Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 9, 2023

Administrator
St Lukes Lutheran Care Center
1219 South Ramsey
Blue Earth, MN 56013

RE: CCN: 245372
Cycle Start Date: March 1, 2023

Dear Administrator:

On April 18, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 21, 2023

Administrator
St Lukes Lutheran Care Center
1219 South Ramsey
Blue Earth, MN 56013

RE: CCN: 245372
Cycle Start Date: March 1, 2023

Dear Administrator:

On March 1, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 1, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 1, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	C 03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

(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
E 000	Initial Comments On 2/27/23 - 3/1/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/27/23 - 3/1/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued. H5372046C (MN82585), H5372047C (MN82219 and MN79986), H53728757C (MN86939), H53728759C (MN86220) and H53728661C (MN83808). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/29/2023

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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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide sufficient organized, group activities on the weekend hours to meet resident need and desires for 1 of 1 resident (R10) who voiced there were not enough activities offered. Findings include: R10's annual Minimum Data Set (MDS) dated 1/18/23, identified R10 had intact cognition and was independent with activities of daily living (ADLs). Further, the MDS contained a section for activity preferences which identified R10 preferences included listening to music, doing things with groups of people, participating in activities, spending time outdoors and participating in religious activities or practices.	F 679	It is the goal of the St. Luke's Lutheran Care Center Therapeutic Recreation (TR) Department to provide an ongoing meaningful and interesting program of activities designed to promote the physical, mental, and psychosocial well-being of each resident. Activity programming will be based on the residents' comprehensive assessment, care plan and preference. Residents will be supported in their choice of activities, including facility-sponsored group activities, individual activities, and independent activities. The TR activity program includes organized group activities, 1:1 visits, and individual or small group activities facilitated by campus staff. The full-time	4/7/23

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F 679	Continued From page 2 R10's care plan dated 1/16/23, identified R10 has a potential risk for alteration of culturally competent care and his family and church are very important to him. R10 likes to listen to music to relax, enjoys being outside, gardening, fixing things and riding his 3 wheeled bike. R10 prefers things organized and scheduled. During interview on 2/27/23, at 10:24 a.m., R10 indicated since COVID-19 started, the facility offers very few activities to do. R10 indicated used to have bingo every week and now it is every other week. Weekends get very long. Saturday is generally nothing and Sunday they offer church and that is all. When interviewed on 2/28/23, at 12:47 p.m. R10 stated there was not enough activities offered by the facility especially on weekends. R10 indicated they do get a calendar but as a rule all that is listed is to do something yourself. A group of men play cards but they organize that themselves. R10 indicated part of the problem is a shortage of help. The untitled activity calendars provided for 1/15/23 through 2/28/23, identified each day of the week along with the days' corresponding activities being offered and provided by therapeutic recreation. Days with only worship service and coffee-social doorway/hallway are listed below along with days with only one activity which was play card with your friends not organized or attended by therapeutic recreation: 1/15/23 1/16/23, card games (please play with your friends, no activity person in the room). 1/21/23	F 679	facility chaplain provides Sunday worship services, Monday Bible studies and 1:1 spiritual counseling/support. Area churches provide services for their parishioners who reside at St. Luke's. Special events presented by surrounding community individuals or small groups are scheduled periodically throughout the year. Activity programming geared toward residents with dementia including organized group and individual activities, continues to be provided daily in the facility's secured dementia wing. Organized group activities for residents on B Hall, where R10 resides, and C Hall have been limited on weekends due to the current shortage of TR Department staff and availability of volunteers. To best meet individuals' preference for weekend activities, the TR Director and Social Services staff are surveying facility residents to determine what activities they would be interested in having on the weekend; the survey will be completed on 3/29/23. A Resident Council meeting will be held on 4/6/23. In addition to Social Services staff, the TR Director will be present to share findings from the resident weekend activity survey and discuss feasible plan for weekend programs including organized group activities that will best reflect the residents' preferences. On an ongoing basis, the Director of Therapeutic Recreation will check with resident/responsible party during individual care conferences for concerns or suggestions regarding resident's care	

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F 679	Continued From page 3 1/22/23 1/28/23 1/29/23 2/2/23- Church services in morning and afternoon, resident council meeting. 2/4/23 2/5/23 2/11/23 2/12/23 2/18/23 2/19/23 2/20/23- Please play cards with your friends. 2/22/23- Ash Wednesday Service. 2/25/23 2/26/23 On 2/28/23, at 1:06 p.m., activities coordinator (AC)-A indicated coffee social-doorway/hallway is done by nursing staff. AC-A indicated right now there is no one to work Saturday and Sunday is church service day. AC-A indicated that residents are fairly independent and they will start their own activities. AC-A also added residents have a lot of family visits. AC-A included she is aware of gaps on the calendar due to staff being unavailable. Review of R10's activity attendance from 1/4/23 to 2/28/23 included two worship services and attended bingo four times, played cards or another game 4 times. During interview on 2/28/23, at 2:43 p.m., licensed practical nurse (LPN)-A confirmed the nursing staff deliver a snack cart and beverages to the residents every afternoon. LPN-A indicated the facility started that when COVID-19 outbreaks started and residents really liked it so they have continued to offer daily.	F 679	plan for activities including weekend activities. Social Services will include inquiry regarding activity concerns or suggestions on the agenda of monthly Resident Council meetings. Results of care conference and Resident Council inquiries will be used to guide TR program planning. In addition, the results will be summarized at the quarterly Quality Assurance Performance Improvement Committee Meetings. The Director of Therapeutic Recreation is responsible for overall compliance with this regulation.	

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F 679	Continued From page 4 During interview on 3/1/23, at 3:45 p.m. the administrator acknowledged they are currently short of activities staff. A policy and procedure for TR was requested and none received.	F 679		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review the facility failed to assess and monitor for complications per standard of practice before and after dialysis for 1 of 1 resident (R43) reviewed for dialysis care. Findings include: R43's face sheet printed 3/1/23, included diagnosis of dependence on renal dialysis, heart failure, high blood pressure and atrial fibrillation (irregular heart rhythm that can lead to blood clots in heart). R43's quarterly Minimum Data Set (MDS) assessment dated 12/20/22, identified intact cognition, required limited to extensive assistance with activities of daily living, and was on dialysis. Provider orders dated 1/11/23, indicated R43	F 698	It is the goal of St. Luke's Lutheran Care Center to provide nursing care services consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences. R43 receives hemodialysis through Mayo Clinic Dialysis Services in a neighboring community. Upon initiation of dialysis services for R43, a Memorandum of Understanding was provided to St. Luke's by the dialysis unit to assure collaboration of care. The memorandum states that vital signs should be performed as per routine for nursing home patients. Blood pressure, weight, pulse, and temperature will be determined during each visit to the dialysis unit. The memorandum also includes additional guidance regarding cares including need to monitor the	4/7/23

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F 698	Continued From page 5 receives warfarin (blood thinner) 2 mg tablet daily. R43's care plan dated 4/20/22, included at risk for complications and overall decline related to acute and chronic kidney disease stage 4 with need for dialysis. Interventions included dialysis treatments on Tuesday, Thursday and Saturdays. Monitor for signs of bleeding or infection at access site. Monitor vitals signs per protocol and consult with physician or dialysis center if abnormal blood pressure. During an interview on 2/27/23, at 2:44 p.m., R43 stated he had an access port on his upper chest for dialysis and staff did not assess it or provide any care for it. R43 included after dialysis he is tired and he generally gets in bed and sleeps the rest of the day. During interview on 2/28/23, at 2:43 p.m. licensed practical nurse (LPN)-A indicated there is no special monitoring or assessments that are completed on R43 prior to or after dialysis. The dialysis site is checked every morning to ensure no signs of infection are present. Dialysis monitors the dressing site, catheter and completes site care. LPN-A indicated R43 has not had any issues that she is aware of. Vital signs are done by dialysis and the facility does weekly vital signs per protocol. LPN-A added they (facility) send provider orders with R43 to dialysis and receive from dialysis his last set of vital signs, if midodrine (treatment for low blood pressure) was given, and pre and post weights. During continuous observation and interview on 2/28/23, at 1:50 p.m. R43 returned from dialysis and was assisted into bed by a staff member. No assessment was completed. R43 stated he	F 698	dialysis access site. To assure ongoing communication, coordination, and collaboration of services between the dialysis unit and St. Luke's, R43's care plan has been updated to include assessment of resident prior to leaving for dialysis including vital signs, Central Venous Catheter access site, and any change in resident status since the last dialysis session. A communication form including resident assessment and copy of current orders will be sent with resident to dialysis. Upon return to the facility following dialysis, R43's care plan has been updated to include reassessment of vital signs and Central Venous Catheter access site. The facility's policy for care of dialysis residents has been updated to include assessment of residents prior to leaving for dialysis and upon return as stated above for R43. All residents who are receiving dialysis services upon admission or will be initiating dialysis services during their stay, will have a care plan that follows St. Luke's revised dialysis policy requiring assessment of resident prior to leaving for dialysis including assessment of vital signs, dialysis access site, and any change in resident status. The assessment will be documented on the facility's Hemodialysis Communication Form and sent along with current orders with the resident to their dialysis facility. All residents receiving dialysis will also be assessed upon return from their dialysis sessions. The reassessment will include assessment of vital signs and dialysis access site. The assessment will be	

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F 698	Continued From page 6 was tired and just wanted to sleep. During observation over the next hour at 2:12 p.m., 2:37 p.m., and 3:00 p.m. no staff had entered R43's room and R43 remained sleeping. During interview and observation on 2/28/23, at 3:37 p.m., registered nurse (RN)-B indicated they check R43's catheter insertion site every day to ensure dressing is intact. The catheter that extends from the insertion site is left alone. RN-B added R43 has a central venous catheter (flexible, long plastic, Y-shaped tube threaded through skin into a central vein) for his dialysis site. R43's dialysis site was present on his right chest with an extending catheter with two ports present and covered with 4x4's. RN-B examined site and indicated no redness, swelling or bleeding was present. RN-B indicated R43 comes back tired and sleeps most of the day when he returns. During interview on 3/1/23, at 7:26 a.m. RN-E from dialysis facility indicated they receive physician orders from the facility but no pre-assessment. RN-E indicated they do vital signs before R43 leaves and has a history of low blood pressures. During interview on 3/1/23, at 8:56 a.m., RN-C indicated a physician order sheet is sent with R43 to dialysis and in return dialysis sends back pre and post weights, and vital signs if midodrine is given. RN-C indicated no assessment is completed prior to or after dialysis. The port is checked daily to be sure it is dry and intact. During interview on 3/1/23, at 9:50 a.m., RN-D indicated R43 has routine vital signs which are done weekly. Dialysis is responsible for vital	F 698	documented on the facility's Hemodialysis Communication Form and concerns followed up appropriately per guidance provided by resident's dialysis facility in Memorandum of Understanding, or similar document provided for each resident receiving dialysis from their dialysis facility. All Nursing Department licensed staff members are required to read and sign the revised Dialysis Policy and Procedure. On a weekly basis for one month and then on a monthly basis, the Director of Nursing or her designee will randomly audit documentation of residents receiving dialysis to assure that assessments prior to and following dialysis sessions are documented. Results of auditing will guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assurance and Assessment Committee Meeting. After 1 year, the Quality Assurance and Assessment Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Nursing is responsible for overall compliance with this regulation.	

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F 698	Continued From page 7 signs before and after dialysis. The dialysis port site is monitored for infection daily but otherwise site care and monitoring is done by the dialysis center. During interview on 3/1/23, at 11:55 a.m., the director of nursing (DON) confirmed R43 should be assessed before and after dialysis including observing the port site for bleeding. The DON indicated this is the first dialysis patient they have had and she developed the policy and procedure today but prior to request for the policy did not have one. Facility policy titled Dialysis, undated, included the facility is responsible for the overall quality of care the resident receives, including ongoing assessments, care planning and provisions of care.	F 698		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		3/26/23

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(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 812	Continued From page 8 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dishwashing sanitization for 1 of 1 dishmachine was appropriately monitored. Findings include: During an interview and observation on 2/27/23, at 6:55 a.m., the initial kitchen tour was conducted with culinary services director (CSD). The dishmachine was observed and CSD stated dishes were sanitized by chemical disinfection with chlorine. During an interview and observation on 3/1/23, at 8:40 a.m., the dishmachine log, titled Dishwasher Temperature and Sanitizer Log, located in the dishmachine room, was observed to have sanitizer concentrations of chlorine documented below the required 50 to 200 ppm (parts per million). Some readings on the log were 0, some were 10, 50, 100 or 200 ppm. Dietary aide (DA)-A demonstrated the process of measuring the level of chlorine disinfectant in the dishmachine water by taking a long handled, metal scoop and obtained a sample of water from inside the dishmachine. As she was doing this, DA-A stated, "We've been having issues with the sanitizer for awhile." DA-A then dipped a Lamotte brand chlorine test strip (expiration date 6/24), into the solution and held it against the colored squares on the container of strips. The paper strip did not change color indicating the proper ppm had not been reached. DA-A stated she had told assistant	F 812	St. Luke's Lutheran Care Center's policy for assuring proper sanitization of dishes states that dishwashing staff will check temperature and sanitizing level of the dish machine prior to washing dishes at each meal. Staff will be trained to report any problem with the dish machine to the shift supervisor as soon as it occurs. On 3/1/23 when the dish machine was observed to have sanitizer concentration below the required level, EcoLab was contacted and the facility switched from use of dishes to paper products for serving meals. On 3/2/23, EcoLab representative came to facility, fixed dish machine sanitizing problem and documented chemical sanitation level of 150ppm in report stating dish machine is working well. On 3/8/23, the Culinary Services Director updated the Dishwasher job description to reflect the process of reporting temperatures and sanitizer levels out of compliance. The Dishwasher Temperature and Sanitizer Log was updated with a color highlighted area requiring documentation of corrective action. An orange colored Service Request slip was made for reporting out of compliance temperature or sanitation levels to shift supervisors immediately. From 3/16/23 through 3/25/23, the Director of Culinary Services and shift supervisors provided individual training	

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	245372	A. BUILDING _____ B. WING _____	C 03/01/2023

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F 812	Continued From page 9 culinary services director (ACSD) about it today and he looked at it. DA-A did not know how long there had been readings below 50 ppm. The paper Dishwasher Temperature and Sanitizer Log had eight columns and three rows for each of the daily meals. One of the column headings was "sanitizer concentration (ppm)" and one column was "corrective action taken." The date range on the log was from 2/22/23, through 3/1/21. Out of 21 readings, five entries on the following dates 2/24/23, 2/28/23, and 3/1/22, were documented at 0 or 10 ppm. The only date where corrective action was taken was on 3/1/23, when during the interview with DA-A, she noted the ppm to be zero and informed ACSD. During an interview on 3/1/23, at 8:55 a.m., ACSD stated they had problems with the dishmachine reaching appropriate disinfectant levels, adding it had been a problem for awhile and he had just called the vendor about it. ACSD was asked to provide logs from the past four months. Upon review, some logs had documented readings of 0 or 10 ppm, some dates were missing readings. ACSD stated he reviewed the sheets after they were filled, but had not noticed documented readings below 50 ppm. ACSD admitted he did not monitor the logs daily or on a regular basis in order to identify potential problems early on. ACSD provided additional Dishwasher Temperature and Sanitizer Logs from 10/25/22, through 2/21/23, which indicated: --11/1/22: following two of three meals, "0" ppm sanitizer concentration was documented on the log. No corrective action noted. --11/7/22: following two of three meals, "10" ppm	F 812	including a return demonstration with all dietary staff whose duties include dishwashing. The training included: 1. Review of Cleaning Schedules Daily/Weekly/Monthly 2. Pot and Pan Test Trip Procedure and Log 3. Dish Machine Temperature/PPM Tests and Log 4. Sanitizer Test Strip and Log and procedure for reporting sanitizer concentration levels below required 50 to 200ppm 5. Personal Hygiene, Hand Washing, Hair Covering, Beard Covering 6. De-Lime Dishwasher On an ongoing basis, this training will be provided to all new dietary staff who duties will include dishwashing. The Director of Culinary Serivces will be accountable for checking test strip expiration dates weekly and assuring unexpired test strips are available in the facility at all times. On an ongoing basis, the Director of Culinary Services, Assistant Director of Culinary Services or Shift Supervisors will complete daily audits including checking to assure that dish machine temperatures were recorded and sanitizer log was completed. Results of the auditing will be summarized at the quarterly Quality Assurance and Assessment Committee Meeting. After 1 year, the Quality Assurance and Assessment Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Culinary Services is	

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F 812	Continued From page 10 sanitizer concentration was documented on the log. No corrective action noted. --12/25/22: following all three meals, "10" ppm sanitizer concentration was documented on the log. No corrective action noted. --12/26/22: following two of three meals, "0" ppm sanitizer concentration was documented on the log. ACSD was notified after the second. --12/28/23: following one of three meals, "10" ppm sanitizer concentration was documented on the log. No corrective action noted. --1/17/23: following all three meals, "10" ppm sanitizer concentration was documented on the log. ACSD was notified after the second. --1/18/23: following two of three meals, "10" ppm sanitizer concentration was documented on the log. No corrective action noted. The bottom of the form indicated: Report any inappropriate temperatures or sanitizing issues to the supervisor immediately for corrective action. During an interview on 3/1/23, at 9:48 a.m., culinary services director (CSD) stated she had not been aware the level of chlorine in the dishmachine had been below the required concentration. CSD stated they had done training on it in the past and staff were to let either CSD or ACSD know when out of compliance. During a telephone interview on 3/1/23, at 12:24 p.m., Ecolab representative (ER)-C stated they conducted preventative maintenance visits to the facility monthly. Staff were to test the dishmachine solution and if it dropped below 50 ppm, were to call the representative. When informed what was observed when DA-A obtained the water from the dishmachine with the scoop, ER-C stated by doing that, they might be getting mixed wash water, rather than just rinse	F 812	responsible for overall compliance with this regulation.	

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F 812	Continued From page 11 water at the very end. ER-C suggested running an upside down plate through the dishmachine, then test the residual water. ER-C stated the risk of low concentration of chlorine meant dishes were not getting properly sanitized. During an observation on 3/1/23, at 12:40 p.m., CSD ran an upside down plastic plate cover through the dishmachine, then tested the water collected in the top of the dome. The chlorine strip did not change color indicating proper chlorine concentration had not been achieved. During an interview and observation on 3/1/23, at 12:47 p.m., with ER-C on speaker phone, and CSD and maintenance technician (MT)- B standing at the dishmachine, ER-C explained to MT-B what to do to verify correct placement of tubes/hoses in the bucket of liquid chlorine under the dishmachine. From MT-B's description provided to ER-C, the tubing/hose arrangement in chlorine bucket seemed to be positioned accurately. On 3/1/23, at 1:07 p.m., CSD stated she met with the administrator and the decision was made to switch to disposable dish products until the situation was resolved. During an interview on 3/1/23, at 3:26 p.m., the administrator stated after the last time this happened, they had trained staff and did audits. It was her expectation staff followed policies that were in place to monitor the solution and to report to CSD or ACSD if the solution was out of the required range. The Dishwasher Temperature and Sanitizer Logs were reviewed with the administrator and entries of 0 or 10 ppm and no action taken were pointed out.	F 812		

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F 812	Continued From page 12 Facility policy titled Sanitation of Dishes/Dish Machine, dated 2010, indicated for low temperature dishwater, spray type dish machine using chemicals to sanitize: the wash water temperature was required to be at 120 degrees Fahrenheit, minimum. The final rinse sanitization should be 50 to 200 ppm hypochlorite range.	F 812		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident bathroom call light cords were within reach from the bathroom floor for 3 of 3 residents (R36, R153, R12), reviewed for call lights. Findings include: R36 R36's annual Minimum Data Set (MDS) assessment dated 1/5/23, included diagnoses of arthritis, weakness and glaucoma (eye disease that can cause blindness). R36 who was cognitively intact and required extensive assistance of one staff member for toileting, and did not walk.	F 919	St. Luke's Lutheran Care Center is committed to providing each resident with a reliable means of contacting care givers. St. Luke's resident rooms have a call light located at the resident's bedside and in the bathroom by the toilet. To meet the requirement of having bathroom call light cords within reach from the bathroom floor, all bathroom cords were replaced with longer cords that hang within 3 inches from the floor by 3/15/23. A memo for all facility staff will be posted 3/29/23 with information regarding requirement to have bathroom call light cords within reach from bathroom floor; staff are requested to assist in monitoring	3/15/23

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F 919	Continued From page 13 During an observation on 2/27/23, at 7:22 a.m., the call light cord in R36's bathroom was measured at 22 inches from the floor. R153 R153's admission Minimum Data Set (MDS) assessment dated 2/8/23, included diagnoses of weakness and arthritis. R153 who was cognitively intact and required limited assistance of one staff member for toileting, walked with limited assistance of one staff. During an observation on 2/27/23, at 7:24 a.m., the call light cord in R153's bathroom was measured at 18 inches from the floor. R12 R12's quarterly Minimum Data Set (MDS) assessment dated 1/24/23, included diagnoses of osteoarthritis and weakness. R12 who was cognitively intact and required extensive assistance of one staff member for toileting, did not walk. During an observation on 2/27/23, at 1:58 p.m., the call light cord in R12's bathroom was measured at 26 inches from the floor. During an interview and observation on 2/28/23, at 1:20 p.m., building services director (BSD) stated he was not aware of the regulation which required call light cords in resident bathrooms to extend to the floor and be accessible to a resident lying on the floor. Together looked in R153's bathroom and BSD verified the cord was not to the floor. During an interview on 2/28/23, at 3:02 p.m., the	F 919	to assure that cords are accessible from bathroom floor. On an ongoing basis, Building Services staff conduct monthly audits of call lights. During the monthly audits, bathroom call light cords will be checked to assure that the cord length comes within 3 inches of the bathroom floor. Results of the monthly call light audits will be summarized at the quarterly Quality Assurance and Assessment Committee Meeting. After 1 year, the Quality Assurance and Assessment Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Building Services is responsible for overall compliance with this regulation.	

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F 919	Continued From page 14 administrator was unaware of the regulation which required call light cords in resident bathrooms to extend to the floor and be accessible to a resident lying on the floor, and stated BSD would get going on that [replacing cords] right away. Facility policy on call lights was requested. According to the director of nursing on 3/1/23, at 3:30 p.m., the facility did not have a call light policy.	F 919		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/01/2023. At the time of this survey, ST LUKES LUTHERAN CARE CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 03/29/2023

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 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ST LUKES LUTHERAN CARE CENTER is a 1 story building with partial basement. The building was constructed at 5 different times. The original building was constructed in 1963, being a one-story with partial basement and was determined to be of Type II (111) construction. In 1969 an addition was constructed, one-story in height with no basement, and was determined to be of Type II (111) construction. In 1975 an addition was constructed, one-story in height with	K 000		

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K 000	Continued From page 2 no basement, and was determined to be of Type II (111) construction. In 2005 an addition was constructed, one-story in height with no basement, and was determined to be of Type V (111) construction. In 2008 a mechanical building addition was constructed, one-story in height with no basement, and was determined to be of Type II (111) construction. Because the original building and the addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type V (111). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2	K 324		4/21/23

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K 324	Continued From page 3 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper safety and security measures related to a cooking device in a resident accessible corridor in accordance with the Life Safety Code NFPA 101, 2012 edition, section 19.3.2.5.3(9). This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 03/01/2023 between 10:30 AM and 4:00 PM, it was revealed by observation that there were cooking ranges located in Activities Room and Physical Therapy Room. There was no switch with a safety timer to deactivate the cooking range. The facility was using the circuit breaker to instead of a safety isolation switch. An interview with the Maintenance Director	K 324	On 4/21/23, a safety isolation switch with a 60-minute maximum timer was installed on the cooking range in the Activities Room. Staff will be instructed with memo posting not to leave a cooking range unattended until the power is deactivated. On 4/21/23, the cooking range located in the Physical Therapy/Occupational Therapy Room was permanently removed. The Physical Therapy/Occupational Therapy Department will plan to use the cooking range with a safety isolation switch that is located in the Activities Room. On an ongoing basis, the Building Services Director or designee will conduct random monthly audits to assure that facility staff are present until the safety isolation switch has deactivated power to the cooking range. Results of auditing will	

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K 324	Continued From page 4 verified these deficient findings at the time of discovery.	K 324	be summarized at the quarterly Quality Assessment and Assurance Committee Meetings. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Building Services is responsible for overall compliance with this regulation.	
K 353 SS=D	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: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and	K 353	On 3/1/23, the additional load was taken off the sprinkler piping. The Director of Building Services will instruct Maintenance staff regarding need to keep sprinkler pipe free of any additional	3/1/23

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ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

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K 353	Continued From page 5 Maintenance of Water-Based Fire Protection Systems, sections 5.2.2.2 This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/01/2023 between 10:30 AM and 4:00 PM, it was revealed by observation in the basement, that in RM146, there was additional physical loading on the sprinkler piping in the form of a wire that was wrapped around and tided off to the sprinkler piping to support the load of another mechanical pipe in the room, and a flexible drain line that was resting on the sprinkler piping. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	loading. On an ongoing basis, the Building Services Director or designee will conduct monthly audits to assure that sprinkler pipes are free from any additional loading. Results of auditing will be summarized at the quarterly Quality Assessment and Assurance Committee Meetings. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Building Services is responsible for overall compliance with this regulation.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced	K 374		3/2/23

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K 374	Continued From page 6 by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/01/2023 between 10:30 AM and 4:00 PM, it was revealed during the tour of the facility, that upon testing of the smoke barrier door assembly at the entry to Deerford Lane exhibited an air-gap greater than 1/8" that would allow the passage of smoke. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 374	On 3/2/23, a door sweep that eliminated the air gap was installed on the smoke barrier door at the entry to Deerfield Lane. On an ongoing basis, the Building Services Director or designee will conduct monthly audits to assure there are no air gaps greater than 1/8 inch in the facility's smoke barrier doors. Results of auditing will be summarized at the quarterly Quality Assessment and Assurance Committee Meetings. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Building Services is responsible for overall compliance with this regulation.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 712	Documentation for facility fire drills due	3/16/23

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K 712	Continued From page 7 and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.2, and 4.7.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/01/2023 between 10:30 AM and 4:00 PM, it was revealed by a review of available documentation, that no evidence was presented for review to confirm that 3rd shift - 1st quarter and 2nd shift - 4th quarter fire drills had occurred. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	on the 3rd shift in the first quarter of 2023 and 2nd shift in the 4th quarter of 2022 was missing when the Life Safety Code was conducted. A revised template for scheduling fire drills for 2023 has been completed that will assure drills are completed in appropriate timeframe per NFPA 101 standards. The Director of Building Services is accountable for the scheduling of fire drills to meet NFPA standards, and is responsible for overall compliance with this regulation.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and 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	K 920		3/2/23

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K 920	Continued From page 8 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: Based on observation and staff interview, the facility failed to manage usage of flexible cords and cables as-well-as listed and labeled equipment in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400-8 (1) and UL1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: 1. On 03/01/2023 between 10:30 AM and 4:00 PM, it was revealed by observation, that in RM 242, Dietary Assistant Office, an extension cord was found in use 2. On 03/01/2023 between 10:30 AM and 4:00 PM, it was revealed by observation, that in RM 600A a refrigerator was connected to relocatable power tap. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	The extension cord in Room 242 was immediately removed. In Room 600A, the refrigerator was unplugged from a relocatable power tap and plugged directly into an outlet. assure there are no extension cords being utilized in the facility and appliances are connected directly into an outlet. Results of auditing will be summarized at the quarterly Quality Assessment and Assurance Committee Meetings. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Building Services is responsible for overall compliance with this regulation.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101	K 923		3/1/23

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K 923	Continued From page 9 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 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: Based on observation and staff interview, the	K 923	The oxygen cylinder in Room C412A that	

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K 923	Continued From page 10 facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5.2. This deficient findings could have an isolated impact on the residents within the facility. Findings include: On 03/01/2023 between 10:30 AM and 4:00 PM, it was revealed by observation, that in the Med Gas Storage Room (Room C412A), there was mixed storage of empty/full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 923	had an integral pressure gauge attached, was removed from the oxygen storage rack for full cylinders, and was placed in the storage rack for empty cylinders. A sign has been posted instructing staff not to place regulators on an oxygen tank until the tank is needed. The Building Services Director or his designee will conduct monthly audits of the facility's Medical Gas Storage Rooms to assure that oxygen cylinders with regulators applied are stored in the empty storage rack. Results of auditing will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Building Services is responsible for overall compliance with this regulation.	