 923** **Corrective action taken for the Identified problem** Secondary signage for no-smoking in the physical therapy and room 226 is not required per NFPA 101 2012 edition 18.7.4.2. The facility has no smoking signs at all major entrances. *(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.* Oxygen stored at the nurse's station did not exceed the <300 cubic feet (12-e-cylinderss) per smoke compartment. **Address how facility will identify Similar occurrences of the problem** This is not a deficiency **Identify measures/systemic changes to ensure deficient practice will not recur.** This is not a deficiency **Indicate how facility will monitor its performance** This is not a deficiency	6-30-19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FORM APPROVED
OMB NO. 0938-0391

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K 923	Continued From page 12 identified by observation there was oxygen in use in room 226 without signage. On 6/6/2019 at approximately 11:55 AM, it was identified by observation there was oxygen stored at the grove nurse station.	K 923		