| DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPR | | | | | | | |
|---|--|---|---------------------|--|----------------------------|--|--|
| CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | - | OMBIN | O. 0938-0391 | | |
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | • • | | DATE SURVEY OMPLETED | | |
| | | 345551 | B. WING _ | | 2/07/2014 | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| | | | | 5935 MOUNT SINAI ROAD | | | |
| UNIHEAL | TH POST-ACUTE CA | RE - CAROLINA POINT | | DURHAM, NC 27705 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 323 SS=D | 483.25(h) FREE OI HAZARDS/SUPER | | F 32 | 23 | 2/19/14 | | |
| | environment remain as is possible; and | isure that the resident ns as free of accident hazards each resident receives on and assistance devices to | | | | | |
| | by: Based on observat failed to secure use of 68 occupied resi of 2 storage areas between rooms 407 include: 1) A review of the f procedures, "Oxyge | NT is not met as evidenced tions and interviews the facility ed oxygen cylinder bottles in 1 dent rooms (Room 605) and 1 (oxygen storage room 1 and 403). The findings facility's policies and en Administration Safety and uary 2009 and revised art: | | This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirement. Preparation and/or execution of this correction do not constitute admission or agreement by th provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely becaus it is required by the provision of the state | e | | |
| | Paragraph entitled fasten an oxygen ta Tanks in use must | - Safety - Item #3: Do not ank to a patient/resident's bed. either be installed on a stable, an oxygen tank stand. | | and federal law. It also demonstrates o good faith and desire to continue to improve the quality of care and services our residents. F323 | ur | | |
| | that oxygen tanks k either chained to th wheeled dolly or flo On 02/03/14 a tour | - Storage - Item #1: Assure ept in storage rooms are e wall or installed on a stable, or stand. of the facility was conducted. oservation was made of | | Immediate Correction Safety item #1 and item #3, oxygen tank were placed in appropriate stable, wheeled dolly or an oxygen tank stand. | ss, | | |
| | resident room 605. | During the room observation er was also observed. | | Identification of others with potential to backets affected: | e | | |
| ABORATOR | Y DIRECTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | TITLE | (X6) DATE | | |
| Electron | ically Signed | | | | 02/19/2014 | | |

Electronically Signed

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.

PRINTED: 04/30/2014

| TATEMENT | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | PLE CONSTRUCTION | (X3) DATE | 0938-039 | |
|--|--|---|--------------------------|--|--|---------------------------|--|
| ND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDIN | IG | COM | COMPLETED | |
| | | 345551 | B. WING | | | 07/2014 | |
| NAME OF | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, ST | | P CODE | | |
| UNIHEALTH POST-ACUTE CARE - CAROLINA POINT | | | | 5935 MOUNT SINAI ROAD DURHAM, NC 27705 | | | |
| (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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETIO DATE | |
| F 323 | Continued From pa | age 1 | F 32 | 23 | | | |
| | Observed in the bathroom's shower stall in front of and next to a wheelchair and wooden room chair (1/2 in and ½ out of the shower stall) was a used medium metal oxygen cylinder. The oxygen cylinder was not secured to any wall and not in any type of stand, dolly, or rack to support it and was found to be easily tipped over by anyone entering the bathroom and accidently touching the bottle. 02/03/14 at 12:27 p.m. a second observation of room 605's bathroom was conducted. The oxygen cylinder was again observed standing ½ in and ½ out of the shower stall in front of and next to a wheelchair and wooden room chair without any support. There was no means of support to keep the oxygen bottle from tipping over if accidently bumped. | | | 100% audit of all Oxygen conducted and completer facility on 2-5-14 by the M Director, Housekeeping I Director of Health Service comprised of all residents tanks and the proper sec device in an appropriate dolly or on an oxygen tank as all oxygen tanks being storage rooms are prope by being chained to the w a stable, wheeled dolly on other tanks were identifie audit. | d throughout the Maintenance Director and es. This audit s on oxygen uring of said stable, wheeled k stand, as well g stored in rly secured either vall or installed on r floor stand. No ed during this | | |
| | conducted with res was sitting in her w resident was asked had been in her ba not state how long bathroom. After th of the resident 's b oxygen cylinder bo standing ½ in and 1 front of and next to room chair without it from falling on a n member if accident observation a fema the room and assis | 8:38 p.m. an interview was ident #93 in room 605A who rheelchair next to her bed. The d how long the oxygen bottle throom. The resident could the bottle had been in the e interview a third observation bathroom was conducted. The ttle was again observed 1/2 out of the shower stall in a wheelchair and wooden any means of support to keep resident, visitor, or staff tly moved. During the ale nursing assistant entered sted resident #93 with her bath room for toileting | | Administrator, Director of Unit Managers, and all D Managers initiated in-ser 2-5-14 with all staff on all the importance of safety securing of oxygen tanks stored by being installed during transportation. All staff will be educated staff not educated by 2-1 allowed to work until educ proper storage of oxygen process will be added on process for our new staff The Root Cause Analysis by Dr. Jackson on Feb.5, | epartment vice education on shifts to stress related to proper when in use or in a carrier even by 2-19-14. Any 9-14, will not be cated on the tanks. This orientation moving forward. | | |

Facility ID: 20090049

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| TATEMENT | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | IPLE | | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED | |
|--|----------------------|---|---------------------|--|---|---|---------------------------|
| ND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDIN | IG _ | | | |
| | | 345551 | B. WING | | | 02/07/2014 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| UNIHEALTH POST-ACUTE CARE - CAROLINA POINT | | | | | 135 MOUNT SINAI ROAD URHAM, NC 27705 | | |
| (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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | (X5) COMPLETIO DATE |
| F 323 | Continued From pa | age 2 | F 32 | 23 | | | |
| | oxygen cylinder bo | om was conducted. The ttle was again observed | | | Monitoring Process | | |
| | | ½ out of the shower stall in a wheelchair and wooden | | | Department Managers and clinical sta | aff | |
| | | any means of support | | | who conduct compliance rounds will monitor the securing of oxygen tanks | in | |
| | (chained to the wal | | | use by residents daily, Monday throug | | | |
| | rack). | - | | | Friday, and the weekend Supervisor | | |
| | Op 02/05/14 of 7:2 | 0 a.m. a fifth observation of | | | and/or weekend clinical manager on d | | |
| | | om was conducted. The | | | will monitor on Saturday and Sunday. Central Supply Clerk will monitor stora | | |
| | resident was up dre | | | areas for the proper securing of oxyge | | | |
| | wheelchair next to | | | tanks Monday through Friday, and the | | | |
| | bottle was again of | | | weekend supervisor and/or weekend | | | |
| | | stall without any means of rom falling over if bumped. | | | clinical manager on duty will monitor of Saturday and Sunday. The Administra | | |
| | | igain asked how long the | | | or Director of Health Service will moni | | |
| | | been in the bathroom. The | | | compliance weekly x 3 months then | | |
| | resident still could | not state how long the oxygen | | | monthly afterwards, unless recommer | nded | |
| | | her bathroom. After the | | | otherwise by the Quality Assurance | | |
| | | e nursing assistant entered the | | | Performance Improvement Committee | e. | |
| | | I he was back to take her to oileting assistance). The male | | | Additional action planning will be implemented by the Quality Assurance | <u>م</u> | |
| | | as observed to wheel resident | | | Performance Improvement Committee | | |
| | | wheelchair, into the bathroom. | | | necessary. | | |
| | | 0 a.m. an interview and | | | | | |
| | | n 605's bathroom/shower was | | | | | |
| | | facility's Director of Nursing vation revealed the previously | | | | | |
| | | sylinder bottle still standing $\frac{1}{2}$ in | | | | | |
| | | nower stall in front of and next | | | | | |
| | | d wooden room chair without | | | | | |
| | | ort to keep it from falling. | | | | | |
| | | I the oxygen bottle was used supported by any means as it | | | | | |
| | | per the facility's policies and | | | | | |
| | procedures. The D | OON indicated the metal | | | | | |
| | | not being supported and could | | | | | |
| | tall over and injure | on any resident, visitor, and/or | | | | | |

If continuation sheet Page 3 of 9

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ``' | PLE CONSTRUCTION G | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED | | |
|---|---|---|---------------------|--|---|---------------------------|--|
| | | 345551 | B. WING | | 02/07/2014 | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 02 | 01/2014 | |
| UNIHEALTH POST-ACUTE CARE - CAROLINA POINT | | | | | | | |
| (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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETIO DATE | |
| F 323 | DON indicated the been in a dolly or s wheelchair located also observed. The support or store the indicated that wher used it was suppos resident's room and room on the 400 ha or stands. The DO expectation that all oxygen cylinder bot policies and proced An interview was co 02/07/2014 at 4:30 the facility's QA&A with oxygen tanks of rack during a tour of The DON stated th that prompted an ir plan that included r managers/coordina and by the weeken weekends. The DO Assistant Director of monitor compliance then monthly afterv date of 02/15/2014 produce document monitoring had bee QA&A plan, the DO documentation ava | age 3 may accidently bump it. The oxygen bottle should have tand. The back of the in the resident's shower was e wheelchair had no device to e oxygen cylinder. The DON n an oxygen cylinder bottle was sed to be removed from the d placed in the oxygen storage all in one of the dollies, racks, N indicated it was his staff secured the facility's ttles according to the facility's dures to prevent accidents. onducted with the DON on p.m. The DON indicated that team had identified a problem not being stored on a secured of the facility on 01/14/2014. at this was an identified issue nmediate corrective action monitoring to be done by unit ators Monday through Friday d supervisors on the DN indicated that he and the of Nursing (ADON) would e weekly for three weeks and vard with a target correction . When asked if he could ation that would indicate the en initiated according to the DN indicated that there was no ilable and the monitoring was with the completion date of | F 32 | 3 | | | |

If continuation sheet Page 4 of 9

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|--|--|---|------------|---|--|--|
| | | 345551 | B. WING _ | | 02/07/2014 | | | |
| NAME OF | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD | | | | |
| UNIHEA | TH POST-ACUTE CA | ARE - CAROLINA POINT | | DURHAM, NC 27705 | | | | |
| (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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY) | LD BE | (X5) COMPLETIO DATE | | |
| F 323 | immediate corrective after identifying the tour of the facility. A weeks) was made p indicated the facility of monitoring by the weekend superviso 02/04/2014. Per th no documentation of could provide to she monitored the ident or after the initial 3 completed. A revie indicated the facility oxygen bottles wee monthly for three m observation dates to and after the initial indicated by the DO no action to monito quality deficiency, in monitoring the qual revisions to the actific deficiency was corr survey. On 02/07/2014 at 5 conducted via phor supplier (Life Gas) The supplier indicate cylinder bottle woul knocked over howe empty or full should not indicate the risk | d the facility initiated the ve action plan on 01/14/2014 quality deficiency during a A calculation of 21 days (3 per the DON' s interview which v completed the initial 3 weeks e unit managers, coordinators, ors, ADON, and DON on e DON's interview there was or other means the facility ow the facility actually tified quality deficiency during weeks of monitoring was w of the facility's Action Plan v was to monitor for unsecured kly for three months then nonths. A review of the between 02/03-05/2014 (during 3 weeks of monitoring) ON's interview the facility took r or correct the identified mplement changes in ity deficiency, or make needed ion plan to ensure the quality rected prior to or during the 5:00 p.m. an interview was he with the facility's oxygen at the insistence of the DON. ted that any used oxygen d not cause any harm if it was ever, all oxygen tanks whether d be secured. The supplier did a of possible injury due to a tear injury if the tank fell on a | F 32 | | | | | |

If continuation sheet Page 5 of 9

| STATEMENT | OF DEFICIENCIES OF CORRECTION | KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | (X3) DA |). 0938-039 TE SURVEY MPLETED |
|---|---|--|---------------------|---|----------|-------------------------------------|
| | | 345551 | B. WING | | 02 | /07/2014 |
| NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST-ACUTE CARE - CAROLINA POINT | | | | STREET ADDRESS, CITY, STATE, ZIP CO 5935 MOUNT SINAI ROAD | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | DURHAM, NC 27705 PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| F 323 | procedures, "Oxyge Storage" dated Jan 05/2013 reads in pa Paragraph entitled fasten an oxygen ta Tanks in use must wheeled dolly or on Paragraph entitled that oxygen tanks k either chained to th wheeled dolly or flo On 02/03/14 at 11:0 was being conducted observation of the of 400 hall (between r was conducted. Th unlocked and accessor or staff member op observations revea size oxygen tanks, together making it of unused oxygen cyli room three used m were observed star door without any m dolly, stand, or rack tipped over by anyo On 02/03/14 at 12:3 of the 400 hall's oxy conducted. The thi observed to still be | facility's policies and en Administration Safety and uary 2009 and revised art: Safety - Item #3: Do not ank to a patient/resident's bed. either be installed on a stable, an oxygen tank stand. Storage - Item #1: Assure kept in storage rooms are e wall or installed on a stable, for stand. 7 a.m. a tour of the facility During the tour an oxygen supply room on the resident rooms 401 and 403) he door was observed to be ssible to any resident, visitor, rening the door. The led several racks of differing both full and used, comingled difficult to identify used from nders. When entering the edium oxygen cylinder tanks hding to the left of the open eans of support (chain to wall, k etc.) and could be easily one entering the room. 35 p.m. a second observation ygen storage room was ree empty oxygen tanks were standing unsecured on the upport (chain to wall, dolly, | F 3: | 23 | | |

Facility ID: 20090049

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| | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | IPLE CONSTRUCTION | | <u>). 0938-039</u> TE SURVEY | |
|--------------------------|--|--|---------------------|---|--------|---------------------------------|--|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | | COMPLETED | |
| | 345551 | | B. WING _ | | 02 | 2/07/2014 | |
| NAME OF | NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| UNIHEA | LTH POST-ACUTE CA | RE - CAROLINA POINT | | 5935 MOUNT SINAI ROAD DURHAM, NC 27705 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETIO DATE | |
| F 323 | On 02/03/2014 at 3 the 400 hall's oxyge conducted. The thr observed to still be floor without any su stand, or rack etc.). On 02/04/14 at 4:05 the oxygen storage made. The door re accessible to any re member opening th oxygen tanks were standing on the floor rack etc.) to the left entering the room. On 02/05/14 at 9:15 interview with the fa (DON) was conduct storage room. The unlocked and acces or staff member op side of the door who previously observed were observed to st chain, dolly, stand, tipped over by anyo DON indicated the should have been st fall and possibly inju- indicated it was his secured the facility' according to the face to prevent accident. | 245 p.m. a third observation of en storage room was ree empty oxygen tanks were standing unsecured on the pport (chain to wall, dolly, 5 p.m. a fourth observation of room on the 400 hall was mained unlocked and esident, visitor, or staff ne door. The three empty observed to still be free or without any support (stand, side of the door when 5 a.m. an observation and acility's Director of Nursing ted of the 400 hall's oxygen door was observed to still be ssible to any resident, visitor, ening the door. To the left en entering the room the three d used oxygen cylinder bottles till be unsupported by any or rack and could be easily or rack and could be easily one entering the room. The three oxygen cylinder bottles supported so they would not ure someone. The DON expectation that all staff s oxygen cylinder bottles cility's policies and procedures | F 32 | 23 | | | |

Facility ID: 20090049

If continuation sheet Page 7 of 9

| AND PLAN C | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | · · / | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|---------------------|---|---------|---|--|--|
| | | | | IG | | | | |
| | | 345551 | B. WING | | | /07/2014 | | |
| NAME OF I | NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| UNIHEAI | TH POST-ACUTE CA | ARE - CAROLINA POINT | | 5935 MOUNT SINAI ROAD DURHAM, NC 27705 | | | | |
| (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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETIO DATE | | |
| F 323 | rack during a tour of The DON stated th that prompted an in plan that included in managers/coordina and by the weeken weekends. The DO Assistant Director of monitor compliance then monthly after date of 02/15/2014 produce document monitoring had bee QA&A plan, the DO documentation ava a work in progress 02/15/2014. A review of the info during the interview information indicate immediate correcti after identifying the tour of the facility. weeks) was made indicated the facility of monitoring by th weekend superviso 02/04/2014. Per th no documentation could provide to sh | age 7 not being stored on a secured of the facility on 01/14/2014. This was an identified issue mmediate corrective action monitoring to be done by unit ators Monday through Friday of supervisors on the DN indicated that he and the of Nursing (ADON) would e weekly for three weeks and ward with a target correction . When asked if he could ation that would indicate the en initiated according to the DN indicated that there was no allable and the monitoring was with the completion date of ormation provided by the DON v was conducted. The ed the facility initiated the ve action plan on 01/14/2014 e quality deficiency during a A calculation of 21 days (3 per the DON's interview which y completed the initial 3 weeks e unit managers, coordinators, ors, ADON, and DON on he DON's interview there was or other means the facility iow the facility actually tified quality deficiency during | F 32 | 23 | | | | |

If continuation sheet Page 8 of 9

| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | FORM | 04/30/2014 APPROVED 0938-0391 |
|------------------------------|--|--|---------------------|--|-------------------------------|-------------------------------------|
| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 345551 | B. WING | | 02/ | 07/2014 |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| UNIHEA | LTH POST-ACUTE CA | ARE - CAROLINA POINT | | 5935 MOUNT SINAI ROAD DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | 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 APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 323 | and after the initial indicated by the DC no action to monitor quality deficiency, ir monitoring the qual revisions to the acti deficiency was corresurvey. On 02/07/2014 at 5 conducted via phone supplier (Life Gas) The supplier indicate cylinder bottle would knocked over howe empty or full should not indicate the risk | 3 weeks of monitoring) ON's interview the facility took or or correct the identified mplement changes in lity deficiency, or make needed ion plan to ensure the quality rected prior to or during the 5:00 p.m. an interview was ne with the facility's oxygen at the insistence of the DON. ted that any used oxygen Id not cause any harm if it was ever, all oxygen tanks whether d be secured. The supplier did of possible injury due to a tear injury if the tank fell on a | F 323 | | | |

Facility ID: 20090049

If continuation sheet Page 9 of 9