Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 26, 2026

Administrator
LB BROEN HOME
824 SOUTH SHERIDAN STREET
FERGUS FALLS, MN 56537

RE: CCN:245453

Cycle Start Date: May 19, 2026

Dear Administrator:

On May 19, 2026, 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:

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College Way
Fergus Falls, 56537
Email:stacy.line@state.mn.us
Office: 218-332-5159 Mobile: 612-419-0950

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 August 19, 2026 (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 November 19, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division

445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING B. WING	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 56537

(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
E0000	Initial Comments On 5/17/26 to 5/19/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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.	E0000		05/26/2026
F0000	INITIAL COMMENTS On 5/17/26 to 5/19/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54532048C (3002552), H54532049C (2678789). NO deficiencies were cited. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		06/15/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F0550	The facility failed to provide services in a dignified manner for 1 of 1 residents (R31). R31 is found to be cognitively intact and to be continent of bowel and bladder. R31 is aware of the need to void or defecate and would request assistance to the toilet as needed. R31	06/15/2026

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 reverse for further 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.

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

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F0550 SS = D	Continued from page 1 access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in a dignified manner for 1 of 1 residents (R31), reviewed for dignity. Findings include: R31's quarterly Minimum Data Set dated 4/9/26, identified R31 was cognitively intact and had diagnosis which included renal insufficiency, diabetes mellitus (DM), and hypertension (elevated blood pressure). MDS further identified R31 was	F0550	Continued from page 1 states staff put "diapers" on him and does not like this. Staff was aware R31 did not like the "diaper" but applied anyways. All residents within the facility have the potential to be affected by this deficient practice. The facility will identify residents who are continent of bowel and bladder and ask the resident if they are wearing the desired undergarments. LB Homes Nursing Care Audit, BH #1296-18 This audit will be completed weekly x4 weeks on all units within the facility and quarterly ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance improvement (QAPI). All Nursing Staff meeting is scheduled for Tuesday, June 9 , 2026. The revised audit as identified above will be presented to all nursing staff. All facility nursing staff will be reeducated on the requirement of Resident Rights June 15, 2026, and on-going.	06/15/2026

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F0550 SS = D	Continued from page 2 continent of bowel and bladder and required staff assistance with activities of daily living (ADL's) which includes bed mobility, transfers, and toileting. Review of a bowel and bladder assessment dated 4/9/26, identified R31 was continent (has control of) bowel and bladder. Review of R31's care plan revised 1/30/26, identified R31 was aware of the need to void or defecate and would request to use the toilet as needed. During an interview on 5/17/26 at 11:54 a.m., R31 stated staff put diapers on me, I know when I need to use the bathroom and I am not incontinent. R31 stated I have told staff it makes me feel like a baby when they put a diaper on me. During an observation on 5/18/26 at 8:20 a.m., nursing assistant (NA)-A excited R31's room and wheeled R31 to the dining room and returned to the hallway. R31 motioned for surveyor to come over to his table. R31 pulled his pants outward slightly and grabbed at his brief and stated she just put this on me a few minutes ago. During an interview on 5/18/26 at 8:45 a.m., NA-A verified she placed a brief on R31 this morning even though R31 was not incontinent of his bowel or bladder. NA-A stated she was unsure why she placed a brief on R31 but was aware that R31 did not like to wear briefs and stated R31 would take the brief down and place it around his ankles. During an interview on 5/18/26 at 9:27 a.m., registered nurse (RN)-A verified R31 was continent of bowel and bladder. RN-A stated staff puts a brief on R31 out of habit. R31 stated her expectation was that staff not place a brief on any resident that is continent to maintain resident dignity. During an interview on 5/18/26 at 9:27 a.m., director of nursing (DON) stated her expectation was that staff not place a brief on residents that are continent. DON stated it was important to maintain R31's dignity. Review of a document / facility policy titled	F0550		06/15/2026

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F0550 SS = D	Continued from page 3 Combined Federal and State Resident Bill of Rights dated 12/22/25, identified a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each residents individuality. The facility must protect and promote the rights of the resident.	F0550		06/15/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted on 05/19/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, LB Broen Home Bldg 01 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The 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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K0000		06/01/2026

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 reverse for further 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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K0000 Bldg. 01	Continued from page 1 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. Building 01 of LB Broen Memorial Home is a 2-story building with a partial basement. The building was constructed at three different times. The Main building was built in 1969 and is 2-stories with a partial basement that was determined to be Type II (222) construction. In 1984 a 2- story addition was built to the south of the 1969 building, with a partial basement, and was determined to be Type II (222) construction. This building is separated from the 1969 building with a 2-hour fire barrier. In 1996 a chapel addition was built to the northwest of the 1969 building is 1-story without a basement and was determined to be Type II (000). The facility was surveyed as two buildings. The building is completely protected by an automatic fire sprinkler system installed and also has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 77 beds and a census of 50 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET.	K0000		06/01/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K0353	K353: dust loaded sprinklers were identified in multiple locations (3N Dining Room, 3N Tub Room, A17 Soiled Laundry, and Clean Laundry); the sprinkler heads were cleaned, with a goal correction date of 06/19/2026 and actual completion on 05/19/2026, and to prevent recurrence, regular	05/20/2026

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K0353 SS = F Bldg. 01	Continued from page 2 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(5). These deficient findings could have a widespread impact on residents within the facility. Findings include: On 05/19/2026 at 10:43 AM, 10:45 AM, 12:06 PM, and 12:07 PM it was revealed by observation that sprinkler heads in the following areas showed signs of loading with dust and debris: 3 North Dining Room 3 North Tub Room Room A17 Soiled Laundry area in basement Clean Laundry area in basement An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0353	Continued from page 2 visual inspections will be conducted in high-risk areas, with annual inspections coordinated with the fire sprinkler provider, monitored by the Director of Facilities.	05/20/2026
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K0372	K372: Improper fire caulking was identified on rated fire walls (3N East, 2N East, and Chapel storage ceiling tile), and the holes were properly fire caulked, & Fire walls inspected with other penetrations sealed	06/19/2026

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K0372 SS = E Bldg. 01	Continued from page 3 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.2.1, and 8.5.2.2. These deficient findings could have a patterned impact on residents within the facility. Findings include: On 05/19/2026 at 10:52 AM, it was revealed by observation that the smoke barrier wall above the smoke barrier doors leading to 3 North East wing had penetrations that were not properly fire caulked. On 05/19/2026 at 11:13 AM, it was revealed by observation that the smoke barrier wall above the smoke barrier doors leading to 2 North East wing had a hole in the barrier that was not properly fire caulked. On 05/19/2026 at 11:30 AM, it was revealed by observation that a ceiling tile was missing in the Chapel Storage Room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0372	Continued from page 3 also. with a goal completion date of 06/19/2026; to prevent recurrence, smoke partitions will be inspected during annual door inspections and after ceiling work or vendor activity, with monitoring by the Director of Facilities.	06/19/2026
K0920 SS = E Bldg. 01	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	K0920	K920 (extension cord): A two-prong extension cord in use for the 3N fish tank was removed and the device was plugged directly into a wall outlet, with a goal correction date of 06/19/2026 and actual completion on 05/19/2026, and future prevention will include ongoing staff education on removing unauthorized power cords and conducting internal assessments after equipment movement or vendor work, monitored by the Director of Facilities.	05/20/2026

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LB BROEN HOME	**824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 56537**

(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
K0920 SS = E Bldg. 01	Continued from page 4 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to properly use electrical equipment per NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.4.2.1, and NFPA 70 (2011 edition), National Electrical Code, section 400.8. These deficient findings could have a patterned impact on residents within the facility. Findings include: On 05/19/2026 at 10:49 AM, it was revealed by observation that an extension cord was being used to provide power to aquarium equipment in the 3 North Day Room. On 05/19/2026 at 11:03 AM, it was revealed by observation that the resident's CPAP in Room 350 was plugged into a power strip that was not properly listed to be used with PCREE. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0920	Continued from page 4 K920 (power tap): A PCREE device plugged into a non-healthcare rated power tap was corrected by reconfiguring the room to allow use of a wall outlet, with a goal correction date of 06/19/2026 and actual completion on 05/19/2026; prevention measures include staff coaching to prioritize wall outlets and incorporating proper power tap listing into inspection criteria, with ongoing monitoring by the Director of Facilities and maintenance staff.	05/20/2026
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from	K0321	K321: Room 275, found to be used for storage, combustible materials were removed, with a goal correction date of 06/19/2026 and actual completion on 05/20/2026; to prevent recurrence, storage rooms will be equipped with self-closing hardware and routinely assessed for load and occupancy by the Director of Facilities.	05/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

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K0321 SS = D Bldg. 01	Continued from page 5 other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, and 19.3.2.1.3. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 05/19/2026 at 11:22 AM, it was revealed by observation that room 275 was being used to store combustible items and the door did not have a self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0321		05/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **05 - FREEZER/HV...** B. WING	**05/19/2026**

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K0000 Bldg. 05	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/19/2026. At the time of this survey, LB Broen Home Building 05 was found 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 18 New Health Care Occupancies and the 2012 edition of NFPA 99, the Health Care Facilities Code. Building 05 is a single-story building of type II (000) construction and is fully sprinkled. It includes areas for a cooler and freezer for the main kitchen as well as a loading dock. There is a 3-hour fire curtain separating the addition from the existing building. At the time of the addition several HVAC roof top units were replaced with the addition of a new unit for the kitchen. The facility has a capacity of 77 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K0000		06/01/2026

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 reverse for further 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.

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