Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2024

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

RE: CCN: 245453
Cycle Start Date: August 28, 2024

Dear Administrator:

On August 28, 2024, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 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.

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 November 28, 2024 (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 February 28, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

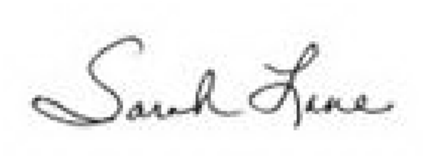
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 On 8/26/24 to 8/28/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/26/24 to 8/28/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed. The following complaints were reviewed with no deficiency issued. H54536802C (MN00104834) H54536803C (MN00100811) H54536801C (MN00101636) H54536804C (MN00101698) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/12/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		9/26/24

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 880	Continued From page 2 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate donning/doffing of personal protective equipment (PPE) practices to prevent the spread of infection	F 880	Enhanced Barrier Precautions: The facility failed to implement appropriate donning/doffing of personal	

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 880	Continued From page 3 for 3 of 5 residents (R2, R16, R34) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). In addition, the facility failed to ensure equipment was sanitized between 2 of 2 residents (R24, R34) observed during transfers by nursing staff. Further, the facility failed to implement hand hygiene for 5 of 5 residents (R1, R29, R32, R37, R43) observed during medication administration. Findings include: Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated examples of high-contact resident care activities requiring gown and glove use for EBP included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R16 R16's quarterly Minimum Data Set (MDS) dated 8/18/24, identified R16 had severe cognitive impairment and had diagnoses which included: hypertension (high blood pressure), dementia, anxiety. Indicated R16 required extensive assistance of staff for transfers and toileting. R16's care plan created 3/21/19, identified R16	F 880	protective equipment (PPE) practices to prevent the spread of infection for 3 of 5 residents (R2, R16, R34) observed for enhanced barrier precautions (EBP). In addition, the facility failed to ensure equipment was sanitized between 2 of 2 residents. (R24, R34) observed during transfers by nursing staff. Further, the facility failed to implement hand hygiene for 5 of 5 residents (R1, R29, R32, R37, R43) observed during medication administration. R2, R16, R34 care plans were reviewed to ensure that EBP was included (all had EBP on current care plan), EBP signs present outside resident doorways who require EBP, and NA/R worksheet reflects the need for EBP. All staff will be reeducated on when to use EBP. All residents within the facility have the potential to be affected by the same deficient practice if they require enhanced barrier precautions while residing at the LB Broen Home. All Nursing Staff meeting is scheduled for 9/18/2024. All nursing staff will be reeducated on EBP, stressing when to use EBP and encouranging team members to remember the importance of EBP for the saftey of residents and staff. LB Broen Home policy and procedure, Enhanced Barrier Precautions, was reviewed with no content changes indicated. A system of change was	

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 880	Continued From page 4 required assistance with activities of daily living (ADL's) related to dementia, unsteadiness and anxiety. Indicated staff were to assist with transfers and had interventions of EBP. R16's care plan lacked documentation of a stage three ulcer to the left buttock. R16's resident condition report to physician dated 8/11/24, identified R16 had an area to the left buttock measuring nine centimeters (cm) by seven cm with an open area measuring 0.2 cm with drainage. R16's wound assessment dated 8/26/24, identified R16 had a stage three ulcer to the left buttock measuring 1.5 cm in length by 1 cm in width by 0.5 cm in depth. A stage two ulcer to left buttock measuring 1 cm in length by 0.8 cm in depth. A hard boil/lesion to the left buttock measuring 5 cm in length by 4 cm in width. R16's hospital report dated 8/21/24, identified R16's wound culture grew both Methicillin-resistant Staphylococcus Aureas (MRSA- a type of staph bacteria that's resistant to many antibiotics) and Escherichia coli (E. coli- a bacteria that could cause infections in the gut, urinary tract and other parts of the body). The hospital report further identified the growth of four different organisms and to treat with Bactrim antibiotic along with wound treatments. The report instructed staff to change the dressing every four days or as needed if saturated. R16's nursing progress note dated 8/22/24, identified EBP initiated due to positive wound culture of buttock for MRSA. During an observation on 8/27/24 at 10:57 a.m.,	F 880	initiated including development of a new EBP PPE audit BH# 1384-24, and EBP Criteria audit BH #1385-24. BH# 1384-24 LB Broen Home Nursing Care Audit, EBP PPE columns titled, Can staff name 3 examples of high-contact resident care activities when PPE is required for a resident on EBP, Did staff perform hand-hygiene before donning PPE?, Did staff properly don PPE (gown and gloves) before providing high-contact resident cares?, Did staff properly doff PPE (gloves then gown) after providing high-contact resident cares? Did staff dispose of soiled PPE properly? Did staff perform hand-hygiene after removing PPE?, and If a resident requires an assist of two, were both staff wearing appropriate PPE (gown and gloves) when providing cares?; BH #1385-24 LB Broen Home Nursing Care Audit, EBP Criteria columns titled, Reviewed current census to check if any additional residents meet criteria for enhanced barrier precautions, Care plan includes EBP for residents who meet critiera, will be completed weekly on all shifts x 4 weeks on all resident care units within the facility and quarterly on-going. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit item findings are an agenda item reported to the Safety and Infection control committee, a sub-committee of the Quality Assessment and Assurance	

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 880	Continued From page 5 nursing assistant (NA)-B applied a gown and gloves outside of R16's room and entered R16's room. Registered nurse (RN)-A was sitting on R16's bed next to R16 applying a gait belt to R16's waist. NA-B and RN-A held onto the gait belt on each side of R16 and assisted R16 to stand and transfer to the wheelchair. RN-A sanitized her hands and left the room. RN-A was not wearing a gown or gloves during the entire observation. During an interview on 8/27/24 at 2:06 p.m., NA-B verified R16 had a wound and was on EBP. NA-B confirmed EBP were in place to prevent the spread of infection. During an interview on 8/27/24 at 11:16 a.m., RN-A verified R16 was on EBP because of a wound on R16's buttock. RN-A stated staff were to wear a gown and gloves when doing cares for residents on EBP. R34 R34's admission MDS dated 7/15/24, identified R34 had moderate cognitive impairment and diagnoses which included: Parkinson's disease, arthritis, and anxiety. R34's Indicated R34 required partial/moderate assistance with dressing, personal hygiene and sit to stand transfers. R34's care plan printed 8/27/24, identified R34 had ADL self-performance deficit, and required assistance with dressing, grooming, bathing and transferring. R34's care plan identified R34 had a foley catheter for urination. R34's care plan lacked documentation related to EBP.	F 880	Committee and Quality Assurance and Performance Improvement. 9/26/24 and ongoing. Lifts/Stands: The facility failed to ensure equipment was sanitized between 2 of 2 residents. (R24, R34) observed during transfers by nursing staff. R24 and R34 require the use of mechanical lifts. Lifts are disinfected between resident use. All residents within the facility have the potential to be affected by the same deficient practice if they require the use of a mechanical lift, mechanical stand, or non-mechanical stand aide. All Nursing Staff meeting is scheduled for 9/18/2024. All nursing staff will be reeducated on disinfecting stands and lifts between resident use. LB Broen Home Policy and Procedure Standard Precautions: Equipment, Nursing Unit	

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 880	Continued From page 6 During an observation on 8/27/24, at 8:12 a.m., R34 was lying in bed, while NA-C and NA-B were in R34's room, NA-B wore a gown and gloves, while NA-C had only gloves on. R34's doorway had a sign identifying R34 was on EBP and a covered cart was located outside R34's room which contained gowns and gloves. NA-C gave R34 drinks of water from glass and straw while NA-C stood on the left side of R34's bed. NA-B removed gown and gloves and left R34's room. At 8:16 a.m., NA-B returned to room wearing a gown and gloves, with mechanical lift, and began to attach the sling under R34 to the lift with NA-C, then NA-B and NA-C transferred R34 to his wheelchair. NA-B removed the mechanical lift from the room to the hallway without sanitizing the lift, and returned to the room. NA-B and NA-C continued to assist R34 with dressing and grooming, then NA-C made R34's bed. NA-C remained in R34's room not wearing a gown from 8:12 a.m. until 8:34 a.m., when NA-B transported R34 out of room. During an interview on 8/27/24 at 9:52 a.m., NA-C indicated R34 was on EBP and staff were to wear a gown and gloves when in R34's room performing cares. NA-C stated NA-C had forgotten to wear a gown and when starting to assist NA-B with R34's cares, had then remembered during the cares, however did not want to leave the room. NA-C confirmed NA-C had helped R34 with dressing, grooming, transferring, and made R34's bed while not wearing a gown. During an interview on 8/27/24 at 10:06 a.m., NA-B indicated NA-C did not wear a gown while assisting R34, who was on EBP. NA-B stated	F 880	Cleaning of □ Signature Sheet, Use of Form #BMH 689-91 Utensils (Nursing) and Personal Nursing Items, Washing and Sanitizing of, was reviewed with content changes made including specific examples such as, mechanical lifts, mechanical stands, and nonmechanical stands to be disinfected after each resident use. A system of change was initiated including development of a new Disinfection of Lifts and Stands audit BH# 1382-24. BH# 1382-24 LB Broen Home Nursing Care Audit, Disinfection of Lifts/Stands column titled, Was the lift/stand disinfected with a germicidal wipe allowing for appropriate wet time per manufacturers instruction after use? will be completed weekly on all shifts x 4 weeks on all resident care units within the facility and quarterly on-going. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit items findings are an agenda item reported to the Safety and Infection control committee, a sub-committee of the Quality Assessment and Assurance Committee and Assurance Committee and Quality Assurance and Performance Improvement. 9/26/24 and ongoing.	

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 880	Continued From page 7 following EBP for R34 was important to protect the staff, the resident and the next resident they took care of. NA-B stated they had not sanitized the lift when removed from R34's room, because they had forgotten. NA-B indicated usual process was to sanitize the lift after each resident use to prevent the potential for infection transmission. During an interview on 8/27/24 at 10:38 a.m., licensed practical nurse (LPN)-B, stated all nursing staff were to wear a gown and gloves when working with R34's catheter, or completing transfers or cares. LPN-B confirmed the mechanical lift was not usually sanitized between resident use, however should have been to prevent the potential spread of infection. R24 R24's significant change in status MDS dated 6/11/24, identified R24 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia and arthritis. Indicated R24 was dependent on staff for dressing, personal hygiene and transfers. R24's care plan printed 8/27/24, identified an ADL self-care performance deficit and R24 was dependent on staff for dressing, bathing and transferring with a mechanical lift. During an observation on 8/27/24 at 8:54 a.m., NA-D removed the mechanical lift from room 225, then moved the lift to R24's room. NA-D began to attach the sling under R24 to the mechanical lift, and at 8:56 a.m. NA-A entered the room and began to assist NA-D to transfer R24 to bed. NA-D pushed the mechanical lift out to the hallway, then both sanitized hands and NA-D took	F 880	Hand Hygiene: The facility failed to implement hand hygiene for 5 of 5 residents (R1, R29, R32, R37, R43) observed during medication administration. R1, R29, R32, R37, and R43 have had medication administration completed by staff who have completed hand hygiene before and after medication pass. All residents within the facility have the potential to be affected by the same deficient practice of failure to implement hand hygiene during medication administration. All Nursing Staff meeting is scheduled for 9/18/2024. All nursing staff will be reeducated on the use of proper hand hygiene during medication administration. LB Broen Home policy and procedure, Medication Administration, Authorized Staff was reviewed with no content changes indicated. A system of change was initiated including development of a new Hand Hygiene With Medication Pass audit BH# 1383-24. BH# 1383-24 LB Broen Home Nursing Care Audit, Hand Hygiene with Medication Pass column titled, Was hand hygiene observed before medication pass and was	

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 880	Continued From page 8 the garbage to the soiled utility room. During an interview on 8/27/24 at 9:06 a.m., NA-D stated NA-D had taken the lift from room 225 and brought to R24's room. NA-D stated the usual process was not to sanitize the lift between residents unless they were on transmission based precautions, and confirmed staff had not sanitized the mechanical lift that day. NA-D stated the night shift usually sanitized the lifts. During an interview on 8/27/24 at 10:26 a.m., NA-A stated NA-A had not sanitized the mechanical lift that day. NA-A indicated housekeeping usually sanitized the lifts. During an interview on 8/27/24 at 10:31 a.m., housekeeper (HSK)-A stated housekeeping staff cleaned lifts when noticed they were soiled. HSK-A indicated housekeeping did not have a routine to sanitize the lifts. During an interview on 8/27/24 at 11:09 a.m., registered nurse unit coordinator (RN)-C stated lifts should have been sanitized between resident use and it was important for infection control purposes. R2 EBP R2's quarterly MDS dated 5/16/24, identified R2	F 880	hand hygiene observed after medication pass. will be completed weekly on all shifts x 4 weeks on all resident care units within the facility and quarterly on-going. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit items findings are an agenda item reported to the Safety and Infection control committee, a sub-committee of the Quality Assessment and Assurance Committee and Assurance Committee and Quality Assurance and Performance Improvement. 9/26/24 and ongoing.	

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 880	Continued From page 9 had mildly impaired cognition and diagnoses which included hypertension (high blood pressure), seizure disorder and anxiety. R2's care plan updated 8/22/24 identified R2 was on EBP due to infection control. R2's lab culture results from 8/18/24 revealed that R2 had MRSA, in a wound located on the right breast. During an observation on 8/27/24 at 1:57 p.m., NA-A entered R2's room to answer the bathroom call light. R2 had a sign above her name beside the door indicating R2 was on EBP. A plastic bin was next to the door which had gloves and gowns. NA-A applied gloves, however did not apply a gown. NA-A assisted R2 in standing up and performing perineal cares. NA-A changed gloves and assisted R2 with pulling up her underwear and pants. NA-A removed gloves and washed hands. During an interview on 8/27/24 at 2:03 p.m., NA-A stated she was unaware of R2 being on EBP. NA-A verified there was a EBP sign by R2's door. NA-A stated the process was to wear gowns and gloves when working with a resident on EBP. During an interview on 8/27/24 at 2:12 p.m., RN-A stated R2 was on EBP as R2 had a wound on her breast. RN-A stated she expected staff would wear a gown and gloves when assisting with toileting care. HAND HYGIENE/MEDICATION PASS During an observation on 8/26/24 at 6:40 p.m.,	F 880		

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 880	Continued From page 10 LPN-A entered the dining room, lifted R29's shirt and administered R29's insulin with her bare hands. LPN-A returned to the medication cart and discarded the insulin pen needle into the sharps container and placed the insulin pen back into the medication cart. LPN-A gathered medications and eye drops for R1, while touching the medication cart, computer mouse, and drawers. LPN-A walked to the sitting area where R1 was seated and administered eye drops to R1 wearing one glove on her left hand, touched both of R1's eyes with gloved left hand, removed glove from left hand and disposed of it into the garbage on the medication cart. LPN-A then put R1's eye drop bottle back in the medication cart and proceeded to gather medications for R32, touching the medication cart drawers, computer mouse, and cups on the medication cart.. LPN-A handed medications to R32 and noted R32 did not have anything in her glass. LPN-A proceeded to open the refrigerator on the unit and poured a glass of juice and handed it to R32. LPN-A returned to the medication cart to gather medications for R43. LPN-A administered medications to R43, picked up R43's glass and provided a drink of juice between each medication administered. LPN-A returned to the medication cart and gathered R37's medications. LPN-A stated medications needed to be crushed and proceeded to crush seven medications and placed them in a medication cup. Two medications were unable to be crushed; LPN-A opened the two capsules with bare hands and sprinkled them into the medication cup containing the other crushed medications. LPN-A mixed applesauce into the crushed medications. LPN-A handed R37 their glass while administering the crushed medications to R37. LPN-A did not sanitize her hands during the entire medication pass.	F 880		

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 880	Continued From page 11 During an interview on 8/26/24 at 7:27 p.m., LPN-A verified that she had not performed hand hygiene during the medication pass. LPN-A stated it was not her normal process to perform hand hygiene during her medication pass. LPN-A indicated she should have performed hand hygiene after every resident contact and medication pass. During an interview on 8/27/24 at 1:44 p.m., infection preventionist (IP)-A stated her expectation was that staff would have performed hand hygiene before and after medication pass, between resident contact, and entering in and out of resident rooms. During a follow-up interview on 8/27/24 at 1:51 p.m., IP-A indicated the facility had an expectation for all staff to sanitize all lifts with a Sani-wipe (germicidal cleansing wipe) after each use. IP-A stated it was important to sanitize the lifts after each use to prevent cross contamination. During a follow-up interview on 8/27/24 at 1:52 p.m., IP confirmed EBP were utilized for high resident contact cares; toileting, transferring, dressing and bathing or anytime a staff would come in direct contact with a resident. IP verified the expectation of staff were to be wearing a gown and gloves with cares. IP further stated EBP were in place because staff did not know what germs could have been present on clothing and staff wanted to protect our residents. During an interview on 8/27/24 at 3:06 p.m. director of nursing (DON) confirmed the expectation lifts were to be wiped down with Sani-wipes after the lifts were removed from a	F 880		

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 880	Continued From page 12 resident's room to prevent the spread of infection from one resident to another. During a follow-up interview on 8/27/24 at 4:32 p.m., director of nursing DON confirmed EBP were put in place to prevent the spread of potential infections's to other residents and staff. DON verified the expectation of staff was to wear a gown and gloves with any close personal contact with residents on EBP. DON confirmed it was important to stop the transmission of infections from staff and residents and from room to room. During a follow-up interview on 8/27/24 at 4:48 p.m., DON stated her expectation was staff would have performed hand hygiene prior to administering medications, after administering medication, and after any resident contact to prevent the spread of infection. Review of a facility policy dated April 2024, identified the facility would implement enhanced barrier precautions for prevention of transmission of multidrug-resistant organisms. The policy further identified EBP employed targeted gown and glove use during high contact resident care activities which included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, wound care: any skin opening requiring a dressing. The policy also identified the facility would make gowns and gloves available near or outside of the resident's room; PPE for enhanced barrier precautions were necessary when performing high-contact care activities and EBP would have been used for the duration of the	F 880		

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 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN STREET 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 880	Continued From page 13 affected resident's stay in the facility or until the wound heals or indwelling medical device was removed. The facility policy titled Standard Precautions: Equipment, Nursing Unit Cleaning Of-Signature sheet, Use Of Form #BMH 689-91 Utensils (Nursing) And Personal Nursing Items, Washing And Sanitizing Of dated 12/2019, identified all shared equipment would be disinfected between residents. The policy also identified Tuesday night staff tasks included mechanical lifts and stands would have all hard surfaces disinfected using gloves and a Professional Disposables International Inc (PDI) Sani-cloth germicidal wipe after gross loose debris had been removed. A policy titled Hand Hygiene Policy dated 10/2020, indicated when to perform hand hygiene, "before having direct contact with patients, after contact with a patient's intact skin, after contact with mucous membranes, after contact with inanimate objects (including medical equipment" in the immediate vicinity of the patient, and after removing gloves."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	**824 SOUTH SHERIDAN STREET** **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
K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted on 08/28/2024 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.	K 000		

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

Electronically Signed | 09/11/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	**824 SOUTH SHERIDAN STREET** **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
K 000	Continued From page 1 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: 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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	**824 SOUTH SHERIDAN STREET** **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
K 000	Continued From page 2 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 74 beds and a census of 48 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET.	K 000		
K 321 SS=E	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 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	K 321		9/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	**824 SOUTH SHERIDAN STREET** **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
K 321	Continued From page 3 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors to hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, 7.2.1.15, and 7.2.1.15.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 08/28/2024 between 9:00 and 11:30 AM, it was revealed by observation that the doors to the following hazardous areas did not latch properly when closed: Soiled Utility room by Room 106, and the Storage Room by the Chapel. 2. On 08/28/2024 between 9:00 and 11:30 AM, it was revealed by observation that the following	K 321	1) 1. Door closers on doors to two hazardous areas noted not to latch properly during inspection have been adjusted to latch properly per code. 2. Staff education provided to all LB Broen Home staff to submit repair requests, via the LB Homes Ticket System, for all doors noted not to latch properly. 3. Ongoing monitoring of the Ticket System by maintenance staff with timely follow up on concerns will ensure solutions are sustained. 4. Jerry Oswald, Interim Facilities Engineer, will be responsible for the corrective action and monitoring of compliance. 5. Date of completion was September 9,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	**824 SOUTH SHERIDAN STREET** **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
K 321	Continued From page 4 rooms were being used to store combustible items without self-closing doors: Rooms 104 A and B, 117, and 120. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 321	2024. 2) 1. Rooms 104 a & b, 117, and 120 were noted to contain extra combustible items during the inspection, without the presence of self-closure doors. Extra items have been removed from rooms 104 a & b, 117, and 120. 2. Maintenance staff were re-educated on the storage of combustible items and the requirement for self-closing doors on all areas of storage. 3. Combustible items will be stored only in designated storage locations with self-closing doors. Monitoring of non-storage areas will be ongoing by all facility employees and reported to maintenance if noted. 4. Jerry Oswald, Interim Facilities Engineer, will be responsible for the corrective action and monitoring of compliance. 5. Date of completion was September 6, 2024.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small	K 324		9/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	**824 SOUTH SHERIDAN STREET 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
K 324	Continued From page 5 appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to install proper protection for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, 19.3.2.5.3 (9). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/28/2024 between 9:00 and 11:30 AM, it was revealed by observation that the stove in the 3 North community room did not have timer, not exceeding 120 minutes, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Maintenance Director verified	K 324	1. The power cord has been removed from the 3 North Community Room stove rendering it inoperable. 2. A tag will be installed on the back of the stove that reads "The power cord for this device was removed to comply with NFPA 101 (2012) edition Life Safety Code sections 19.3.2.5.1 and 19.3.2.5.3. This device must have a timer not exceeding 120 minutes that automatically deactivites the cooktop or range, independent of staff action." 3. Staff education provided to all LB Homes staff regarding removal of the power cord. 4. Jerry Oswald, Interim Facilities Engineer, will be responsible for the corrective action and monitoring of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	**824 SOUTH SHERIDAN STREET 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
K 324	Continued From page 6 this deficient finding at the time of discovery.	K 324	compliance. 5. Date of completion September 11, 2024.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		9/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	**824 SOUTH SHERIDAN STREET** **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
K 363	Continued From page 7 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/28/2024 between 9:00 and 11:30 AM, it was revealed by observation the door to room 380 was propped open with a garbage can. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	1. The corridor door to room 380 has had the hinges adjusted to assure compliance with NFPA 101 (2012 edition), Life Safety Code section 19.3.6.3.10. 2. Staff education provided to all LB Broen Home staff to submit repair requests, via the LB Homes Ticket System, for all doors noted to require propping. 3. Ongoing monitoring of the Ticket System, by maintenance staff, with timely follow up on concerns will ensure solutions are sustained. 4. Jerry Oswald, Interim Facilities Engineer, will be responsible for the corrective action and monitoring of compliance. 5. Date of completion September 11, 2024.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for	K 374		9/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	**824 SOUTH SHERIDAN STREET** **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
K 374	Continued From page 8 swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke and fire barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8, 8.3.3.3, and 8.5.4.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 08/28/2024 between 9:00 and 11:30 AM, it was revealed by observation that the smoke barrier doors by rooms 354 and 355 did not close completely leaving a gap between the door leaves when released from the magnetic hold-open device. 2. On 08/28/2024 between 9:00 and 11:30 AM, it was revealed by observation that the fire barrier door between Alcott Manor and 3 North did not latch when released from the magnetic hold-open device. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 374	1) 1. Smoke barrier doors and door closers, by rooms 354 and 355, noted not to close completely during inspection have been adjusted to facilitate proper sequence of closing and latching per code. 2. Staff education provided to all LB Broen Home staff to submit repair requests, via the LB Homes Ticket System, for all doors noted not to close completely. 3. Ongoing monitoring of the Ticket System, by maintenance staff, with timely follow up on concerns will ensure solutions are sustained. 4. Jerry Oswald, Interim Facilities Engineer, will be responsible for the corrective action and monitoring of compliance. 5. Date completed September 11 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **05 - FREEZER/HVAC ADDITION** B. WING _____	**08/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	**824 SOUTH SHERIDAN STREET 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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/28/2024. 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. This addition 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 74 beds and had a census of 48 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET:	K 000		

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

Electronically Signed | 09/11/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245453	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING	DATE SURVEY COMPLETE: **8/28/2024**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the automatic 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 5.2.1.2. This deficient findings could have an isolated impact on the residents within the facility. Findings include: On 08/28/2024, between 9:00 and 11:30 AM, it was revealed by observation that storage of items in IT Room A-20 were being stored within 18 inches of the sprinkler head on top of a storage rack. Violation was corrected at the time of discovery. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.
K 923	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245453	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING	DATE SURVEY COMPLETE: **8/28/2024**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 923	Continued From Page 1

aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure.
Cylinders must be handled with precautions as specified in 11.6.2.
A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."
Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion.
Cylinders stored in the open are protected from weather.
11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to maintain proper storage of gas cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2. This deficient finding could have an isolated impact on residents within the facliity.

Findings include:

On 08/28/2024 between 9:00 and 11:30 AM, it was revealed by observation that empty and full oxygen cylinders were stored in the oxygen storage room without being separated from each other. Violation was corrected at the time of discovery.

An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 2, 2024

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

RE: CCN: 245453
Cycle Start Date: August 28, 2024

Dear Administrator:

On October 1, 2024, the Minnesota Department 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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us