DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 6, 2022

Administrator
Lb Broen Home
824 South Sheridan
Fergus Falls, MN 56537

RE: CCN: 245453
Cycle Start Date: March 3, 2022

Dear Administrator:

On April 21, 2022, the Minnesota Department(s) of Health 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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 6, 2022

CMS Certification Number (CCN): 245453

Administrator
Lb Broen Home
824 South Sheridan
Fergus Falls, MN 56537

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 12, 2022 the above facility is certified for:

88 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 88 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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Electronically delivered
March 23, 2022

Administrator
Lb Broen Home
824 South Sheridan
Fergus Falls, MN 56537

RE: CCN: 245453
Cycle Start Date: March 15, 2022

Dear Administrator:

Please Note: Health and Life Safety Code survey findings will be processed under separate enforcement cycles.

On March 15, 2022, 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 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

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 15, 2022 (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 15, 2022 (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.

Feel free to contact me if you have questions.

Sincerely,

Signature Block goes here

Electronically delivered
March 23, 2022

Administrator
LB Broen Home
824 South Sheridan
Fergus Falls, MN 56537

RE: CCN: 245453
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- 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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.

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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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	**824 SOUTH SHERIDAN FERGUS FALLS, MN 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
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 2/28/22, to 3/3/22, during a recertification survey. The facility was in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 2/28/22, to 3/3/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5453047C (MN00080186). 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 that substantial compliance with the regulations has been attained.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State	F 577		4/12/22

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

Electronically Signed | 04/01/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 577	Continued From page 1 surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure three years of survey results were posted in a location easily accessible by residents and visitors. This had the potential to affect all 52 residents residing in the facility and visitors. Findings include: During an observation on 3/1/22, at 11:30 am, an eight inch (in) by 11 in. plaque was affixed to the wall in the main lobby of the facility, by the front door. The plaque revealed the facility's survey results were located at the desk at the main entrance and the past three years survey results	F 577	F 577 Upon receipt of notification of survey results not being visible or easily accessible. The DON procured a separate desk for the survey results so that they would be easily accessible to all residents and visitors of the facility. The desk was labeled identifying the contents of the survey results within. The desk is in the main lobby. Survey Result Posting Policy was created to include readily accessible survey results, results for 3 preceding years, posted notices of where survey results are located, and education to staff ongoing.	

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F 577	Continued From page 2 would be made available upon request. A large wooden desk with two drawers and a lower shelf were observed in the main lobby. The desk was completely covered and taped with thick clear plastic. The top of the desk held various items for a staff/visitor screening station and the survey results were not visible. During an observation on 3/2/22, at 2:08 p.m. no changes were noted at the desk. During an interview on 3/2/22, at 2:09 p.m. with the facility's human resources (HR) director confirmed the survey results were in the lower shelf of the desk located at the main entrance. The HR director stated the desk which held the survey results was covered with plastic and was currently used as a screening station for visitors. The HR director confirmed the results were not easily accessible to residents or visitors. During an interview on 3/2/22, at 2:15 with the director of nursing (DON) confirmed the survey results were located in the lower shelf of the desk in the main entrance. The DON stated the desk which held the survey results was currently being used as a screening station for visitors and was covered with plastic. The DON confirmed the survey results were not easily accessible. A facility policy on posting of survey results was requested however one was not provided.	F 577	Regulatory Posting Audit, form BH# 1368-22, was created to assure survey results are posted and easily accessible to all residents and visitors of the facility. It will be added to the nursing audit system for completion on all units and all shifts weekly x 4 and then quarterly ongoing. The DON will monitor audit findings and assure prompt follow-up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of Quality Assessment and Assurance Committee and QAPI. All Staff Meeting scheduled April 7th will include: 1. Education on where survey results are located. 2. How they are stored so they are readily accessible 3. Contents of survey binder include the surveys for the 3 preceding years. 4/12/2022 and ongoing	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		4/12/22

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F 684	Continued From page 3 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure care was appropriately coordinated with Hospice to provide continuity in care for 1 of 1 resident (R38) reviewed currently receiving Hospice services. Findings include: R38's significant change Minimum Data Set (MDS) dated 3/1/22, indicated R38 had moderately impaired cognition and diagnoses which included benign prostatic hyperplasia (BPH) (enlargement of the prostate)and renal failure. The MDS identified R38 was on Hospice. R38's MDS indicated R38 required extensive assistance of one for personal hygiene and toilet use, limited assistance with dressing, and supervision with transfers. The MDS identified R38 had an indwelling catheter. R38's care plan revised 2/22/22, identified R38 was admitted to Hospice services on 1/7/22, due to worsening condition of the scalp wound and R38 was not a surgical candidate. Review of a Hospice document titled Hospice Certification and Plan of Care dated 1/7/22, revealed R38 had a diagnoses of squamous cell carcinoma of skin, scalp, and neck. The Hospice orders of discipline and treatment identified the following:	F 684	F684 R38 was found to have a lack of a recognizable Hospice Care Plan and current Hospice progress notes. Upon notification of this lack of care coordination, LB Broen Home and Knute Nelson Hospice communication occurred, and progress note documentation was obtained from Knute Nelson Hospice. Knute Nelson Hospice Plan of Care was found to be in the scanned in portion of the chart but was not recognized as a care plan. Education was given to RN Unit Coordinator (RNUC) and MDS-RN regarding what the Knute Nelson Hospice Plan of Care looks like and where it is located. Knute Nelson Hospice Plan of Care was then incorporated into the LB Broen Home Care Plan. A lack of education was identified with LPN A and LPN B as not knowing where to find the Hospice documentation, thought they did not have access to the Hospice documentation, and were not able to find the phone number for Hospice. LPN A and LPN B were educated on the above. All charts of residents who are currently receiving hospice were reviewed for hospice care plan and hospice progress notes. The hospice care plan was integrated into the LB Broen Home care	

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F 684	Continued From page 4 -Hospice nurse to collaborate/coordinate patient status and plan of care with facility staff. -Hospice registered nurse to evaluate patient and develop a nursing plan of care. -A nursing plan of care would be established. -Facility staff was knowledgeable and involved in Hospice plan of care for patient. During an interview on 3/2/22, at 8:15 a.m. licensed practical nurse (LPN-A) stated R38's indwelling catheter had been changed by a hospice nurse however was unsure as to when and where that information would have been documented. LPN-A was unable to locate the Hospice documentation. During an interview on 3/2/22, at 10:15 a.m. LPN-B stated there had been a Hospice number in the phone directory however was not able to locate it. LPN-B indicated staff did not have access to the Hospice documentation. LPN-B indicated she relied on the charge nurse when Hospice needed to be contacted when R38's condition changed. LPN-B verified the care plan directed staff to contact Hospice. During an interview on 3/2/22, at 12:35 p.m. registered nurse (RN-A) stated the Hospice nurse came to visit R38 once a week and discussed any changes to be made with her. RN-A verified the Hospice documentation had been completed on a whole different computer system and the staff had been unable to access the notes or care plan. RN-A stated staff had to contact the Hospice nurse and request the information	F 684	plan for all residents that are currently receiving hospice. Hospice Services Policy was created and includes the process for ongoing collaboration and communication between the hospice organization and LB Broen Home. This includes a process utilizing the Transcribing Orders Master File list for Hospice Admission whereby the staff member transcribing the admission to hospice order will add the specific organization as an External Facility in the resident□s EHR, add a Hospice Supplemental Care Plan section to the LB Homes care plan for individualization and signature of the RNUC or Charge Nurse, add a task to clinic coordinator calendar to check for hospice documentation weekly in the EHR and will notify DON if it is not present, and add the name and phone number of the hospice RN Case Manager to the resident□s EHR. The phone numbers for the current hospice providers were placed on the LB Homes Phone Extensions list. Nursing Staff Meeting will be held April 7th and will include the following education: 1. Hospice Services Policy 2. New Transcribing Orders Master File List for Hospice, adding the specific organization as an External Facility in the resident□s EHR, add a Hospice Supplemental Care Plan section to the LB Homes care plan for individualization and signature of the RNUC or Charge Nurse, add a task to clinic coordinator calendar to check for Hospice documentation weekly in the EHR and will notify DON if it is not present, and add the name and phone	

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F 684	Continued From page 5 needed each time. During a follow up interveiw on 3/3/22, at 10:20 a.m. RN-A stated R38's care plan had very few changes made since he had been admitted to Hospice. RN-A identified R38's care plan should have been updated by now and a Hospice section added to ensure coordination care between Hospice and facility nursing staff occurred. RN-A stated the facility and Hospice care plans should have been combined to ensure a coordinated comprehensive plan of care approach was used. RN-A indicated a Hospice care plan should have been requested. During a telephone interveiw on 3/3/22, at 10:38 a.m. Hospice nurse manager (HNM) stated the care plan should have been faxed directly to the facility once it had been initiated by the Hospice nurse. HNM confirmed the Hospice documentation had not been placed in the facility computer system yet and the Hospice nurse updated the nurse floor manager each week. During an interview on 3/3/22, at 1:00 p.m. the director of nursing (DON) verifed Hospice had not shared a plan of care or progress notes regarding R38's care and visits. DON stated a Hospice document titled Hospice Certification and Plan of Care dated 1/7/22, indicated a plan of care would be established. DON confirmed a lack of coordination of care existed for R38 between the facility and Hospice. DON stated it would have been important to follow the plan of care R38 agreed on once Hospice care had started to ensure staff provided continuity in care. Review of a facility policy and procedures titled Advanced Care Planning dated 4/18/13, identified	F 684	number of the Hospice RN Case Manager to the resident□s EHR. 3. Transcription of Orders Nursing Care Audit 4. Updated Phone Extension List The Transcription of Orders Nursing Care Audit, form # BMH 1190-06, was updated to include an audit on completion of all steps in the transcription of orders of a hospice resident. This audit will be completed on all units, weekly x 4, and then quarterly ongoing. The DON will monitor audit findings and assure prompt follow-up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of Quality Assessment and Assurance Committee and QAPI. 4/12/2022 and ongoing	

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F 684	Continued From page 6 the purpose was to ensure the resident's plan of care had been reviewed and updated periodically to support and honor resident's choices and rights and provided basis for selecting and implementing care and services at the end of life.	F 684		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		4/12/22

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F 732	Continued From page 7 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required daily staffing, and census information was posted daily in a location that was accessible to all residents and visitors in the facility. This had the potential to affect all 52 residents residing in the facility. Findings include: On 2/28/22, at 11:30 a.m. upon entrance to the facility, in the main lobby, was an eight inch (in) by 11 in plaque on a wall by the front door. The plague identified the facility's nurse staff posting hours were located on the second floor. On 2/28/22, at 5:24 p.m. during an observation of the facility's second floor, a wooden box/holder was affixed to the wall in the common area. The box contained a clip board with a laminated sheet of paper that revealed the facility's nurse staffing information was to be posted on the clipboard, however, no nurse staffing information was on the clipboard. On 3/1/22, at 2:10 p.m. during an observation of the facility's second floor staff posting, revealed the facility's nurse staff information was not posted. On 3/2/22, at 2:35 p.m.. during an observation of	F 732	F732 The facility failed to ensure the required daily staffing, and census information was posted daily in a location that was accessible to all residents and visitors in the facility. This had the potential to affect all 52 residents residing in the facility. Upon notification of daily staffing and census information not being in the assigned location that was accessible to all residents and visitors in the facility, a root cause analysis was completed. Results of root cause analysis identified that there was a miscommunication that occurred with the orientation of a new Scheduling Coordinator regarding who was responsible for initiating the daily posting. There was a second miscommunication that the charge RN□s thought it was being completed by someone else. Education to Scheduling Coordinator and Charge RN□s was completed. Scheduling Coordinator was able to complete missing daily staffing and census information for the time period that it had not been completed in order to be compliant with maintaining the posted daily nurse staffing data for a minimum of 18 months. Nursing Staff Meeting will be held April 7th and will include the following education:	

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F 732	Continued From page 8 the facility's second floor staff posting , revealed the facility nurse staff information was not posted. On 3/2/ 22, at 2:37 p.m. during an interview, the director of nursing(DON) identified the facility's nurse staffing information was located on the second floor in a wooden holder on the wall. Upon observation, the DON confirmed the nurse staffing information had not been posted. The DON stated she would expect the facility's nurse staffing information to be posted on a daily basis. On 3/2/22, at 2:39 p.m. during an interview, the facility's staffing scheduler confirmed the nurse staffing information had not been posted throughout the week and was not sure of when the facility's nurse staffing information was last posted. Review of the facility's policy titled, Nurse Staffing Information, dated September 2011, identified it was the facility's policy to allow public access to posted nurse staffing data which would include the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care and would be posted daily per shift.	F 732	1. Education on who is responsible for initiating the Posted Nurse Staffing Information, form BMH 1230-11on a daily basis. 2. The process for completion by the charge nurses 3. Review of Policy, Posted Nurse Staffing Information 4. Where the Posted Nurse Staffing Information is located to be accessible to all residents and visitors in the facility. Revisions made to the policy Posted Nurse Staffing Information for clarity of process including who initiates the form, how to complete the form, and to notify DON if there are any issues with the posting of this information Revisions made to Posted Nurse Staffing Information form included instructions for charge nurses on how to complete the form. Added to Regulatory Posting Audit, form BH# 1368-22, the required posting and completion of the Posted Nurse Staffing Information. This audit will be added to the nursing audit system for completion on all units and all shifts weekly x 4 and then quarterly ongoing. The DON will monitor audit findings and assure prompt follow-up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of Quality Assessment and Assurance Committee and QAPI. 4/12/2022 and ongoing	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5)	F 791		4/12/22

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F 791	Continued From page 9 §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and	F 791		

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F 791	Continued From page 10 §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dental services were provided and/or offered for 1 of 2 residents (R22) reviewed for dental care. Findings include: R22's quarterly Minimum Data Set (MDS) dated 12/16/21, indicated R22 had diagnoses which included: Diabetes Mellitus, malnutrition, viral hepatitis and was cognitively intact. The MDS identified R22 required extensive assistance of one staff for personal hygiene and was independent with eating after set-up help from staff. Further, the MDS indicated R22 had no obvious or likely cavities or broken natural teeth and no mouth or facial pain, discomfort or difficulty with chewing. R22's care plan revised on 1/10/22, indicated R22 had a self care deficit related to weakness and decreased mobility. The care plan indicated R22 had his own teeth and staff were to set up supplies, monitor for completion and to assist as needed with personal hygiene. Further, the care plan indicated R22 was independent with eating. R22's Admission Nursing Assessment dated 8/3/21, under oral assessment indicated R22 did not have a dentist and had not had an exam for many years. The assessment indicated R22 had natural teeth that were unhealthy, four or more decayed or broken teeth/roots or very worn down	F 791	F 791 R22 asked for dental services and the facility failed to ensure dental services were provided and/or offered. An appointment was made for April 22nd at 10:30am with Dr. Drake for R22. All residents who have not had a dental visit in the last 3 months will have an oral assessment completed and a dental exam offered and/or made before April 12, 2022. If refused, the reason for refusal and education regarding the consequences of refusal will be documented. An Oral Assessment will be completed on all residents each quarter, prior to the resident□s care conference. The care conference documentation in the resident□s EHR was updated to include the following: did the resident accept the dental exam (yes or no), and if yes, was the clinic coordinator notified; if no, the risk to the resident health education given due to refusing dental exam and reason resident refused to have dental exam was documented. Nursing Staff Meeting will be held April 7th and will include the following education: 1. Oral Assessment will be completed on all residents each quarter prior to the resident□s care conference. 2. The updated care conference documentation including the following: did	

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F 791	Continued From page 11 teeth, or less than four teeth with no denture. During an observation on 3/3/22, at 9:05 a.m. R22 laid in bed and was observed to have several natural teeth, both on the top and bottom of his mouth, which were gray/black hewn color, with some of R22's natural teeth broken/jagged off to gum line, missing or cracked, decayed and in very poor condition. On 3/3/22, at 8:43 a.m. the MDS coordinator (MDSC) verified R22 had asked her to make an appointment to see the dentist to obtain dentures or get his teeth fixed. The MDSC confirmed R22 had not seen the dentist and an appointment had not been made for R22. The MDSC verified R22 had natural teeth that were in poor condition and needed to be fixed. On 3/3/22, at 8:54 a.m. the unit clerk (UC) verified R22 had not seen a dentist recently and had no appointment scheduled to see the dentist. The UC indicated no one had informed her R22 wanted to see the dentist. On 3/3/22, at 9:01 a.m. R22 indicated a few months ago he had talked to the MDSC about making an appointment to get his teeth fixed. R22 stated MDSC said she would make the arrangements and R22 indicated he never heard anything more about it. R22 indicated he had several natural teeth which were broken off and chipped. R22 stated he had broken at least five front teeth off since he had been admitted to the facility. R22 indicated he had to be careful with what he ate and had to take his time to eat. R22 stated no one had looked at his teeth recently and stated it was embarrassing for him to even talk about it. R22 indicated he would like to obtain	F 791	the resident accept the dental exam (yes or no), and if yes, was the clinic coordinator notified; if no, the risk to the resident health education given due to refusing dental exam and reason resident refused to have dental exam was documented. 3. Dental Services Nursing Care Audit, form # BH 1257-16. 4. Dental Services Policy updated to include the RNUC must ask the resident if the resident wants to see a dentist and provide any necessary help to make the appointment at or before quarterly care conference. Dental Services Nursing Care audit was updated to include dental exam offered with last care conference assessment. This audit will be completed on all units, weekly x 4, and then quarterly ongoing. The DON will monitor audit findings and assure prompt follow-up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of Quality Assessment and Assurance Committee and QAPI. 4/12/2022 and ongoing	

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F 791	Continued From page 12 dentures. On 3/3/22, at 9:10 a.m. and at 11:48 a.m. called R22's dental office, left message and no return phone call was received from the dental office. On 3/3/22, at 11:57 a.m. the director of nursing (DON) indicated on admission staff were expected to complete an oral assessment and to set up an appointment for residents to see a dentist if the resident wished to. The DON confirmed the above findings and indicated she would expect staff to document the resident's request to see a dentist, assess the resident for issues, complete an oral assessment and have the UC make the dental appointment for the resident. The DON indicated she was not aware R22's teeth were in poor condition and of his request to see a dentist. The DON indicated staff were expected to follow the facility policy for dental care. Review of the facility policy titled, Dental Services undated, indicated staff were expected to promote oral hygiene, make dental services available as requested and to make available to all residents, emergency dental services as needed.	F 791		
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	F 812		4/12/22

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F 812	Continued From page 13 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. §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 maintain clean and sanitary ceiling fans to prevent contamination of foods and dishware in the main kitchen of the facility. This deficient practice had the potential to affect all 52 residents who currently resided in the facility. Findings include: During the initial kitchen tour on 2/28/22, at 11:48 a.m. with the dietary manager (DM) the ceiling fan located to the left of the main entrance door of the kitchen had a moderate to heavy amount of dark gray to black fuzzy substance present on it. The ceiling fan blew air down from the ceiling towards the main kitchen cooking area, prepping area, entries of the refrigerator and freezer and over the clean dishes that were drying and stored. The ceiling fan located on the corner of the dirty/clean dish area had a moderate to heavy amount of dark gray to black fuzzy substance present on it. The ceiling fan blew air down from the ceiling towards the dirty dish area and over clean dishes coming out of the dishwasher.	F 812	F812 The facility failed to maintain clean and sanitary equipment (fans) to prevent cross-contamination of foods and dishware, potentially affecting all residents in the facility. The facility identified a lack of communication between food service and maintenance regarding equipment cleaning (fans). The scheduled cleaning was inadvertently deleted from the ticket system. Consequences include but are not limited to the potential for infecting all residents who reside at the facility, due to a lack of compliance to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Food and Nutrition Services Staff Meeting scheduled for 3/31/22 included:	

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F 812	Continued From page 14 -at 3:12 p.m. the ceiling fans in the main kitchen area continued to blow air towards the main kitchen cooking area, prepping area, entries of the refrigerator/freezer, over the clean dishes that were drying/stored and towards the dirty dish area and over clean dishes coming out of the dishwasher. -at 5:18 p.m. the ceiling fans remained the same. During observations on 3/1/22, at 1:03 p.m. the ceiling fans remained the same and were blowing air towards the main kitchen cooking area, prepping area, entries of the refrigerator/freezer, over the clean dishes that were drying/stored and towards the dirty dish area and over clean dishes coming out of the dishwasher. During the kitchen tour on 3/1/22, at 2:09 p.m. with the DM the ceiling fan located to the left of the main entrance door of the kitchen had a moderate to heavy amount of dark gray to black fuzzy substance on it. The ceiling fan blew air down from the ceiling towards the main kitchen cooking area, prepping area, entries of the refrigerator and freezer and over the clean dishes that were drying and stored. The ceiling fan located on the corner of the dirty/clean dish area had a moderate to heavy amount of dark gray to black fuzzy substance on it. The ceiling fan blew air down from the ceiling towards the dirty dish area and over clean dishes coming out of the dishwasher. The DM confirmed the fans were dirty and had a build up of debris on them. The DM indicated she did not know the last time the fans had been cleaned and indicated maintenance staff cleaned the fans. The DM stated she had filled out a maintenance ticket for	F 812	1. Education on the importance of following the weekly cleaning schedule, review of the updated form, AM weekly cleaning/task schedule. This education will emphasize the position (cooks/supervisors) who will be in charge of monitoring the fans weekly and reporting back to the Food Services Manager (FSM) or Food Services Dietician (FSD). 2. The weekly cleaning task schedule will be monitored weekly by the FSM/FSD and filed. Staff will be held accountable for cleaning assignments. 3. Review the updated monthly sanitation checklist Q/A audit form. (Added: Are the fans free of dust and debris) This will be conducted by the designated position monthly and delivered to the FSM/FSD for review. 4. Review with staff the new policy regarding commercial fans. 5. Review of the updated policy for Cleaning and Sanitation of Dining and Food Service Areas. Food and Nutrition Services Policies were added, reviewed, and in the approval process of being updated to include the following: 1. Added/Updated new policy/procedure regarding Commercial Fan Cleaning	

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F 812	Continued From page 15 the fans to be cleaned on 1/1/22, and verified maintenance staff had not completed the request yet. On 3/1/22, at 2:25 p.m. the DM indicated she would expect staff to make sure the ceiling fans were cleaned routinely. On 3/1/22, at 3:00 p.m. the maintenance manager (MM) confirmed the above findings and indicated the ceiling fans in the kitchen had only been cleaned every 6 months. The MM indicated the fans were due to be cleaned again in May of 2022 according to his schedule. In a follow up interview on 3/2/22, at 11:18 a.m. the MM indicated he would expect staff to clean the fans when they were dusty and dirty and stated staff were supposed to be cleaning the fans monthly after he checked his logs and indicated some how the regular maintenance order had been deleted out of the system. The MM verified the last time the ceiling fans in the kitchen had been cleaned was 9/21. Review of the facility policy titled, General Sanitation of Kitchen dated 2019, indicated food and nutrition service staff would maintain the sanitation of the kitchen through compliance with written and comprehensive cleaning schedules. Review of the facility policy titled, Cleaning Instructions Commercial Fans undated, indicated commercial fans in the food service department would be cleaned regularly per maintenance schedule.	F 812	2. Reviewed, and updated audit form Sanitation QA Checklist: Updated to include fans on monthly inspection under kitchen equipment. 3. Reviewed and updated policy (Cleaning and Sanitation of Dining and Food Service Areas), updated the procedure to include maintenance will have specific equipment be on a regular cleaning schedule, Designee will accomplish comprehensive sanitation inspections on a monthly basis using the Sanitation QA Checklist then given to the FSD/FSM for review. When the survey was conducted the maintenance department cleaned the fans and did remove (1) fan by the entrance door into the kitchen, this fan will not be replaced. (Removed 3/2/22) In addition to updated policies, procedures, and staff education, the Food and Nutrition Services Manager reviewed with the Facilities Manager the updated policy for Commercial Fan Cleaning, a review of the Cleaning and Sanitation of Dining and Food Service Areas policy. At this time FSM/Maintenance Manager (MM) reviewed and updated the cleaning frequency for the commercial fans. (4 x a year). If additional cleaning is needed the FSM/FSD will submit a facilities maintenance request as the policy states. Corrective Action: The ceiling fan located left of the main	

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LB BROEN HOME	824 SOUTH SHERIDAN FERGUS FALLS, MN 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
F 812	Continued From page 16	F 812	door of the kitchen was removed. 3/2/22 Updated Policy Cleaning and Sanitation of Dining and Food Service areas. 3/30/22 Updated policy/procedure Commercial Fan Cleaning 3/30/22 Updated AM Weekly Cleaning Checklist to include the fans, being monitored weekly by FSM. 3/30/22 The maintenance manager will be informed of policy revisions. Audits will be conducted weekly x4 by the FSM/FSD, and monthly thereafter to assure compliance of sanitation procedures. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of Quality Assessment and Assurance Committee and QAPI. 4/12/2022 and ongoing.	
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with	F 886		4/12/22

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F 886	Continued From page 17 COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.	F 886		

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F 886	Continued From page 18 §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to test staff for COVID-19 according to Centers for Medicare and Medicaid (CMS) guidance for routine testing requirements. This deficient practice had the potential to affect all 52 vaccinated and unvaccinated residents residing in the facility. Findings include: The CMS QSO-20-38-NH memo revised 9/10/21 directed, "a new COVID-19 infection in any staff triggers an outbreak investigation. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. Upon identification of a single new case of COVID-19 infection in any staff, testing should begin immediately. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g., facility-wide) testing. If the facility can identify close contacts of the individual with COVID-19, they could choose to conduct focused testing based on known close contacts. If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility). Broader approaches might also be required if the facility is directed to do so by the jurisdiction's public health authority, or in	F 886	F886 Individuals were identified as not testing bi-weekly according to guidance and current tracking form did not identify if or when staff were in the facility or had worked having the potential to affect all residents residing in the facility. The facility identified a lack of communication regarding current testing guidelines that may have contributed to staff not complying with bi-weekly testing. Individuals that were identified as not testing bi-weekly according to guidance will be educated individually regarding current requirements and consequences of not testing. Consequences include but are not limited to potential for infecting residents and coworkers, noncompliance with State and Federal guidelines, and disciplinary action by facility. All Staff Meeting scheduled April 7th will include 1. Education on the importance of testing according to current guidelines 2. Consequences of not testing according to current guidelines 3. Review of the COVID-19 Testing Residents and Staff Policy	

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F 886	Continued From page 19 situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission." Outbreak testing intervals should be conducted as follows: all healthcare personnel (HCP) who have had a higher-risk exposure, regardless of vaccination status, should be tested as described in the testing section. If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify residents with close contact or HCP with higher-risk exposures to the newly identified individual(s) with SARS-CoV-2 infection. A facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility) approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. If the outbreak investigation is broadened to either a facility-wide or unit-based approach, follow recommendations below for alternative approaches to individual contact tracing. An alternative, broad-based approach can be used if a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-level or group-level (e.g., unit, floor, or other specific area(s) of the facility): broader approaches might also be required if the facility is directed to do so by the jurisdiction's public health authority, or in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission. Perform testing for all HCP on the affected unit(s), regardless of vaccination status, immediately (but generally not earlier than 24 hours after the exposure, if known) and, if negative, again 5-7 days later. If additional cases are identified, testing should	F 886	4. Education on communication utilized regarding current testing requirements including the use of Call Multiplier, emailed weekly newsletter, and posted sign to the left of the elevator in the main lobby of LB Broen Home. LB Broen Homes COVID-19 Testing Residents and Staff Policy was reviewed and updated to include the following: 1) Procedure for daily monitoring of staff who need to test prior to work, utilizing a worksheet COVID-19 Daily Staff Testing, form #LBH 1074-22. This form will include the names of the staff who need to test prior to the start of their shift, the date they are scheduled to work, and the notification they were given to test prior to work. Testing Coordinator or Designee will update COVID-19 Daily Staff Testing on a Monday through Friday basis, with Friday including the weekend. Those who have not tested on the testing day will be notified via text or phone call and an email will be sent to their department head for follow up with individual to assure testing is completed prior to their shift. The text/call will state: You will not be able to work until you have tested. Please come 15 minutes prior to the start of your shift and be tested. Failure to test will result in an unexcused absence and disciplinary action. The Charge Nurse will be given a list by the testing coordinator on a Monday through Friday basis, with Friday including the weekend staff that need to test, and when they are next scheduled utilizing the COVID-19 Daily Staff Testing form. The Charge Nurse will follow-up or delegate	

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F 886	Continued From page 20 continue affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of residents who are not up to date with all recommended COVID-19 vaccine doses, until there are no new cases for 14 days. Additionally, if antigen testing is used, more frequent testing (every 3 days), should be considered." During entrance conference on 8/9/21, at 3:28 p.m. the administrator and director of nursing (DON) stated the facility census included 52 residents and there were no active or suspected resident COVID-19 cases in the facility. However, due to staff positive COVID-19 cases, the facility was in outbreak status since 12/31/21, and had been conducting COVID-19 testing bi-weekly on Mondays and Thursdays. The facility log titled COVID testing Broen staff/essential caregivers dated January and February 2022, included staff name, phone number, antigen test result Monday, antigen test result Thursday, other antigen, PCR, and a highlighted retest date (if applicable). Additionally, the forms identified the facility was conducting high risk exposure staff testing until the week of 1/30/22, when the facility began a broad-based testing of all facility staff. However, the form identified ten vaccinated staff and seven unvaccinated staff who had not conducted bi-weekly testing according to guidance. Additionally, the form did not identify if or when staff were in the facility or had worked. On 3/2/22, at 1:19 p.m. the facility infection prevention nurse (IP)-A, IP-B, and director of nursing (DON) provided the COVID-19 testing documents. The DON explained the	F 886	follow-up with these staff members prior to the start of their next shift. 2) If staff member decline testing per current guidelines, they will be re-educated and if they continue to decline testing, they will not be allowed to work until they are tested or there is an end of the pandemic. 3) Information regarding testing for LB Broen staff will be communicated via the use of Call Multiplier, emailed weekly newsletter, and posted sign to the left of the elevator in the main lobby of LB Broen Home. 4) The COVID Testing Broen Staff/Visitors Audit, form #LBH 1075-22 was created and will be completed at the time frames we are currently testing indefinitely, i.e. twice a week, by the Infection Preventionist or Designee to assure that all staff have been compliant with testing as per the current requirements. This audit includes testing dates and if staff were not in the facility during the testing period. The DON will monitor audit findings and assure prompt follow-up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of Quality Assessment and Assurance Committee and QAPI. 4/12/2022 and ongoing	

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F 886	Continued From page 21	F 886		

spreadsheets were printed weekly and, depending on the testing requirements for the week, were sent out to the departments for staff to complete testing. Staff members would collect the test sample individually and another staff member would verify the result. All staff were marked off as they were tested, and the results were then sent into the National Health Safety Network (NHSN). When an employee did not test, an email was sent to the department head and the charge nurse was given a form that identified everyone who still needed to be tested. However, the DON stated "when the logs were collected for the survey process, 'holes' were identified". The DON indicated there were facility staff who did not comply with testing guidance. The DON stated she was "quite upset. There was a failure on our part to ensure everyone tested". The DON provided a list of ten vaccinated staff and seven unvaccinated staff who were identified to not conduct testing per guidance.

During an interview on 3/3/2, at 10:42 a.m. the administrator stated the facility had identified staff had not completed COVID-19 testing according to guidance, which included himself. The administrator stated this error was a result of miscommunication.

The facility policy Long Term Care and Assisted Living Response Plan for Supporting COVID-19 Testing dated 2/2022, indicated if an asymptomatic staff member refused to be tested the testing team would provide education about the importance of testing and if the staff member continued to refuse testing no further action would be taken. If the staff member missed the testing, the administrator would contact the staff member and reschedule a time within 24 hours to

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F 886	Continued From page 22 be tested.	F 886		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted on 03/15/2022 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	K 000		

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

Electronically Signed | 04/01/2022

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K 000	Continued From page 1 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: 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. 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	K 000		

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K 000	Continued From page 2 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 78 beds and a census of 52 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET.	K 000		
K 353 SS=C	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	K 353		4/15/22

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K 353	Continued From page 3 _____ 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 observations, documentation review, and staff interview, the automatic sprinkler system is not maintained per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code, section 9.7.5, and the 2011 edition of National Fire Protection Association (NFPA) Standard 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, 5.3.2.1, and 5.4.1.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, at 12:28 PM, it was revealed by observation that there were 15 unsecured fire sprinkler heads that were not protected from being damaged, stored within the spare sprinkler head-box that is located at the main fire sprinkler riser. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 353	K353 1. Additional spare sprinkler head storage boxes have been ordered to store, protect, and secure the unsecured fire sprinkler heads found at the time of inspection. 2. Monthly checks of the fire suppression equipment will now include checking for unsecured sprinkler heads. This item has been added to the monthly checklist. 3. Our fire suppression system service contractor, NOVA Fire Protection, will also be made aware of this deficiency and will be asked to monitor during all their inspections which occur on a quarterly basis. 4. Kevin Rogness, Facilities Engineer, will be responsible for the corrective action and monitoring of compliance. 5. Once the spare sprinkler head storage boxes arrive, they will be installed forthwith. Our proposed date for completion is prior to April 15th, 2022.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories	K 901		4/15/22

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K 901	Continued From page 4 Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per the 2012 edition of National Fire Protection Association (NFPA) Standard 99, The Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, at 11:15 AM, during a review of available documentation and an interview with the Maintenance Supervisor, it was revealed that the facility provided a utility risk assessment document that did not contain a complete list of the electrical and gaseous patients/residents care equipment and the associated risk categories for the patients/residents as outlined in 2012 edition of NFPA 99, The Health Care Facilities Code chapters 10 and 11. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 901	K901 1. The utility risk assessment documentation will contain a complete list of electrical and gaseous patients/residents care equipment and the associated risk categories for the patients/residents as outlined in 2012 edition of NFPA 99. 2. Once the risk assessment for the missing elements is performed and documented, this deficiency will not occur again. 3. Our NFPA 99 Risk Assessment is reviewed annually by our multidisciplinary team as identified on the NFPA 99 Risk Assessment policy. This will ensure solutions are sustained. 4. Kevin Rogness, Facilities Engineer, will be responsible for the corrective actions and monitoring of compliance along with the multidisciplinary team identified on the NFPA 99 Risk Assessment policy. 5. Missing documentation will be gathered, assessed, and added to the risk assessment by April 15th, 2022. This will make the risk assessment complete prior to the next annual review of August 2022.	

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