Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 29, 2023

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

RE: CCN: 245453
Cycle Start Date: September 5, 2023

Dear Administrator:

On September 19, 2023, we informed you that we may impose enforcement remedies.

On September 20, 2023, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 5, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 5, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 5, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 5, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lb Broen Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 5, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 5, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
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

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Electronically delivered
September 29, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: PTCJ11

Dear Administrator:

The above facility was surveyed on September 18, 2023 through September 20, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00862	A. BUILDING: ______ B. WING ______	C 09/20/2023

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/18/23, to 9/20/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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

Electronically Signed | 10/06/23

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2 000	Continued From page 1	2 000		

identify the date when they will be completed.

The following complaints were reviewed during the survey:
H54535555C (MN00083354).
H54535554C (MN00083367).
H54535557C (MN00096826).
H54535556C (MN00083435).
H5453048C (MN000081788).
H54535553C (MN00086679) and NO licensing orders were issued.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic

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2 000	Continued From page 2 State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 690	MN Rule 4658.0465 Subp. 3 Transfer, Discharge, and Death Subp. 3. Transfer or discharge to another facility.	2 690		10/19/23

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2 690	Continued From page 3	2 690		

When a resident is transferred or discharged to another health care facility or program, the nursing home must send the discharge summary compiled according to subpart 2, and pertinent information about the resident's immediate care and sufficient information to ensure continuity of care prior to or at the time of the transfer or discharge to the other health care facility or program. Additional information not necessary for the resident's immediate care may be sent to the new health care facility or program at the time of or after the transfer or discharge.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure minimum required information was provided to a receiving healthcare facility for 1 of 1 residents (R42) who was transferred to the hospital and was subsequently admitted to the hospital.

Corrected.

Findings include:

R42's discharge Minimum Data Set (MDS) dated 7/24/23, indicated R42 was cognitively intact and had diagnoses which included cancer, anemia, diabetes mellitus. The MDS identified R42 required staff assistance with activities of daily living.

Review of R42's progress notes from 8/17/23 to 8/24/23, revealed the following:
- on 7/24/23 at 4:53 p.m. R42 had a temperature of 102.3, productive cough, lungs clear with low volume hum on expiration and COVID-19 test negative. R42's primary provider called and order a complete blood count and basic metabolic panel be drawn on 7/25/23, and would be seen on rounds. R42's daughter was updated.

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2 690	Continued From page 4 - at 7:21 p.m. R42 had a large liquid emesis, his stomach was upset, running a fever and coughing. - at 8:15 p.m. R42 had another large projectile emesis, temperature 102.9, oxygen levels 88 percent on room air with slightly labored breathing and fine crackles in his lungs. Family notified. - at 8:50 p.m. R42 sent to the emergency room for further evaluation. - at 10:42 p.m. R42 was admitted to hospital with pneumonia. R42's medical record lacked any documentation the required transfer information was sent to the receiving hospital. During an interview on 9/20/23 at 9:28 a.m., licensed social worker (LSW) stated R42 had been hospitalized and was not able to locate documentation in R42's medical record regarding his transfer to the hospital. The LSW indicated her expectation was for staff to complete the interagency referral form, the code status and the resident's medical condition and it should have been sent with the resident to the hospital. The LSW indicated staff should have made a copy of the transfer forms and placed them in the medical record. During an interview on 9/20/23 at 11:15, the director of nursing (DON) confirmed the above findings and indicated she would expect staff to follow the facility's policy and procedures for transfers and discharges. The DON indicated she would expect staff to make sure the necessary paper work including interagency form, face sheet, emergency contact information, medication sheets, treatment sheets and code status were sent to the receiving facility.	2 690		

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2 690	Continued From page 5 Review of the facility policy titled, Transfer and Discharge revised on 7/98, indicated the interagency referral form would be completed and sent to the receiving hospital for all transfers. The policy indicated staff would make a copy of the completed form and attachments and place in the front of the resident's medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to residents transferring to another health care facility so the receiving facility has all the information needed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure facilities have the correct information when they are transferred. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 690		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		10/19/23

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2 830	Continued From page 6	2 830		

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to implement interventions to prevent further falls for 1 of 3 resident (R 41) reviewed for falls.

Corrected.

Findings include:

R41's quarterly Minimum Data Set (MDS) dated 6/29/23, identified R41 had severely impaired cognition and had diagnosis which included non traumatic brain dysfunction and cancer Indicated R41 required extensive assistance with activities of daily living (ADL's) which included, bed mobility, transfers, toileting, and locomotion. Identified R41 required physical assistance to maintain balance during transitions and toileting. Revealed R41 has two falls with no injury since the last required assessment.

R41's significant change Care Area Assessment (CAA), dated 10/3/22, identified R41 had impaired cognition and had diagnosis which included dementia, cancer and diabetics mellitus (DM). Indicated R41 required extensive assistance with activities of daily living (ADL's). Identified R41 was a high fall risk related to dementia and not communicating her needs for assistance with transfers.

Review of R41's current care plan revised 10/18/22, revealed R41 was incontinent of bowel and bladder. Care plan revealed R41 was at high risk for falls related to de-conditioning , cognitive deficits and history of falls prior to admission. R41's care plan listed various fall interventions which included bed in low position, bed and wheelchair alarms, ensure resident wore gripper

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	00862	A. BUILDING: ______ B. WING ______	C **09/20/2023**

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) COMPLETE DATE
2 830	Continued From page 7 socks or shoes when out of bed, remind resident to use call light and to move wheelchair and walker out into hallway when resident was in bed. Review of R41's most recent fall risk assessment dated 7/10/23, identified R41 was at high risk for falls related to impaired mobility, impaired cognition and urinary incontinence. Review of R41's undated nursing assistant (NA) worksheet revealed R41 required a bed alarm and directed staff to place wheelchair and walker in the hallway when not using. Review of R41's adverse event reports from 3/16/23 to 7/8/23, revealed the following: - 3/16/23, R41 had an unwitnessed fall at 4:40 p.m.. R41 was found sitting on the floor hanging onto the grab bar on the bed. R41 attempted to transfer from the bed to the wheelchair. R41 had not received any injuries and an intervention was added to ensure R41 was wearing non slip socks or shoes. -7/8/23, R41 had an unwitnessed fall at 2:45 p.m. R41 was found on the floor with her head on her right arm toward the foot of the bed and her feet toward the head of the bed. R41 had not received any injuries and an intervention was added to implement a raised edge mattress. During an observation on 9/18/23 at 11:34 a.m., R41 was lying in bed and R41's wheelchair was noted to be five feet from the bed against the wall within sight of R41. During an observation on 9/19/23 at 3:38 p.m., nursing assistant (NA)-A exited R41's room and placed a pal lift in the hallway. R41 was lying in	2 830		

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2 830	Continued From page 8	2 830		

bed and R41's wheelchair was noted to be five feet from the bed against the wall within sight of R41.

During an observation on 9/19/23 at 4:17 p.m., R41 continued to be lying in bed with the wheelchair noted to be five feet from the bed against the wall within sight of R41.

During an interview on 9/19/23 at 4:19 p.m., NA-A stated she had placed the wheelchair five feet from the bed against the wall when she laid R41 down in bed. NA-A stated R41's care plan identified staff were to move R41's wheelchair into the hallway when not in use. NA-A stated she was not aware R41's wheelchair was to be placed in the hallway when not in use.

During an interview on 9/19/23 at 4:24 p.m., licensed practical nurse (LPN)-A verified R41's wheelchair was placed five feet from R41's bed against the wall and was visible to R41. LPN-A stated staff were expected to place R41's wheelchair in the hallway and out of R41's sight when not in use as a fall intervention. LPN-A stated R41 was a high fall risk and had fallen out of bed when she was able to see her wheelchair in the room. LPN-A indicated he expected staff would place R41's wheelchair in the hallway when not in use. LPN-A proceeded to place R41's wheelchair in the hallway at that time.

During an interview on 9/19/23 at 4:29 p.m., registered nurse (RN)-B verified R41's wheelchair had been in her room near the bed before LPN-A moved it into the hallway. RN-B stated R41 was at high risk for falls and had fallen in the facility however, she was not aware R41's wheelchair was to be placed in the hallway when not in use.

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2 830	Continued From page 9	2 830		

Continued From page 9

During an observation on 9/20/23 at 7:15 a.m., R41 was lying in bed and the wheelchair was noted to be five feet from the bed against the wall within R41's sight.

During an observation on 9/20/23 at 7:49 a.m., R41 was lying in bed and the wheelchair continued to be five feet from the bed against the wall within R41's sight.

During an interview on 9/20/23 at 7:51 a.m., RN-B verified R41's wheelchair was five feet from the bed against the wall and within sight of R41. RN-B moved R41's wheelchair into the hallway and stated her expectation was R41's care plan would have been followed.

During an interview on 9/20/23 at 9:05 a.m., director of nursing (DON) verified R41 was a high risk for falls and has had falls in the facility. DON stated she was not aware R41's wheelchair was to be placed in the hallway when not in use however verified R41's care plan stated to ensure R41's wheelchair was in the hallway when not in use. DON indicated she expected staff to follow R41's care plan and ensure falls interventions were in place.

Review of a facility policy titled Fall Prevention Program revised 6/2013, revealed the facility assessed residents upon admission and at least quarterly for falls and promptly began a falls prevention plan. Policy indicated a post - fall analysis was done after each fall and appropriate care planned interventions were to be follow.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review care plan interventions with staff related to fall prevention, then audit to ensure compliance.

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2 830	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section	21880		10/19/23

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21880	Continued From page 11 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure grievance forms and procedures were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 4 of 4 residents (R40, R28,R8 and R19) reviewed for grievances. Findings include: On 9/19/23 at 2:00 p.m., a resident council meeting was held with four residents which included R40, R28, R8, and R19. During the resident council meeting, all four residents indicated they were not aware how to file a grievance. During an observation on 9/19/23 at 2:22 p.m., a walk through was conducted of the first floor, second floor and third floor of the facility. The walk through revealed there were no grievance forms or procedures posted for residents or resident representatives to refer to. During an interview on 9/19/23 at 2:22 p.m., registered nurse (RN)-A stated grievance forms were located at the front desk on first floor in a	21880	Corrected.	

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21880	Continued From page 12	21880		

binder. RN-A indicated any staff member could complete the forms if a resident made a grievance.

During an interview on 9/19/23 at 3:10 p.m., licensed social worker (LSW)-A identified a binder located on the front desk titled Room/Apartment Directory And Quality Improvement Request Form And Corporate Compliance Report Form And Envelopes. LSW-A opened the binder and indicated the grievance policy and forms were inside the binder in plastic sleeves near the back of the binder. The binder lacked identification it contained the grievance procedure and forms. LSW-A confirmed the binder at the front desk was the only place the grievance procedure and forms were stored. LSW-A indicated information was provided in the admission packet to each resident upon admission.

During an interview on 9/19/23 at 3:32 p.m., DON-A stated she was the grievance officer. DON confirmed the facility had not posted the grievance procedure or forms in prominent locations within the facility. DON stated she felt it was important to inform residents at resident council how to file a grievance and to have forms available to complete anonymously when desired.

The facility policy titled Complaint/Grievance Policy And Procedure dated 6/23, identified the purpose was to ensure all residents were informed of their ability to file a complaint and how to file a complaint. The policy identified each resident and/or resident representative received written notice of the facility's process for receiving and resolving complaints, which was located in the facility resident hand book. The policy lacked identification of further notification to residents individually or through postings in prominent

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21880	Continued From page 13 locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or their designee should review the facility's policy and procedures and educate the facility staff responsible for grievances. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		

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	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/19/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted on 09/19/2023 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: Electronically Signed
TITLE:
(X6) DATE: 10/06/2023

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

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K 000	Continued From page 1 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 74 beds and a census of 42 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET.	K 000		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by:	K 511		10/19/23

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K 511	Continued From page 3 Based on observation and staff interview, the facility failed to properly secure electrical panel(s) per NFPA 101 (2012 edition), Life Safety Code, section 19.5.1.1, 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.27. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/19/2023 between 10:15 AM to 2:30 PM, it was revealed by observation an electrical panel in the resident corridors by rooms were found to be unsecured and readily accessible to unqualified individuals. An interview with the Facilities Engineer verified this deficient finding at the time of discovery.	K 511	1. Electrical panels found within resident corridors will be secured per code. 2. Monthly checks of the corrected electrical panels will be added to the monthly fire equipment/emergency lighting log. 3. Electrical contractors will be held responsible for installing new electrical panels per code. 4. Kevin Rogness, Facilities Engineer, will be responsible for the corrective action and monitoring of compliance. 5. Our proposed date of completion is prior to October 19th, 2023.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies	K 521	There are 2 parts to this correction. Part 1: 1. Failed dampers will be tested again and documentation of passing, or	10/19/23

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K 521	Continued From page 4 and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12 . This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 09/19/2023 at 12:15 PM, it was revealed by a review of available documentation at the time of the survey the facility, the documentation provided stated that there are 12 dampers in total and 2 dampers in the basement near the laundry failed and no further documentation could be provided if they were repaired since the time of the inspection dated 03/4/2022. 2. On 09/19/2023 at 1:10 PM, it was revealed by observation a duct penetrating a one hour fire barrier without a fire damper from a hazardous storage area in central storage to the elevator equipment room. An interview with the Facilities Engineer verified this deficient finding at the time of discovery.	K 521	documentation of repair or replacement will be kept on file following the test. 2. Proper documentation of repairs or replacements of failed systems will now be required from vendors. 3. Proper documentation of repairs or replacements of failed systems will not be required from vendors. 4. Kevin Rogness, Facilities Engineer, will be responsible for the corrective actions and monitoring of compliance. 5. Our proposed date for completion is prior to October 19, 2023. Part 2: 1. The duct in question will be clocked by a cap or plug on both ends preventing a hazard from leaving or coming into inappropriate areas. 2. Educational measures have been taken to ensure this will not reoccur. 3. Vendors and contractors will be monitored closely while performing work within our facilities to ensure this solution is sustained. 4. Kevin Rogness, Facilities Engineer, will be responsible for the corrective actions and monitoring of compliance. 5. Our proposed date for completion is prior to October 19, 2023.	

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K 914	Continued From page 5	K 914		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, sections 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/19/2023 between 10:15 AM and 02:30 PM,	K 914	1. A corrected method of inspection to include annual completion of inspection has been implemented. 2. A new form has been implemented to track, document, and note inspection dates. 3. A new form has been implemented to track, document, and note inspection dates.	10/19/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 6 it was revealed by a review of available documentation that the electrical receptacle inspection form that the facility provided had various dates of completion. Not all receptacles were completed annually at the time of the survey. An interview with the Facilities Engineer verified this deficient finding at the time of discovery.	K 914	4. Kevin Rogness, Facilities Engineer, will be responsible for the corrective actions and monitoring of compliance. 5. The new form is currently being implemented and will be used moving forward from October 2023.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		10/14/23

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 ______	**09/19/2023**

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

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K 918	Continued From page 7 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/19/2023 at 10:30 AM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. An interview with the Facilities Engineer verified this deficient finding at the time of discovery.	K 918	1. A four-hour load bank test will be performed. 2. The Emergency Generator Testing Logs have been updated to include the proper tests per code. 3. The Emergency Generator Testing Logs have been updated to include the proper tests per code. 4. Kevin Rogness, Facilities Engineer, will be responsible for the corrective actions and monitoring of compliance. 5. The four-hour load bank test is scheduled to be performed during the week of October 9th, 2023.	

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 ______	**09/19/2023**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted on 09/19/2023, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, LB Broen Home Bldg 05 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 18 New 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		10/06/2023

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

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 ______	**09/19/2023**

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

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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 Home Bldg 05 is a single-story building of type II (000) construction and is fully sprinkled. It includes areas for a cooler and freezer for the main kitchen as well as a loading dock. There is a 3-hour fire curtain separating the addition from the existing building. The facility was surveyed as two buildings.	K 000		

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	245453	A. BUILDING **05 - FREEZER/HVAC ADDITION** B. WING ______	**09/19/2023**

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

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K 000	Continued From page 2 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 42 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET.	K 000		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918		10/19/23

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 ______	**09/19/2023**

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K 918	Continued From page 3 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/19/2023 at 10:30 AM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. An interview with the Facilities Engineer verified this deficient finding at the time of discovery.	K 918	1. A four-hour load bank test will be performed. 2. The Emergency Generator Testing Logs have been updated to include the proper tests per code. 3. The Emergency Generator Testing Logs have been updated to include the proper tests per code. 4. Kevin Rogness, Facilities Engineer, will be responsible for the corrective actions and monitoring of compliance. 5. The four-hour load bank test is scheduled to be performed during the week of October 9th,2023.	

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	245453	A. BUILDING ______ B. WING ______	C 09/20/2023

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E 000	Initial Comments On 9/18/23, to 9/20/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		10/19/23

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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain standards for the emergency and standby power system. This deficient practice had the potential to affect all 42 residents residing in the facility. Findings include: On 9/20/23 at 11:25 a.m., the facility's emergency management procedures were reviewed. The facility lacked documentation of 36 monthly 4 hour generator load bank test. During an interview on 9/20/23 at 12:04 p.m., maintenance supervisor MS confirmed the above findings.	E 041	The facility failed to maintain standards for the emergency and standby power system, lacking documentation of the thirty-six month four-hour generator load bank test. All residents of LB Broen Home have the potential to be impacted by the deficient practice in the event of a loss of electrical power at the facility. Administrator and Facilities Engineer were educated on the requirement for a thirty-six month, four-hour generator load bank test by the Fire Marshall onsite on 10.03.2023. System changes include update of the Emergency Generator Testing Logs, BH #6120-23 and BH #6119-23, to include documentation of the proper tests per code. The four-hour load bank test was completed successfully on both generators on 10/11/2023 by Interstate Power Systems. Kevin Rogness, Facilities Engineer, will be responsible for completion of BH #6120-23 and BH #6119-23 which are completed monthly with required monthly testing and now include the thirty-six month testing requirement. An agenda item was added to the minutes of the Safety Committee Agenda, a subcommittee of the Quality Assessment and Assurance Committee and QAPI. 10.19.23 and ongoing.	

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F 000	Continued From page 4	F 000		
F 000	INITIAL COMMENTS On 9/18/23, to 9/20/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54535555C (MN00083354). H54535554C (MN00083367). H54535557C (MN00096826). H54535556C (MN00083435). H5453048C (MN00081788). H54535553C (MN00086679). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or	F 585		10/19/23

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F 585		F 585		

Continued From page 5
reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey

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F 585	Continued From page 6	F 585		

Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as

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

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F 585	Continued From page 7 the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure grievance forms and procedures were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 4 of 4 residents (R40, R28,R8 and R19) reviewed for grievances. Findings include: On 9/19/23 at 2:00 p.m., a resident council meeting was held with four residents which included R40, R28, R8, and R19. During the resident council meeting, all four residents indicated they were not aware how to file a grievance. During an observation on 9/19/23 at 2:22 p.m., a walk through was conducted of the first floor, second floor and third floor of the facility. The walk through revealed there were no grievance forms or procedures posted for residents or resident representatives to refer to. During an interview on 9/19/23 at 2:22 p.m., registered nurse (RN)-A stated grievance forms were located at the front desk on first floor in a binder. RN-A indicated any staff member could complete the forms if a resident made a	F 585	The facility failed to ensure grievance forms and procedure were posted in prominent locations throughout the facility for residents and resident representatives accessibility. R40, R28, R8, and R19 have been notified of the process of how to file a grievance, as well as the prominent location of the grievance policy and forms throughout the facility. All residents at LB Broen Home have the potential to file a grievance. All were notified in writing of the process and new prominent locations of the posted grievance policy and forms. We will continue to review the grievance process with newly admitted residents and their resident representatives as we have been to this point. BH # 1260-16, How to submit a Compliant/Grievance or Quality Improvement Request, has been updated with the availability of the grievance policy and forms on each care area at LB Broen Home. The ability to file a grievance anonymously has also been added to #1260-16. BH #1260-16 was updated and reviewed with each resident at the	

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grievance.

During an interview on 9/19/23 at 3:10 p.m., licensed social worker (LSW)-A identified a binder located on the front desk titled Room/Apartment Directory And Quality Improvement Request Form And Corporate Compliance Report Form And Envelopes. LSW-A opened the binder and indicated the grievance policy and forms were inside the binder in plastic sleeves near the back of the binder. The binder lacked identification it contained the grievance procedure and forms. LSW-A confirmed the binder at the front desk was the only place the grievance procedure and forms were stored. LSW-A indicated information was provided in the admission packet to each resident upon admission.

During an interview on 9/19/23 at 3:32 p.m., DON-A stated she was the grievance officer. DON confirmed the facility had not posted the grievance procedure or forms in prominent locations within the facility. DON stated she felt it was important to inform residents at resident council how to file a grievance and to have forms available to complete anonymously when desired.

The facility policy titled Complaint/Grievance Policy And Procedure dated 6/23, identified the purpose was to ensure all residents were informed of their ability to file a complaint and how to file a complaint. The policy identified each resident and/or resident representative received written notice of the facility's process for receiving and resolving complaints, which was located in the facility resident hand book. The policy lacked identification of further notification to residents individually or through postings in prominent locations throughout the facility of the right to file

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facility and mailed to each resident representative 10.06.2023. Grievance procedure and forms have been removed from the front desk binder. LB Broen Home Complaint/Grievance Policy and Procedure dated June 2023 has been updated to include Complaint/Grievance Records and process are prominently posted on each resident unit. An impromptu Resident Council meeting was held 10.10.2023 to provide feedback to R40, R28, R8, and R19 including physically bringing the group to the prominent posting/form areas. All staff were notified of the posting and form location on each unit, 10.19.2023 via email and written notice at the unit desk.

A Nursing Care Audit BH# 1378-23, Complaint/Grievance Posting/Forms has been created and will be completed on all shifts, weekly, x 4 weeks on all resident care units within the facility and quarterly ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a sub-committee of the Quality Assessment and Assurance Committee and QAPI.

10.19.2023 and ongoing

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F 585	Continued From page 9 grievances orally (meaning spoken) or in writing.	F 585		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or	F 622		10/19/23

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F 622	Continued From page 10 discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including	F 622		

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F 622	Continued From page 11 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure minimum required information was provided to a receiving healthcare facility for 1 of 1 residents (R48) who was transferred to the hospital and was subsequently admitted to the hospital. Findings include: R48's discharge Minimum Data Set (MDS) dated 7/24/23, indicated R48 was cognitively intact and had diagnoses which included cancer, anemia, diabetes mellitus. The MDS identified R48 required staff assistance with activities of daily living. Review of R48's progress notes from 8/17/23 to 8/24/23, revealed the following: - on 7/24/23 at 4:53 p.m. R48 had a temperature of 102.3, productive cough, lungs clear with low volume hum on expiration and COVID-19 test negative. R48's primary provider called and order a complete blood count and basic metabolic panel be drawn on 7/25/23, and would be seen on rounds. R48's daughter was updated. - at 7:21 p.m. R48 had a large liquid emesis, his stomach was upset, running a fever and	F 622	The facility failed to ensure minimum required information was provided to a receiving healthcare facility for a resident who was transferred to the hospital and subsequently admitted. R48 was transferred to the emergency room 7.24.2023 at 8:50pm. R48 was discharged from the facility 07.24.2023. All residents within the facility have the potential to be affected by the same deficient practice if they require transfer from the facility. A review of residents transferred since 04.10.2023 was completed and revealed 8 additional residents having been affected by the same deficient practice. All LPN/RN Charge Nurses have been re-educated on completion of transfer documentation to ensure a safe and effective transition of care for each resident. LB Broen Home policy and procedure, Transfer and Discharge, was reviewed with no content changes indicated. All LPN and RN Charge nurses were re-educated on the transfer process	

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coughing.
- at 8:15 p.m. R48 had another large projectile emesis, temperature 102.9, oxygen levels 88 percent on room air with slightly labored breathing and fine crackles in his lungs. Family notified.
- at 8:50 p.m. R48 sent to the emergency room for further evaluation.
- at 10:42 p.m. R48 was admitted to hospital with pneumonia.

R48's medical record lacked any documentation the required transfer information was sent to the receiving hospital.

During an interview on 9/20/23 at 9:28 a.m., licensed social worker (LSW) stated R48 had been hospitalized and was not able to locate documentation in R48's medical record regarding his transfer to the hospital. The LSW indicated her expectation was for staff to complete the interagency referral form, the code status and the resident's medical condition and it should have been sent with the resident to the hospital. The LSW indicated staff should have made a copy of the transfer forms and placed them in the medical record.

During an interview on 9/20/23 at 11:15, the director of nursing (DON) confirmed the above findings and indicated she would expect staff to follow the facility's policy and procedures for transfers and discharges. The DON indicated she would expect staff to make sure the necessary paper work including interagency form, face sheet, emergency contact information, medication sheets, treatment sheets and code status were sent to the receiving facility.

Review of the facility policy titled, Transfer and

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identified in this policy and procedure by the DON 10.12.2023. BMH # 110-93, Discharge Checklist - to Another Facility With or Without Services, was retitled to Discharge/Transfer Checklist - to Another Facility With or Without Services to better describe its intended use. Use of the LB Broen Home Discharge/Transfer Checklist - To Another Facility With or Without Services, was also reviewed at the 10.12.2023 meeting. All charge nurses verbalized understanding of the requirements after meeting with the DON for re-education. A system change was initiated including development of a new Health Information Management (HIM) checklist titled, Resident Transfer Documentation Checklist. This checklist will be completed by LB Broen Home Clinic Coordinator on an ongoing basis to ensure a safe and effective transition of care for each resident transferred from the facility in accordance with 483.12 (c) (2).

HIM Resident Transfer Documentation Checklist has been created and will be completed on an ongoing basis by the LB Broen Home Clinic Coordinator. The HIM Manager will monitor checklist findings weekly and ongoing and ensure prompt follow-up of concerns identified involving the DON, and/or Social Services Director as needed. Checklist findings have been added to the Resident Care and Customer Relations Committee agenda, a sub-committee of the Quality Assessment and Assurance Committee and QAPI.

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F 622	Continued From page 13 Discharge revised on 7/98, indicated the interagency referral form would be completed and sent to the receiving hospital for all transfers. The policy indicated staff would make a copy of the completed form and attachments and place in the front of the resident's medical record.	F 622	10.19.2023 and ongoing	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		10/19/23

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be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 15 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the Long Term Care (LTC) ombudsman of a facility initiated transfer for 1 of 1 residents (R48) who was transferred to an acute care facility on an emergency basis. In addition, the facility failed to provide written notifications for transfers to the resident and/or resident representative for 1 of 1 residents (R48) reviewed for hospitalization. Findings include: R48's discharge Minimum Data Set (MDS) dated	F 623	The facility failed to notify the Ombudsman of a facility-initiated transfer of a resident to an acute facility on an emergency basis and failed to provide written notifications to the resident and/or the resident representative in the form of a bed hold. The Ombudsman was not notified as required at 483.15(c)(4)(ii)(D) An immediate transfer or discharge is required by the resident□s urgent medical needs. R48 was discharged from the facility 07.24.2023.	

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7/24/23, indicated R48 was cognitively intact and had diagnoses which included cancer, anemia, and diabetes mellitus. The MDS identified R48 required staff assistance with activities of daily living.

Review of R48's progress notes from 8/17/23 to 8/24/23 revealed the following:
- on 7/24/23 at 4:53 p.m. R48 had a temperature of 102.3, productive cough, lungs clear with low volume hum on expiration and COVID-19 test negative. R48's primary provider called and ordered a complete blood count and basic metabolic panel be drawn on 7/25/23, and would be seen on rounds. R48's daughter was updated.
- at 7:21 p.m. R48 had a large liquid emesis, his stomach was upset, running a fever and coughing.
- at 8:15 p.m. R48 had another large projectile emesis, temperature 102.9, oxygen levels 88 percent on room air with slightly labored breathing and fine crackles in his lungs. Family notified.
- at 8:50 p.m. R48 sent to the emergency room for further evaluation.
- at 10:42 p.m. R48 was admitted to hospital with pneumonia.

R48's medical record lacked documentation the notification of the emergency transfer was sent to the LTC ombudsman and lacked documentation a written transfer notification was provided to the resident and/or resident's representative.

During an interview on 9/20/23 at 9:28 a.m., licensed social worker (LSW) confirmed R48 had been hospitalized and was not able to locate in the medical record that a written notification had been provided to the family or the ombudsman. The LSW stated she would expect staff to provide

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A review of all residents transferred since 4.10.2023 was completed and revealed eight additional recurrences of the deficient practice. A list of residents transferred from the facility, date of transfer, and location transferred to was sent to the Ombudsman. All LPN and RN Charge Nurses have received additional training on the need to issue the bed hold as identified on the Interagency Referral Form. This re-education was provided by the DON on 10.12.2023.

LB Broen Home policy and procedure, Transfer and Discharge Notification, was reviewed with no content changes indicated. LB Broen Home policy and procedure, Transferred Residents & Therapeutic Leave Bed-Hold Policy dated January 2017, was updated to include "In case emergency transfer is required by the resident's urgent medical needs, notice of transfer must be provided to resident and resident representative as soon as practicable before the transfer." All LPN and RN Charge Nurses were re-educated on the requirements of 483.15(c)(4)(ii)(D) ensuring notification of the resident and/or the resident□s representative as soon as practicable before the transfer. All Charge Nurses verbalized understanding of the requirements after meeting with the DON for re-education. A system change was initiated including development of a new Health Information Management checklist titled, Resident Transfer Documentation Checklist. This checklist will be completed by LB Broen Home Clinic

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F 623	Continued From page 17 the required written notices to the resident/family and the ombudsman. During an interview on 9/20/23 at 11:15 a.m., the director of nursing (DON) confirmed the above findings and indicated she would expect staff to follow the facility's policy and procedures for transfers and discharges. The DON stated she would expect staff would ensure the required notifications were completed for the resident, resident representative and the ombudsman. Review of the facility policy titled, Transfer and Discharge Notification revised on 3/94, indicated the resident and the resident representative would be provided proper ad timely notice of discharge as required by regulations and laws. The policy identified the facility would notify the LTC Ombudsman with 30 days of discharge from the facility.	F 623	Coordinator on an ongoing basis to ensure completion of notice requirements before transfer in accordance with 483.12(c)(3). HIM Resident Transfer Documentation Checklist, has been created and will be completed on an ongoing basis by the LB Broen Home Clinic Coordinator. The HIM Manager will monitor checklist findings weekly and ongoing and ensure prompt follow-up of concerns identified involving the DON, or Social Services Director as needed. Checklist findings have been added to the Resident Care and Customer Relations Committee agenda, a sub-committee of the Quality Assessment and Assurance Committee and QAPI. 10-19-2023 and ongoing.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement interventions to prevent further falls for 1 of 3 resident (R 41) reviewed for falls.	F 689	The facility failed to implement interventions to prevent further falls for R41. A fall prevention intervention to move wheelchair and walker out into hallway when resident was in bed added	10/19/23

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	245453	A. BUILDING ______ B. WING ______	C 09/20/2023

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F 689 Continued From page 18

Findings include:

R41's quarterly Minimum Data Set (MDS) dated 6/29/23, identified R41 had severely impaired cognition and had diagnosis which included non traumatic brain dysfunction and cancer Indicated R41 required extensive assistance with activities of daily living (ADL's) which included, bed mobility, transfers, toileting, and locomotion. Identified R41 required physical assistance to maintain balance during transitions and toileting. Revealed R41 has two falls with no injury since the last required assessment.

R41's significant change Care Area Assessment (CAA), dated 10/3/22, identified R41 had impaired cognition and had diagnosis which included dementia, cancer and diabetics mellitus (DM). Indicated R41 required extensive assistance with activities of daily living (ADL's). Identified R41 was a high fall risk related to dementia and not communicating her needs for assistance with transfers.

Review of R41's current care plan revised 10/18/22, revealed R41 was incontinent of bowel and bladder. Care plan revealed R41 was at high risk for falls related to de-conditioning , cognitive deficits and history of falls prior to admission. R41's care plan listed various fall interventions which included bed in low position, bed and wheelchair alarms, ensure resident wore gripper socks or shoes when out of bed, remind resident to use call light and to move wheelchair and walker out into hallway when resident was in bed.

Review of R41's most recent fall risk assessment dated 7/10/23, identified R41 was at high risk for falls related to impaired mobility, impaired

F 689 (Provider's Plan of Correction)

to R41s Care Plan on 05.08.2022, was not implemented as directed, instead wheelchair and walker were left in the resident room. Fall interventions for R41 were reviewed with resident representative 09.20.2023 with the above noted intervention discontinued as the intervention was no longer appropriate.

Care plans for all residents identified as at high risk of falls were reviewed to ensure implemented interventions are listed on the care plan, the Nursing Assistant Worksheet, and are being completed as directed. No additional residents were identified as being impacted by the same deficient practice.

LB Broen Homes Fall Prevention Program dated June 2013, was reviewed with no needed change of content identified. All nursing staff were re-educated on the importance of following the residents care plan and Nursing Assistant Worksheet to assure interventions to prevent further falls were implemented as listed, 10.12.2023 by the DON. BMH # 1181-05, LB Broen Home Nursing Care Audit, Fall, Acute Care Plan #2 was updated to include a column titled Observe resident, is the implemented intervention being completed as directed?

BMH #1181-05, LB Broen Home Nursing Care Audit, Fall, ACP #2 columns titled, Was the intervention implemented after the fall? and Observe resident, is the implemented intervention being completed as directed?, will be completed

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F 689

Continued From page 19

cognition and urinary incontinence.

Review of R41's undated nursing assistant (NA) worksheet revealed R41 required a bed alarm and directed staff to place wheelchair and walker in the hallway when not using.

Review of R41's adverse event reports from 3/16/23 to 7/8/23, revealed the following:

- 3/16/23, R41 had an unwitnessed fall at 4:40 p.m.. R41 was found sitting on the floor hanging onto the grab bar on the bed. R41 attempted to transfer from the bed to the wheelchair. R41 had not received any injuries and an intervention was added to ensure R41 was wearing non slip socks or shoes.

-7/8/23, R41 had an unwitnessed fall at 2:45 p.m. R41 was found on the floor with her head on her right arm toward the foot of the bed and her feet toward the head of the bed. R41 had not received any injuries and an intervention was added to implement a raised edge mattress.

During an observation on 9/18/23 at 11:34 a.m., R41 was lying in bed and R41's wheelchair was noted to be five feet from the bed against the wall within sight of R41.

During an observation on 9/19/23 at 3:38 p.m., nursing assistant (NA)-A exited R41's room and placed a pal lift in the hallway. R41 was lying in bed and R41's wheelchair was noted to be five feet from the bed against the wall within sight of R41.

During an observation on 9/19/23 at 4:17 p.m., R41 continued to be lying in bed with the

F 689

weekly on all shifts x 4 weeks on all resident care units within the facility and quarterly ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a sub-committee of the Quality Assessment and Assurance Committee and QAPI.

10/19/2023 and ongoing

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F 689	Continued From page 20	F 689		

wheelchair noted to be five feet from the bed against the wall within sight of R41.

During an interview on 9/19/23 at 4:19 p.m., NA-A stated she had placed the wheelchair five feet from the bed against the wall when she laid R41 down in bed. NA-A stated R41's care plan identified staff were to move R41's wheelchair into the hallway when not in use. NA-A stated she was not aware R41's wheelchair was to be placed in the hallway when not in use.

During an interview on 9/19/23 at 4:24 p.m., licensed practical nurse (LPN)-A verified R41's wheelchair was placed five feet from R41's bed against the wall and was visible to R41. LPN-A stated staff were expected to place R41's wheelchair in the hallway and out of R41's sight when not in use as a fall intervention. LPN-A stated R41 was a high fall risk and had fallen out of bed when she was able to see her wheelchair in the room. LPN-A indicated he expected staff would place R41's wheelchair in the hallway when not in use. LPN-A proceeded to place R41's wheelchair in the hallway at that time.

During an interview on 9/19/23 at 4:29 p.m., registered nurse (RN)-B verified R41's wheelchair had been in her room near the bed before LPN-A moved it into the hallway. RN-B stated R41 was at high risk for falls and had fallen in the facility however, she was not aware R41's wheelchair was to be placed in the hallway when not in use.

During an observation on 9/20/23 at 7:15 a.m., R41 was lying in bed and the wheelchair was noted to be five feet from the bed against the wall within R41's sight.

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F 689	Continued From page 21 During an observation on 9/20/23 at 7:49 a.m., R41 was lying in bed and the wheelchair continued to be five feet from the bed against the wall within R41's sight. During an interview on 9/20/23 at 7:51 a.m., RN-B verified R41's wheelchair was five feet from the bed against the wall and within sight of R41. RN-B moved R41's wheelchair into the hallway and stated her expectation was R41's care plan would have been followed. During an interview on 9/20/23 at 9:05 a.m., director of nursing (DON) verified R41 was a high risk for falls and has had falls in the facility. DON stated she was not aware R41's wheelchair was to be placed in the hallway when not in use however verified R41's care plan stated to ensure R41's wheelchair was in the hallway when not in use. DON indicated she expected staff to follow R41's care plan and ensure falls interventions were in place. Review of a facility policy titled Fall Prevention Program revised 6/2013, revealed the facility assessed residents upon admission and at least quarterly for falls and promptly began a falls prevention plan. Policy indicated a post - fall analysis was done after each fall and appropriate care planned interventions were to be follow.	F 689		

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F 689	Continued From page 22 . .	F 689		
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	F 732		10/19/23

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F 732	Continued From page 23 available to the public for review at a cost not to exceed the community standard. §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 nurse staffing information was posted daily. This deficient practice had the potential to affect all 42 residents who resided in the facility and/or any visitors who may have wished to view the information. Findings include: During an observation on 9/18/23 at 9:32 a.m., a sign was posted in the main lobby of the nursing home to the right of the entrance which revealed the following: The sign identified the nurse staffing information was located on the second floor north in the day room near the nurses' station. Hanging on the wall approximately three feet form the ground was a square wooden box. On the outside of the wooden box a sign indicated the posting of nursing staff levels were inside the box. Inside the box was a clipboard with a posting indicating Posted Nurse Staffing Information. The posting was dated 9/18/23, and identified a census of 42. - at 10:37 a.m., the staff posting remained the same. - at 3:09 p.m., the staff posting remained the same. - at 7:37 p.m., the staff posting remained the	F 732	The facility failed to ensure the required nurse staffing information was posted daily. This deficient practice has the potential to affect all residents and/or visitors to the facility who wish to view the nurse staffing information. The rectangular wooden box previously attached approximately three feet from the ground on facility unit 2 North has been relocated to the main lobby of the nursing home near the main entrance and the sign identifying the prior 2 North location of the posted staffing information has been removed. The main lobby location increases visibility and allows the public increased access to the posted nursing hours. Review of facility policy, Posted Nurse Staffing Information, dated 4.2022, was completed and did not require updating. The DON, Scheduling Coordinator, and facility Charge Nurses were re-educated on ensuring the posted forms are updated to include census changes reflecting admissions, discharges, and hospitalizations occurring on the shift as well as updated total number and actual hours worked by licensed and unlicensed nursing staff by	

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F 732	Continued From page 24 same. The posting lacked the actual and total number of hours worked per shift by registered nurses (RN), licensed practical nurses (LPN) and nursing assistant (NA). During an observation on 9/20/23 at 8:31 a.m., the staff posting located on the second floor north by the nurses station in the wooden box revealed the posting was dated 9/19/23, and identified the census of 42. - at 12:09 p.m., the staff posting remained the same. - at 1:41 p.m., the staff posting remained the same. The posting lacked the actual and total number of hours worked per shift by RN's, LPN's and NA's. During an interview on 9/19/23 at 1:43 p.m., the director of nursing (DON) confirmed the above findings and indicated the staff scheduler (SS) was responsible for the daily staff postings. The DON indicated her expectation for staff would be for the staff posting to be completed daily and to reflect the current staffing patterns and census. The DON stated she would expect the staff posting to be visible for everyone to see and to be completed. During an interview on 9/19/23 at 1:53 p.m., the SS confirmed the above findings and indicated she was responsible to ensure the staff posting was updated on a daily basis. The SS stated she was not aware the staff posting needed to be posted for the public to see. The SS indicated she would expect the staff posting to be completed and updated to reflect the current staffing and	F 732	the DON 10.12.2023. Resident representatives were notified of the changed location via written letter mailed 10.06.2023. Nursing Care Audit BH# 1368-22, Posted Regulatory Information will be completed weekly x 4 weeks on all resident care units within the facility and quarterly ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a sub-committee of the Quality Assessment and Assurance Committee and QAPI. 10/19/2023 and ongoing	

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F 732	Continued From page 25 census. Review of the facility policy titled, Posted Nurse Staffing Information dated 4/2022, indicated the total number and the actual hours worked by licensed and unlicensed nursing staff (RN, LPN, NA/R) directly responsible for resident care would be posted daily per shift to allow the public access to posted nurse staffing data.	F 732		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 2, 2023

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

RE: CCN: 245453
Cycle Start Date: September 5, 2023

Dear Administrator:

On September 29, 2023, we notified you a remedy was imposed. On October 24, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 19, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 5, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 29, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 5, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 19, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 2, 2023

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

Re: Reinspection Results
Event ID: PTCJ12

Dear Administrator:

On October 24, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 20, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any 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

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