DEPARTMENT	OF HEALTH	AND HUMAN	SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDIC	ARE/MEDI	CAID CER	FIFICATION	AND TRANS	MITTAL
DADTI	TOPECO	MDI ETED	DV THE CTA	TE CUDVEV	ACENCY

ID: Q7HK

	PART I	- TO BE COMP	PLETED BY T	THE STAT	TE SURVEY	AGENCY	Facility ID: 00862
1. MEDICARE/MEDICAID I	PROVIDER NO.	3. NAME AND AI		LITY			4. TYPE OF ACTION: <u>7 (</u> L8)
(L1) 245453		(L3) LB BROEN					1. Initial 2. Recertification
2.STATE VENDOR OR MEDI	CAID NO.	(L4) 824 SOUTH	SHERIDAN				3. Termination 4. CHOW
(L2) 678740100		(L5) FERGUS FA	ALLS, MN		(L	6) 56537	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHAN	GE OF OWNERSHIP	7. PROVIDER/SU	PPLIER CATEGO	RY	(L7)	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY	07/26/2018 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATE	JS:(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		
0 Unaccredited 2 AOA	1 TJC 3 Other	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		04/30
11LTC PERIOD OF CERTIF	ICATION	10.THE FACILITY	IS CERTIFIED AS	S:			
From (a):		X A. In Complia					e Following Requirements:
To (b) :			Requirements ice Based On:		2.	Technical Personnel	6. Scope of Services Limit
						24 Hour RN	7. Medical Director
12.Total Facility Beds	107 (L18)	1.	Acceptable POC			7-Day RN (Rural SNF)	·
13.Total Certified Beds	107 (L17)	B. Not in Co	mpliance with Prog	ram	5.	Life Safety Code	9. Beds/Room
			and/or Applied Wa		* Code:	Α	(L12)
14. LTC CERTIFIED BED BI	REAKDOWN				15. FACILI	TY MEETS	
18 SNF 13	8/19 SNF 19 SNF	ICF	IID		1861 (e) (1)	or 1861 (j) (1):	(L15)
	107						
(L37)	(L38) (L39)	(L42)	(L43)				
16. STATE SURVEY AGEN	CY REMARKS (IF APPLICABI	E SHOW LTC CANC	ELLATION DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATUR	E	Date :			10 07 17 1	SURVEY AGENCY A	APPROVAL Date:
17. SURVEYOR SIGNATOR	E	Date :			18. SIAIE	SURVET AGENCT A	APPROVAL Date:
Denise Fricksor	<u>, HEE - NE II</u>		08/20/2018	(L19)	Joanne	Simon, Enfor	rcement Specialist 12/13/2018 (L20)
	PART II - TO B	E COMPLETED	BY HCFA RI	EGIONAI	OFFICE (DR SINGLE STA	
19. DETERMINATION OF E	LIGIBILITY		MPLIANCE WITH	CIVIL			cial Solvency (HCFA-2572) l Interest Disclosure Stmt (HCFA-1513)
X 1. Facility is E	ligible to Participate		Shirb ne i.			3. Both of the Above	
2. Facility is r							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREEN	IENT 2	24. LTC AGREEM	IENT	26. TERMI	NATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Έ	VOLUNTAR	<u>Y</u> 00	INVOLUNTARY
04/01/1987					01-Merger, C	losure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfac	tion W/ Reimburseme	ent 06-Fail to Meet Agreement
25. LTC EXTENSION DAT	E: 27. ALTERNATI	VE SANCTIONS			03-Risk of Inv	voluntary Termination	<u>OTHER</u>
	A. Suspensio	n of Admissions:			04-Other Reas	son for Withdrawal	07-Provider Status Change
			(L44)				00-Active
	(L27) B. Rescind Su	spension Date:					
			(L45)				
28. TERMINATION DATE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARK	KS	
		03001					
	(L28)			(L31)			
-							
21 DO DECEIDE OF CMC 14	520 24		OF ADDDOVAL D	ATE			
31. RO RECEIPT OF CMS-1:	539 32	2. DETERMINATION 06/05/2018	OF APPROVAL D	ATE			

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN 24 5453

An onsite post certification revisit was conduct on June 20, 2018; this facility is not substantial compliance. F 688 Increase/prevent Decrease in Rom/mobility s/s E and St 895 Rehab - Range of Motion were reissued at this revisit.

On July 26, 2018 a second PCR was conducted which this facility is now in substantial compliance.



Protecting, Maintaining and Improvingthe Health of All Minnesotans

CMS Certification Number (CCN): 245453

August 20, 2018

Ms. Andrea Zeta, Administrator Lb Broen Home 824 South Sheridan Fergus Falls, MN 56537

Dear Ms. Zeta:

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

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

Effective July 19, 2018 the above facility is recommended for:

107 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 107 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File



Electronically delivered August 20, 2018

Ms. Andrea Zeta, Administrator LB Broen Home 824 South Sheridan Fergus Falls, MN 56537

RE: Project Number S5453029

Dear Ms. Zeta:

On May 14, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 26, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 5, 2018, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective July 26, 2018. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of June 5, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 26, 2018.

On June 20, 2018, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed on April 26, 2018 and a FMS Survey completed May 22, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on April 26, 2018. The deficiency not corrected is as follows:

F0688 -- S/S: E -- 483.25(c)(1)-(3) -- Increase/prevent Decrease In Rom/mobility

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

LB Broen Home August 20, 2018 Page 2

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective July 15, 2018. (42 CFR 488.422)

On June 25, 2018, the Minnesota Department of Public Safety and Centers for Medicare & Medicaid Services completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed on April 26, 2018 and Federal Monitoring survey completed on May 22, 2018. Based on our visit, we have determined that your facility has achieved substantial compliance, for the Life Safety code, with the deficiencies issued pursuant to our standard survey, completed on May 22, 2018. On July 10, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective July 15 2018. (42 CFR 488.422)
- Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 26, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on April 26, 2018, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on June 20, 2018. The most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 26, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 20, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 19, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 20, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 15, 2018.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following action related to the remedy outlined in their letter of June 5, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of the action:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 26, 2018 be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 26, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 26, 2018 is to be rescinded.

LB Broen Home August 20, 2018 Page 3

In their letter of June 5, 2018, CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 26, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 19, 2018,, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on July 26, 2018.

July 26, 2018

Ms. Andrea Zeta, Administrator LB Broen Home 824 South Sheridan Fergus Falls, MN 56537

Re: Project # S5453029

Dear Ms. Zeta:

On June 20, 2018, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 26, 2018 with orders received by you electronically on May23, 2018.

State licensing orders issued pursuant to the last survey completed on April 26, 2018, found not corrected at the time of this June 20, 2018 revisit and subject to penalty assessment are as follows:

20895 -- MN Rule 4658.0525 Subp. 2.B -- Rehab - Range Of Motion \$350.00

The details of the violations noted at the time of this revisit completed on June 20, 2018 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$350.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to:

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 LB Broen Home July 26, 2018 Page 2

> Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Kami Fiske-Downing, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

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

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

August 20, 2018

Ms. Andrea Zeta, Administrator LB Broen Home 824 South Sheridan Fergus Falls, MN 56537

RE: Project Number S5453029

Dear Ms. Zeta:

On July 26, 2018, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on July 26, 2018, imposed a daily fine in the amount of \$350.00.

On July 19, 2018, an acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on July 26, 2018 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is \$350.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$121.80, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$471.80 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Lb Broen Home August 20, 2018 Page 2 Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File Kami Fiske-Downing, Licensing and Certification Program Penalty Assessment Deposit Staff

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improvingthe Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

ndrea Zetah	Administrates	_, received
Jame)(Please Print)	(Title)(Please Print)	
sessment dated July 26, 2018	8 and licensing orders issued to:	
	ndrea Zetah Name)(Please Print) sessment dated July 26, 201	

LB Broen Home 824 South Sheridan Fergus Falls, MN 56537

The Penalty Assessments and licensing orders attached here to have been corrected as of July 26, 2018.

Signed:	Andrea Zetah	Administrator	_, Date _	7-26-18
	(Name)(Please Print)	(Title)(Please Print)		

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On J	uly 26, 2018, Denise Erick son HFE	HFEIL	
l,	Andrea Zetah	Administrater	, of the Division of
	(Name)(Please Print)	(Title)(Please Print)	

Compliance Monitoring, Minnesota Department of Health, delivered the Notice of Penalty Assessment dated July 26, 2018 and issued to:

LB Broen Home 824 South Sheridan Fergus Falls, MN 56537

Administrator, Date 7-26-18

(Title)(Please Print)

Signed:	andrea Utal	Admilistrates	, Date _	7-26-18
	(Name)(Please Print)	(Title)(Please Print)		

An equal opportunity employer.

DEPARTMENT OF HEALTH AN	D HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES

N	AEDIC	ARE/MED	ICAID (CERTIF	ICATIO	N AND	TRANSN	AITTAL
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ID: Q7HK

	PART I	- TO BE COMP	PLETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00862
1. MEDICARE/MEDICAID PROVI (L1) 245453 2.STATE VENDOR OR MEDICAID (L2) 678740100		3. NAME AND AI (L3) LB BROEN (L4) 824 SOUTH (L5) FERGUS FA	HOME I SHERIDAN	LITY	(L6) 56537	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	F OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEGO 05 HHA	RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Oth		02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 04/30
11LTC PERIOD OF CERTIFICATI From (a) : To (b) : 12.Total Facility Beds 13.Total Certified Beds	10N 107 (L18) 107 (L17)	A. In Compli Program Compliar 1.	Y IS CERTIFIED AS ance With Requirements nee Based On: Acceptable POC ompliance with Progr		And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
		Requirements	and/or Applied Wai	ivers:	* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKI 18 SNF 18/19 SI 107	NF 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY RE See Attached Remarks 17. SURVEYOR SIGNATURE	MARKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE):	18. STATE SURVEY AGENCY /	APPROVAL Date:
<u>Susan Bachleitner,</u>	HFE -NE II		07/10/2018	(L19)	Joanne Simon, Enforc	
	PART II - TO BI	E COMPLETED	BY HCFA RE	EGIONAI	OFFICE OR SINGLE ST	
19. DETERMINATION OF ELIGIB 1. Facility is Eligible 2. Facility is not Eligible	to Participate		MPLIANCE WITH IGHTS ACT:	CIVIL	 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 	l Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREEN	IENT 2	24. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 04/01/1987	BEGINNING	DATE	ENDING DAT	E	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	······································
25. LTC EXTENSION DATE: (L27)	-	n of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
			(L45)			
28. TERMINATION DATE:	29	0. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION 06/05/2018	OF APPROVAL D.	ATE		
	(L32)	50,00,2010		(L33)	DETERMINATION APPR	OVAL

CCN 24 5453

An onsite post certification revisit was conduct on June 20, 2018; this facility is not substantial compliance. F 688 Increase/prevent Decrease in Rom/mobility s/s E and St 895 Rehab - Range of Motion were reissued at this revisit.



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

July 10, 2018

Ms. Andrea Zeta, Administrator LB Broen Home 824 South Sheridan Fergus Falls, MN 56537

RE: Project Number S5453029

Dear Ms. Zeta:

On May 14, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 26, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 22, 2018, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious cited as follows:

• K711 -- S/S: F -- NFPA 101 -- Evacuation and Relocation Plan.

On June 5, 2018, CMS forwarded the results of the FMS to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed the following enforcement remedy:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 26, 2018. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of June 5, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 26, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 26, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 26, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

On June 20, 2018, the Minnesota Department of Health and on June 25, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed on April 26, 2018 and a FMS Survey completed May 22, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on April 26, 2018. The deficiency not corrected is as follows:

F0688 -- S/S: E -- 483.25(c)(1)-(3) -- Increase/prevent Decrease In Rom/mobility

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective July 15, 2018. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 26, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 26, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 26, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, LB Broen Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 26, 2018. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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 <u>https://dab.efile.hhs.gov</u> 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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at <u>Tamika.Brown@cms.hhs.gov</u>.

DEPARTMENT CONTACT

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

> Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 October 26, 2018 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

		I AND HUMAN SERVICES			PRINTED: 07/16/2018 FORM APPROVED
STATEMENT	RS FOR MEDICARE	KONTERPORT NUMBER: A STATE OF CONTRACT OF CONTRACT.		E CONSTRUCTION	X3) DATE SURVEY COMPLETED
NAME OF F	PROVIDER OR SUPPLIER	245453	1 8	TREET ADDRESS, CITY, STATE, ZIP CODE 24 SOUTH SHERIDAN	R 06/20/20 <u>18</u>
			I	ERGUS FALLS, MN 56537	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION
{E 000}	Initial Comments		{E 000}		
{F 000}	No deficiencies we survey 06/20/2018 INITIAL COMMEN	ere noted at the time of the TS	{F 000}		
	completed on 6/19/ certification tags th found on the CMS2 were not found cor	tification revisit (PCR) was /18 and 6/20/18. The at were corrected can be 2567B. Also there are tags that rected at the time of onsite ated on the CMS2567.			
{F 688} SS=E	signature is not reo page of the CMS-2 submission of the F verification of comp	ecrease in ROM/Mobility	{F 688}		7/19/18
	resident who enters range of motion do range of motion un	facility must ensure that a s the facility without limited es not experience reduction in less the resident's clinical rates that a reduction in range			
	motion receives ap services to increas	sident with limited range of propriate treatment and e range of motion and/or to rease in range of motion.			
	receives appropriat assistance to main the maximum prac	sident with limited mobility te services, equipment, and tain or improve mobility with ticable independence unless a y is demonstrably unavoidable.			
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Electronically Signed

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.

	OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED
			A. BUILDING	11 PP PS // PP II // P	R
		245453	B. WING		06/20/2018
	PROVIDER OR SUPPLIE	INTER GALLEN IN	S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/20/20 10
		110110111	, 8	24 SOUTH SHERIDAN	
LB BROI	EN HOME		F	ERGUS FALLS, MN 56537	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION
{F 688}	Continued From	page 1	{F 688}		
(*)		ENT is not met as evidenced	[1 000]		
	Based on observice review the facility	vation, interview and document failed to provide exercises to f motion (ROM) services for 4 of		Nursing Rehabilitation is completed ordered for R15. Date completed:	
	4 residents (R67	, R28, R15 and R66) reviewed nursing program.		Nursing Rehabilitation is completed ordered for R67. Date completed:	
	Findings include: R67			Nursing Rehabilitation is completed ordered for R66. Date completed:	
	R67's quarterly M 3/29/18, indicated	linimum Data Set (MDS) dated d R67 had moderate cognitive diagnoses which included		R28 died on 6/21/18, the day follow exit. Date completed: 6/21/18	ing
	anemia, heart dy disease. The MD staff assistance w (ADL's). The MD	srhythmia and end stage renal S identified R67 required total vith all activities of daily living S further indicated R67 was not om a seated to standing position,		All residents with a Nursing Rehabi program will be reviewed by the RN Coordinator (RNUC), evaluating completion and documentation of provided Rehabilitative Nursing ser	I Unit
	moving on and of	if the toilet and surface to (transfer between bed and chair		Date completed: 7/17/18. RNUCs and Charge Nurses will be	
	had an ADL self of to disease proces	evised 4/19/18, indicated R67 care performance deficit related ss, limited mobility and pain. The arious interventions which		re-educated on their responsibility t manage the Rehabilitative Program their unit and to assure rehabilitative services are being completed as or A review of policy and procedure	n on e
	included restorati	ve program services.		Rehabilitative Nursing, Charting Co Reporting Requirements will be completed with the RNUCs and Ch	
	dated 10/26/17, instructions:	identified the following		Nurses. Date completed: 7/19/18	
	(FWW), shoes or	bed: with front wheeled walker n, gait belt, CGA (contact guard elevated bed. Stand Time to per week.		Rehabilitation Assistant assignment be reviewed and adjusted on all uni ensure proper time and completion restorative nursing program. Date completed: 7/17/18	its to

Facility ID: 00862

If continuation sheet Page 2 of 12

		H AND HUMAN SERVICES			FORM APPROV OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED
	CNIN	245453	B. WING	/I EDCEM	R
	PROVIDER OR SUPPLIE			TREET ADDRESS, CITY, STATE, ZIP CODE	06/20/20 <u>18</u>
				24 SOUTH SHERIDAN	Int I V
LB BROI	EN HOME			ERGUS FALLS, MN 56537	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉT
{F 688}	Continued From	bage 2	{F 688}		
	instructions:	-		Competency Checklist (Form #1	149-04)
		p flexion, abduction, adduction,		will be updated to include initial t	raining for
		and ankle planter/dorsal flexion		new Rehabilitation Assistants co	
		s per week as tolerated. Yellow		by a Therapist and a section will to this form to review the purpose	
		ed with yellow theraband, 15 x 2 (hip height), punch downs		Rehabilitation Assistant's essent	
		2, hand grippers 15 x 2, active		understanding and completing th	
		f motion (AAROM) bilaterally		Nursing Rehabilitation Program.	
	U U	0 x 2, complete 3 times per		completed: 7/16/18	
				Re-education will be provided to	
		on on 6/20/18 at 11:35 a.m. R67		Rehabilitation Assistants stressir	
		wheelchair in his room f around with his feet in his		importance of timely completion resident rehab modalities and wi	
		ted he was tired on dialysis days		a review of the policy and proced	
		st when he got back from		Rehabilitative Nursing, Charting	
		cated staff would offer		Reporting Requirements. A revie	
		xercises after he returned from		Rehabilitation Assistant (RA) Col	
		ould tell them , he would do		Checklist (Form #1149-04) inclue	
		dicated staff usually never return		presentation of the updates to th	
	to assist him with	his exercises.		The Director of Rehab will prese	
	ot 10:10 p m DA	A-A entered R67's room and		essential function and purpose o Rehabilitation Assistant's role in	
	· ·	rom his wheelchair to the edge		Nursing Rehabilitation Program.	
		chanical standing lift. RA-A		completed: 7/17/18	Date
		ce R67's walker in front of him,			
	placed gait belt a	round his waist, R67 positioned		Five Nursing Care Audits: Reha	
		ent on the edge of the bed with		Nursing will be completed on eac	
		olding his walker and stood up		7/19/18,then one audit weekly X	
	with RA-A standir	ig at his ieit side.		on all units. (Each audit includes	
	-at 12:15 n m R6	7 indicated that was enough		3 residents.) This audit is compl an on-going basis and is include	
		the bed. R67 rested for a short		quarterly Nursing Care Audit sys	
		to stand and sit repeatedly x 3		each unit. DON will monitor and	
	and stated "that's	all I can do". R67 attempted to		findings and assure prompt follow	w up of
		ime then sat back on his bed		potential concerns. Audit finding	
		wanted to stop. RA-A		agenda item reported to the Res	
		rom his bed to his wheelchair via		Care and Customer Relations Co	
	mecnanical lift. R	67 indicated he did pretty good		a subcommittee of the Quality ar	ומ

Facility ID: 00862

If continuation sheet Page 3 of 12

STATEMENT	OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	OMB NO. 0938-((X3) DATE SURVE COMPLETED	
NAME OF I	PROVIDER OR SUPPLIE	245453 R	B. WING S	TREET ADDRESS, CITY, STATE, ZIP CODE	06/20/20 <u>1</u>	
LB BRO	EN HOME		8: F	1.10001111		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE	
{F 688}	for a dialysis day used to do this ev	page 3 and indicated at one time he veryday and now he doesn't. R67 s his exercises maybe 2 times a	{F 688}	Assessment and Assurance Com and QAPI. Date completed: 7/19		
	grippers and R67 repeatedly 40 tim straight up then h floor repeatedly a R67 move his rig	A-A handed R67 bilat hand ' began to squeeze them es. RA-A had R67 lift his left leg his right leg straight up off the liternating his legs. RA-A had ht foot to the side then his left epeatedly alternating his feet.				
	side and began to his arm straight of RA-A positioned began to lift his a	ositioned herself on R67's right o lift his arm up and down with out in front of him 20 times. herself on R67's left side and rm in a up and down motion with out in front of him.				
	remained seated observed to perfore exercise to incluc height), 2) punch	A-A exited R67's room while he in his wheelchair. RA-A was not orm any yellow theraband le 1) external rotation 15 x 2 (hip downs 15 x 2 and 3) curls 15 x ecommendations.				
	to 6/30/18, indica of bed exercise p out of 9 opportun which included: abduction, adduc planter/dorsal fle bilaterally should grippers 15 x 2 w	rsing Record (RNR) dated 6/1/18 ted R67's standing by the edge rogram was completed only 3 ities for the month, exercises 1 x 15 seated: hip flexion, tion, long arch quads and ankle xion bilaterally, AAROM er flexion 10 x 2 and hand rere completed 6 out of 9 the month and R67's RNR				

Facility ID: 00862

If continuation sheet Page 4 of 12

		AND HUMAN SERVICES			FORM	07/16/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE	E SURVEY PLETED
D	ENNI	245453	B. WING	/I ENCEM		२ 2 0/2018
NAME OF I	PROVIDER OR SUPPLIER	NU AUNIN		TREET ADDRESS, CITY, STATE, ZIP CODE 24 SOUTH SHERIDAN		
LB BRO	EN HOME			ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 688}	Continued From pa	age 4	{F 688}			
		owns 15 x 2, 3) curls 15 x 2				
	6/4/18 to 6/20/18,	ursing progress notes from lacked any notation of R67's program participation.				
	not feel like his res had been getting d "maybe a couple ti staff had gotten so	2 p.m. R67 indicated he does torative and ROM exercises one 3x/week and indicated mes a week." R67 indicated mewhat better but he wished exercises more often to get him s.				
	was to receive rest 3x/week. RA-A ind he did not receive indicated that she but indicated there needed to be done residents. RA-A ind	8 p.m. RA-A confirmed R67 corative and ROM exercises icated that she felt sometimes, the exercises as ordered. RA-A tried to get the exercises done was a lot of other cares that through out the day for other dicated she had notified the n she cannot get her work				
	confirmed R67 was ROM exercises 3x not receiving his re 3x/week per therap indicated she has l restorative program because of other re eating and answer when it comes to re the facility would has	p.m. registered nurse (RN)-A s to receive restorative and /week. RN-A verified R67 was estorative and ROM exercises bies recommendations. RN-A nad staff voice concerns about nming not getting done esident cares such as toileting, ing call lights. RN-A indicated esident cares verses rehab, ave the RA help out with the e residents are getting bileted.				

If continuation sheet Page 5 of 12

		I AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: (FORM AI OMB NO. 0	PPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	SURVEY
D	CNINII	245453	B. WING	U ENCEM	R 06/20)/2018
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 24 SOUTH SHERIDAN	EN	
LB BROI	EN HOME		-	ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 688}	Continued From pa	age 5	{F 688}			
	R28					
	R28 had severe co diagnoses which in hemiparesis (paral body), cerebral vas and seizure disorde identified R28 requ and had range of n that affected her lo R28's care plan rev had an ADL self ca to stroke. The care intervention which	OS dated 5/17/18, indicated ognitive impairment, had included hemiplegia or ysis of one entire side of the scular accident (CVA) (stroke). er. R28's MDS further irred total assistance with ADLs notion impairment on one side wer and upper extremities. vised 6/19/18, indicated R28 tre performance deficit related e plan listed several included rehab interventions				
	therapy recommen R28's Therapy to N dated 3/30/17, ide extremity PROM (aff to see rehab book and dations in chart. Jursing Communication form, ntified the following: upper passive range of motion) and i times a week or as patient				
	was in her room lyi head of bed elevat relieving boots on h	on 6/20/18 at 9:40 a.m. R28 ng in bed, on her back, with ed, fully clothed, with pressure ner feet bilaterally and was ia gastrostomy tube while she dow.				
	R28 had received r	6/1/18 to 6/20/18, indicated restorative and ROM exercises ities for the month.				
		ursing progress notes from lacked any notation of R28's				

If continuation sheet Page 6 of 12

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	07/16/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	ENNI	245453	B. WING	/I ENCEM		२ 20/20 <u>18</u>
NAME OF I	PROVIDER OR SUPPLIER	NU AUNIN		TREET ADDRESS, CITY, STATE, ZIP CODE 24 SOUTH SHERIDAN	L IV	
LB BRO	EN HOME			ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{F 688}	Continued From pa restorative nursing	age 6 program participation.	{F 688}			
	was to receive RO confirmed R28 had services as per the	8 p.m. RA-A confirmed R28 M exercises 3x/week. RA-A I not been receiving ROM prapies recommendations and ROM exercises in the last ar this week.				
	to receive ROM ex indicated restorative floor sometimes to indicated she had ver- restorative program instructed the restor come first, then the indicated concerns and management in	p.m. RA-B confirmed R28 was ercises routinely. RA-B re staff would get pulled to the help with cares. RA-B voiced her concerns about the n and indicated management prative staff resident cares e restorative program. RA-B had been voiced to the RN's n the recent past and they ne problem with the restorative g done.				
	was to receive RO was not receiving F was not sure why h RN-C indicated the gotten better, but h recently and indica to have a RA. RN-0 staff complaints al	p.m. RN-C confirmed R28 M exercises routinely and she ROM as recommended. RN-C her ROM did not get done. The restorative program had er floor had not had a RA until ted every floor was supposed C indicated she was aware of pout the restorative program the complaints to the director of				
	had intact cognition	DS dated 5/3/18, indicated R15 n, had diagnoses which sorder, osteoarthritis and				

STATEMEN	OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		OMB NO. (X3) DATE COMF	SURVEY PLETED
	PROVIDER OR SUPPLIE	245453	245453 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			20/20 <u>18</u>
	EN HOME		824	RGUS FALLS, MN 56537	llm1311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
{F 688}	systemic lupus. T extensive assista of ADL's. The MI steady moving fromoving on and of surface transfers or wheelchair). R15's care plan r had an ADL self of to disease process pain in right knee erythematous, as osteoporosis The intervention which as set up. R15's Therapy to dated 3/24/17, ic theraband (she h x 2, 2) tricep pund checks 20 x 2, 4) tucked), 3 to 4 x p Lower extremity s adduction, long a planter/dorsi flexi hamstring curls 1 as patient tolerate During observation was in her room, feet elevated up of -at 10:06 a.m. RA cart which contain such as theraban equipment. RA-C proceeded to cor	The MDS identified R15 required ince of one staff with all activities DS further indicated R15 was not om a seated to standing position, if the toilet and surface to (transfer between bed and chair evised on 5/12/18, indicated R15 care performance deficit related as, limited mobility weakness , recent falls, systemic lupus, thma hypothyroidism and the care plan listed several h included restorative program Nursing Communication form , lentified the following: dark blue as in her room) 1) horizontal 20 ch outs 20 x 2, 3) shoulder external rotation 20 x 2 (elbows per week or as patient tolerates. seated: hip flexion, abduction, rch quads and ankle on and blue theraband x 20 bilaterally. 3 x per week or	{F 688}			

If continuation sheet Page 8 of 12

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DA	0. 0938-039 FE SURVEY MPLETED R
	PROVIDER OR SUPPLIE	245453 R	. .	STREET ADDRESS, CITY, STATE, ZIP CODE	06	/20/20 <u>18</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FERGUS FALLS, MN 56537 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
{F 688}	and completed lo was able to partic extremity and low R15's RNR dated R15 had complete exercises 5 out of Review of R15's n 6/4/18 to 6/20/18, restorative nursin On 6/20/18 at 11: received restorati week. R15 indica receiving restorat times a week. R66 R66's quarterly M R66 was severely diagnoses which and Parkinson's of R66 required exter with all ADL's and for grooming. The not steady moving position, walking, opposite direction off the toilet and s (transfer between R66's care plan re had ADL self care dementia, diseas depression, acute weakness. The o	bage 8 wer extremity exercises. R15 sipate and complete both upper rer extremity exercises. 6/1/18 to 6/30/18, documented ed her restorative and ROM f 9 opportunities for the month. Inursing progress notes from lacked any notation of R15's g program participation. 52 a.m. R15 indicated she ve program maybe two times a ted she did not believe she was ive exercise and ROM three IDS, dated 3/29/18, identified v cognitively impaired and had included dementia, depression disease. The MDS indicated ensive assistance of two staff a needed ext assistance of one e MDS further indicated R66 was g from a seated to standing turning around facing the n while walking, moving on and surface to surface transfers a bed and chair or wheelchair). evised on 3/28/18, identified R66 e performance deficit related to e process: parkinsonism, e kidney injury and generalized care plan listed various ch included restorative nursing				

If continuation sheet Page 9 of 12

		AND HUMAN SERVICES			FORM /	07/16/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE	
D	CNINI	245453	B. WING	LEDCEM	F	₹ 2 0/2018
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	00/2	.0/20 10
	EN HOME		-	24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		~
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 688}	Continued From pa program in place.	age 9	{F 688}			
	dated 1/16/18, ide AAROM, hip flexior	lursing Communication form, ntified the follows: bilateral LE n, hip abduction, knee ankle planter/dorsi flexion,				
	dated 4/27/18, ide or AROM upper ex shoulders-flex, exte elbow-flex, extension	lursing Communication form, ntified the following: AAROM tremities 1 to 2 sets 10 reps, ension abduction/adduction, on, no weights, wrists- flex, on and pronation, 3 times per ed.				
	R66 was lying in be present in his room laid R66 down so s exercises. RA-C in exercises when he complete upper ext	ns on 6/20/18 at 10:35 a.m. ed on his back and RA-C was a. RA-C indicated she had just the could complete his dicated R66 did better with his laid down. RA-C proceeded to tremity and lower extremity . R66 was cooperative rcises.				
	R66 had received h	6/1/18 to 6/30/18, indicated his restorative and ROM but of 9 opportunities for the				
	6/4/18 to 6/20/18,	rsing progress notes from lacked any notation of R66's program participation.				
	and R66 was to rec	5 a.m. RA-C confirmed R15 ceive restorative and ROM . RA-C indicated it was a				

If continuation sheet Page 10 of 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		X3) DATE SURVEY COMPLETED R	
	PROVIDER OR SUPPLIE	245453	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	06/20/2018	
	EN HOME		824	SOUTH SHERIDAN RGUS FALLS, MN 56537	I ha I V I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
{F 688}	completed daily. R15 only had her week and indicate back and forth be programs and he On 6/20/18 at 2:2 R66 were to rece exercises 3x/wee were not receivin exercises 3x/wee recommendation trying prioritize th to receive therapy facility wanted to were struggling g and stated "work RA's had voiced restorative progra indicated this cor DON. On 6/20/18 at 2:5 confirmed finding program not bein residents as reco moving forward, to program weekly to changes need be had not received regards to the residente as the residente as the residente as the residente as the residente and the residente as the r	e restorative program done and RA-C indicated she had noticed exercises done one time last ed it was a struggle of bouncing etween restorative nursing lping other staff on the floor. 27 p.m. RN-D confirmed R15 and ive restorative and ROM ek. RN-D verified R15 and R66 g restorative and ROM	{F 688}			

Facility ID: 00862

If continuation sheet Page 11 of 12

		AND HUMAN SERVICES			FORM	07/16/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		СОМ	E SURVEY PLETED
	CNDI	245453	B. WING	MENCEM	F 06/2	≺ 20/2018
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME			24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		~
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
{F 688}	aware of any other A facility policy title Charting Code and revised 9/2003, rev was to record resid care plan. The poli record resident's p facility Rehab Nurs revealed if a reside perform for three o restorative aid sho coordinator for follo the RN or substitut complete ordered	DN indicated she was not concerns since this one time. d, Restorative Nursing, d Reporting Requirements, vealed the purpose of the policy dent's compliance with rehab cy directed facility staff to articipation and refusals on the sing Care Record. The policy ent refuses or was unable to or more scheduled days the uld report to the RN ow up. The RA shall report to the any anticipated inability to modalities before the end of assignments can be adjusted to	{F 688}			

Facility ID: 00862

If continuation sheet Page 12 of 12

DEPART	IMENT OF HEALTH	AND HUMAN SERVICES		ľ		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		(MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	` ´co⊮	E SURVEY IPLETED
		245453	B. WING			R / 20/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LB BRO	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{E 000}	Initial Comments		{E 000)}		
{F 000}	No deficiencies we survey 06/20/2018 INITIAL COMMEN	ere noted at the time of the	{F 000	n		
{F 688} SS=E	An onsite post cert completed on 6/19/ certification tags that found on the CMS2 were not found corr PCR which are local Because you are en- signature is not req page of the CMS-2 submission of the F verification of comp Increase/Prevent D CFR(s): 483.25(c)(§483.25(c) Mobility §483.25(c)(1) The f resident who enters range of motion do range of motion un- condition demonstr of motion is unavoid §483.25(c)(2) A res motion receives ap services to increase prevent further dec §483.25(c)(3) A res receives appropriat assistance to main the maximum pract	ification revisit (PCR) was (18 and 6/20/18. The at were corrected can be 2567B. Also there are tags that rected at the time of onsite ated on the CMS2567. nrolled in ePOC, your juired at the bottom of the first 567 form. Your electronic POC will be used as bliance. Decrease in ROM/Mobility 1)-(3) facility must ensure that a is the facility without limited es not experience reduction in less the resident's clinical ates that a reduction in range	{F 688			7/19/18
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
	ically Signed					09/07/2018

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.

PRINTED: 09/12/2018

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
						F	7
		245453	B. WING			06/2	20/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BROE	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 688}	Continued From pa	ige 1	{F 68	38}			
	This REQUIREMEN	NT is not met as evidenced					
Based on observation, intervireview the facility failed to promaintain range of motion (RC 4 residents (R67, R28, R15 a with a restorative nursing program) Findings include:	ailed to provide exercises to			Nursing Rehabilitation is completed ordered for R15. Date completed:			
	4 residents (R67, F	, R28, R15 and R66) reviewed			Nursing Rehabilitation is completed ordered for R67. Date completed:		
	Findings include:				Nursing Rehabilitation is completed ordered for R66. Date completed:		
	3/29/18, indicated F	imum Data Set (MDS) dated R67 had moderate cognitive agnoses which included			R28 died on 6/21/18, the day follow exit. Date completed: 6/21/18	ring	
	anemia, heart dysrh disease. The MDS staff assistance with (ADL's). The MDS steady moving from moving on and off t	hythmia and end stage renal identified R67 required total h all activities of daily living further indicated R67 was not n a seated to standing position, the toilet and surface to ransfer between bed and chair			All residents with a Nursing Rehabi program will be reviewed by the RN Coordinator (RNUC), evaluating completion and documentation of provided Rehabilitative Nursing ser Date completed: 7/17/18.	Rehabilitative the RN Unit ating ion of	
	or wheelchair). R67's care plan rev had an ADL self can to disease process care plan listed vari included restorative	rised 4/19/18, indicated R67 re performance deficit related , limited mobility and pain. The ious interventions which e program services.			RNUCs and Charge Nurses will be re-educated on their responsibility t manage the Rehabilitative Program their unit and to assure rehabilitativ services are being completed as or A review of policy and procedure Rehabilitative Nursing, Charting Co Reporting Requirements will be	esponsibility to ative Program on e rehabilitative mpleted as ordered. procedure , Charting Code and hts will be	
	dated 10/26/17, ide instructions: Stand by edge of be (FWW), shoes on,	Nursing Communication form, entified the following ed: with front wheeled walker gait belt, CGA (contact guard			completed with the RNUCs and Ch Nurses. Date completed: 7/19/18 Rehabilitation Assistant assignment be reviewed and adjusted on all unit	ts will its to	
	pt's tolerance, 3x pe				ensure proper time and completion restorative nursing program. Date completed: 7/17/18	oi trie	
		Nursing Communication form, ntified the following			The Rehabilitation Assistant (RA)		

Facility ID: 00862

If continuation sheet Page 2 of 12

				TID'			0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
					R		
		B. WING			06/20/2018		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME				24 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
{F 688}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 instructions: 1 x 15 seated: hip flexion, abduction, adduction, long arch quads and ankle planter/dorsal flexion bilaterally, 3 times per week as tolerated. Yellow Theraband- seated with yellow theraband, external rotation 15 x 2 (hip height), punch downs 15 x 2, curls 15 x 2, hand grippers 15 x 2, active assistive range of motion (AAROM) bilaterally shoulder flexion 10 x 2, complete 3 times per week. During observation on 6/20/18 at 11:35 a.m. R67 was seated in his wheelchair in his room propelling himself around with his feet in his room. R67 indicated he was tired on dialysis days and wanted to rest when he got back from dialysis and he would tell them , he would do them later. He indicated staff would offer assistance with exercises after he returned from dialysis and he would tell them , he would do them later. He indicated staff usually never return to assist him with his exercises. -at 12:10 p.m. RA-A entered R67's room and transferred R67 from his wheelchair to the edge of his bed via mechanical standing lift. RA-A proceeded to place R67's walker in front of him, placed gait belt around his waist, R67 positioned himself independent on the edge of the bed with feet on the floor holding his walker and stood up with RA-A standing at his left side. -at 12:15 p.m. R67 indicated that was enough and sat down on the bed. R67 rested for a short		{F 6	88}	 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Competency Checklist (Form #1149-04) will be updated to include initial training for new Rehabilitation Assistants completed by a Therapist and a section will be added to this form to review the purpose and the Rehabilitation Assistant's essential role in understanding and completing the Nursing Rehabilitation Program. Date completed: 7/16/18 Re-education will be provided to all Rehabilitation Assistants stressing the importance of timely completion of the resident rehab modalities and will include a review of the policy and procedure Rehabilitation Assistant (RA) Competency Checklist (Form #1149-04) including presentation of the updates to this form. The Director of Rehab will present the essential function and purpose of the Rehabilitation Assistant's role in the Nursing Rehabilitation Program. Date completed: 7/17/18 Five Nursing Care Audits: Rehabilitative Nursing will be completed on each unit by 7/19/18,then one audit weekly X 4 weeks on all units. (Each audit includes review of 3 residents.) This audit is completed on an on-going basis and is included in a 		
	placed gait belt aro himself independer feet on the floor ho with RA-A standing -at 12:15 p.m. R67 and sat down on th period and began to and stated "that's a stand one more tim and indicated he wa transferred R67 fro	und his waist, R67 positioned ht on the edge of the bed with lding his walker and stood up at his left side. indicated that was enough			Nursing will be completed on each 7/19/18,then one audit weekly X 4 v on all units. (Each audit includes re 3 residents.) This audit is complete	unit by weeks view of ed on n a n for idit up of are an ent	

Facility ID: 00862

If continuation sheet Page 3 of 12

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	(X3) DAT	MB NO. 0938-039 (X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245453 NAME OF PROVIDER OR SUPPLIER		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		B. WING			R		
			STREET ADDRESS, CITY, STATE, ZIP CODE	06/20/2018 P CODE			
LB BRO	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
{F 688}	Continued From page 3 for a dialysis day and indicated at one time he used to do this everyday and now he doesn't. R67 indicated he does his exercises maybe 2 times a week now. -at 12:21 p.m. RA-A handed R67 bilat hand grippers and R67 began to squeeze them repeatedly 40 times. RA-A had R67 lift his left leg straight up then his right leg straight up off the floor repeatedly alternating his legs. RA-A had R67 move his right foot to the side then his left foot to the side repeatedly alternating his feet. -at 12:27 RA-A positioned herself on R67's right side and began to lift his arm up and down with his arm straight out in front of him 20 times. RA-A positioned herself on R67's left side and began to lift his arm in a up and down motion with his arm straight out in front of him. -at 12:37 p.m. RA-A exited R67's room while he		{F 688				
	remained seated in observed to perform exercise to include	h his wheelchair. RA-A was not m any yellow theraband 1) external rotation 15 x 2 (hip owns 15 x 2 and 3) curls 15 x					
	to 6/30/18, indicate of bed exercise pro- out of 9 opportuniti which included: 1 x abduction, adduction planter/dorsal flexion bilaterally shoulder grippers 15 x 2 were opportunities for th	ng Record (RNR) dated 6/1/18 d R67's standing by the edge ogram was completed only 3 es for the month, exercises x 15 seated: hip flexion, on, long arch quads and ankle on bilaterally, AAROM flexion 10 x 2 and hand re completed 6 out of 9 e month and R67's RNR the use of the yellow					

Facility ID: 00862

If continuation sheet Page 4 of 12

DEPAR [.] CENTE	PRINTED: 09/12/2018 FORM APPROVED MB NO. 0938-0391									
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245453	B. WING			F 06/2	≺ 20/2018			
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
LB BROEN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
{F 688}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 height), 2) punch downs 15 x 2, 3) curls 15 x 2 any time during the month. Review of R67's nursing progress notes from 6/4/18 to 6/20/18, lacked any notation of R67's restorative nursing program participation. On 6/20/18 at 12:02 p.m. R67 indicated he does not feel like his restorative and ROM exercises had been getting done 3x/week and indicated "maybe a couple times a week." R67 indicated staff had gotten somewhat better but he wished they would do his exercises more often to get him stronger in his legs. On 6/20/18 at 12:38 p.m. RA-A confirmed R67 was to receive restorative and ROM exercises 3x/week. RA-A indicated that she felt sometimes, he did not receive the exercises as ordered. RA-A indicated that she tried to get the exercises done but indicated there was a lot of other cares that needed to be done through out the day for other residents. RA-A indicated she had notified the charge nurse when she cannot get her work done. On 6/20/18 at 2:10 p.m. registered nurse (RN)-A confirmed R67 was to receive restorative and ROM exercises 3x/week. RN-A verified R67 was not receiving his restorative and ROM exercises 3x/week per therapies recommendations. RN-A indicated she has had staff voice concerns about restorative programming not getting done because of other resident cares such as toileting, eating and answering call lights. RN-A indicated when it comes to resident cares verses rehab, the facility would have the RA help out with the cares to make sure residents are getting		{F 6	88}						

Facility ID: 00862

If continuation sheet Page 5 of 12

		AND HUMAN SERVICES				FORM	09/12/2018 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	0938-0391 E SURVEY PLETED
		245453	B. WING				R 20/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LB BROI	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 688}	Continued From pa	ige 5	{F 6	88}			
	R28						
	R28 had severe cog diagnoses which in hemiparesis (paraly body), cerebral vas and seizure disorde identified R28 requi and had range of m that affected her low	S dated 5/17/18, indicated gnitive impairment, had cluded hemiplegia or ysis of one entire side of the cular accident (CVA) (stroke). er. R28's MDS further ired total assistance with ADLs notion impairment on one side wer and upper extremities.					
	had an ADL self car to stroke. The care intervention which i	re performance deficit related e plan listed several included rehab interventions aff to see rehab book and					
	dated 3/30/17, ider extremity PROM (p	lursing Communication form, ntified the following: upper bassive range of motion) and times a week or as patient					
	was in her room lyir head of bed elevate relieving boots on h	on 6/20/18 at 9:40 a.m. R28 ng in bed, on her back, with ed, fully clothed, with pressure her feet bilaterally and was ia gastrostomy tube while she dow.					
		6/1/18 to 6/20/18, indicated estorative and ROM exercises ities for the month.					
		irsing progress notes from lacked any notation of R28's					

If continuation sheet Page 6 of 12

		AND HUMAN SERVICES				FORM	09/12/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATI COM	E SURVEY PLETED
		245453	B. WING				R 20/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LB BROE	EN HOME			-	324 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 688}	On 6/20/18 at 12:38 was to receive ROM confirmed R28 had services as per then had only received F couple of days so fa On 6/20/18 at 2:38 to receive ROM exe indicated restorative floor sometimes to indicated she had v restorative program instructed the resto come first, then the indicated concerns and management ir were all aware of th program not getting On 6/20/18 at 2:44 was to receive ROM was not receiving R was not sure why h RN-C indicated the gotten better, but he recently and indicat to have a RA. RN-C staff complaints ab and had reported th nursing (DON.) R15 R15's quarterly MD	 program participation. B. p.m. RA-A confirmed R28 M exercises 3x/week. RA-A not been receiving ROM rapies recommendations and ROM exercises in the last ar this week. p.m. RA-B confirmed R28 was ercises routinely. RA-B e staff would get pulled to the help with cares. RA-B roiced her concerns about the n and indicated management rative staff resident cares restorative program. RA-B had been voiced to the RN's n the recent past and they he problem with the restorative g done. p.m. RN-C confirmed R28 M exercises routinely and she ROM as recommended. RN-C er ROM did not get done. restorative program had er floor had not had a RA until the restorative program had er floor was supposed cout the restorative program had er floor store to the director of S dated 5/3/18, indicated R15 	{F 6	88}			
		n, had diagnoses which sorder, osteoarthritis and					

If continuation sheet Page 7 of 12

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/12/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245453	B. WING				R 20/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 688}	systemic lupus. The extensive assistance of ADL's. The MDS steady moving from moving on and off t surface transfers (th or wheelchair). R15's care plan rew had an ADL self can to disease process, pain in right knee, r erythematous, asth osteoporosis The intervention which i as set up. R15's Therapy to N dated 3/24/17, iden theraband (she has x 2, 2) tricep punch checks 20 x 2, 4) et tucked), 3 to 4 x pe Lower extremity sea adduction, long arc planter/dorsi flexion hamstring curls 1 x as patient tolerates During observations was in her room, se feet elevated up on -at 10:06 a.m. RA-C cart which containe such as theraband's equipment. RA-C s proceeded to comp	a MDS identified R15 required the of one staff with all activities of urther indicated R15 was not in a seated to standing position, the toilet and surface to ransfer between bed and chair rised on 5/12/18, indicated R15 re performance deficit related limited mobility weakness ecent falls, systemic lupus, ma hypothyroidism and care plan listed several ncluded restorative program ursing Communication form , ntified the following: dark blue in her room) 1) horizontal 20 outs 20 x 2, 3) shoulder xternal rotation 20 x 2 (elbows r week or as patient tolerates. ated: hip flexion, abduction, h quads and ankle and blue theraband 20 bilaterally. 3 x per week or	{F 6	88}			

If continuation sheet Page 8 of 12

		AND HUMAN SERVICES				FORM	09/12/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245453	B. WING				R 20/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 688}	and completed lower was able to particip extremity and lower R15's RNR dated 6 R15 had completed exercises 5 out of 9 Review of R15's nu 6/4/18 to 6/20/18, 14 restorative nursing p On 6/20/18 at 11:52 received restorative week. R15 indicated receiving restorative times a week. R66 R66's quarterly MD R66 was severely c diagnoses which ind and Parkinson's dis R66 required extensi with all ADL's and n for grooming. The N not steady moving f position, walking, tu opposite direction w off the toilet and sui (transfer between b R66's care plan rev had ADL self care p dementia, disease p depression, acute k weakness. The car	ge 8 er extremity exercises. R15 ate and complete both upper r extremity exercises. (1/18 to 6/30/18, documented d her restorative and ROM 0 opportunities for the month. rsing progress notes from acked any notation of R15's program participation. 2 a.m. R15 indicated she e program maybe two times a d she did not believe she was e exercise and ROM three S, dated 3/29/18, identified cognitively impaired and had cluded dementia, depression sease. The MDS indicated sive assistance of two staff needed ext assistance of one MDS further indicated R66 was from a seated to standing urning around facing the while walking, moving on and rface to surface transfers ned and chair or wheelchair). rised on 3/28/18, identified R66 performance deficit related to process: parkinsonism, sidney injury and generalized re plan listed various included restorative nursing	{F 6	888}			

If continuation sheet Page 9 of 12

		AND HUMAN SERVICES				FORM	09/12/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245453	B. WING				R 20/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BROI	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 688}	Continued From pa program in place.	ige 9	{F 68	38}			
	dated 1/16/18, ider AAROM, hip flexior	lursing Communication form, ntified the follows: bilateral LE n, hip abduction, knee ankle planter/dorsi flexion,					
	dated 4/27/18, ider or AROM upper ext shoulders-flex, exte elbow-flex, extensio	lursing Communication form, ntified the following: AAROM tremities 1 to 2 sets 10 reps, ension abduction/adduction, on, no weights, wrists- flex, on and pronation, 3 times per d.					
	R66 was lying in be present in his room laid R66 down so s exercises. RA-C ind exercises when he complete upper ext	ns on 6/20/18 at 10:35 a.m. ed on his back and RA-C was a. RA-C indicated she had just he could complete his dicated R66 did better with his laid down. RA-C proceeded to tremity and lower extremity . R66 was cooperative rcises.					
	R66 had received h	6/1/18 to 6/30/18, indicated his restorative and ROM but of 9 opportunities for the					
	6/4/18 to 6/20/18, I	irsing progress notes from lacked any notation of R66's program participation.					
	and R66 was to rec	5 a.m. RA-C confirmed R15 ceive restorative and ROM RA-C indicated it was a					

If continuation sheet Page 10 of 12

		AND HUMAN SERVICES				FORM	09/12/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245453	B. WING				R 20/2018
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 688}	struggle to get the r completed daily. RA R15 only had her ex week and indicated back and forth betw programs and helpi On 6/20/18 at 2:27 R66 were to receive exercises 3x/week recommendations. trying prioritize their to receive therapy 3 facility wanted to se were struggling get and stated "work in RA's had voiced the restorative program indicated this conce DON. On 6/20/18 at 2:54 confirmed findings program not being residents as recom moving forward, the program weekly to changes need be d had not received ar regards to the restor done properly. The expect staff to mak was getting comple indicated she was a restorative program	restorative program done and A-C indicated she had noticed xercises done one time last I it was a struggle of bouncing veen restorative nursing ing other staff on the floor. p.m. RN-D confirmed R15 and e restorative and ROM RN-D verified R15 and R66 restorative and ROM	{F 6	88}			

If continuation sheet Page 11 of 12

		AND HUMAN SERVICES				FORM	09/12/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245453	B. WING				ך 2 0/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 688}	aware of any other A facility policy titled Charting Code and revised 9/2003, rev was to record resid care plan. The polic record resident's pa facility Rehab Nurst revealed if a reside perform for three of restorative aid shou coordinator for follo the RN or substitute complete ordered m	DN indicated she was not concerns since this one time. d, Restorative Nursing, Reporting Requirements, ealed the purpose of the policy ent's compliance with rehab cy directed facility staff to articipation and refusals on the ing Care Record. The policy nt refuses or was unable to r more scheduled days the uld report to the RN w up. The RA shall report to e any anticipated inability to nodalities before the end of ssignments can be adjusted to	{F 68	38}			

Facility ID: 00862

If continuation sheet Page 12 of 12

	OF DEFICIENCIES	& MEDICAID SERVICES			<u>3 NO. 0938-039</u> 3) DATE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:	· ,			COMPLETED	
		245453	B. WING		05	05/22/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LB BROE	EN HOME			324 SOUTH SHERIDAN FERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
K 000	INITIAL COMMEN	TS	K 000				
	Monitoring Survey for Medicare & Med 5/22/18 following a Health survey on 4. Federal Monitoring found not in substa requirements for pa Medicare/Medicaid Life Safety from Fir	Comparative Federal was conducted by the Centers dicaid Services (CMS) on Minnesota Department of /24/18. At this Comparative Survey, LB Broen Home was ntial compliance with the articipation in at 42 CFR Subpart 483.90(a), re, and the related National ociation (NFPA) standard 101					
LB buil cor with Typ II (0 fac II (0 spr det	building ("1969 Bui constructed in 1969 with addition of the Type II (222) and the II (000). For the pu facility was surveyed II (000) construction sprinklered and the detection located in	composed of a two story lding) with partial basement 9 of Type II (222) construction "1984 Building" in 1984 of ne "Auditorium" in 1996 of Type proses of this survey, the ed as a single building of Type n. The building is fully ere is supervised smoke the corridors, spaces open to ome resident rooms.					
K 353 SS=E	time of the survey, The requirement at NOT MET as evide	7 dually certified beds. At the the census was 75. 2 42 CFR, Subpart 483.90(a) is enced by: Maintenance and Testing	K 353			6/15/18	
	Automatic sprinkler inspected, tested, a	Maintenance and Testing r and standpipe systems are and maintained in accordance idard for the Inspection,					

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.

		AND HUMAN SERVICES		FOR	D: 09/06/2018 MAPPROVED D. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED	
		245453	B. WING _	0	5/22/2018	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
LB BROE	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	Testing, and Mainta Protection Systems maintenance, inspe- maintained in a sec available. a) Date sprinkler s b) Who provided s c) Water system s Provide in REMARI any non-required of system. 9.7.5, 9.7.7, 9.7.8, a This REQUIREMED by: Based on observat failed to maintain ch accordance with NF Sections 19.3.5, 9.7. Sections 5.1.1, 5.2. practice could affeo residents. Findings include: On 5/22/18 at 3:00 revealed a wall mon directly in front of a sidewall sprinkler.	aining of Water-based Fire a. Records of system design, ection and testing are cure location and readily system last checked system test supply source KS information on coverage for r partial automatic sprinkler and NFPA 25 NT is not met as evidenced tion and interview, the facility learances around sprinklers in FPA 101 - 2012 edition, 7 and NFPA 25 - 2010 edition, 1, and 5.4.1. This deficient ct approximately 10 of the 75 pm, observation in room 279 unted television installed nd within 18 inches of the onfirmed by the Facilities	K 35	On June 8,2018, the wall mounted TV in room 279 was relocated more than 18 inches away from the sidewall sprinkler. All facility wall mounted TVs are more than 18 inches away from the sidewall sprinkler. The Facilities Engineer was responsible for the correction and will monitor to prevent the re-occurrence of this deficiency.	6/30/18	
	Subdivision of Build	ding Spaces - Smoke Barrier				

Facility ID: 00862

If continuation sheet Page 2 of 6

		AND HUMAN SERVICES			F	ORM A	09/06/2018 APPROVED 0938-0391	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245453	B. WING			05/22/2018		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K 372	Construction 2012 EXISTING Smoke barriers sha fire resistance ratin be permitted to terr Smoke dampers ar penetrations in fully an approved sprink smoke compartment barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. This REQUIREMENT by: Based on observation failed to maintain si with the requirement Sections 19.3.7, 19 8.5.6. This deficient approximately 20 o Findings include: 1. On 5/22/18 at 21 smoke barrier leadi "Two South" corridor penetration that wa approximate one in barrier. 2. On 5/22/18 at 31 smoke barrier in the room 371 revealed diameter cutout that gap in the smoke barrier in the	all be constructed to a 1/2-hour g per 8.5. Smoke barriers shall ninate at an atrium wall. e not required in duct ducted HVAC systems where ler system is installed for nts adjacent to the smoke anical smoke control system NT is not met as evidenced tion and interview, the facility moke barriers in accordance nts of NFPA 101 - 2012 edition, .3.7.1, 19.3.7.3, 8.5, 8.5.2 and it practice could affect f the 75 residents. 10pm, observation at the ng to the dining room in the or revealed a conduit s not firestopped leaving an ch diameter gap in the smoke 20pm, observation at the e "Three North" corridor near an approximate one inch t was not firestopped leaving a arrier. e confirmed by the Facilities	K	372	 Approved firestop will be installed the approximate one-inch diameter ga near the conduit penetration in the sm barrier leading to the dining room in th "Two South" corridor. This correction shall be completed by June 15, 2018. The Facilities Engineer is responsible the correction and will monitor to prev the re-occurrence of this deficiency. Approved firestop will be installed i approximate one-inch diameter cutou the smoke barrier in the "Three North corridor near room 371. This correcti shall be completed by June 15, 2018. The Facilities Engineer is responsible the correction and will monitor to prev the re-occurrence of this deficiency. All smoke barriers will be inspected for gaps by 6/30/2018. Firestop will be installed in all identified gaps. Areas also be inspected after or during any performed on or around all smoke barriers. The Facilities Engineer is responsible for the correction and will 	ap noke he i for vent in the ut in " ion for vent or will work		

Facility ID: 00862

If continuation sheet Page 3 of 6

		AND HUMAN SERVICES			FORM	09/06/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245453	B. WING	05/2	22/2018	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
LB BROE	EN HOME			324 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 372	Continued From page 3		K 372	monitor to prevent re-occurrence of	this	
K 711 SS=F	Evacuation and Re CFR(s): NFPA 101	location Plan	K 711	deficiency.		6/15/18
	patients and for the an emergency. Employees are per informed with their copy of the plan is of operator or with see basic response req and provides for all components per 18 18.7.1.1 through 18 18.7.2.3, 19.7.1.1 th 19.7.2.2, 19.7.2.3 This REQUIREMENT by: Based on record ref failed to have a write addressed all of the 2012 edition, Section practice could affect Findings include: On 5/22/18 at 1:33pt titled "Emergency F 2013) revealed the information on prep for evacuation. This finding was co	lan for the protection of all bir evacuation in the event of iodically instructed and kept duties under the plan, and a readily available with telephone curity. The plan addresses the uired of staff per 18/19.7.2.1.2 of the fire safety plan 8/19.2.2. 3.7.1.3, 18.7.2.1.2, 18.7.2.2, hrough 19.7.1.3, 19.7.2.1.2, NT is not met as evidenced eview and interview, the facility tten fire safety plan that e items required by NFPA 101 - on 19.7.2.2. This deficient et all of the 75 residents.		"Emergency Fire Plan" will be upda June 15, 2018 to include informatio preparing a floor and building evacu The Facilities Engineer is responsib the correction and will monitor to pr the re-occurrence of this deficiency	n on uation. ble for event	
K 923		ngineer at the exit conference. ylinder and Container Storag	K 923			6/6/18

If continuation sheet Page 4 of 6

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/06/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245453	B. WING			05/3	22/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 923 SS=D	Continued From pa CFR(s): NFPA 101	age 4	К 9	23			
	Greater than or equ Storage locations a ventilated in accord 5.1.3.3.3. >300 but <3,000 cL Storage locations a within an enclosed limited- combustible gates outdoors) that gases are not store separated from cord sprinklered) or enc noncombustible co 1/2 hr. fire protection Less than or equal In a single smoke of cylinders available care areas with an or equal to 300 cub stored in an enclos handled with preca A precautionary sig each door or gate of where the sign inclu- minimum "CAUTIC STORED WITHIN Storage is planned of which they are re- Empty cylinders are cylinders. When fai integral pressure g- considered empty i are marked to avoid in the open are pro-	are outdoors in an enclosure or interior space of non- or e construction, with door (or at can be secured. Oxidizing ed with flammables, and are mbustibles by 20 feet (5 feet if losed in a cabinet of nstruction having a minimum on rating. to 300 cubic feet compartment, individual for immediate use in patient aggregate volume of less than bic feet are not required to be ure. Cylinders must be utions as specified in 11.6.2. In readable from 5 feet is on of a cylinder storage room, udes the wording as a DN: OXIDIZING GAS(ES)					

If continuation sheet Page 5 of 6

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245453	B. WING		05/	22/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
K 923	This REQUIREMEN by: Based on observat failed to store oxygwith the requiremen Section 19.3.2.4, 8. Section 11.3. This an isolated number visitors. Findings include: On 5/22/18 at 2:00p room revealed oxyg holder made of com	NT is not met as evidenced tion and interview, the facility en cylinders in accordance nts of NFPA 101 - 2012 edition, 7 and NFPA 99 - 2012 edition, deficient practice could affect of residents, staff, and om, observation in the oxygen gen cylinders were stored in a nbustible material (wood).	K 92	On June 6, 2018, the oxygen cy holder made of combustible ma removed and metal racks install oxygen cylinder storage. The F Engineer is responsible for the c and will monitor to prevent the re-occurrence of this deficiency.	erial was ed for acilities	

If continuation sheet Page 6 of 6

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00862	B. WING		F 06/2	ץ 0/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LB BROI	EN HOME		TH SHERIDA FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	19th and 20th, 2018	visit was completed on June 3. During this visit it was following correction order,				
	will be reviewed at t	der will remain in effect and the next onsite visit. To be				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 09/07/18

STATE FORM

6899

If continuation sheet 1 of 12

	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED	
		00862	B. WING		R 06/20/2018	
	PROVIDER OR SUPPLIER	824 SOU	TH SHERIDA			
(X4) ID	SUMMARY STA	FERGUS	FALLS, MN	56537 PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLET	
{2 000}	Continued From pa	ge 1	{2 000}			
	reviewed for possib	le penalty assessment.				
{2 895}	MN Rule 4658.0528 Motion	5 Subp. 2.B Rehab - Range of	{2 895}		7/26/18	
	that is directed towa through positioning implemented and m comprehensive res of nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				
	receives appropriat	h a limited range of motion e treatment and services to notion and to prevent further of motion.				
	by: Uncorrected based original licensing or	ent is not met as evidenced on the following findings. The der issued on 4/26/18 will nalty assessment issued.		Correct.		
	review the facility fa maintain range of m	on, interview and document iled to provide exercises to notion (ROM) services for 4 of R28, R15 and R66) reviewed ursing program.				
	Findings include:					
	3/29/18, indicated F impairment, had dia	imum Data Set (MDS) dated 867 had moderate cognitive agnoses which included hythmia and end stage renal				

Minnesota Department of Health STATE FORM

Q7HK12

If continuation sheet 2 of 12

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED	
		00862	B. WING			R 06/20/2018	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		00/	20/2010	
			TH SHERIDAN				
		FERGUS	FALLS, MN 5	56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
{2 895}	Continued From pa	age 2	{2 895}				
	staff assistance wit (ADL's). The MDS steady moving fron moving on and off	identified R67 required total th all activities of daily living further indicated R67 was not n a seated to standing position the toilet and surface to transfer between bed and chain	,				
	had an ADL self ca to disease process care plan listed var	vised 4/19/18, indicated R67 re performance deficit related , limited mobility and pain. The ious interventions which e program services.	,				
	dated 10/26/17, id instructions: Stand by edge of b (FWW), shoes on,	Nursing Communication form, entified the following ed: with front wheeled walker gait belt, CGA (contact guard elevated bed. Stand Time to per week.					
	dated 2/15/17, ide instructions: 1 x 15 seated: hip long arch quads ar bilaterally, 3 times Theraband- seated external rotation 15 15 x 2, curls 15 x 2 assistive range of r	Nursing Communication form, ntified the following flexion, abduction, adduction, nd ankle planter/dorsal flexion per week as tolerated. Yellow d with yellow theraband, 5 x 2 (hip height), punch downs the hand grippers 15 x 2, active motion (AAROM) bilaterally 0 x 2, complete 3 times per					
	was seated in his v propelling himself a room. R67 indicate	on 6/20/18 at 11:35 a.m. R67 vheelchair in his room around with his feet in his od he was tired on dialysis days when he got back from					

STATE FORM

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If continuation sheet 3 of 12

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00862	B. WING	B. WING		R 06/20/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
LB BRO	EN HOME		TH SHERIDAN FALLS, MN 5				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SECTION			(X5) COMPLET DATE	
{2 895}	Continued From pa	age 3	{2 895}				
	 dialysis. R67 indicated staff would offer assistance with exercises after he returned from dialysis and he would tell them , he would do them later. He indicated staff usually never return to assist him with his exercises. -at 12:10 p.m. RA-A entered R67's room and transferred R67 from his wheelchair to the edge of his bed via mechanical standing lift. RA-A proceeded to place R67's walker in front of him, 		ו				
	placed gait belt aro himself independer feet on the floor ho with RA-A standing	und his waist, R67 positioned nt on the edge of the bed with Iding his walker and stood up at his left side.					
	and sat down on th period and began t and stated "that's a stand one more tim and indicated he w transferred R67 fro mechanical lift. R67 for a dialysis day au used to do this eve	indicated that was enough e bed. R67 rested for a short o stand and sit repeatedly x 3 III I can do". R67 attempted to he then sat back on his bed anted to stop. RA-A im his bed to his wheelchair via 7 indicated he did pretty good nd indicated at one time he ryday and now he doesn't. R67 his exercises maybe 2 times a					
	grippers and R67 b repeatedly 40 times straight up then his floor repeatedly alto R67 move his right	A handed R67 bilat hand began to squeeze them s. RA-A had R67 lift his left leg right leg straight up off the ernating his legs. RA-A had foot to the side then his left eatedly alternating his feet.					
	side and began to l his arm straight ou	itioned herself on R67's right ift his arm up and down with t in front of him 20 times. erself on R67's left side and					

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STATEMEN	D <u>ta Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00862	B. WING			R 06/20/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
LB BRO	EN HOME		TH SHERIDAN FALLS, MN 5				
(X4) ID PREFIX TAG			SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION				
{2 895}	Continued From pa began to lift his arm his arm straight out -at 12:37 p.m. RA-/ remained seated in observed to perforr exercise to include height), 2) punch de 2 per therapies rec R67's Rehab Nursi to 6/30/18, indicate of bed exercise pro out of 9 opportunitie which included: 1 x abduction, adductio planter/dorsal flexic bilaterally shoulder grippers 15 x 2 wer opportunities for the lacked evidence of theraband for 1) ex height), 2) punch de any time during the Review of R67's nu 6/4/18 to 6/20/18, f restorative nursing On 6/20/18 at 12:02 not feel like his rest had been getting de "maybe a couple tin staff had gotten son	age 4 h in a up and down motion with t in front of him. A exited R67's room while he h is wheelchair. RA-A was not m any yellow theraband 1) external rotation 15 x 2 (hip owns 15 x 2 and 3) curls 15 x ommendations. ng Record (RNR) dated 6/1/18 d R67's standing by the edge ogram was completed only 3 es for the month, exercises x 15 seated: hip flexion, on, long arch quads and ankle on bilaterally, AAROM flexion 10 x 2 and hand re completed 6 out of 9 e month and R67's RNR the use of the yellow ternal rotation 15 x 2 (hip owns 15 x 2, 3) curls 15 x 2	{2 895}				
	was to receive rest	8 p.m. RA-A confirmed R67 orative and ROM exercises cated that she felt sometimes,					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00862	B. WING			R 06/20/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
LB BRO	EN HOME		H SHERIDAN FALLS, MN 5				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCS	TION SHOULD BE CO THE APPROPRIATE	
{2 895}	Continued From pa	age 5	{2 895}				
indicated that she to but indicated there needed to be done residents. RA-A ind		he exercises as ordered. RA-A ried to get the exercises done was a lot of other cares that through out the day for other licated she had notified the she cannot get her work					
	confirmed R67 was ROM exercises 3x/ not receiving his re 3x/week per therap indicated she has h restorative program because of other re eating and answeri when it comes to re the facility would ha	p.m. registered nurse (RN)-A a to receive restorative and week. RN-A verified R67 was storative and ROM exercises bies recommendations. RN-A had staff voice concerns about nming not getting done esident cares such as toileting, ng call lights. RN-A indicated esident cares verses rehab, ave the RA help out with the e residents are getting illeted.					
	R28 had severe co diagnoses which in hemiparesis (paral body), cerebral vas and seizure disorde identified R28 requ and had range of m	S dated 5/17/18, indicated gnitive impairment, had cluded hemiplegia or ysis of one entire side of the acular accident (CVA) (stroke). er. R28's MDS further ired total assistance with ADLs notion impairment on one side wer and upper extremities.					
	had an ADL self ca to stroke. The care intervention which i	ncluded rehab interventions aff to see rehab book and					

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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED R
		00862	B. WING		06/20/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
LB BROI	EN HOME		TH SHERIDAN			
			FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{2 895}	Continued From pa	ige 6	{2 895}			
	R28's Therapy to Nursing Communication form, dated 3/30/17, identified the following: upper extremity PROM (passive range of motion) and bilateral LE ROM 5 times a week or as patient tolerates.					
	was in her room lyin head of bed elevate relieving boots on h	on 6/20/18 at 9:40 a.m. R28 ng in bed, on her back, with ed, fully clothed, with pressure her feet bilaterally and was ia gastrostomy tube while she low.				
		5/1/18 to 6/20/18, indicated estorative and ROM exercises ities for the month.				
	6/4/18 to 6/20/18, I	rrsing progress notes from lacked any notation of R28's program participation.				
	was to receive ROM confirmed R28 had services as per the	8 p.m. RA-A confirmed R28 M exercises 3x/week. RA-A not been receiving ROM rapies recommendations and ROM exercises in the last ar this week.				
	to receive ROM exe indicated restorative floor sometimes to indicated she had w restorative program	p.m. RA-B confirmed R28 was ercises routinely. RA-B e staff would get pulled to the help with cares. RA-B roiced her concerns about the n and indicated management rative staff resident cares	5			
	come first, then the indicated concerns and management in	e restorative program. RA-B had been voiced to the RN's n the recent past and they ne problem with the restorative				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00862	B. WING			R 06/20/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
	EN HOME		TH SHERIDAN				
		FERGUS	FALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
{2 895}	Continued From pa	age 7	{2 895}				
	program not getting	g done.					
	was to receive ROI was not receiving F was not sure why h RN-C indicated the gotten better, but h recently and indica to have a RA. RN-C staff complaints at	p.m. RN-C confirmed R28 M exercises routinely and she ROM as recommended. RN-C her ROM did not get done. The restorative program had er floor had not had a RA until ted every floor was supposed C indicated she was aware of pout the restorative program the complaints to the director of					
	R15						
	had intact cognition included anxiety dis systemic lupus. Th extensive assistant of ADL's. The MDS steady moving from moving on and off	PS dated 5/3/18, indicated R15 n, had diagnoses which sorder, osteoarthritis and e MDS identified R15 required ce of one staff with all activities S further indicated R15 was not n a seated to standing position, the toilet and surface to gransfer between bed and chair	t ,				
	had an ADL self ca to disease process pain in right knee, i erythematous, asth osteoporosis The	vised on 5/12/18, indicated R15 re performance deficit related , limited mobility weakness recent falls, systemic lupus, ama hypothyroidism and care plan listed several included restorative program	5				
	dated 3/24/17, ide theraband (she has	lursing Communication form, ntified the following: dark blue in her room) 1) horizontal 20 outs 20 x 2, 3) shoulder					

STATE FORM

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If continuation sheet 8 of 12

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED	
						R	
		00862	B. WING		06/	06/20/2018	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
B BRO	EN HOME		ITH SHERIDAN 5 FALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{2 895}	Continued From pa	ige 8	{2 895}				
	tucked), 3 to 4 x pe Lower extremity se adduction, long arc planter/dorsi flexior hamstring curls 1 x as patient tolerates	and blue theraband 20 bilaterally. 3 x per week or					
	was in her room, se	s on 6/20/18 at 9:20 a.m. R15 eated in her recliner with her the foot rest of the recliner.					
	cart which containe such as theraband' equipment. RA-C s proceeded to comp the blue theraband and completed low was able to particip	C entered R15's room with her of several items for exercising s, weights and other at down on a foot stool and blete upper arm exercises with applied weights her ankles er extremity exercises. R15 hate and complete both upper r extremity exercises.					
	R15 had completed	6/1/18 to 6/30/18, documented I her restorative and ROM 9 opportunities for the month.					
	6/4/18 to 6/20/18, I	rsing progress notes from acked any notation of R15's program participation.					
	received restorative week. R15 indicate	2 a.m. R15 indicated she e program maybe two times a d she did not believe she was e exercise and ROM three					
	R66						
		S, dated 3/29/18, identified cognitively impaired and had					

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If continuation sheet 9 of 12

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00862	B. WING			R 06/20/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
	EN HOME		TH SHERIDAN				
			FALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
{2 895}	Continued From pa	ige 9	{2 895}				
	and Parkinson's dis R66 required exten with all ADL's and r for grooming. The N not steady moving f position, walking, tu opposite direction v off the toilet and su (transfer between b R66's care plan rev had ADL self care p dementia, disease depression, acute k weakness. The car	cluded dementia, depression sease. The MDS indicated sive assistance of two staff needed ext assistance of one MDS further indicated R66 was from a seated to standing urning around facing the vhile walking, moving on and rface to surface transfers bed and chair or wheelchair). rised on 3/28/18, identified R66 performance deficit related to process: parkinsonism, kidney injury and generalized re plan listed various included restorative nursing					
	dated 1/16/18, ider AAROM, hip flexior	lursing Communication form, ntified the follows: bilateral LE n, hip abduction, knee ankle planter/dorsi flexion,					
	dated 4/27/18, ider or AROM upper ext shoulders-flex, exte elbow-flex, extension	lursing Communication form, ntified the following: AAROM tremities 1 to 2 sets 10 reps, ension abduction/adduction, on, no weights, wrists- flex, on and pronation, 3 times per d.					
	R66 was lying in be present in his room laid R66 down so s exercises. RA-C ind exercises when he	ns on 6/20/18 at 10:35 a.m. ed on his back and RA-C was . RA-C indicated she had just he could complete his dicated R66 did better with his laid down. RA-C proceeded to gremity and lower extremity					

STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00862	B. WING		R 06/20/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	EN HOME		TH SHERIDAN			
		FERGUS	FALLS, MN 5	6537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{2 895}	Continued From pa	age 10	{2 895}			
	exercises with R66 throughout the exe	. R66 was cooperative rcises.				
	R66 had received h	6/1/18 to 6/30/18, indicated his restorative and ROM but of 9 opportunities for the				
	6/4/18 to 6/20/18,	ursing progress notes from lacked any notation of R66's program participation.				
	and R66 was to rec exercises 3x/week. struggle to get the completed daily. R/ R15 only had her e week and indicated back and forth betw	5 a.m. RA-C confirmed R15 ceive restorative and ROM . RA-C indicated it was a restorative program done and A-C indicated she had noticed exercises done one time last d it was a struggle of bouncing ween restorative nursing ing other staff on the floor.				
	R66 were to receiv exercises 3x/week. were not receiving exercises 3x/week recommendations. trying prioritize thei to receive therapy 3 facility wanted to se were struggling get and stated "work in RA's had voiced the restorative program	p.m. RN-D confirmed R15 and e restorative and ROM . RN-D verified R15 and R66 restorative and ROM per therapies RN-D indicated the RA were r work and if the resident was 3 times a week that's what the ee done. RN-D indicated staff tting restorative exercises done a progress." RN-D indicated eir concerns about the n not getting done and ern had been reported to the				
		p.m. DON reviewed and				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDING: _			
		B. WING		R 06/20/2018		
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
B BRO	EN HOME		TH SHERIDAN FALLS, MN 5			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
{2 895}	Continued From pa	age 11	{2 895}			
	program not being residents as recom moving forward, the program weekly to changes need be d had not received an regards to the rester done properly. The expect staff to mak was getting complet indicated she was a restorative program the staff involved a addressed. The DC aware of any other A facility policy titler Charting Code and revised 9/2003, rev was to record resid care plan. The polic record resident's pa facility Rehab Nurs revealed if a reside perform for three o restorative aid show coordinator for follo the RN or substitute complete ordered r each shift so that a assure completion.	regarding the restorative completed consistently for imended. The DON indicated e RN's would be looking at the see what adjustments and lone. The DON indicated she ny complaints from staff in prative program not getting DON indicated she would as ordered. The DON aware of one time when the time and it was DN indicated she was not concerns since this one time. d, Restorative Nursing, Reporting Requirements, realed the purpose of the policy lent's compliance with rehab cy directed facility staff to articipation and refusals on the ing Care Record. The policy ont refuses or was unable to r more scheduled days the uld report to the RN ow up. The RA shall report to e any anticipated inability to modalities before the end of ssignments can be adjusted to R CORRECTION: Fourteen				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 07HK

PART	I - TO BE COMPLETED BY THE STAT	TE SURVEY AGENCY	Facility ID: 00862
 MEDICARE/MEDICAID PROVIDER NO. (L1) 245453 2.STATE VENDOR OR MEDICAID NO.	 NAME AND ADDRESS OF FACILITY (L3) LB BROEN HOME (L4) 824 SOUTH SHERIDAN (L5) FERGUS FALLS, MN 	(L6) 56537	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 04/26/2018 (L34) 8. ACCREDITATION STATUS:	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 04 SNF 08 OPT/SP 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 04/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 107 (L18)	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC X B. Not in Compliance with Program	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
	Requirements and/or Applied Waivers:	* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 107	ICF IID	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICAB 17. SURVEYOR SIGNATURE	Date:	18. STATE SURVEY AGENCY A	
Susan Bachleitner, HFE NE II	05/30/2018 (L19)	Douglas S. Larson, Enfo	(L20)
PART II - TO B	E COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE STA	ATE AGENCY
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21) 	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREE	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNING 04/01/1987	DATE ENDING DATE	VOLUNTARY	05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination	
25. LTC EXTENSION DATE: 27. ALTERNAT	IVE SANCTIONS on of Admissions:	04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
(1.27)	(L44) aspension Date:		00-Active
	(L45)		
28. TERMINATION DATE: 2	9. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	03001 (L31)		
31. RO RECEIPT OF CMS-1539 3	2. DETERMINATION OF APPROVAL DATE		
(L32)	(L33)	DETERMINATION APPR	OVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 14, 2018

Ms. Andrea Zeta, Administrator Lb Broen Home 824 South Sheridan Fergus Falls, MN 56537

RE: Project Number S5453029

Dear Ms. Zeta:

On April 26, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 5, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by July 26, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 October 26, 2018 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Program Health Regulation Division Telephone: 651-201-4206 Fax: 651-215-9697 Email: alison.helm@state.mn.us

Enclosure

cc: Licensing and Certification File

		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES	1		0	<u>MB NO.</u>	. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245453	B. WING _			04/	26/2018	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
LB BROE	EN HOME				4 SOUTH SHERIDAN RGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 0	00				
F 000	Emergency Prepare conducted on 4/23/ recertification surve	iance with CMS Appendix Z edness Requirements, was 18, through 4/26/18, during a ey. The facility is in compliance Z Emergency Preparedness	F 01	00				
	was completed at y Department of Hea was in compliance	th 4/26/18, a standard survey our facility by the Minnesota lth to determine if your facility with requirements of 42 CFR 3, and Requirements for Long s.						
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.						
F 550 SS=D	on-site revisit of you validate that substa		F 5	50			6/4/18	
	self-determination, access to persons outside the facility, this section.	right to a dignified existence, and communication with and and services inside and including those specified in						
	r DIRECTOR'S OR PROVID ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NALURE		TITLE		(X6) DATE 05/23/2018	
	loany olynou						00,20,2010	

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.

PRINTED: 05/30/2018

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ((X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED			
		245453	B. WING _			04/2	26/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LB BROE	EN HOME				4 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From pa	ige 1	F 55	50			
	with respect and dig resident in a manner promotes maintena her quality of life, re individuality. The fa promote the rights of						
	access to quality ca severity of condition must establish and practices regarding provision of service	facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the sounder the State plan for all so f payment source.					
		e right to exercise his or her of the facility and as a citizen					
	resident can exercis	facility must ensure that the se his or her rights without ion, discrimination, or reprisal					
	free of interference, reprisal from the fac rights and to be sup exercise of his or he subpart.	resident has the right to be , coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this NT is not met as evidenced					
	Based on observat review, the facility fa dining experience for	tion, interview and document ailed to ensure a dignified or 1 of 1 resident (R66) e supper meal in the second			R19 recliner cushion and wheelcha cushion have been thoroughly clea and white incontinent padding has removed from use. Recliner cushio	ned been	

Facility ID: 00862

If continuation sheet Page 2 of 47

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245453	B. WING _			04/2	26/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE	•		
LB BROEN HOME				824 SOUTH SHERIDAN FERGUS FALLS, MN 56537				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 550	floor dining room. In ensure dignity was (R19) who utilized a Findings include; R66's quarterly Min 3/29/18, identified F impaired and had of dementia, depressi The MDS indicated assistance of two s transfers, dressing eating. R66's care plan dat an activities of daily deficit and potentia weight gain or loss disease process ar plan listed various if regular diet, provide R66. During continual of on 4/23/18 at 6:26 f dining room R66 w table and his food s consisted of turkey fruit salad with whip (NA)-E approached and began talking t at 6:39 p.m. NA-E when he opened hi him to eat his soup -at 6:45 p.m. NA-E food and started wa table asking other r	in addition the facility failed to maintained for 1 of 1 resident an incontinent pad.	F 5	been cover colored pad entry to cha 3x/week. I All resident odor and us recliners ar wanting/rec were provid padding. D Housekeep updated to clean, orde interior& an Protocol wa visual inspe- ceilings, reg and furnish directions for chairs/reclin free and if of manner. ie. padding. Da An Audit titl Dignity, BH audit will m resident en of: incontine the room an locations, re intervention are address preferred n Plan. Nurs completed then weekly audit is con and is inclu	ed with a more discreet d with R19 approval. eT ange recliner and w/c pa Date Completed: 5/18/1 rooms were evaluated se of incontinent paddin nd wheelchairs. Those quiring incontinent paddid ded with discreet colored bate completed: 5/30/20 bing Tasks, Routine Daily include maintenance of rly, odor free and comfo d I. Routine Room Clea as updated to expand M ection of privacy curtains gisters, lighting, persona ings to include specific or resident furnishing: ners, bed, expectations covered, covered in a di with discreet incontiner ate completed: 5/22/201 led Nursing Care Audit #1296-18, was created onitor the dignity of the vironment including more ent care items being vis nd in the residents to assu- sing residents by their ame as indicated on the ing Care Audit Dignity of each unit by 6/4/2011 y x 4 weeks on each uni- neled on an on-going ided in a quarterly Nursi m for each unit. DON w	AR dds 8 for g in ng 1 18 y was a brtable uning . Make s, walls, al fans, of odor gnified nt 8 . This nitoring ible in ng ure staff e Care y will be 8 and t. This basis ng		

Facility ID: 00862

If continuation sheet Page 3 of 47

PRINTED: 05/30/2018 FORM APPROVED

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245453 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **824 SOUTH SHERIDAN** LB BROEN HOME FERGUS FALLS, MN 56537 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 550 Continued From page 3 F 550 the table and gave R66 a bite of his vegetable monitor and audit findings and assure soup while she stood on the left side of him. prompt follow up of potential concerns. NA-F briefly walked away from the table and then Audit findings are an agenda item returned and sat down next to R66 and assisted reported to the Resident Care and Customer Relations Committee, a him to eat. -at 6:49 p.m. NA-F got up from assisting R66 to subcommittee of the Quality Assessment eat and began to pick up the soiled clothing and Assurance Committee and QAPI. protectors from the other tables in the ding room. Date Completed: 6/4/2018 and ongoing. -at 6:50 p.m. NA-E approached R66, sat down Nursing Staff meeting scheduled May 30, next to him, and stated "hi buddy" and began to 2018 to include review of updated policy feed him a bite of his vegetable soup using a and procedure and Nursing Care Audit sliver spoon. Dignity. Further information was provided -at 6:51 p.m. NA-E gave R66 a bite of his to staff regarding availability of discreet vegetable soup and said "here ya go buddy." colored padding and that visibility of -at 6:53 p.m. NA-E cut R66's turkey sandwich in incontinence padding and products is not half, tried handing it to him while she stated "there dignified. Date completed: 5/30/2018 ya go buddy I cut it into a smaller piece." Housekeeping staff updated with review -at 6:58 p.m. NA-E gave R66 a bite of his fruit of policy and procedure Housekeeping dessert and stated "here va go buddy." Tasks, Routine Daily and expectations of -at 7:09 NA-E gave R66 a bite of his turkey odor free and dignified interior sandwich and stated "here ya go buddy you environment. Date completed: 5/29/2018 almost ate all of your sandwich." 2 dozen additional discreet colored -at 7:11 p.m. NA-E gave R66 a drink of his milk incontinent pads have been ordered for and said "it's ok buddy you can let go of it (glass facility use. Date completed: 5/18/2018 of milk)." NA-E took the glass from R66's hand R66 is experiencing a dignified dining and sat it on the table. experience at every meal. Date -at 7:15 p.m. R66 was done eating his supper completed: 5/31/2018 meal, NA-E got up from sitting next to R66 and All residents in the dining room served by stated "here we go buddy" and wheeled R66 out NA-E have the potential for an undignified of the dining room via his wheel chair to the living dining room experience. NA-E was room area. counselled on the important of maintaining a dignified experience for all residents by addressing them by their On 4/26/18 at 2:30 p.m. NA-E confirmed she was preferred name. NA-E verbalized using nicknames while she was assisting R66 with his supper meal. NA-E confirmed the usual understanding. All staff were educated on facility practice was for staff to remain seated the importance of maintaining dignity of all residents by addressing them by their next to the resident while they were eating and not to interrupt their meal time by getting up and preferred name as identified on their Care leaving. NA-E verified staff should not be using Plan at the Nursing Staff meeting held

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00862

If continuation sheet Page 4 of 47

PRINTED: 05/30/2018

TATEMENT	OF DEFICIENCIES OF CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION		SURVEY PLETED	
		245453	B. WING		04/2	26/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE			
B BRO	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 5653	37		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE	(X5) COMPLETIC DATE	
F 550	pet names unless t called by the nickna was better to use th attention more. On 4/26/18 at 1:12 confirmed the usua were assisting resid stay with the reside and let them have a verified staff should residents meal and rotate while they we because that staff n resident was eating should not be using indicated staff had dementia training. only being using the resident preferred a "buddy should not b R19 R19's quarterly MD R19 was moderate diagnoses which in and depression. The required extensive bed mobility, transf toileting, personal her review of the MDS incontinent of urine program. R19's care plan dat	he resident preferred to be ame. NA-E indicated she felt it he residents name to get their p.m. director of nursing (DON) a facility practice while staff dents to eat, was for staff to ent until they are done eating a good hot meal. The DON a not be interrupting the she did not like the staff to ere assisting a resident, member knew how the g. The DON confirmed staff g pet names or nicknames and been trained on this in The DON verified staff should e residents name, unless the a different name and stated be used." S, dated 2/15/18, identified ly cognitively impaired and had cluded dementia, hemiplegia he MDS indicated R19 assistance of two staff with ers and one staff for dressing, hygiene and eating. Further indicated R19 was always and was not on a toileting	F 55	5/30/2018. Date comp LB Broen Home Comp Assisting a Resident to was updated to include resident s Care Plan assistance needed and 7. Sit beside the reside and remain with reside throughout the meal, a address resident by a Completed: 5/22/2018 LB Broen Home Comp Assisting a Resident to completed with all NA/ Home by 6/4/2018. Da 6/4/2018 LB Broen Home Food/ Audit Tool, BMH #691- include Food Service: while feeding (did not s remained with the resi throughout the meal, a Residents are address preferred name as ide Plan. LB Broen Home Service Audit Tool was units, at all meals by 6 weekly on all units, at a This audit is completed basis and is included i Nursing Care audit sys DON will monitor audit assure prompt follow u concerns. Audit findin item reported to the Re Customer Relations C subcommittee of the C	betency Checklist: b Eat, BH #1275-17, e 1. Check for diet order, eating d preferred name, ent during feeding ent as able and 17. Did not pet name. Date betency Checklist: b Eat will be 'R s at LB Broen ate completed: '/Dining Service -94 was updated to 5. Staff were seated stand) and dent as able and Atmosphere: 6. Sed by their ntified on their Care e Food/Dining s completed on all i/4/2018 and then all meals x 4 weeks. d on an on-going n a quarterly stem for each unit. t findings and up of potential gs are an agenda esident Care and ommittee, a Quality Assessment		

Facility ID: 00862

If continuation sheet Page 5 of 47

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATI	0938-039		
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	PLETED		
		245453	B. WING		04/2	26/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
LB BRO	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE		
F 550	dignity and required two staff with all pe- clothing and chang During observation was in her room lyi cloth covered reclir and the seat of the white incontinent pa- odor of urine noted room. During observation was seated in her r reclining chair with the recliner. R19's covered with a whit of the recliner. The visible to the public recliner while the e- the reclining chair. -at 7;38 a.m. R19 r with the white incor the left side of her re- at 7:53 a.m. remai the white incontiner left side of her recli -at 8:07 a.m. regist R19 out of her roor the dining room are her a menu to look covered with a whit hanging partially ou of her wheel chair, under the seat of th on all sides of the s -at 8:22 a.m. R19 w	included provide privacy, d physical assistance of one to rineal care, adjusting of ing of incontinent padding. s on 4/24/18 at 1:16 p.m. R19 ng in bed sleeping. A brown her was present in R19's room recliner was covered with a ad. R19's room had a strong permeating through out the s on 4/25/18 at 7:04 a.m., R19 oom in her brown cloth her feet up on the foot rest of brown reclining chair was e incontinent pad on the seat white incontinent pad was on the left side of R19's dge of it hung from the front of emained seated in her recliner thinent pad visibly hanging on recliner. ned seated in her recliner with ht pad visibly hanging on the ner. ered nurse (RN)-B wheeled n via her black wheelchair into ea for breakfast and handed at. R19's wheel chair seat was e incontinent pad and was at of the back and the left side while the rest of it was tucked ne wheel chair but was visible	F 55(0 Nursing Staff meeting held 5/30/2 included review of Competency O Assisting a Resident to Eat and L Home Food/Dining Service Audit updates. The correct way to addr resident by their preferred name demonstrated. Date Completed: 5/30/2018	Checklist: B Broen Tool ess a			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245453 B. WING 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **824 SOUTH SHERIDAN** LB BROEN HOME FERGUS FALLS, MN 56537 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 550 Continued From page 6 F 550 Ensure independently while she continued to have a white incontinent pad hanging out of the back and left side of her wheelchair. -at 8:42 a.m. R19 was seated in her wheel chair at the dining room table eating her breakfast independently while she continued to have a white incontinent pad hanging out of the back and left side of her wheelchair. -at 9:03 a.m. RN-B sat down next to R19 at the dining room table and assisted R19 to eat her cream of wheat. R19 continued to have a white incontinent pad hanging out of the back and left side of her wheelchair. -at 9:19 a.m. R19 was done eating her breakfast when NA-G approached R19, wheeled R19 out of the dining room via wheel chair back to her room. R19 continued to have a white incontinent pad hanging out of the back and left side of her wheelchair. NA-G proceeded to assist R19 to the bathroom via mechanical lift, slid R19 pants and incontinent brief down, sat R19 on the toilet. assisted her with removing her incontinent wet brief, provided peri cares, applied a clean incontinent brief, assisted R19 out of the bathroom via mechanical lift and sat R19 in her brown recliner in her room. The seat of R19's recliner was covered with a white incontinent pad which was visible from her door way of her room on the left side. -at 11:21 a.m. R19 remained seated in her recliner listening to music, with the white incontinent pad visibly hanging on the left side of her recliner. -at 12:14 p.m. R19 was seated in her wheel chair at the dining room table eating her dessert independently while the seat of her black wheel chair was covered with a white incontinent pad which hung partially out of the back and the left side of her wheel chair, while the rest of it was

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 7 of 47

		AND HUMAN SERVICES				FORM	: 05/30/2018 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245453	B. WING			04/:	26/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 550	tucked under the servisible on all sides. -at 12:30 p.m. R19 chair at the dining r the right side of her R19 continued to has still visible on all side- at 12:42 p.m. R19 chair at the dining r the right side of her R19 continued to hav visible on the seat at On 4/25/18 at 11:14 was incontinent of has and needed staff as changed. NA-H ind pads on the seats of due R19 being inco- furniture from being indicated staff tried off the recliner but of are in a hurry. On 4/25/18 at 1:30 (LPN)-C confirmed bowel/bladder, word assistance to be too indicated R19 had i of her recliner and v accident and so the being soiled with ur facility had brown ir used, but indicated always available. On 4/26/18 at 1:06 confirmed R19 was	age 7 eat of the wheel chair but still remained seated in her wheel room table while NA-F sat on r assisting her to eat her lunch. ave a white incontinent pad des of the wheelchair seat. remained seated in her wheel room table while NA-F sat on r assisting her to eat her lunch. ave a white incontinent pad and sides of the wheelchair. 4 a.m. NA-H confirmed R19 bowel/bladder, wore a brief ssistance to be toileted and icated R19 had incontinent of her recliner and wheel chair ontinent and to protect the g soiled with urine. NA-H to take the incontinent pads does not always happen if they p.m. licensed practical nurse R19 was incontinent of e a brief and needed staff ileted and changed. LPN-C incontinent pads on the seats wheel chair in case she had an ey don't ruin the furniture from rine. LPN-C indicated the ncontinent pads staff normally the supply was limited and not		50			

If continuation sheet Page 8 of 47

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245453 B. WING 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **824 SOUTH SHERIDAN** LB BROEN HOME FERGUS FALLS, MN 56537 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 550 Continued From page 8 F 550 toileted and changed. The DON indicated the facility had colorful incontinent pads to protect the seats/recliners and usually used these for the recliners and the seats of wheel chairs. The DON indicated if staff were using the white incontinent pads she would expect them to fold them up, put them away when not in use and should not be lying out due to dignity issues. The DON indicated staff should not be using the white incontinent pads for wheelchairs and recliners. Review of facility policy titled, Food/Dining Service Audit Tool revised on 5/14, indicated staff to include resident in conversation and dignity was maintained. Review of facility policy titled, Nursing Department Orientation revised on 6/16, indicated under resident rights: preserve an individuals dignity, protecting and promoting privacy and confidentiality of residents Safe/Clean/Comfortable/Homelike Environment F 584 F 584 6/4/18 CFR(s): 483.10(i)(1)-(7) SS=E §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00862

If continuation sheet Page 9 of 47

		AND HUMAN SERVICES			F	ORM A	05/30/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE	SURVEY PLETED	
		245453	B. WING	i		04/26/2018		
NAME OF	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
LB BRO	EN HOME		824 SOUTH SHERIDAN FERGUS FALLS, MN 56537					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 584	 (ii) The facility shall the protection of the or theft. §483.10(i)(2) House services necessary and comfortable int §483.10(i)(3) Clean in good condition; §483.10(i)(4) Privat resident room, as s §483.10(i)(5) Adequarter levels in all areas; §483.10(i)(6) Comfalevels. Facilities init 1990 must maintain 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENED by: Based on observatire review the facility far good repair to prevair to prevair nesident personal rooms (rm 350, rm 366, rm 364, rm rm 356), and in comand third floor of the Findings include: 	does not pose a safety risk. exercise reasonable care for e resident's property from loss ekeeping and maintenance to maintain a sanitary, orderly, erior; a bed and bath linens that are the closet space in each pecified in §483.90 (e)(2)(iv); uate and comfortable lighting ortable and safe temperature ially certified after October 1, in a temperature range of 71 to the maintenance of comfortable NT is not met as evidenced tion interview and document ailed to maintain windows in ent the elements from entering I rooms in 12 of 12 resident 357, rm 365, rm369, rm368, 361, rm 360, rm 359, rm 358, nmon areas on the second	F	584	R29 s window is repaired and is in g weather tight and safe operating condition. Date Completed: 5/22/201 Windows in rooms 350, 356, 357, 358 359, 360, 361, 364, 365, 366, 368 and 369 will be repaired and in good, wea tight and safe operating condition. Date Completed: 6/4/2018 Second floor north (2N) windows are repaired and in good weather tight an safe operating condition. Date Completed: 6/4/2018	I8. 8, Id ather ate		

Event ID:Q7HK11

Facility ID: 00862

If continuation sheet Page 10 of 47

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245453 **B** WING 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **824 SOUTH SHERIDAN** LB BROEN HOME FERGUS FALLS, MN 56537 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 584 Continued From page 10 F 584 of the facility was conducted with the facilities All facility windows inspected by the facility engineer (FE)A, and he confirmed the following maintenance team using the Window Inspection Checklist, BH # 6116-18 and findings: 3rd floor: Guidelines, BH # 6117-18, to identify -Room 350-the wooden edges of the three paned windows in need of repair or replacement. window were soft. cracked: Date Completed: 6/4/2018 -Room 357- the wooden edges of the three A Window Inspection Checklist, BH # paned window were soft, cracked and crumbled 6116-18, has been added to the **Environmental Inspection Checklist which** when touched: -Room 365-the wooden edges of the three is completed quarterly. Date Completed: paned window were soft, cracked and crumbled 5/22/2018 when touched: Environmental Services Audit, Resident -Room 369-the wooden edges of the window Safe Environment Window Inspection, were soft, cracked and crumbled when touched. BH # 6118-18 was created. This audit will There was white duct tape on the bottom edge of monitor the inspection, condition and the smaller window: repair of facility windows. Date Completed: 5/22/2018 -Room 368-the middle windowpane had tape on the lower edge of the window that had been Environmental Services Audit, Resident painted over with brown paint. This taped area Safe Environment Window Inspection. was soft when touched: BH # 6118-18, will be completed on all -Room 366-the middle windowpane had tape on units by 6/4/2018 and then weekly x 4 the lower edge of the window that had been weeks on all units. This audit is painted over with brown paint. This taped area completed on an on-going basis and is was soft when touched: included in a quarterly maintenance audit -Room 364-the small window to the left of the system. Director of Support Services will larger middle window had soft, cracked edges; monitor findings and assure prompt follow -Room 361-the wooden edges of the three paned up of potential concerns. Audit findings window were soft, cracked and gave way to are an agenda item reported to the pressure when touched. Cold air flow was felt by **Resident Care and Customer Relations** the edges of the window; Committee, a subcommittee of the Quality -Room 360-the wooden edges of the three Assessment and Assurance Committee paned window were soft, cracked and gave way and QAPI. Date Completed: 6/4/2018 to pressure when touched. Cold air flow was felt and ongoing. Education provided to Maintenance team by the edges of the window; -Room 359-the wooden edges of the three paned on addition of Window Inspection Checklist to the guarterly Environmental window were soft, cracked and gave way to pressure when touched. Cold air flow was felt by Inspection Checklist and Environmental the edges of the window; Services Audit, Resident Safe -Room 358-the wooden edges of the three paned Environment Window Inspection. Date

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00862

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245453	B. WING	i		04/:	26/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 584	window were soft, or pressure when touc -Room 356-the woo were soft and crack -The five large wind the third floor were the window were m laminate overlay. T missing in some are the snack area had not open this windo -The large window laminate on the low particle board was touched. The top of down. -One of the three d area along the low touch and air was five window. 2nd floor: The windows at the and missing the lan fitting particle board seal with the window R29's quarterly min 2/15/18, indicated F On 4/25/18, at 11:3 winter, snow had co edges of the window R29 indicated staff were able to stop th however; R29 indic come in through the	cracked and gave way to ched; oden edges of the window ked dows in the common area on in poor repair. The edges of hade of particle board with a he laminate was warped and eas. The large window near I sign taped to the window, "do ow it is broken." at end of hall was missing the ver edge and the exposed broken and moved when f the window frame bowed ining room windows had an er edge which was soft to elt coming through the e end of both halls had warped minate with exposed and ill d which did not create a tight w and wall. nimum data set (MDS) dated R29 had intact cognition. 7 a.m. R29 indicated this past ome in through the lower w near R29's chair this winter. screwed the window shut and he snow from coming in, tated the wind continued to	F	584	Completed: 5/31/2018		

If continuation sheet Page 12 of 47

		AND HUMAN SERVICES			FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245453	B. WING		04/:	26/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 584 F 637 SS=D	above findings. FE- have plans to replace thought window rep the future. FE-A ind an estimate for the one floor, in order to cost to plan how to replacements. FE-A be to repair the curr functional and then facility is able. The facility provided replacement dated been signed as acco order was provided On 4/26/18, at 3:22 (DON) verified she be clean, presentate provide a safe and each resident. The requested facil Comprehensive Ass CFR(s): 483.20(b)(2)(ii) W determines, or shout there has been a si resident's physical of purpose of this sect means a major dec resident's status that itself without further implementing stand interventions, that h	A indicated the facility did not ce the windows, however; blacements would be done in dicated the facility had obtained cost of replacing windows on o get a ball park number of the pay for the window A indicated the best plan would rent windows to make them replace the windows as the d a estimate for window 1/16/18. The estimate had not cepted and no purchasing 2 p.m. the director of nursing expected the environment to oble, and functional, in order to comfortable environment for lity policy was not provided. sessment After Signifcant Chg	F 584	4		6/4/18

If continuation sheet Page 13 of 47

		AND HUMAN SERVICES			FORM	05/30/2018 APPROVEI 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	()	E SURVEY PLETED	
		245453	B. WING		04/2	26/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT		•	
LB BRO	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 565	537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIOI DATE	
F 637	care plan, or both.) This REQUIREMEN by: Based on interview facility failed to com Status Assessment areas of change in the Minimum Data (R33, R59) reviewe status. Findings include: R33's quarterly MD R33's diagnosis of cognitive impairme assistance with are staff with bed mobi dressing, personal MDS further identif motion (ROM) limit extremities and had incontinence. R33's quarterly MD R33 had severe co total ADL assistance transfers, toileting, and bathing, had lir upper or lower extra of bowel. Review of the abow had a decline in All extensive assistance assistance of two s limitation to limited	linary review or revision of the NT is not met as evidenced v and document review, the pplete a Significant Change in t (SCSA) when two or more resident status were noted on Set (MDS) for 2 of 3 residents ed for a decline in health PS dated 11/23/17, identified dementia, had severe nt and required extensive eas of daily living (ADL)s of one lity, transfers, toileting, hygiene and bathing. The ied R33 had no range of ation of the upper or lower	F 6	 A Significant Change Assessment was com for R33. Date Compl A Significant Change Assessment was com for R59. Date Compl IDT reviewed each re to determine if a signi status had been met. 5/22/2018 Nursing Care Audit Assessment/Care Pla Implementation, BMH updated to include: IE significant change, by and current MDS. Da 5/22/2018 Nursing Resident A Planning and Implem BMH# 1142-03, upda reviewed for significa comparing previous a Date completed: 5/22 Nursing Care Audit Assessment/Care Pla Implementation will b units by 6/4/18 and th on all units. This aud on-going basis and is quarterly Nursing Car each unit. DON will n findings and assure p potential concerns. A agenda item reported Care and Customer F 	npleted on 5/15/2018 eted: 5/15/2018 in Status MDS npleted on 5/15/2018 eted: 5/15/2018 esident in the facility ificant change in Date Completed: Resident anning and # 1187-06, was DT reviewed for / comparing previous te completed: Assessment/Care entation Checklist, ted to include: IDT nt change, by and current MDS. 2/2018 Resident anning and e completed on all en weekly x 4 weeks it is completed on an included in a re Audit system for nonitor and audit the prompt follow up of Audit findings are an I to the Resident		

Facility ID: 00862

If continuation sheet Page 14 of 47

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245453 **B** WING 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **824 SOUTH SHERIDAN** LB BROEN HOME FERGUS FALLS, MN 56537 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 637 Continued From page 14 F 637 continence from occasional to always incontinent a subcommittee of the Quality and Assessment and Assurance Committee of bowel. and QAPI. Date Completed: 6/4/2018 an R59's annual MDS dated 12/21/17, identified R59 ongoing. had diagnoses which included Alzheimer's DON will monitor (CM)-B s completed disease and dementia, had severe cognitive MDS s weekly beginning 6/4/18 and then impairment, required extensive ADL assistance weekly x 4 weeks to evaluate of staff with bed mobility, transfers, dressing, understanding of significant change in eating, toileting, bathing, had occasional bladder status assessment needs and provide incontinence and a PHQ-9 score of 00, which follow up as needed with (CM)-B. Date indicated no signs or symptoms of depression. Completed: 6/4/2018 and ongoing Education provided to the IDT, consisting R59's quarterly MDS dated 3/22/18, identified of RNUC s, Social Services, Activities R59 had severe cognitive impairment, required and Dietician, on updates to Nursing total ADL assistance from staff with bed mobility, Resident Assessment/Care Planning and Implementation Checklist and Nursing transfers, dressing, eating, toileting, bathing, had Care Audit Resident Assessment/Care frequent bladder incontinence and a PHQ-9 score of 03, which indicated minimal signs and Planning and Implementation Checklist. symptoms of depression. Reeducation on definition of a significant change in status, IDT s responsibility for Review of the above assessments indicated R59 recognizing a significant change in status had a decline in ADL's performance from has occurred and scheduling of the Significant Change in Status completed. extensive assistance of staff to total assistance of staff, a decline in bladder continence from Date Completed: 5/29/2018 occasional to frequent, and a PHQ-9 score (CM)-B reeducated and counseled on use which indicated a decline in mood from no signs of Nursina **Resident Assessment/Care** or symptoms of depression to minimal signs and Planning and Implementation Checklist as (CM)-B completes the assignments, symptoms of depression. identification of Significant Change in On 4/26/18, at 3:04 p.m. the clinical manager status and communication of identified (CM)-B verified she was responsible for changes with IDT. Date Completed: completing MDS assessments in the facility. 5/22/18 CM-B verified the above findings and indicated both R33 and R59 should have been reviewed for a significant change. On 4/26/18, at 3:22 p.m. the director of nursing (DON) indicated the facilities MDS program had alerts to indicate a decline or improvement in the

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245453 B. WING 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **824 SOUTH SHERIDAN** LB BROEN HOME FERGUS FALLS, MN 56537 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 637 Continued From page 15 F 637 resident's abilities. The DON indicated the facility protocol was to follow the resident assessment instrument (RAI) manual and expected R33 and R59 would have been reviewed for a significant change. The facility policy titled MDS Assessment, dated 10/2010, identified the Procedure: I. Documentation of ADL function is completed every shift for all residents on Point of Care Electronic Documentation. A. Team leaders will provide direction and support to ensure that Point of Care Documentation id completed in an accurate and timely manner. B. Direct care staff assigned to the resident shall promptly complete Point of Care documentation through out shift. C. Point of Care documentation is uploaded directly to MDS and monitored by RN (registered nurse). The facility provided forms printed from their RAI Manuel dated 10/2017, which identified the following: A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self limiting; 2. Impacts more than one area of the resident's health status; and 3. requires interdisciplinary review and/or revision of the care plan. F 676 Activities Daily Living (ADLs)/Mntn Abilities F 676 6/4/18 CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) SS=D

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES				FORM	: 05/30/2018 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245453	B. WING	i		04/	26/2018
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LB BRO	EN HOME			-	24 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 676	§483.24(a) Based of assessment of a re- resident's needs an provide the necessa ensure that a reside daily living do not di of the individual's of that such diminution includes the facility §483.24(a)(1) A res- treatment and servi- or her ability to carr- living, including thos- of this section §483.24(b) Activitie The facility must pro- accordance with pa- activities of daily livi- §483.24(b)(1) Hygie grooming, and oral §483.24(b)(2) Mobi- including walking, §483.24(b)(3) Elimi- §483.24(b)(4) Dinin snacks, §483.24(b)(5) Com- (i) Speech, (ii) Language, (iii) Other functional This REQUIREMEN	on the comprehensive sident and consistent with the ad choices, the facility must ary care and services to ent's abilities in activities of iminish unless circumstances linical condition demonstrate in was unavoidable. This ensuring that: ident is given the appropriate ices to maintain or improve his y out the activities of daily se specified in paragraph (b) s of daily living. ovide care and services in aragraph (a) for the following ing: ene -bathing, dressing, care, lity-transfer and ambulation,	F	676		o all	

Facility ID: 00862

If continuation sheet Page 17 of 47

		& MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY IPLETED	
		245453	B. WING		04/2	26/2018	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE		
LB BRO	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 676	review, the facility f recommendations a ambulation services resident (R31) revie Findings include: R31's admission M 2/16/18, identified F had diagnoses white anxiety, obesity and identified R31 requinant activities of daily livies bed mobility, transf assistance of two fa R31 was not able to staff assistance, ha of motion (ROM) are both physical therap therapy (OT) service back period. R31's admission Ca dated 2/16/18, iden assistance with AD identified R31 had is services with the go independence and his strength. R31's 14-day prosp MDS dated 2/22/18 extensive assistance mobility and transfe had ambulated less seven day look bac	ailed to implement therapy and routinely provide s to maintain function for 1 of 1 ewed for ambulation. inimum Data Set (MDS) dated R31 was cognitively intact and ch included depression, d hypertension. The MDS ired extensive assistance with ing (ADL's) which included ers and walking with acility staff. The MDS revealed o maintain his balance without ad no impairments of his range nd had received five days of py (PT) and occupational ces during the seven day look are Area Assessment (CAA) tified R31 required extensive L's including walking. The CAA received both OT and PT bal to improve his to prevent further decline in Dective payment system (PPS) B, identified R31 required ce with ADL's including bed ers. The MDS identified R31 is than three times within the ck period. The MDS further ived both PT and OT services	F 67	 meals. eTAR updated to Encourage to ambulate to wheeled walker and w/c Date Completed: 5/18/20 All resident records were presence of a PT Ther and Discharge Summary Plans and Instructions se all ambulation recommer been transcribed. Date 5/30/2018 Policy and Procedure, Th Recommendations for Re Nursing Program created therapy recommendation communicated to Nursing direction for completion of Recommendations for Re Nursing Program, BH 12 Completed: 5/18/2018 Form, Therapy Recomm Restorative Nursing Prog 1297-18, created and ind communication of recom all modalities upon disch contracted therapy servic nursing. Date Completed Transcribing Orders Mas THERAPY: Physical, Oct Speech updated to includ for therapy recommenda outside of Rehabilitative Date Completed: 5/22/20 Nursing Care Audit Tra Orders, BH# 1190-06, (# completed on three resid by 6/4/2018 and then we residents x 4 weeks on a 	o all meals with 4 following behind. 18 reviewed for apist Program form. Discharge action to assure adations have Completed: herapy estorative d to assure all us are clearly g staff and of Form, Therapy estorative 97-18. Date endations for gram, BH # sludes mendations for arge from ces to restorative d: 5/18/2018 ter File, cupational, de use of eTAR tions occurring Nursing hours. 18 anscription of 5. Only) will be lents on each unit ekly on three		

Facility ID: 00862

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245453 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **824 SOUTH SHERIDAN** LB BROEN HOME FERGUS FALLS, MN 56537 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 676 Continued From page 18 F 676 R31's care plan revised 4/13/18, revealed R31 and is included in a quarterly Nursing required assistance from staff with bed mobility, Care Audit system for each unit. DON will transfers with one assist and ambulation with a monitor and audit findings and assure walker and transfer belt. The care plan directed prompt follow up of potential concerns. facility staff to encourage R31 to ambulate and to Audit findings are an agenda item assist R31 to ambulate with a wheelchair to follow reported to the Resident Care and behind. The care plan further directed facility staff Customer Relations Committee, a to encourage R31 to participate in activities that subcommittee of the Quality and Assessment and Assurance Committee promoted exercise, physical activity for strengthening and improved mobility such as: and QAPI. Date Completed: 6/4/2018 walking with assistance, using NuStep. and ongoing. Contracted Therapy group staff educated on of Policy and Procedure changes and R31's end of therapy discharge plan and updates to Therapy Recommendations for instructions dated 3/2/18, revealed R31 was Restorative Nursing Program. Date assist of one with transfers and ambulation. The Completed: 5/23/2018 Unit Clerks, RNUC s and Charge Nurses instructions directed nursing staff to ambulate with meals with a four wheeled walker and a gait educated on new Policy and Procedure titled Therapy Recommendations for belt. R31 was to be added to the facility restorative nursing program with the NuStep Restorative Nursing Program, updates to machine. The discharge plan revealed R31 had the Transcribing Master Orders File titled ambulated up to 90 feet with a four wheeled THERAPY: Physical, Occupational, Speech and Therapy Recommendations walked at the time of discharge from skilled therapy services. for Restorative Nursing Program, BH 1297-18 at May 30, 2018 Nursing Staff On 4/24/18, at 8:53 a.m. R31 stated he used to meeting. Date Completed: 5/30/2018 walk with the facility staff when he first came to the facility and had periodically walked with staff to meals, though staff had not offered to walk with him recently. R31 stated he was also supposed to exercise with facility staff and use the NuStep machine (exercise machine) 5 days a week. He stated facility staff did not routinely offer to walk with him and did not routinely offer any other exercises, such as the NuStep machine. R31 stated he felt facility staff did not have time to help him with his walking or exercises. He stated he would like to walk so he could get stronger and felt he was not able to walk at that time.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 19 of 47

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245453	B. WING			04/:	26/2018
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676	Continued From pa	ige 19	F 6	76			
	-	a.m. R31 was seated in a dby nursing assistant (NA)-B					
	wheelchair, wheele	8 a.m. R31 was seated in a d by NA-B back to his room. erved to offer R31 assistance					
	wheelchair and was room by NA-C to hi	00 p.m. R31 was seated in a s wheeled out of the dining is room. R31's front wheeled com, at the end of his bed.					
	not offered R31 to a She indicated she f refusing to ambulat also refuse his rest indicated there wer	04 p.m. NA-C stated she had ambulate to the noon meal. felt R31 had a history of te and indicated R31 would corative program. NA-C further re times when she felt it was st R31 with his restorative ffing shortages.					
	assistant (TMA)-As with R31 since he h from the short term month ago. TMA-A ambulate and comp would inform the lic TMA-A further state most recent time sh	5 p.m. trained medical stated she had not ambulated had transferred to the 3rd floor a stay unit, approximately a stated R31 would refuse to plete exercises and stated she censed nurse of R31's refusals. ed she could not recall the he had offered to assist R31 otion (ROM) or NuStep					
	wheelchair in the di	6 p.m R31 was seated in a ining room and had propelled f his feet approximately 30					

Facility ID: 00862

If continuation sheet Page 20 of 47

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245453	B. WING	i		04/:	26/2018
NAME OF F	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LB BRO	EN HOME				324 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 676	feet. At that time N/ to his room. NA-B or R31. On 4/25/18, at 2:26 been asked or offer either breakfast of t the day prior. R31 s in his ability to amb weakened. Review of R31's rel 3/3/18, to 4/26/18, rf March, 2018, R31 h machine 4 times, ho opportunities. The r received ROM exer April, 3108, R31 ha machine 3 times, ho opportunities. The r received ROM exer R31's rehab nursing of R31's ambulation On 4/26/18, at 8:24 program was review manager (NM)-B. N routinely received h routine basis. NM-E record lacked docu to and from meals. formal program for would not be docum record. NM-B stated ambulate with R31,	A-B offered to wheel R31 back did not offer to ambulate with b p.m. R31 stated he had not red by facility staff to walk to the noon meal that day, nor stated he felt he had declined outate and had overall hab nursing record from revealed: had completed the NuStep ad refused one time out of 28 record revealed R31 had not rcises.		576			

If continuation sheet Page 21 of 47

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245453	B. WING	i		04/2	26/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 676	confirmed R31's me documentation of R nursing staff and div refusals of restorati On 4/26/18, at 8:42 wheelchair in the ha way down the hall to propelled himself th approximately 30 fe On 4/26/18, at 8:44 with the physical the not feel he would be declined to have PT ambulate. R31 furth use the NuStep for loosen up. On 4/26/18, at 9:54 occasionally use the refused to ambulate recall the last time h R31. NA-B indicate his mobility within th On 4/26/18, at 9:35 received skilled PT 3/2/18. PT-A stated the facility restorativ were to assist R31 with a front wheeled time of discharge fr able to ambulate, w	the NuStep machine. NS-B edical record lacked 31 refusing to ambulate with d not routinely reveal R31's ve nursing program. a.m. R31 was seated in a allway. NA-B wheeled R31 part o his room. R31 then he rest of the way to his room, et. a.m. R31 was offered to walk erapist (PT). R31 stated he did e able to walk with therapy and assess his current ability to her stated he felt he needed to a few days first in order to a.m. NA-B stated R31 would e NuStep and had routinely b. NA-B stated he could not he had offered to walk with d he felt R31 had declined in	F	676			

Facility ID: 00862

If continuation sheet Page 22 of 47

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED
STATEMENT	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
		245453	B. WING			04/:	26/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME			-	24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676 F 688 SS=D	On 4/26/18, at 2:59 (DON) stated she w to walk to and from machine and ROM was not aware R31 restorative nursing would expect to be difficulty routinely of A facility policy titled Charting Code and dated 9/2003, revea was to record reside care plan. The polic record resident's pa facility Rehab Nursi revealed if a resider perform for three or restorative aid shou coordinator for follo Increase/Prevent D CFR(s): 483.25(c)(1) §483.25(c)(1) The f resident who enters range of motion doe range of motion un condition demonstr- of motion is unavoid §483.25(c)(2) A res motion receives ap services to increase prevent further deci	 p.m. the director of nursing vould expect R31 to be offered meals, assist with the NuStep exercises. She stated she had not routinely received services and indicated she informed if staff were having ffering restorative services. d, Restorative Nursing, Reporting Requirements, aled the purpose of the policy ent's compliance with rehab cy directed facility staff to articipation and refusals on the ing Care Record. The policy nt refuses or was unable to r more scheduled days the uld report to the RN ow up. Decrease in ROM/Mobility 1)-(3) facility must ensure that a s the facility without limited es not experience reduction in less the resident's clinical ates that a reduction in range 		576			6/4/18

If continuation sheet Page 23 of 47

H AND HUMAN SERVICES		(FORM APP OMB NO. 09	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY
245453	B. WING		04/26/2	2018
		STREET ADDRESS, CITY, STATE, ZIP CODE		
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE CO	(X5) DMPLETIC DATE
nimum Data Set (MDS) dated R67 had moderate cognitive iagnoses included anemia, attivities of daily living (ADL's). 0 a.m. R67 stated staff were to d but this service was not being us, it was only for a short time. worry of no longer being able to t allowed to stand often or long vised 4/12/18, indicated R67 are performance deficit r/t e process, limited mobility and n identified a restorative ace.	F 68	R67 nursing rehabilitation is com as ordered. Date Completed: 6/4 R31 nursing rehabilitation is comp ordered. Date Completed: 6/4/20 R 28 nursing rehabilitation is com as ordered. Date Completed: 6/4 All residents with a Nursing Rehal program have been reviewed by t RNUC evaluating completion and documentation of provided Rehat Nursing Services. Date Complet 5/30/2018 Rehabilitative Nursing, Charting C Reporting Requirements Policy ar Procedure reviewed and updated increase frequency of RNUC mor of completion and documentation nursing rehab program. Date Com 5/23/2018 Rehab Assistants reeducated reg the importance of completion and documentation of therapy services ordered, the need to communication anticipated inability to complete of modalities before the end of the s that assignments can be adjusted assure completion. Date Comple 5/31/2018 RNUC s and Charge Nurses ree on their responsibility to manage to Rehabilitation program on their ur assure rehabilitative services are	2018 oleted as 18 pleted 2018 oilitative he oilitative ed: code and nd to itoring of the npleted: arding s as e any rdered hift so to ted: ducated he it and to being	
	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 245453 B. WING 245453 B. WING 3 ID TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ID PREFIX LSC IDENTIFYING INFORMATION) PREFIX TAG adage 23 F 688 ntain or improve mobility with cticable independence unless a ity is demonstrably unavoidable. ENT is not met as evidenced ation, interview and document failed to routinely provide ses for 2 of 3 residents (R67 d with a restorative nursing ion the facility failed to provide ervices for 1 of 2 residents eviewed for limited range of inimum Data Set (MDS) dated R67 had moderate cognitive flagnoses included anemia, and end stage renal disease. dd R67 required total staff I activities of daily living (ADL's). 0 a.m. R67 stated staff were to d but this service was not being as, it was only for a short time. worry of no longer being able to ot allowed to stand often or long exised 4/12/18, indicated R67 are performance deficit r/t ere process, limited mobility and un identified a restorative ace. attitled Therapy to Nursing	E & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDERSUPPLER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION 245453 B. WING 3 STREET ADDRESS, CITY, STATE, ZIP CODE 8 STREET ADDRESS, CITY, STATE, ZIP CODE 9 STREET ADDRESS, CITY, STATE, ZIP CODE 9 B. WING 1 STREET ADDRESS, CITY, STATE, ZIP CODE 9 B. WING 1 CASS OUTH SHEIDDAN FERGUS FALLS, MN 56537 1 D 2 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) 2 PREFIX TAG 2 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) 2 PREFIX TAG 2 PREFIX TAG 2 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) 2 PROVIDER'S PLAN OF CORRECTIVE TAG 2 PROVIDER'S PLAN OF CORRECTIVE TAG 2 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION STATES 2 PROVIDER'S PLAN OF CORRECTIVE TAG 2 PROVIDER'S PLAN OF CORRECTIVE ACTION 2	E & MEDICAID SERVICES OMB NO. 09 (X1) PROVIDERSUPPLERICLA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) DATE SU 245453 B. WING 004/26/7 3 STREET ADDRESS, CITY, STATE, ZIP CODE 245453 B. WING PROVIDERS PLAN OF CORRECTION 04/26/7 A BUILDING PROVIDERS PLAN OF CORRECTION 04/26/7 TATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION 04/26/7 TATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION 04/26/7 TATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION 04/26/7 TATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION 02/26/7 TATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION 02/26/7 TATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION 02/26/7 TATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION 02/26/7 TATES TARGE TADDRESS, CITY, STATE, ZIP CODE EACORRECTION 02/26/7 TATEMENT OF DEFICIENCY F 688 F 688 00/26/7 02/26/7

If continuation sheet Page 24 of 47

PRINTED: 05/30/2018 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00862

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245453 B. WING 04/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **824 SOUTH SHERIDAN** LB BROEN HOME FERGUS FALLS, MN 56537 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 688 Continued From page 24 F 688 following: Charting Code and Reporting Goal area; Maintain LE (lower extremity) strength Requirements reviewed. Date and standing ability 3x (three times) per week or Completed: 5/31/2018 Nursing Care Audit Rehabilitative as pt. (patient). Suggested approaches; Stand by edge of bed: Nursing, BH # 1298 - 18, created. This with FWW (front wheeled walker), shoes on, gait audit monitors the completion and belt, CGA (Contact Guard Assistance), from documentation of the Nursing elevated bed. Stand Time to pt's tolerance. One Rehabilitative program. Date Completed: time 3x per week. 5/23/2018 Nursing Care Audit Rehabilitative On 4/25/18, at 11:17 a.m. R67 was observed in Nursing will be completed on all units by his room seated on the front edge of the wheel 6/4/18 and then weekly x 4 weeks on all chair leaning back to rest on the back of the units. This audit is completed on an chair. R67 informed nursing assistant (NA)-C he on-going basis and is included in a was sliding out of the wheel chair and needed quarterly Nursing Care Audit system for help to scoot back onto the seat. With the use of each unit. DON will monitor and audit a EZ stand lift (mechanical lift to standing findings and assure prompt follow up of position), NA-C stood R67 and repositioned him potential concerns. Audit findings are an to sit farther back onto the wheel chair seat. agenda item reported to the Resident Care and Customer Relations Committee, On 4/25/18, at 11:53 a.m. R67 self propelled the a subcommittee of the Quality and wheel chair to the dining room. Assessment and Assurance Committee and QAPI. Date completed: 6/4/2018 an On 4/26/18, at 9:48 a.m. R 67 participated with ongoing. seated exercises lead by the activity staff, in the common area of the unit. R67's physician orders signed 4/12/18, directed R67 to stand by the edge of the bed: with FWW, shoes on, gait belt, CGA from elevated bed. Stand-time to residents tolerance, one time a day for 3x/week. The restorative aid untitled and undated form identified the following: [R67] 3x/wk stand by edge of bed: with FWW, shoes on, gait belt, CGA, from elevated bed. Stand time to residents tolerance.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 25 of 47

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245453	B. WING	i		04/:	26/2018
NAME OF I	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LB BRO	EN HOME				824 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	Record dated April of R67's participatio program with except indicated the progra- that date. Review of R67's nut through 4/26/18, la restorative nursing referral. On 4/26/18, at 9:55 indicated a binder w all resident restorat indicated R67 want and was seen by th was not able to wal but was able to star by the bed with a w CM-B verified a not programs be provid assistant. CM-B ind R67 is too weak to program. On 4/26/18, at 10:4 had not completed NA-C verified the or restorative binder in program was only of verified the program completed three tim On 4/26/18, at 10:5 was responsibile to program. NA-B indi participate with the	y form titled Rehab Nursing 2018, lacked documentation on or refusal of the sit to stand btion of 4/11/18, which am had been completed on rising progress notes 1/26/18, icked any notation of R67's program participation or a.m. clinical manager (CM)-B vas available with direction for ive nursing programs. CM-B ed to regain the ability to walk erapy. CM-B indicated R67 k after therapy was completed nd and the program to stand alker and staff was started. e in the binder directed R67's led by a specific nursing dicated often on dialysis days participate in the sit to stand 2 a.m. NA-C indicated he/she R67's restorative programs. documentation in the ndicated the sit to stand completed on the 11th. NA-C n was supposed to be	F	6888			

If continuation sheet Page 26 of 47

		AND HUMAN SERVICES			FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245453	B. WING		04/;	26/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LB BROE	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	Continued From pa restorative aid.	-	F 688	3		
	nurse (LPN)-B indi with the restorative reported to her, how	6 a.m. licensed practical cated refusals to participate nursing program would be wever; NA-B would also report estorative aid who would be iment the refusal.				
	indicated she expect reason residents di services (for examp illness). CM-A indic	2 a.m. clinical manager (CM)A cted staff to document the d not receive the rehab ble because of refusals or cated she did not review the documentation throughout the				
	stand lift belt around belt loops to the how the assistance of the R67 onto the bed. N R67's waist and witt walker, R67 stood f and then sat down.	9 p.m. NA-B placed the EZ d R67's back, attached the lift oks on the lift, stood R67 with the EZ stand and transferred NA-B placed a gait belt around h CGA and the use of a from the bed for two minutes R67 stood and sat a total of me standing between two conds.				
	(DON) indicated sh restorative nursing by therapy to maint DON indicated door completed whether completed. If the re completed, the clin informed. The DON	p.m. the director of nursing e expected staff to follow the programs as they were set up ain strength and ability. The umentation should have been or not the program was storative program was not ical manager should be I indicated communication order to ensure the program dered.				

If continuation sheet Page 27 of 47

		AND HUMAN SERVICES				FORM	APPROVED	
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:				COMPLETED		
		245453	B. WING					
NAME OF F	PROVIDER OR SUPPLIER	243433	D. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE			26/2018	
					24 SOUTH SHERIDAN			
LB BROE	LB BROEN HOME			F	ERGUS FALLS, MN 56537			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETION DATE	
ind		,	inte		DEFICIENCY)			
			l					
F 688	Continued From pa	ge 27	F 6	88				
	R31 R31's admission M	DS dated 2/16/18 identified						
		DS, dated 2/16/18, identified / intact and had diagnoses						
		ression, anxiety, obesity and						
	hypertension. The M	MDS identified R31 required						
		e with activities of daily living						
		ded bed mobility, transfers sistance of two facility staff.						
		R31 was not able to maintain						
		staff assistance, had no						
		range of motion (ROM) and						
		ays of both physical therapy nal therapy (OT) services						
		ay look back period.						
		are Area Assessment (CAA) tified R31 required extensive						
		L's including walking. The CAA						
	identified R31 had r	received both OT and PT						
	services with the go							
	his strength.	to prevent further decline in						
	nis strength.							
		ective payment system (PPS)						
		, identified R31 required						
		e with ADL's including bed ers. The MDS identified R31						
		than three times within the						
	seven day look bac	k period. The MDS further						
		ved both PT and OT services						
	five out of seven da	ays.						
		ed 3/16/18, revealed R31						
	required assistance	from staff with bed mobility,						

If continuation sheet Page 28 of 47

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245453	B. WING	·		04/;	26/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME			-	24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	transfers with one a walker and transfer directed facility staf participate in activit physical activity for mobility such as: wa NuStep. R31's current physi revealed an order of 8 for 20 minutes or NuStep then let res supervision and aid the machine, one til or as resident tolerat R31's physician ord 3/2/18, for seated o four pound weight to band used for stren extension, abductio flexion/extension, o time a day for 3 tim tolerated. R31's end of therap instructions dated 3 assist of one with tr instructions directed facility restorative n NuStep machine ar with meals with a for belt. The discharge ambulated up to 90 walked at the time of therapy services.	assist and ambulation with a r belt. The care plan further ff to encourage R31 to ties that promoted exercise, strengthening and improved alking with assistance, using ician orders signed 4/5/18, dated 3/2/18, for NuStep level as tolerated, may set up sident use machine with d for safety getting off and on ime a day for five times a week	F	5888			

Facility ID: 00862

If continuation sheet Page 29 of 47

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245453	B. WING			04/:	26/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LB BRO	EN HOME				24 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	the facility and had to meals, though st him recently. R31 s exercise with facility machine (exercise stated facility staff of with him and did no exercises, such as exercises, such as exercises. R31 stat have time to help h exercises. He state could get stronger a walk at that time. On 4/25/18, R31 wa wheeled by nursing room. On 4/25/18, at 8:48 wheelchair, wheele NA-B was not obse with ambulation. On 4/25/18, at 12:0 wheelchair and was room by NA-C to hi walker was in his ro On 4/25/18, at 12:0 not offered R31 to a She stated R31 had ambulate and indica restorative program and the NuStep. NA were times when st assist R31 with his staffing shortages.	age 29 periodically walked with staff aff had not offered to walk with tated he was also supposed to y staff and use the NuStep machine) 5 days a week. He did not routinely offer to walk ot routinely offer any other the NuStep machine or arm ed he felt facility staff did not im with his walking or d he would like to walk so he and felt he was not able to as seated in a wheelchair, assistant (NA)-B to the dining a.m. R31 was seated in a d by NA-B back to his room. rved to offer R31 assistance 0 p.m. R31 was seated in a s wheeled out of the dining s room. R31's front wheeled bom, at the end of his bed. 4 p.m. NA-C stated she had ambulate to the noon meal. d a history of refusing to ated R31 would also refuse his n which included arm exercises A-C further indicated there he felt it was challenging to restorative program due to 5 p.m. trained medical	F	5888			

If continuation sheet Page 30 of 47

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245453	B. WING	i		04/2	26/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LB BROE	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	with R31 since he h from the short term month ago. TMA-A ambulate and comp would inform the lic TMA-A further state most recent time sh with his range of me exercises. On 4/25/18, at 12:3 wheelchair in the di himself with both of feet. At that time N/ to his room. NA-B of R31. On 4/25/18, at 2:26 been asked or offer either breakfast of t the day prior. R31 s in his ability to ambu weakened. Review of R31's ref 3/3/18, to 4/26/18, r March, 2018, R31 h machine 4 times, ha opportunities. The r received ROM exer	stated she had not ambulated had transferred to the 3rd floor stay unit, approximately a stated R31 would refuse to oblete exercises and stated she ensed nurse of R31's refusals. ad she could not recall the he had offered to assist R31 otion (ROM) or NuStep 6 pm. R31 was seated in a ning room and had propelled his feet approximately 30 A-B offered to wheel R31 back did not offer to ambulate with p.m. R31 stated he had not red by facility staff to walk to he noon meal that day, nor stated he felt he had declined ulate and had overall hab nursing record from revealed: had completed the NuStep ad refused one time out of 28 record revealed R31 had not reises.	F	6888			

If continuation sheet Page 31 of 47

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245453	B. WING	i		04/2	26/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME			-	824 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	manager (NM)-B. N routinely received h routine basis. NM-E record lacked docu to and from meals. formal program for would not be docum record. NM-B states ambulate with R31, received training in included ROM and NS-B confirmed R3 documentation of F nursing staff and di refusals of restorati On 4/26/18, at 8:42 wheelchair in the ha way down the hall to propelled himself th approximately 30 fe On 4/26/18, at 8:44 with the physical the not feel he would be declined to have PT ambulate. R31 furth use the NuStep for loosen up. On 4/26/18, at 9:54 occasionally use the refused to ambulate recall the last time I R31. NA-B indicate his mobility within th	wed with registered nursing IM-S confirmed R31's had not is restorative program on a 3 confirmed R31's medical mentation of R31's ambulation She stated there was no R31's ambulation, therefore nented in the restorative d any nursing staff could however different NA's had restorative programs, which the NuStep machine. Further, R1's medical record lacked R31 refusing to ambulate with d not routinely reveal R31's ve nursing program. a.m. R31 was seated in a allway. NA-B wheeled R31 part o his room. R31 then he rest of the way to his room, pet. a.m. R31 was offered to walk erapist (PT) R31 stated he did e able to walk with therapy and T assess his current ability to her stated he felt he needed to a few days first in order to a.m. NA-B stated R31 would e NuStep and had routinely e. NA-B stated he could not he had offered to walk with d he felt R31 had declined in	F	688			

If continuation sheet Page 32 of 47

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/30/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245453	B. WING			04/2	26/2018	
NAME OF F	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-		
LB BROI	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 688	3/2/18. PT-A stated the facility restoration were to assist R31 with a front wheeled time of discharge fr able to ambulate, w and was able to tole NuStep machine. On 4/26/18, at 2:59 (DON) stated she w to walk to and from machine and ROM was not aware R31 restorative nursing would expect to be	ge 32 services from 2/9/18, to she had discharged R31 to /e program, and nursing staff to ambulate to and from meals d walker. PT-A stated at the om skilled therapy R31 was ith breaks, to and from meals erate daily exercises with the p.m. the director of nursing vould expect R31 to be offered meals, assist with the NuStep exercises. She stated she had not routinely received services and indicated she informed if staff were having ffering restorative services.	F 6	88				

Facility ID: 00862

If continuation sheet Page 33 of 47

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245453	B. WING			04/;	26/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BROE	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From pa	ige 33	F 6	88			
	R28						
	had diagnosis which hemiparesis (paraly body), arthritis and further identified R2 with ADLs and had on one side. R28's had diagnosis of Ce (CVA) (stroke). R28's care plan las R28 had an ADL se (related to) Stroke. interventions which book and therapy re On 4/23/18, at 7:16 bed in her room on was elevated, and s was covered by her	dated 2/15/18, indicated R28 h included hemiplegia or ysis of one entire side of the seizure disorder. R28's MDS 28 required total assistance range of motion impairment o quarterly MDS identified R28 erebral Vascular Accident t revised 2/26/18, indicated elf care performance deficit r/t Interventions included rehab instructed staff to see rehab ecommendations in chart. 6 p.m. R28 was lying on her her back. Her head of bed she wore pink pajamas and r sheet and blanket. Her left d resting on her left side, on a					
	fist. On 4/24/18, at 8:41 her recliner in her re	a.m. R28 was observed in oom. Her feet were elevated closed. R28's left hand was					
	resting on a pillow a into a loose fist.	and her fingers were curled					
	recliner in her room feet elevated. She	a.m. R28 was sitting in her with her eyes closed and her was dressed and had her left willow. Her left fingers were fist.					

If continuation sheet Page 34 of 47

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245453	B. WING _			04/;	26/2018
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	On 4/26/18, at 10:3 required total assist indicated the facility performed the reha NA-A indicated the complete the progra R28's physician orco orders for PROM to one time a day for 5 3/31/17. R28's ordo lower extremities 1 (bending movemen from body) /adducti knee flexion/extens Ankle Planter flexio /dorsi flexion (move (inversion-tilt toward away from the body a week. R28's facility form ti care (evaluation on physician 3/30/17, discharged to the s facility) for RNP (ref R28's facility form ti of care (evaluation physician 3/30/17, i discharged to the s appropriate for RNF PROM. R28's facility form ti Communication, da by restorative coord areas were to main	7 a.m. NA-A indicated R28 tance with all her cares. NA-A had rehabilitation staff who bilitation nursing program. rehabilitation staff tried to	F 68	88			

If continuation sheet Page 35 of 47

		AND HUMAN SERVICES			FORM	05/30/2018 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		245453	B. WING		04/2	26/2018			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
LB BRO	EN HOME		824 SOUTH SHERIDAN FERGUS FALLS, MN 56537						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE			
F 688	LE ROM 5 times a s Suggested approace and PROM 1 x 10 h adduction, knee flex (plantar flexion)/ DF R28's Rehab Nursin 4/26/18, all included bilateral upper extrex X/week, start date 3 extremities; 1 x 10 h abduction/adduction Ankle Planter flexio time a day for 5 x /v Review of R28's Re 11/1/17, to 4/26/18 following: -11/1/17, to 11/30/1 exercises and LE P 23 opportunities. -12/1/18, to 1/31/18, exercises and LE P 24 opportunities. -2/1/18, to 2/28/18, exercises and LE P 20 opportunities. -3/1/18, to 3/31/18,	week or as patient tolerates. thes included PROM to B UE hip flexion, abduction, xion/extension, ankle PF (dorsal flexion), IV/EV. Ing Records dated 4/1/17, to d instructions for: PROM to emities. One time a day for 5 3/31/17. PROM to Lower hip flexion, n, knee flexion/extension. n/dorsi flexion, IV/EV. One	F 688	8					

If continuation sheet Page 36 of 47

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245453	B. WING	ì		04/26/2018	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	EN HOME				324 SOUTH SHERIDAN		
				F	FERGUS FALLS, MN 56537		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	-4/1/18, to 4/26/18, exercises and LE P 20 opportunities. R28's medical reco multiple days the exercises on 4/26/18, at 12:5 had a PROM rehab- lower extremities. Or records indicated R exercises 5 times a therapy department evaluations then ser rehabilitation nursin R28's nursing rehal 3/30/17. CM-A ind with a resident's ref- managers talked to needed would discu- resident's primary of for treatment if nee- had not received PI week as ordered ar concerns. She expl restorative aide mo nursing assistant if CM-A indicated the exercises as ordered. On 4/26/18, at 1:07 indicated the facility restorative nursing staff educating the and ROM exercises expect R28 to recei- week, as ordered. expect them to noti-	R28 received UE PROM PROM exercises 3 days out of and lacked documentation why exercises were not completed. 55 p.m. CM-A indicated R28 program for both upper and CM-A verified R28's medical R28 was to receive the PROM a week. CM-A indicated the t completed resident		688			

If continuation sheet Page 37 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		· · /		(X3) DATE SURVEY COMPLETED			
		245453	B. WING		04/26/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LB BRO	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 688	exercises, such as PT-A evaluated R24 R28's upper and lov felt R28's ROM to h extremeties had no left pointer finger ha which she felt was shortening. On 4/26/18, at 1:26 facility did not have scheduled on the u the facility's usual p nursing staff to do e if behind and to get week. TMA-A indic were specially train assistants were trai never completed th the facility. TMA-A nursing staff assiste by helping get resid during breakfast. D the floor and covere the resident's restor and after lunch. TM the week the restor caught up with the n scheduled exercise On 4/26/18, at 1:35 (SC)-A indicated th restorative nursing indicated the facility nursing staff daily. S nursing staff were e catch up to complet program of 3 to 5 til	pain or decreased tolerance. 8 as requested by surveyor to wer body. PT-A indicated she her upper and lower at changed and identified R28's ad a small distal contracture, an arthritic change, not muscle 6 p.m. TMA-A confirmed the restorative nursing staff nit that day. TMA-A indicated oractice was for the restorative extra programs when working caught up by the end of the cated restorative nursing staff ed and not all nursing ined. TMA indicated she had re rehabilitation programs for indicated the restorative ed on the floor in the morning lents up and feed residents During lunch they helped on ed breaks. Staff completed rative programs in the morning MA-A indicated by the end of rative nursing staff usually got resident's rehabilitation	F 688				

Facility ID: 00862

If continuation sheet Page 38 of 47

	RINTED: 05/30/2018 FORM APPROVED MB NO. 0938-0391							
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245453	B. WING	B. WING			04/26/2018	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 688	they usually got cau the usual practice v scheduled daily, ev expectation would b exercises when the On 4/26/18, at 1:44 therapy department set up the restorativ indicated the facility the resident's prima program. DON indi were responsible to residents on their u restorative nursing would expect reside number of days the them. DON confirm exercises 5 times a DON indicated she review the rehab nu exercises were con did not know why R scheduled exercise if the staff were una she would expect the document why the o The facility policy tit Care Policy and Pro instructed the rehab record the completi his/her initials on th Home) Rehab Nurs appropriate date an completed the RA s circle them on the r	ught up then. SC-A indicated was for a restorative aide to be en if working on the floor, the be for them to complete the	F	588				

Facility ID: 00862

If continuation sheet Page 39 of 47

		AND HUMAN SERVICES			FORM	05/30/2018 APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		245453	B. WING _		04/26/2018			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
LB BROE	EN HOME		824 SOUTH SHERIDAN FERGUS FALLS, MN 56537					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 688 F 880 SS=E	ordered. R=Refuse other inability to per further instructed th for follow-up. The p report to the RN UC anticipated inability modalities before th assignments could completion. A facility policy titled Charting Code and dated 9/2003, revea was to record reside care plan. The polic record resident's pa facility Rehab Nursi revealed if a resider perform for three or restorative aid shou coordinator for follor Infection Preventior CFR(s): 483.80(a)(f §483.80 Infection C The facility must es infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infectior program. The facility must es	did not receive the modality ed, U=Unable due to illness or form the tasks. The policy e RA to report to the RN UC policy also indicated the RA to c or charge nurse any to complete ordered he end of the shift so be adjusted to assure d, Restorative Nursing, Reporting Requirements, aled the purpose of the policy ent's compliance with rehab by directed facility staff to articipation and refusals on the ng Care Record. The policy in trefuses or was unable to more scheduled days the lid report to the RN w up. n & Control 1)(2)(4)(e)(f) ontrol tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable ions. n prevention and control tablish an infection prevention n (IPCP) that must include, at	F 68			6/4/18		

Facility ID: 00862

If continuation sheet Page 40 of 47

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245453	B. WING			04/;	26/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 40	F٤	380			
	reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s §483.80(a)(2) Writte procedures for the but are not limited t (i) A system of surv possible communic infections before th persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tr to be followed to pre- (iv)When and how i resident; including the (A) The type and du depending upon the involved, and (B) A requirement the least restrictive pos- circumstances. (v) The circumstance must prohibit emplo disease or infected contact with resider contact will transmi (vi)The hand hygier	d upon the facility assessment ng to §483.70(e) and following standards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a out not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct nts or their food, if direct					

If continuation sheet Page 41 of 47

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE	E SURVEY PLETED
		245453	B. WING		04/2	26/2018
NAME OF I	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE		
LB BROI	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	§483.80(a)(4) A sys identified under the corrective actions ta §483.80(e) Linens. Personnel must hau transport linens so infection. §483.80(f) Annual r The facility will cond IPCP and update th This REQUIREMEN by: Based on observat review, the facility fa laundry was covere contamination for 4 the facility laundry. Findings include: On 4/24/18, at 10:2 North unit, an uncor resident clean folde hall. On 4/25/18, at 8:43 unit an uncovered hanging shirts and stockings and unde observed against a On 4/25/18, at 8:06 North unit a facility metal cart with resid residents, staff and	 Attem for recording incidents facility's IPCP and the facility. Attem by the facility. Andle, store, process, and as to prevent the spread of eview. Attem by the facility is not met as evidenced to an annual review of its heir program, as necessary. AT is not met as evidenced to ensure clean personal d and transported to prevent of 4 resident units served by 7 a.m. on the Second floor vered metal cart which held to clothes was observed in the a.m. on the Third floor North metal laundry cart held dresses and folded pajamas, or clothing on shelves, was wall in the hall way. a.m. on the Second floor staff pushed an uncovered dent personal clothing past 	F 88(All residents on all units have clear personal laundry covered during transportation from the facility laund the unit. Date completed: 6/4/2018 Covers for all personal laundry cart ordered. Date Completed: 5/22/20 Policy and Procedure Standard Precautions: Work Place Controls, Laundry Practices was updated to I.B.1. f. Clean personal laundry sha transported to the units from the fa- laundry in enclosed personal clothin carts. Date Completed: 5/22/2018 Infection Control Committee Depar Surveillance Checklist was updated include: Task Transportation of of personal clothing and Standard of Measure Clean personal clothing transported from the facility laundry nursing units in an enclosed persor clothing cart. Infection Control Committee Departmental Surveillan	dry to s were 18 include: all be cility ng tmental d to clean g is y to the nal	

Facility ID: 00862

PRINTED: 05/30/2018

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			OMB NO.	APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245453	B. WING _	·····	04/2	26/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
LB BRO	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	resident personal c of the facility. The c clothing on hangers clothing, including s pajamas. On 4/26/18, at 8:21 facility practice was laundry uncovered, room to each reside resident unit receiv clothing daily. The c designated spot in indicated the uncov resident clothing re floor staff to return rooms. On 4/26/18, at 8:25 unit, an uncovered hangers and folded observed. On 4/26/18, at 9:25 South unit, two und clothing on hangers shelves were obset dresses, pajamas, garments. On 4/26/18, at 9:14 resident unit had de transport resident p	age 42 by with an uncovered cart of clothing in the basement level cart had a hanging rack of s and shelves with folded stockings, under clothing, and a.m. LS-E verified the usual s to deliver resident personal from the basement laundry ent unit. LS-E indicated each ed a cart with clean resident carts were placed in a a hall on each wing. LS-E vered carts with personal mained in the halls for the the clothing to the resident 6 a.m. on the Third floor North cart with resident clothing on a clothing on shelves was 6 a.m. on the Second floor covered carts with resident s and folded clothing on rved. The carts held shirts, stockings, and under 4 a.m. LS-E identified each esignated laundry carts to bersonal clothing which did not ere not covered in transport.	F 88	Checklist is completed a completed: 5/22/2018 Nursing Care Audit entit Control Laundry Tran 18, was developed and monitoring of delivery of laundry in an enclosed of completed: 5/22/2018 Nursing Care Audit Infer Laundry Transport, BH# completed on all units b then weekly x 4 weeks of audit is completed on an and is included in a qua Care Audit system for e monitor audit findings an follow up of potential co findings are an agenda the Resident Care and of Relations Committee, a the Quality Assessment Committee. Date Comp and ongoing. Nursing Staff meeting, N include review of newly Nursing Care Audit Infer Laundry Transport, upda Precautions: Work Plac Laundry Practices and I Committee Department Checklist Laundry. D 5/30/2018 Education provided to L	led Infection sport, BH# 1299- includes f clean personal cart. Date ction Control f 1299-18, will be y 6/4/2018 and on all units. This n on-going basis rterly Nursing ach unit. DON will nd assure prompt ncerns. Audit item reported to Customer subcommittee of and Assurance oleted: 6/4/2018 May 30, 2018, will developed ction Control ates to Standard e Controls, nfection Control al Surveillance tate completed: aundry staff on	
	Second floor south	and north wings:		Policy and Procedure S Precautions: Work Plac	tandard	

Facility ID: 00862

If continuation sheet Page 43 of 47

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245453	B. WING			04/:	26/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME			-	24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	age 43	F 8	880			
	During observation metal clothes hang wall adjacent from thad clean pants, sh silver metal cart wit the clothes hanging personal articles for bras, socks and parack and the silver containing clean cle prevent contaminat -at 8:44 a.m. on the metal clothes hang the wall adjacent from had clean pants, sh silver metal cart wit next to the clothes clean personal article underwear, bras, so clothing rack and the containing clean cle prevent contaminat -at 9:20 a.m. on the wings the metal clot to be parked next to dining room areas to and jacket hanging shelves was also per hanging racks, which articles folded up for bras, socks and paracks and the silver continued to be uncontamination.	on 4/24/18 at 8:42 a.m., a ing rack was sitting next to the the dining room area, which nirts and jacket hanging on it. A th shelves was parked next to g rack, which contained clean lded up such as underwear, jama's. The metal clothing metal cart with shelf's othes were not covered to tion during transportation. e second floor north wing a ing rack was parked next to om the dining room area which nirts and jacket hanging on it. A th shelves was also parked hanging rack, which contained cles folded up such as ocks and pajama's. The metal ne silver metal cart with shelf othes were not covered to tion during transportation. e second floor south and north othes hanging racks continued o the walls adjacent from the which had clean pants, shirts on it. A silver metal cart with arked next to the clothes ch contained clean personal olded up such as underwear, jama's. The metal clothing r metal carts with shelf			Laundry Practices and requirement resident personal laundry is deliver from the facility laundry to the resid units covered. Date completed: 5/29/2018	ed	

If continuation sheet Page 44 of 47

		AND HUMAN SERVICES			FORM	: 05/30/2018 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245453	B. WING		04/	26/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LB BRO	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	medication aid (TM hanging clothes rac clean clothes down hallway. RN-B and clean clothing to the moved down the ha 9:58 a.m. On 4/24/18 at 9:58 laundry staff brough hanging clothes rac nursing staff to delir every day. TMA-B v never been covered indicated they only transportation to pro During observations laundry staff brough elevator from the bas south wing. The lau clothes hanging rac and jackets hanging from the dining roo laundry staff also bas shelves, which com folded up such as u pajama's and parket against the wall. Th silver metal cart wit clothes were not co contamination durin basement. -at 8:47 a.m. on the metal clothes hanging the wall adjacent fro had clean pants, sh	A)-B began to take the metal ck and the metal cart with the second floor south TMA-B began delivering the e resident rooms as they allway until they were done at a.m. TMA-B confirmed nt the clean linen up on the ck and the metal cart for the ver to the resident rooms verified the clean linen had d as far as she knew and cover the dirty laundry during event contamination. s on 4/25/18 at 8:27 a.m. ht clean laundry off the asement to the second floor undry staff brought a metal ck that had clean pants, shirts g on it and parked in adjacent m area next to the wall. The rought a silver metal cart with tained clean personal articles underwear, bras, socks and ed it next to the clothing rack he metal clothes rack and the th shelf containing clean	F 880			

If continuation sheet Page 45 of 47

		AND HUMAN SERVICES				FORM	05/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245453	B. WING	i		04/;	26/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	clean personal artic underwear, bras, so clothing rack and the containing clean clo prevent contaminat -at 9:47 a.m. licens began to take the m clean clothes down hallway and began the resident rooms hallway with the rac delivering the clothe remained adjacent and was uncovered On 4/26/18, at 8:44 (CM)/infection prev soiled linen and per during transport to CM/IP indicated the the units in covered if the clean items w the resident units. C was transported in residents, staff and clothing should be o the laundry to the u On 4/26/18, at 3:22 (DON) verified the f to be laundered retu- however; the perso facility was not cover laundry room to the indicated the reside the potential to bec	hanging rack, which contained cles folded up such as ocks and pajama's. The metal ne silver metal cart with shelf othes was not covered to ion during transportation. e practical, nurse (LPN)-D netal hanging clothes rack with the second floor south delivering the clean clothing to as she moved down the es while the silver metal cart from the dining room area d. a.m. the clinical manager entionist (IP) indicated all rsonal clothing was covered the basement laundry facility. e facility linens were sent from d carts, however; was unaware ere covered when returned to CM/IP indicated the laundry the elevators used by visitors and agreed clean covered during transport from		380			

Facility ID: 00862

If continuation sheet Page 46 of 47

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	05/30/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245453	B. WING	à		04/	26/2018
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LB BROEN HOME				24 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
residents. The facility policy tit 3/20/16, identified "	ige 46 is with staff visitors and tled Laundry practices revised Linens storage on resident d line carts or closets."	F	880			

Facility ID: 00862

DEPARTMENT OF HEALTH AND HUMAN SERVICES

KI1162221

PRINTED: 05/30/2018 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		75455026		. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245453	B. WING		04	/24/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ε	
LB BROE	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMEN	TS	КO	00		
	FIRE SAFETY Building 1					
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT T	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST MS-2567 WILL BE USED AS F COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN /ITH YOUR VERIFICATION.				
	Minnesota Departu time of this survey found not in comp participation in Me Subpart 483.70(a) 2012 edition of Na Association (NFPA Code (LSC), Chap	e Survey was conducted by the ment of Public Safety. At the Broen Memorial Home was liance with the requirements for dicare/Medicaid at 42 CFR, , Life Safety from Fire, and the tional Fire Protection A) Standard 101, Life Safety oter 19 Existing Health Care on of NFPA 99, Health Care		EDOC		
		the E-POC process, a paper f correction is not required."		EPOC		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (H	OR THE FIRE SAFETY				
	Healthcare Fire In	spections			÷	
ABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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.

CENTERS FOR MEDICARE ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	0938-039 E SURVEY IPLETED	
	245453	B, WING		04/	24/2018	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN FERGUS FALLS, MN 56537				
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defic 2. The actual, or pu 3. The name and/or responsible for comprevent a reoccurr Broen Memorial He partial basement. 3 different times. 1969 and is 2-story was determined to In 1984 a 2- story of the 1969 buildin was determined to This building is sep with a 2-hour fire b addition was built to building is 1-story determined to be T surveyed as one b	Division Suite 145 1-5145, OR state.mn.us n@state.mn.us PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency ome is a 2-story building with a The building was constructed at The Main building was built in ses with a partial basement that be Type II (222) construction. addition was built to the south g, with a partial basement, and be Type II (222) construction. parated from the 1969 building parrier. In 1996 a chapel to the north west of the 1969 without a basement and was Type II (000). The facility was	K 000				

Facility ID: 00862

If continuation sheet Page 2 of 5

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E SURVEY PLETED	
		245453	B. WING	04/	24/2018	
NAME OF I	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
LB BROI	EN HOME		824 SOUTH SHERIDAN FERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
K 293	Standard for Install Systems . The facili with smoke detections system and in the or alarm system is more department notificat accordance with N Alarm Code". The facility has a construction census of 76 at the The requirement at NOT MET as evide Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directionat accordance with 7, also served by the 19.2.10.1 (Indicate N/A in on- with less than 30 of travel is obvious.) This REQUIREME by: Based on observat facility failed to pro- path of egress as in Code NFPA 101 20 This deficient cond	t in accordance with NFPA 13 ation of Automatic Sprinkler lity has a fire alarm system on throughout the corridor common spaces. The fire onitored for automatic fire ation and is installed in FPA 72 "The National Fire apacity of 107 beds and had a e time of the survey. t 42 CFR, Subpart 483.70(a) is	К 000	An Exit Sign will be installed in the 3 North Dining room above the exit leading to the corridor. This deficiency will be corrected by May 31, 2018. Facilities Engineer, is responsible for the correctior and will monitor to prevent the recurrence of this deficiency. Date Completed: 5/31/2018		

Event ID: Q7HK21

Facility ID: 00862

If continuation sheet Page 3 of 5

PRINTED: 05/30/2018

		& MEDICAID SERVICES		DIE CONSTRUCTION	OMB NO. (X3) DATE	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG 01 - MAIN BUILDING 01		PLETED
		245453	B. WING		04/2	4/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
LB BRO	EN HOME			824 SOUTH SHERIDAN FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 293	Continued From pa Findings include:	age 3	K 29)3		
	on 04/24/2018 obs	between 8:00 am to 12:00 pm ervations revealed the 3rd floor door did not have an exit sign				
	Facility Engineer	ition was confirmed by the Maintenance and Testing	K 3	53		6/4/18
	Automatic sprinkle inspected, tested, a with NFPA 25, Star Testing, and Mainta Protection Systems maintenance, insp maintained in a set available.	Maintenance and Testing r and standpipe systems are and maintained in accordance ndard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked				
	b) Who provided					
	Provide in REMAR any non-required of system. 9.7.5, 9.7.7, 9.7.8, This REQUIREME by: Based on observa facility failed to ma accordance with th	KS information on coverage for r partial automatic sprinkler	×	The sprinkler head with pair in the closet of resident roon replaced by contractor NOV Protection, Inc. on May 15th	n 379 was A Fire	

Event ID: Q7HK21

Facility ID: 00862

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES				FORM A	05/30/2018 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245453	B. WING			04/2	4/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME				4 SOUTH SHERIDAN ERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 353	sprinkler system no allow for the spread the 107 residents a of staff and visitors Findings include: On the facility tour on 04/24/2018 obs sprinkler head in th	cient condition could cause the ot to function properly and d of fire. This could affect 28 of and an undetermined amount	K	353	correction and will monitor to preve recurrence of this deficiency. Date Completed: 5/15/2018		
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: Q7HK	21	Fac	cility ID: 00862 If contin	uation she	et Page 5 of :

		AND HUMAN SERVICES	Ŧ5	453026	FORM): 05/30/2018 1 APPROVED): 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCTION IG 05 - FREEZER/HVAC ADDITION		TE SURVEY MPLETED
		245453	B. WING_		04	/24/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LB BRO	EN HOME			824 SOUTH SHERIDAN		
				FERGUS FALLS, MN 56537		(20)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	ГS	K 00	00		
	Building 5					
	Minnesota Departn time of this survey found in complianc participation in Mec Subpart 483.70(a), 2012 edition of Nat Association (NFPA Code (LSC), Chap	Survey was conducted by the nent of Public Safety. At the Broen Memorial Home was e with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety ter 18 New Health Care 012 edition of NFPA 99, Health le.				
	(000) construction includes areas for main kitchen as we There is a 3 hour fi addition from the e At the time of the a	ingle story building of type II and is fully sprinkled. It a cooler and freezer for the ell as a loading dock. ire curtain separating the xisting building. Iddition several HVAC roof top d with the addition of a new unit				
		apacity of 107 beds and had a time of the survey.				
	The requirement a MET:	t 42 CFR, Subpart 483.70(a) is				
ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
	nically Signed					05/23/20

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.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 14, 2018

Ms. Andrea Zeta, Administrator Lb Broen Home 824 South Sheridan Fergus Falls, MN 56537

Re: State Nursing Home Licensing Orders - Project Number S5453029

Dear Ms. Zeta:

The above facility was surveyed on April 23, 2018 through April 26, 2018 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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Lb Broen Home May 14, 2018 Page 2 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 Gail Anderson, Unit Supervisor at (218) 332-5140 or gail.anderson@state.mn.us.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us

cc: Licensing and Certification File

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00862	B. WING		04/2	6/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LB BROI	EN HOME		'H SHERIDA FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf elicensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 05/23/18

6899

If continuation sheet 1 of 45

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00862	B. WING		04/26/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
LB BRO	EN HOME		TH SHERIDAN FALLS, MN 5			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, the corrected prior to e Minnesota Departm On 4/23/18 -4/26/1 Department's staff the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. To assigned to Minnes Nursing Homes.	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading the date your orders will be lectronically submitting to the nent of Health.				
	statute/rule out of of "Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo	compliance is listed in the ent of Deficiencies" column fo Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and				
	FOURTH COLUM "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		00862	B. WING		4/26/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
B BROI	EN HOME		FALLS, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 545	MN Rule 4658.0400 Resident Assessme) Subp. 3 A-C Comprehensive ent; Frequency	2 545		6/4/18
	assessments must A. within 14 day B. within 14 day the resident's physi	cy. Comprehensive resident be conducted: rs after the date of admission; rs after a significant change in cal or mental condition; and every 12 months.			
	by: Based on interview facility failed to com Status Assessment areas of change in the Minimum Data	ent is not met as evidenced and document review, the aplete a Significant Change in (SCSA) when two or more resident status were noted on Set (MDS) for 2 of 3 residents d for a decline in health		Corrected.	
	Findings include:				
	R33's diagnosis of a cognitive impairmen assistance with are staff with bed mobil dressing, personal MDS further identifi	S dated 11/23/17, identified dementia, had severe nt and required extensive as of daily living (ADL)s of one ity, transfers, toileting, hygiene and bathing. The ed R33 had no range of ation of the upper or lower d occasional bowel			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
		00862	B. WING		04/	04/26/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
LB BRO	EN HOME		TH SHERIDAN FALLS, MN 5				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE		
2 545	R33's quarterly MD R33 had severe co total ADL assistance transfers, toileting, and bathing, had lir upper or lower extra of bowel. Review of the abow had a decline in AD extensive assistance assistance of two s limitation to limited upper or lower extra continence from oc of bowel. R59's annual MDS had diagnoses whice disease and demer impairment, require of staff with bed mo eating, toileting, bat incontinence and a indicated no signs of R59's quarterly MD R59 had severe co total ADL assistance transfers, dressing, frequent bladder into of 03, which indicate symptoms of depres	S dated 2/22/18, identified ognitive impairment, required e of two staff with bed mobility dressing, personal hygiene nited ROM of both sides of the emities and always incontinent re assessments indicated R33 DL's performance from ce of one staff to total taff, a decline in ROM from no ROM of both sides of the emities and a decline in bowel casional to always incontinent dated 12/21/17, identified R59 ch included Alzheimer's ntia, had severe cognitive ed extensive ADL assistance obility, transfers, dressing, thing, had occasional bladder PHQ-9 score of 00, which or symptoms of depression.		DEFICIENC	YY)		

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00862	B. WING	B. WING		26/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
B BRO	EN HOME		TH SHERIDAN FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 545	Continued From pa	lge 4	2 545			
	or symptoms of depre	pression to minimal signs and ession.				
	On 4/26/18, at 3:04 p.m. the clinical manager (CM)-B verified she was responsible for completing MDS assessments in the facility. CM-B verified the above findings and indicated both R33 and R59 should have been reviewed for a significant change.					
	(DON) indicated the alerts to indicate a resident's abilities. protocol was to follo instrument (RAI) m	p.m. the director of nursing e facilities MDS program had decline or improvement in the The DON indicated the facility ow the resident assessment anual and expected R33 and een reviewed for a significant				
	10/2010, identified I. Documentation of every shift for all re Electronic Docume A. Team leaders support to ensure the Documentation id of timely manner. B. Direct care states shall promptly comp documentation throw C. Point of Care	of ADL function is completed sidents on Point of Care ntation. will provide direction and hat Point of Care completed in an accurate and aff assigned to the resident plete Point of Care				
	Manuel dated 10/20 following: A significant change	d forms printed from their RAI 017, which identified the e is a major decline or esident's status that:				

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00862	B. WING		04/	04/26/2018	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
B BRO	EN HOME		TH SHERIDAN FALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 545	Continued From pa	ge 5	2 545				
	intervention by staff disease-related clin is not considered se 2. Impacts more the alth status; and	than one area of the resident's sciplinary review and/or					
	administrator, direc designee could revi procedures for com assessments. Nurs necessary to the im comprehensive ass	HOD OF CORRECTION: The tor of nursing (DON) or iew and revise policies and prehensive significant change ing staff could be educated as portance of significant change sessments. The DON or nduct audits on a regular basis ce.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one					
2 895	MN Rule 4658.0528 Motion	5 Subp. 2.B Rehab - Range of	2 895			6/4/18	
	that is directed towa through positioning implemented and m comprehensive res of nursing services	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which					
	receives appropriat	h a limited range of motion e treatment and services to notion and to prevent further of motion.					

Minnesc	nesota Department of Health	alth			-	_
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		00862	B. WING		04/2	6/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LB BRO	EN HOME		TH SHERIDA FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 6	2 895			
	by: Based on observati review the facility fa restorative exercise and R31) reviewed program. In addition range of motion set (R28) who were review motion. Findings include: R67's quarterly Min 3/29/18, indicated F impairment, had dia heart dysrythmia an The MDS identified	ent is not met as evidenced on, interview and document illed to routinely provide es for 2 of 3 residents (R67 with a restorative nursing on the facility failed to provide vices for 1 of 2 residents riewed for limited range of imum Data Set (MDS) dated R67 had moderate cognitive agnoses included anemia, and end stage renal disease. R67 required total staff activities of daily living (ADL's).		Corrected.		
	assist him to stand offered and if it was R67 indicated the w stand if he was not enough. R67's care plan rev had an ADL self car (related to) disease	a.m. R67 stated staff were to but this service was not being a, it was only for a short time. vorry of no longer being able to allowed to stand often or long rised 4/12/18, indicated R67 re performance deficit r/t process, limited mobility and identified a restorative				
Minnesota D	program was in pla A facility document Communication, da following:					
STATE FOR	•		6899 (Q7HK11	If continuati	on sheet 7 of 45

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00862	B. WING		04/	04/26/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
LB BROI	EN HOME		TH SHERIDAN FALLS, MN 5				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLET DATE		
2 895	Continued From pa	age 7	2 895				
	as pt. (patient). Suggested approad with FWW (front w belt, CGA (Contact elevated bed. Stan time 3x per week. On 4/25/18, at 11:1 his room seated or chair leaning back chair. R67 informe was sliding out of th help to scoot back a EZ stand lift (me position), NA-C sto to sit farther back of On 4/25/18, at 11:5 wheel chair to the of On 4/26/18, at 9:4	8 a.m. R 67 participated with ead by the activity staff, in the					
	R67 to stand by the shoes on, gait belt,	ders signed 4/12/18, directed e edge of the bed: with FWW, CGA from elevated bed. lents tolerance, one time a day					
	identified the follow edge of bed: with F	untitled and undated form ving: [R67] 3x/wk stand by WW, shoes on, gait belt, d bed. Stand time to residents					
	Record dated April	ty form titled Rehab Nursing 2018, lacked documentation on or refusal of the sit to stand					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00862	B. WING	B. WING		26/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	1 • ··	
B BRO	EN HOME		TH SHERIDAN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 895	Continued From pa	age 8	2 895			
		otion of 4/11/18, which am had been completed on				
	Review of R67's nursing progress notes 1/26/18, through 4/26/18, lacked any notation of R67's restorative nursing program participation or referral.					
	indicated a binder w all resident restorat indicated R67 want and was seen by th was not able to wal but was able to sta by the bed with a w CM-B verified a not programs be provid assistant. CM-B in	a.m. clinical manager (CM)-B was available with direction for tive nursing programs. CM-B ted to regain the ability to walk herapy. CM-B indicated R67 k after therapy was completed and and the program to stand valker and staff was started. te in the binder directed R67's ded by a specific nursing dicated often on dialysis days participate in the sit to stand				
	had not completed NA-C verified the or restorative binder in program was only of	2 a.m. NA-C indicated he/she R67's restorative programs. documentation in the ndicated the sit to stand completed on the 11th. NA-C n was supposed to be nes a week.				
	was responsibile to program. NA-B indi participate with the	i1 a.m. NA-B indicated he/she provide R67's restorative icated if R67 did not restorative sit to stand buld inform the nurse and the				
		6 a.m. licensed practical icated refusals to participate				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00862	B. WING		04/26/20	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LB BRO	EN HOME		TH SHERIDAN FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 895	Continued From pa	age 9	2 895			
	reported to her, how	nursing program would be wever; NA-B would also report estorative aid who would be ument the refusal.				
	indicated she exper reason residents di services (for examp illness). CM-A indic	2 a.m. clinical manager (CM)A cted staff to document the d not receive the rehab ble because of refusals or cated she did not review the documentation throughout the				
	stand lift belt aroun belt loops to the ho the assistance of th R67 onto the bed. I R67's waist and wit walker, R67 stood t and then sat down.	9 p.m. NA-B placed the EZ d R67's back, attached the lift oks on the lift, stood R67 with he EZ stand and transferred NA-B placed a gait belt around th CGA and the use of a from the bed for two minutes R67 stood and sat a total of ime standing between two conds.				
	(DON) indicated sh restorative nursing by therapy to maint DON indicated doc completed whether completed. If the re completed, the clir informed. The DON	e p.m. the director of nursing the expected staff to follow the programs as they were set up thain strength and ability. The umentation should have been or not the program was estorative program was not hical manager should be N indicated communication order to ensure the program dered.				
magazia D	R31 was cognitively	DS, dated 2/16/18, identified y intact and had diagnoses ression, anxiety, obesity and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00862	B. WING		04/	04/26/2018	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
.B BROI	EN HOME		TH SHERIDAN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 895	hypertension. The I extensive assistance (ADL's) which inclu and walking with as The MDS revealed his balance without impairments of his had received five d (PT) and occupatio during the seven da R31's admission Ca dated 2/16/18, iden assistance with AD identified R31 had a services with the go independence and his strength. R31's 14-day prosp MDS dated 2/22/18 extensive assistance mobility and transfe had ambulated less seven day look bac identified R31 recei five out of seven d R31's care plan dat required assistance transfers with one a walker and transfer directed facility staf	MDS identified R31 required ce with activities of daily living ded bed mobility, transfers asistance of two facility staff. R31 was not able to maintain a staff assistance, had no range of motion (ROM) and ays of both physical therapy nal therapy (OT) services ay look back period. are Area Assessment (CAA) tified R31 required extensive L's including walking. The CAA received both OT and PT bal to improve his to prevent further decline in pective payment system (PPS) by identified R31 required ce with ADL's including bed ars. The MDS identified R31 is than three times within the sk period. The MDS further ived both PT and OT services					

STATEMEN	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	EN HOME		TH SHERIDAN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 895	Continued From pa	ige 11	2 895			
	NuStep then let res supervision and aic the machine, one ti or as resident tolera R31's physician orc	as tolerated, may set up ident use machine with I for safety getting off and on me a day for five times a week ated. ders revealed an order dated or supine arm exercises with	¢			
	four pound weight to band used for stren extension, abduction flexion/extension, or	bar or green Thera band (large ngthening) shoulder flexion, on/adduction and elbow one set for 20 repetitions, one es a week as resident	•			
	instructions dated assist of one with tr instructions directed facility restorative n NuStep machine ar with meals with a for belt. The discharge ambulated up to 90	by discharge plan and B/2/18, revealed R31 was ransfers and ambulation. The d R31 was to be added to the pursing program with the nd nursing staff to ambulate our wheeled walker and a gait e plan revealed R31 had 0 feet with a four wheeled of discharge from skilled				
	walk with the facility the facility and had to meals, though st him recently. R31 s exercise with facility machine (exercise stated facility staff of with him and did no exercises, such as exercises. R31 stat have time to help h	a.m. R31 stated he used to y staff when he first came to periodically walked with staff aff had not offered to walk with stated he was also supposed to y staff and use the NuStep machine) 5 days a week. He did not routinely offer to walk ot routinely offer any other the NuStep machine or arm ted he felt facility staff did not im with his walking or ed he would like to walk so he				

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
EN HOME					
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 12	2 895			
could get stronger a walk at that time.	and felt he was not able to				
wheelchair, wheeled by NA-B back to his room. NA-B was not observed to offer R31 assistance					
wheelchair and was room by NA-C to hi	s wheeled out of the dining is room. R31's front wheeled				
not offered R31 to a She stated R31 had ambulate and indic restorative program and the NuStep. No were times when sh	ambulate to the noon meal. d a history of refusing to ated R31 would also refuse his n which included arm exercises A-C further indicated there he felt it was challenging to				
assistant (TMA)-As with R31 since he h from the short term month ago. TMA-A ambulate and comp would inform the lic TMA-A further state most recent time sh	stated she had not ambulated nad transferred to the 3rd floor stay unit, approximately a stated R31 would refuse to plete exercises and stated she censed nurse of R31's refusals ed she could not recall the he had offered to assist R31				
	OF CORRECTION PROVIDER OR SUPPLIER EN HOME SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From particular could get stronger walk at that time. On 4/25/18, R31 w wheeled by nursing room. On 4/25/18, at 8:48 wheelchair, wheele NA-B was not observed with ambulation. On 4/25/18, at 12:0 wheelchair and wat room by NA-C to him walker was in his room On 4/25/18, at 12:0 wheelchair and wat room by NA-C to him walker was in his room On 4/25/18, at 12:0 wheelchair and wat room by NA-C to him walker was in his room On 4/25/18, at 12:0 wheelchair and wat room by NA-C to him walker was in his room On 4/25/18, at 12:0 wheelchair and mat restorative program and the NuStep. Na were times when s assist R31 with his staffing shortages. On 4/25/18, at 12:1 assistant (TMA)-A with R31 since he him from the short term month ago. TMA-A ambulate and com would inform the life TMA-A further state most recent time short	OF CORRECTION IDENTIFICATION NUMBER: 00862 PROVIDER OR SUPPLIER STREET AI 824 SOU FERGUS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 could get stronger and felt he was not able to walk at that time. On 4/25/18, R31 was seated in a wheelchair, wheeled by nursing assistant (NA)-B to the dining room. On 4/25/18, at 8:48 a.m. R31 was seated in a wheelchair, wheeled by NA-B back to his room. NA-B was not observed to offer R31 assistance with ambulation. On 4/25/18, at 12:00 p.m. R31 was seated in a wheelchair and was wheeled out of the dining room by NA-C to his room. R31's front wheeled walker was in his room, at the end of his bed. On 4/25/18, at 12:04 p.m. NA-C stated she had not offered R31 to ambulate to the noon meal. She stated R31 had a history of refusing to ambulate and indicated R31 would also refuse his restorative program which included arm exercises and the NuStep. NA-C further indicated there were times when she felt it was challenging to assist R31 with his restorative program due to staffing shortages. On 4/25/18, at 12:15 p.m. trained medical assistant (TMA)-A stated she had not ambulated with R31 since he had transferred to the 3rd floor from the short term stay unit, approximately a month ago. TMA-A stated R31 would refuse to ambulate and complete exercises and stated she would inform the licensed nurse of R31's refusals TMA-A further stated she could not recall the most recent time she had offered to assist R31 with his range of motion (ROM) or NuStep	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00862 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 12 2 895 could get stronger and felt he was not able to walk at that time. 2 895 On 4/25/18, R13 was seated in a wheelchair, wheeled by nursing assistant (NA)-B to the dining room. 2 895 On 4/25/18, at 8:48 a.m. R31 was seated in a wheelchair, wheeled by NA-B back to his room. NA-B was not observed to offer R31 assistance with ambulation. On 4/25/18, at 12:00 p.m. R31 was seated in a wheelchair and was wheeled out of the dining room by NA-C to his room. R31's front wheeled walker was in his room, at the end of his bed. On 4/25/18, at 12:04 p.m. NA-C stated she had not offered R31 had a history of refusing to ambulate and indicated R31 would also refuse his restorative program which included arm exercises and the NuStep. 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TMA-A further stated she could not recall the most recent time she had offered to assist R31 with his range of motion (ROM) or NUSEp	OF CORRECTION IDENTIFICATION NUMBER: A BULDING: 004/ 00962 B. WING 04/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE. ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES B24 SOUTH SHERIDAN FEGUS FALLS, MN 56537 FROM DEFICIENCY MUST BE PRECEDED BY FULL PREPRIX Continued From page 12 2 895 CROSS-REFERENCED TO THE APPROPRIATE Cond 4/25/18, R31 was seated in a wheelchair, wheeled by nursing assistant (NA)-B to the dining room. 0 4/25/18, at 8:48 a.m. R31 was seated in a wheelchair, wheeled by NA-B back to his room. NA + Was not observed to offer R31 assistance with ambulation. 0 n 4/25/18, at 12:00 p.m. R31 was seated in a wheelchair and was wheeled out of the dining room by NA-C to his room. R31's front wheeled with ambulation. On 4/25/18, at 12:00 p.m. R31 was seated in a wheelchair and was wheeled out of the dining room by NA-C to his room. 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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED
		00862	B. WING		04/2	26/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	EN HOME	824 SOU ⁻	TH SHERIDAN	1		
		FERGUS	FALLS, MN 5	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ge 13	2 895			
	himself with both of feet. At that time N	ning room and had propelled his feet approximately 30 A-B offered to wheel R31 back did not offer to ambulate with				
	On 4/25/18, at 2:26 p.m. R31 stated he had not been asked or offered by facility staff to walk to either breakfast of the noon meal that day, nor the day prior. R31 stated he felt he had declined in his ability to ambulate and had overall weakened.					
	Review of R31's rel 3/3/18, to 4/26/18, r	hab nursing record from revealed:				
	machine 4 times, h	nad completed the NuStep ad refused one time out of 28 record revealed R31 had not rcises.				
	machine 3 times, h	d completed the NuStep ad refused one time out of 26 record revealed R31 had rcises once.				
	program was review manager (NM)-B. N routinely received h routine basis. NM-E record lacked docu to and from meals. formal program for would not be docum	a.m. R31's restorative wed with registered nursing IM-S confirmed R31's had not is restorative program on a 3 confirmed R31's medical mentation of R31's ambulation She stated there was no R31's ambulation, therefore nented in the restorative				
	ambulate with R31, received training in included ROM and	d any nursing staff could however different NA's had restorative programs, which the NuStep machine. Further, 1's medical record lacked				

STATEMENT OF DEFICIENCIES (X* AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00862	B. WING		04/26/2018	
			DDRESS, CITY, ST	ATE, ZIP CODE		
B BROE	N HOME		TH SHERIDAN FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	age 14	2 895			
	nursing staff and di	R31 refusing to ambulate with id not routinely reveal R31's ive nursing program.				
	On 4/26/18, at 8:42 a.m. R31 was seated in a wheelchair in the hallway. NA-B wheeled R31 part way down the hall to his room. R31 then propelled himself the rest of the way to his room, approximately 30 feet. On 4/26/18, at 8:44 a.m. R31 was offered to walk with the physical therapist (PT) R31 stated he did not feel he would be able to walk with therapy and declined to have PT assess his current ability to ambulate. R31 further stated he felt he needed to use the NuStep for a few days first in order to loosen up.		t			
			1			
	occasionally use th refused to ambulat recall the last time	a.m. NA-B stated R31 would the NuStep and had routinely e. NA-B stated he could not he had offered to walk with ad he felt R31 had declined in he last month.				
	received skilled PT 3/2/18. PT-A stated the facility restorati were to assist R31 with a front wheele time of discharge fr able to ambulate, v	5 a.m. PT-A confirmed R31 had services from 2/9/18, to d she had discharged R31 to ve program, and nursing staff to ambulate to and from meals d walker. PT-A stated at the rom skilled therapy R31 was with breaks, to and from meals erate daily exercises with the				
	(DON) stated she water to walk to and from	9 p.m. the director of nursing would expect R31 to be offered meals, assist with the NuStep exercises. She stated she				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00862	B. WING		04/26/2018	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
B BROB	EN HOME		TH SHERIDAN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	FALLS, MN 5	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 895	Continued From pa	ige 15	2 895			
	restorative nursing would expect to be	had not routinely received services and indicated she informed if staff were having ffering restorative services.				
	R28					
	had diagnosis whic hemiparesis (paraly body), arthritis and further identified R2 with ADLs and had on one side. R28's	28's annual MDS dated 2/15/18, indicated R28 ad diagnosis which included hemiplegia or emiparesis (paralysis of one entire side of the ody), arthritis and seizure disorder. R28's MDS in ther identified R28 required total assistance ith ADLs and had range of motion impairment n one side. R28's quarterly MDS identified R28 ad diagnosis of Cerebral Vascular Accident CVA) (stroke).				
	R28 had an ADL se (related to) Stroke. interventions which	t revised 2/26/18, indicated elf care performance deficit r/t Interventions included rehab instructed staff to see rehab ecommendations in chart.				
	bed in her room on was elevated, and a was covered by her hand was observed	p.m. R28 was lying on her her back. Her head of bed she wore pink pajamas and r sheet and blanket. Her left d resting on her left side, on a ers were curled into a loose				
	her recliner in her r and her eyes were	a.m. R28 was observed in oom. Her feet were elevated closed. R28's left hand was and her fingers were curled				
	recliner in her room	a.m. R28 was sitting in her with her eyes closed and her was dressed and had her left				

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00862		B. WING		04/26/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LB BRO	EN HOME		TH SHERIDAN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 895	Continued From pa	age 16	2 895			
	hand resting on a p curled into a loose	illow. Her left fingers were fist.				
	required total assis indicated the facility performed the reha	37 a.m. NA-A indicated R28 tance with all her cares. NA-A y had rehabilitation staff who abilitation nursing program. rehabilitation staff tried to am daily.				
	orders for PROM to one time a day for 3/31/17. R28's ord lower extremities 1 (bending movemer from body) /adduct knee flexion/extens Ankle Planter flexio /dorsi flexion (move (inversion-tilt towar	ders signed 3/13/18 included b bilateral upper extremities 5 times a week, initiated on lers also included PROM to time/ times 10; hip flexion nt), abduction (movement away ion (movement toward body), sion (straightening movement). on (movement downward) ement of the foot upward), IV ds the body)/EV (eversion-tilt y). One time a day for 5 times				
	care (evaluation or physician 3/30/17, discharged to the s	itled physical therapy plan of ly) dated 3/27/17, signed by identified R28 was to be same SNF (skilled nursing habilitation nursing program).				
	of care (evaluation physician 3/30/17, discharged to the s	itled occupational therapy plan only) dated 3/28/17, signed by identified R28 was to be same SNF, and R28 was P of UE (upper extremity)				
	Communication, da	itled Therapy to Nursing ated 3/28/17, signed 3/30/17, dinator included R28's goal				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00862		B. WING		04/26/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
	EN HOME		TH SHERIDAN			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET DATE
2 895	Continued From pa	age 17	2 895			
	contracture prevent LE ROM 5 times a Suggested approad and PROM 1 x 10 H adduction, knee fle (plantar flexion)/ DF R28's Rehab Nursi 4/26/18, all included bilateral upper extra X/week, start date 3 extremities; 1 x 10 abduction/adductio Ankle Planter flexio time a day for 5 x /w Review of R28's R	n, knee flexion/extension. m/dorsi flexion, IV/EV. One				
	following: -11/1/17, to 11/30/1	7, R28 received UE PROM PROM exercises 6 days out of				
		17, R28 received UE PROM PROM exercises 7 days out of				
		R28 received UE PROM PROM exercises 11 days out o	f			
		R28 received UE PROM PROM exercises 11 days out o	f			
		R28 received UE PROM PROM exercises 4 days out of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
00862		00862	B. WING		04/26/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LB BRO	EN HOME		TH SHERIDAN FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	age 18	2 895			
		-4/1/18, to 4/26/18, R28 received UE PROM exercises and LE PROM exercises 3 days out of 20 opportunities.				
	R28's medical record lacked documentation why multiple days the exercises were not completed.					
	On 4/26/18, at 12:55 p.m. CM-A indicated R28 had a PROM rehab program for both upper and lower extremities. CM-A verified R28's medical records indicated R28 was to receive the PROM exercises 5 times a week. CM-A indicated the therapy department completed resident evaluations then set up the residents rehabilitation nursing programs. CM-A confirmed R28's nursing rehabilitation program began 3/30/17. CM-A indicated if problems would arise with a resident's rehabilitation program the clinical managers talked to the restorative staff, and if needed would discuss with the therapists or the resident's primary care physician for new orders for treatment if needed. CM-A confirmed R28 had not received PROM exercises 5 times a week as ordered and felt it was due to staffing concerns. She explained an example of a restorative aide moved to the floor to work as a nursing assistant if call-ins were made by staff. CM-A indicated the risk of not receiving PROM exercises as ordered may decrease R28's ROM.		1			
	indicated the facility restorative nursing staff educating the and ROM exercises expect R28 to rece	7 p.m. physical therapist (PT)-A y's usual practice for the program began with therapy nursing staff for the program s. PT-A indicated she would ive the exercises 5 times a PT-A indicated she would				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00862		B. WING		04/26/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	EN HOME		TH SHERIDAN			
		FERGUS	FALLS, MN 5	6537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ge 19	2 895			
	PT-A evaluated R24 R28's upper and low felt R28's ROM to h extremeties had no left pointer finger has which she felt was a shortening. On 4/26/18, at 1:26 facility did not have scheduled on the u the facility's usual p nursing staff to do e if behind and to get week. TMA-A indic were specially train assistants were train never completed th the facility. TMA-A nursing staff assisted by helping get resided during breakfast. D the floor and coveres the resident's restor and after lunch. TM the week the restor caught up with the function scheduled exercise	t changed and identified R28's ad a small distal contracture, an arthritic change, not muscle p.m. TMA-A confirmed the restorative nursing staff nit that day. TMA-A indicated practice was for the restorative extra programs when working caught up by the end of the sated restorative nursing staff ed and not all nursing ined. TMA indicated she had e rehabilitation programs for indicated the restorative ed on the floor in the morning lents up and feed residents During lunch they helped on ed breaks. Staff completed rative programs in the morning MA-A indicated by the end of rative nursing staff usually got resident's rehabilitation ps.				
	(SC)-A indicated th restorative nursing indicated the facility nursing staff daily. S nursing staff were e catch up to complete	p.m. staffing coordinator he facility did not schedule every day for every unit. SC-A / scheduled 0-3 restorative SC-A indicated the restorative expected to work ahead or te a resident's exercise				
	more staff were sch	mes a week. SC-A indicated neduled on the weekends, and ught up then. SC-A indicated				

		alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00862	B. WING		04/	26/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
			TH SHERIDAN			
LB BRO	EN HOME		FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 895	Continued From pa	ge 20	2 895			
	the usual practice was for a restorative aide to be scheduled daily, even if working on the floor, the expectation would be for them to complete the exercises when they had time.					
	scheduled daily, even if working on the floor, the expectation would be for them to complete the	t completed evaluations and ve nursing program. DON v then obtained orders from any physician for the restorative icated the clinical managers o over see the cares for the nit, which included the programs. DON indicated she ents to receive exercises the y were ordered to receive ned R28 had not received a week as ordered in April. would expect the CM to ursing records to assure the npleted. DON indicated she 28 had not been receiving her s as ordered. DON indicated able to perform the exercises nem to report to the NM and				
	Care Policy and Pro instructed the rehat record the completi his/her initials on th Home) Rehab Nurs appropriate date ar completed the RA s	ted Rehabilitative Nursing becedure, revised 10/86, bilitation assistant (RA) shall on of modalities by entering e BMH (Broen Memorial sing Care Record in the ad time position. If it was not shall enter their initials and record in the appropriate date with a letter indicating the				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	- (X3) DATE SURVEY COMPLETED	
		00862	B. WING		04/	26/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
B BROI	EN HOME		ITH SHERIDAN FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ige 21	2 895			
	further instructed th for follow-up. The report to the RN UC anticipated inability modalities before th assignments could completion. A facility policy titled Charting Code and dated 9/2003, reve- was to record resid care plan. The polic record resident's pa facility Rehab Nurs revealed if a reside perform for three o restorative aid show					
	The director of nurs educate responsibl restorative nursing comprehensively as designee could cor	THOD OF CORRECTION: sing and/or designee could e staff to provide a resident program, based on residents' ssessed needs. The DON or nduct audits of the restorative ensure the residents				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 915	MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915			6/4/18
	comprehensive res home must ensure	of daily living. Based on the ident assessment, a nursing that: given the appropriate				

STATE FORM

STATEMEN	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMPI	
		00862	B. WING		04/26/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LB BRO	EN HOME		H SHERIDA			
	1		FALLS, MN	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLET DATE
2 915	Continued From pa	ge 22	2 915			
	abilities in activities deterioration is a not the resident's condi part, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech	ss, and groom; d ambulate;				
	by: Based on observati review, the facility for recommendations a ambulation services	ent is not met as evidenced on, interview and document ailed to implement therapy and routinely provide s to maintain function for 1 of 1 ewed for ambulation.		Corrected.		
	2/16/18, identified F had diagnoses which anxiety, obesity and identified R31 requi activities of daily live bed mobility, transfe assistance of two fa R31 was not able to staff assistance, ha of motion (ROM) ar both physical therap	inimum Data Set (MDS) dated R31 was cognitively intact and ch included depression, d hypertension. The MDS ired extensive assistance with ing (ADL's) which included ers and walking with acility staff. The MDS revealed o maintain his balance without d no impairments of his range nd had received five days of oy (PT) and occupational es during the seven day look				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00862	B. WING		04/2	26/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LB BRO	EN HOME		TH SHERIDAN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	age 23	2 915			
	back period.					
	dated 2/16/18, ider assistance with AD identified R31 had services with the g	are Area Assessment (CAA) ntified R31 required extensive L's including walking. The CAA received both OT and PT oal to improve his to prevent further decline in	A			
	MDS dated 2/22/18 extensive assistant mobility and transfe had ambulated less seven day look bac	bective payment system (PPS) 3, identified R31 required ce with ADL's including bed ers. The MDS identified R31 s than three times within the ck period. The MDS further ived both PT and OT services lays.				
	required assistance transfers with one a walker and transfer facility staff to enco assist R31 to ambu behind. The care p to encourage R31 to promoted exercise strengthening and	vised 4/13/18, revealed R31 e from staff with bed mobility, assist and ambulation with a r belt. The care plan directed burage R31 to ambulate and to ulate with a wheelchair to follow lan further directed facility staff to participate in activities that , physical activity for improved mobility such as: ance, using NuStep.	v			
	instructions dated assist of one with the instructions directe with meals with a fee belt. R31 was to be restorative nursing	py discharge plan and 3/2/18, revealed R31 was ransfers and ambulation. The d nursing staff to ambulate our wheeled walker and a gait added to the facility program with the NuStep harge plan revealed R31 had				

(EACH DEFICIENC) REGULATORY OR L Continued From pa ambulated up to 90	824 SOU FERGUS TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	B. WING DDRESS, CITY, ST TH SHERIDAN FALLS, MN 5 PREFIX TAG 2 915	l .	ORRECTION ON SHOULD BE E APPROPRIATE	26/2018 (X5) COMPLETE DATE
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa ambulated up to 90 walked at the time	824 SOU FERGUS	TH SHERIDAN FALLS, MN 5 ID PREFIX TAG	6537 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	COMPLET
SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa ambulated up to 90 walked at the time	FERGUS	FALLS, MN 5	6537 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	COMPLET
SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa ambulated up to 90 walked at the time	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Ige 24 I feet with a four wheeled	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	COMPLET
(EACH DEFICIENCY REGULATORY OR L Continued From pa ambulated up to 90 walked at the time	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) uge 24 I feet with a four wheeled	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	COMPLET
ambulated up to 90 walked at the time	feet with a four wheeled	2 915			DATE
walked at the time					
walk with the facility the facility and had to meals, though st him recently. R31 s exercise with facility machine (exercise stated facility staff of with him and did no exercises, such as stated he felt facility help him with his w he would like to wa and felt he was not	periodically walked with staff aff had not offered to walk with stated he was also supposed to y staff and use the NuStep machine) 5 days a week. He did not routinely offer to walk of routinely offer any other the NuStep machine. R31 y staff did not have time to alking or exercises. He stated lk so he could get stronger able to walk at that time.				
wheelchair, wheele	d by NA-B back to his room.				
wheelchair and was room by NA-C to hi	s wheeled out of the dining s room. R31's front wheeled				
not offered R31 to a She indicated she f refusing to ambulat also refuse his rest	ambulate to the noon meal. elt R31 had a history of te and indicated R31 would orative program. NA-C further				
	the facility and had to meals, though st nim recently. R31 s exercise with facility machine (exercise stated facility staff of with him and did no exercises, such as stated he felt facility nelp him with his w ne would like to wa and felt he was not On 4/25/18, at 7:18 wheelchair, wheele to the dining room. On 4/25/18, at 8:48 wheelchair, wheele NA-B was not obse with ambulation. On 4/25/18, at 12:0 wheelchair and was room by NA-C to hi walker was in his ro On 4/25/18, at 12:0 not offered R31 to a She indicated she f refusing to ambulat also refuse his rest ndicated there wer	him recently. R31 stated he was also supposed to exercise with facility staff and use the NuStep machine (exercise machine) 5 days a week. He stated facility staff did not routinely offer to walk with him and did not routinely offer any other exercises, such as the NuStep machine. R31 stated he felt facility staff did not have time to help him with his walking or exercises. He stated he would like to walk so he could get stronger and felt he was not able to walk at that time. On 4/25/18, at 7:18 a.m. R31 was seated in a wheelchair, wheeled by nursing assistant (NA)-B to the dining room. On 4/25/18, at 8:48 a.m. R31 was seated in a wheelchair, wheeled by NA-B back to his room. NA-B was not observed to offer R31 assistance with ambulation. On 4/25/18, at 12:00 p.m. R31 was seated in a wheelchair and was wheeled out of the dining room by NA-C to his room. R31's front wheeled walker was in his room, at the end of his bed. On 4/25/18, at 12:04 p.m. NA-C stated she had not offered R31 to ambulate to the noon meal. She indicated she felt R31 had a history of refusing to ambulate and indicated R31 would also refuse his restorative program. NA-C further ndicated there were times when she felt it was challenging to assist R31 with his restorative	the facility and had periodically walked with staff to meals, though staff had not offered to walk with him recently. R31 stated he was also supposed to exercise with facility staff and use the NuStep machine (exercise machine) 5 days a week. He stated facility staff did not routinely offer to walk with him and did not routinely offer any other exercises, such as the NuStep machine. R31 stated he felt facility staff did not have time to help him with his walking or exercises. He stated he would like to walk so he could get stronger and felt he was not able to walk at that time. On 4/25/18, at 7:18 a.m. R31 was seated in a wheelchair, wheeled by nursing assistant (NA)-B to the dining room. On 4/25/18, at 8:48 a.m. R31 was seated in a wheelchair, wheeled by NA-B back to his room. NA-B was not observed to offer R31 assistance with ambulation. On 4/25/18, at 12:00 p.m. R31 was seated in a wheelchair and was wheeled out of the dining room by NA-C to his room. R31's front wheeled walker was in his room, at the end of his bed. 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STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00862	 В. WING	B. WING		04/26/2018	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
B BROI	EN HOME		TH SHERIDAN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From pa	age 25	2 915				
	program due to sta	ffing shortages.					
	assistant (TMA)-A with R31 since he h from the short term month ago. TMA-A ambulate and com would inform the lid TMA-A further state most recent time sl with his range of m exercises. On 4/25/18, at 12:3 wheelchair in the d himself with both o feet. At that time N	15 p.m. trained medical stated she had not ambulated had transferred to the 3rd floor in stay unit, approximately a stated R31 would refuse to plete exercises and stated she censed nurse of R31's refusals ed she could not recall the he had offered to assist R31 otion (ROM) or NuStep B6 p.m R31 was seated in a ining room and had propelled f his feet approximately 30 A-B offered to wheel R31 back did not offer to ambulate with					
	been asked or offe either breakfast of the day prior. R31 s in his ability to amb weakened.	5 p.m. R31 stated he had not red by facility staff to walk to the noon meal that day, nor stated he felt he had declined bulate and had overall					
	Review of R31's re 3/3/18, to 4/26/18,	hab nursing record from revealed:					
	machine 4 times, h	had completed the NuStep ad refused one time out of 28 record revealed R31 had not rcises.					
	machine 3 times, h	ad completed the NuStep ad refused one time out of 26 record revealed R31 had rcises once.					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00862	B. WING		04/	26/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST			
B BROI	EN HOME		TH SHERIDAN FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	age 26	2 915			
	R31's rehab nursing record lacked documentation of R31's ambulation to and from meals.		1			
	program was review manager (NM)-B. N routinely received h routine basis. NM-E record lacked docu to and from meals. formal program for would not be docur record. NM-B state ambulate with R31, received training in included ROM and confirmed R31's m documentation of F nursing staff and di	a.m. R31's restorative wed with registered nursing VM-S confirmed R31's had not his restorative program on a 3 confirmed R31's medical mentation of R31's ambulation She stated there was no R31's ambulation, therefore mented in the restorative d any nursing staff could , however different NA's had restorative programs, which the NuStep machine. NS-B edical record lacked R31 refusing to ambulate with id not routinely reveal R31's ive nursing program.				
	wheelchair in the hall t	2 a.m. R31 was seated in a allway. NA-B wheeled R31 part to his room. R31 then he rest of the way to his room, eet.	t			
	with the physical th not feel he would b declined to have P ⁻ ambulate. R31 furth	a.m. R31 was offered to walk erapist (PT). R31 stated he did e able to walk with therapy and T assess his current ability to her stated he felt he needed to a few days first in order to				
	occasionally use th	a.m. NA-B stated R31 would e NuStep and had routinely e. NA-B stated he could not				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00862	B. WING		04/	26/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
B BRO	EN HOME		TH SHERIDAN FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	ge 27	2 915			
	recall the last time he had offered to walk with R31. NA-B indicated he felt R31 had declined in his mobility within the last month. On 4/26/18, at 9:35 a.m. PT-A confirmed R31 had received skilled PT services from 2/9/18, to 3/2/18. PT-A stated she had discharged R31 to the facility restorative program, and nursing staff were to assist R31 to ambulate to and from meals with a front wheeled walker. PT-A stated at the time of discharge from skilled therapy, R31 was able to ambulate, with breaks, to and from meals and was able to tolerate daily exercises with the NuStep machine.					
	(DON) stated she w to walk to and from machine and ROM was not aware R31 restorative nursing would expect to be	p.m. the director of nursing vould expect R31 to be offered meals, assist with the NuStep exercises. She stated she had not routinely received services and indicated she informed if staff were having ffering restorative services.				
	Charting Code and dated 9/2003, revea was to record resid care plan. The polic record resident's pa facility Rehab Nursi revealed if a reside					
	The director of nurse educate responsible	HOD OF CORRECTION: sing and/or designee could e staff to provide care to nt on facility staff, based on				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		00862	B. WING		04/26/2018	
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
LB BROB	EN HOME		ዝ SHERIDAN FALLS, MN ៩			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 915	Continued From pa	ge 28	2 915			
	DON or designee c	ensively assessed needs. The ould conduct audits of cares to ensure their personal met consistently.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program) Subp. 1 Infection Control;	21375			6/4/18
	home must establis	n control program. A nursing h and maintain an infection signed to provide a safe and ht.				
	by: Based on observati review, the facility fa laundry was covere	ent is not met as evidenced on, interview, and document ailed to ensure clean personal d and transported to prevent of 4 resident units served by		Corrected.		
	Findings include:					
	North unit, an uncov	7 a.m. on the Second floor vered metal cart which held d clothes was observed in the				
	unit an uncovered hanging shirts and o	a.m. on the Third floor North metal laundry cart held dresses and folded pajamas, r clothing on shelves, was wall in the hall way.				
	On 4/25/18, at 8:06	a.m. on the Second floor				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00862	B. WING		04/	26/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
B BRO	EN HOME		TH SHERIDAN FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 29	21375			
	North unit a facility staff pushed an uncovered metal cart with resident personal clothing past residents, staff and visitors.					
	stood at the elevator resident personal c of the facility. The c clothing on hangers	a.m. laundry staff (LS)E or with an uncovered cart of clothing in the basement level cart had a hanging rack of s and shelves with folded stockings, under clothing, and				
	facility practice was laundry uncovered, room to each resider resident unit receiv clothing daily. The designated spot in indicated the uncov resident clothing re	a.m. LS-E verified the usual s to deliver resident personal from the basement laundry ent unit. LS-E indicated each ed a cart with clean resident carts were placed in a a hall on each wing. LS-E vered carts with personal emained in the halls for the the clothing to the resident				
	unit, an uncovered	a.m. on the Third floor North cart with resident clothing on clothing on shelves was				
	South unit, two une clothing on hangers shelves were observed	a.m. on the Second floor covered carts with resident s and folded clothing on rved. The carts held shirts, stockings, and under				
	resident unit had de transport resident p	4 a.m. LS-E identified each esignated laundry carts to personal clothing which did not ere not covered in transport.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00862	B. WING		04/26/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
B BRO	EN HOME		TH SHERIDAN			
			FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 30	21375			
	Second floor south and north wings:					
	metal clothes hangi wall adjacent from the had clean pants, she silver metal cart with the clothes hanging personal articles fol bras, socks and paj rack and the silver to containing clean clop prevent contamination -at 8:44 a.m. on the metal clothes hanging the wall adjacent from had clean pants, she silver metal cart with next to the clothes hanging clothing rack and the containing clean clop prevent contamination -at 9:20 a.m. on the wings the metal clop to be parked next to dining room areas we and jacket hanging shelves was also pa hanging racks, whice articles folded up for bras, socks and paj	on 4/24/18 at 8:42 a.m., a ng rack was sitting next to the he dining room area, which irts and jacket hanging on it. A h shelves was parked next to rack, which contained clean ded up such as underwear, ama's. The metal clothing metal cart with shelf's othes were not covered to ion during transportation. e second floor north wing a ng rack was parked next to om the dining room area which irts and jacket hanging on it. A h shelves was also parked hanging rack, which contained les folded up such as bocks and pajama's. The metal e silver metal cart with shelf othes were not covered to ion during transportation. e second floor south and north thes hanging racks continued to the walls adjacent from the which had clean pants, shirts on it. A silver metal cart with arked next to the clothes ch contained clean personal lded up such as underwear, ama's. The metal clothing metal carts with shelf covered to prevent				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00862	B. WING	B. WING		04/26/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
B BRO	EN HOME		TH SHERIDAN FALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa -at 9:45 a.m. regist medication aid (TM hanging clothes rat clean clothes down hallway. RN-B and clean clothing to the moved down the ha 9:58 a.m. On 4/24/18 at 9:58 laundry staff brough hanging clothes rat nursing staff to deli every day. TMA-B w never been covered indicated they only transportation to pr During observation laundry staff brough elevator from the ba south wing. The lau clothes hanging rat and jackets hanging from the dining roo laundry staff also b shelves, which com folded up such as u pajama's and parke against the wall. Th silver metal cart wit clothes were not co contamination durin basement. -at 8:47 a.m. on the	age 31 ered nurse (RN)-B and trained A)-B began to take the metal ck and the metal cart with the second floor south TMA-B began delivering the e resident rooms as they allway until they were done at a.m. TMA-B confirmed to the clean linen up on the ck and the metal cart for the ver to the resident rooms verified the clean linen had d as far as she knew and cover the dirty laundry during event contamination. s on 4/25/18 at 8:27 a.m. th clean laundry off the asement to the second floor andry staff brought a metal ck that had clean pants, shirts g on it and parked in adjacent m area next to the wall. The rought a silver metal cart with tained clean personal articles anderwear, bras, socks and ed it next to the clothing rack the metal clothes rack and the h shelf containing clean overed to prevent ng transportation from the	21375				
	metal clothes hang the wall adjacent fro had clean pants, sh	ing rack was parked next to om the dining room area which nirts and jacket hanging on it. A h shelves was also parked					

	ota Department of He					
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00862	B. WING		04/26/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
		824 SOUT	H SHERIDA	N		
	EN HOME	FERGUS	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	ge 32	21375			
	clean personal artic underwear, bras, so clothing rack and th containing clean clo prevent contaminat -at 9:47 a.m. licens began to take the m clean clothes down hallway and began the resident rooms hallway with the rac delivering the clothe	hanging rack, which contained cles folded up such as ocks and pajama's. The metal ne silver metal cart with shelf othes was not covered to ion during transportation. e practical, nurse (LPN)-D netal hanging clothes rack with the second floor south delivering the clean clothing to as she moved down the es while the silver metal cart from the dining room area a.				
	(CM)/infection previsoiled linen and per during transport to the CM/IP indicated the the units in covered if the clean items w the resident units. C was transported in residents, staff and	a.m. the clinical manager entionist (IP) indicated all rsonal clothing was covered the basement laundry facility. a facility linens were sent from I carts, however; was unaware ere covered when returned to CM/IP indicated the laundry the elevators used by visitors and agreed clean covered during transport from nits.				
	(DON) verified the I to be laundered retu- however; the perso facility was not cover laundry room to the indicated the reside the potential to beco- covered when trans	p.m. the director of nursing inens sent out of the building urned in covered bins, nal laundry washed in the ered when returned from the resident rooms. The DON ent personal clean laundry had ome contaminated if not sported through the building s with staff visitors and				

Minneso	ta Department of He	alth				/
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY PLETED
		00862	B. WING		04/2	26/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LB BRO	EN HOME		'H SHERIDA FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 33	21375			
	residents.					
	The facility policy tit 3/20/16, identified " units is on enclosed SUGGESTED MET The director of nurs develop, review, an procedures to ensu clothing is handled manner. The DON appropriate staff. The develop monitoring compliance and rep assurance committed	led Laundry practices revised Linens storage on resident d line carts or closets." THODS OF CORRECTION: sing (DON) or designee could d /or revise policies and re all residents personal and delivered in a sanitary or designee could educate all he DON or designee could systems to ensure ongoing bort those results to the quality ee.				
21665) Physical Environment	21665			6/4/18
21000	A nursing home mu functional, comforta environment, allowi personal belongings This MN Requireme by: Based on observati review the facility fa	ust provide a safe, clean, able, and homelike physical ng the resident to use s to the extent possible. ent is not met as evidenced on interview and document iled to maintain windows in	2.000	Corrected.		0, -, 10
Ainposets D	good repair to preve in resident persona rooms(rm 350, rm 3 rm 366, rm 364, rm	ent the elements from entering I rooms in 12 of 12 resident 357, rm 365, rm369, rm368, 361, rm 360, rm 359, rm 358, nmon areas on the second				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00862	- В. WING	B. WING		26/2018
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
	EN HOME		TH SHERIDAN			
		FERGUS	FALLS, MN 5	6537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21665	Continued From pa	ige 34	21665			
	Findings include:					
	of the facility was co engineer (FE)A, ar findings: 3rd floor: -Room 350-the woo window were soft, of -Room 357- the woo paned window were when touched; -Room 365-the woo paned window were when touched; -Room 369-the woo were soft, cracked There was white du the smaller window -Room 368-the mio the lower edge of th painted over with bi was soft when touc -Room 366-the mio the lower edge of th painted over with bi was soft when touc -Room 364-the smal larger middle windo -Room 361-the woo window were soft, of pressure when touc the edges of the wi -Room 360-the woo paned window were to pressure when tou by the edges of the -Room 359-the woo	oden edges of the three e soft, cracked and crumbled oden edges of the three e soft, cracked and crumbled oden edges of the window and crumbled when touched. uct tape on the bottom edge of r; Idle windowpane had tape on ne window that had been rown paint. This taped area thed; Idle windowpane had tape on ne window that had been rown paint. This taped area thed; Idle windowpane had tape on ne window that had been rown paint. This taped area thed; all window to the left of the pw had soft, cracked edges; oden edges of the three paned cracked and gave way to ched. Cold air flow was felt by ndow; oden edges of the three e soft, cracked and gave way buched. Cold air flow was felt				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			E SURVEY PLETED	
			A. BUILDING: _	A. BUILDING:			
		00862	B. WING		04/	26/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
LB BROI	EN HOME		TH SHERIDAN FALLS, MN 5				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
21665	Continued From pa	ge 35	21665				
	the edges of the wi	ndow;					
		oden edges of the three paned					
		cracked and gave way to					
	Pressure when touc	oden edges of the window					
	were soft and crack	0					
		lows in the common area on					
		in poor repair. The edges of ade of particle board with a					
		he laminate was warped and					
	missing in some are	eas. The large window near					
		sign taped to the window, "do					
	not open this windo	at end of hall was missing the					
		er edge and the exposed					
		proken and moved when					
	touched. The top of down.	the window frame bowed					
	•••	ining room windows had an					
	area along the lowe	er edge which was soft to					
	touch and air was for window.	elt coming through the					
	2nd floor:						
		end of both halls had warped					
		ninate with exposed and ill I which did not create a tight					
	seal with the window						
	R29's quarterly mir	nimum data set (MDS) dated					
	2/15/18, indicated F	R29 had intact cognition.					
	On 4/25/18, at 11:3	7 a.m. R29 indicated this past					
	winter, snow had co	ome in through the lower					
		w near R29's chair this winter. screwed the window shut and					
		screwed the window shut and he snow from coming in,					
		ated the wind continued to					
	come in through the					1	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00862	B. WING		04/	04/26/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE			
LB BRO	EN HOME		TH SHERIDAN FALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
21665	above findings. FE- have plans to replace thought window rep the future. FE-A ind an estimate for the one floor, in order to cost to plan how to replacements. FE-A be to repair the curr functional and then facility is able. The facility provideor replacement dated	2 p.m. FE-A verified the A indicated the facility did not ce the windows, however; blacements would be done in licated the facility had obtained cost of replacing windows on o get a ball park number of the pay for the window A indicated the best plan would rent windows to make them replace the windows as the d a estimate for window 1/16/18. The estimate had not cepted and no purchasing	,				
	(DON) verified she be clean, presentat provide a safe and each resident. The requested facil The director of nurs educate staff regard clean, functional an DON or designee, of maintenance and h periodic audits of an ensure a safe, clea environment is main	p.m. the director of nursing expected the environment to ole, and functional, in order to comfortable environment for ity policy was not provided. sing (DON) or designee, could ding the importance of a safe, id homelike environment. The could coordinate with ousekeeping staff to conduct reas residents frequent to n, functional and homelike ntained to the extent possible. R CORRECTION: Twenty-one					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00862	B. WING		04/26/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
LB BROI	EN HOME		TH SHERIDA FALLS, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
21805	Continued From pa	ge 37	21805		
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805		6/4/18
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a			
	by: Based on observati review, the facility fa dining experience for observed during the floor dining room. In	ent is not met as evidenced ion, interview and document ailed to ensure a dignified or 1 of 1 resident (R66) e supper meal in the second n addition the facility failed to maintained for 1 of 1 resident an incontinent pad.		Corrected.	
	Findings include;				
	3/29/18, identified F impaired and had d dementia, depressi The MDS indicated assistance of two s	imum Data Set (MDS), dated R66 was severely cognitively liagnoses which included on and Parkinson's disease. R66 required extensive taff with bed mobility, and toileting and one staff for			
	an activities of daily deficit and potentia weight gain or loss disease process an plan listed various i	ted 2/2/18, identified R66 had v living self care performance al unplanned /unexpected related to diagnoses and nd varying intakes. The care nterventions which included e dignity, and one staff to feed			

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	0. 00		A. BUILDING:			
		00862	B. WING	B. WING		26/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	EN HOME		TH SHERIDAN			
		FERGUS	FALLS, MN 5	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 38	21805			
	on 4/23/18 at 6:26 dining room R66 with table and his food as consisted of turkey fruit salad with whip (NA)-E approached and began talking t at 6:39 p.m. NA-E when he opened hi him to eat his soup -at 6:45 p.m. NA-E food and started wa table asking other r cream. NA-F walke the table and gave soup while she stoo NA-F briefly walked returned and sat do him to eat. -at 6:49 p.m. NA-F eat and began to p protectors from the -at 6:50 p.m. NA-E next to him, and st feed him a bite of h sliver spoon. -at 6:51 p.m. NA-E vegetable soup and -at 6:53 p.m. NA-E half, tried handing i ya go buddy I cut it -at 6:58 p.m. NA-E dessert and stated -at 7:09 NA-E gave sandwich and stated almost ate all of yo -at 7:11 p.m. NA-E	E continued talking to R66 and s eyes she started to assist got up from feeding R66 his alking around from table to residents if they would like ice ed over from the other end of R66 a bite of his vegetable od on the left side of him. d away from the table and then own next to R66 and assisted got up from assisting R66 to ick up the soiled clothing o ther tables in the ding room. approached R66, sat down rated "hi buddy" and began to is vegetable soup using a gave R66 a bite of his d said "here ya go buddy." cut R66's turkey sandwich in t to him while she stated "there into a smaller piece." gave R66 a bite of his fruit "here ya go buddy." e R66 a bite of his turkey ed "here ya go buddy." gave R66 a dite of his milk ddy you can let go of it (glass				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00862	B. WING		04/26/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	EN HOME		TH SHERIDAN			
		FERGUS	FALLS, MN 5	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	age 39	21805			
21805	meal, NA-E got up stated "here we go of the dining room y room area. On 4/26/18 at 2:30 using nicknames w with his supper me facility practice was next to the resident not to interrupt thei leaving. NA-E verifi pet names unless t called by the nickna	ble. vas done eating his supper from sitting next to R66 and buddy" and wheeled R66 out via his wheel chair to the living p.m. NA-E confirmed she was while she was assisting R66 al. NA-E confirmed the usual s for staff to remain seated t while they were eating and r meal time by getting up and ied staff should not be using the resident preferred to be ame. NA-E indicated she felt it ne residents name to get their				
	confirmed the usua were assisting reside stay with the reside and let them have a verified staff should residents meal and rotate while they we because that staff r resident was eating should not be using indicated staff had dementia training. only being using the	p.m. director of nursing (DON) al facility practice while staff dents to eat, was for staff to ent until they are done eating a good hot meal. The DON d not be interrupting the I she did not like the staff to ere assisting a resident, member knew how the g. The DON confirmed staff g pet names or nicknames and been trained on this in The DON verified staff should e residents name, unless the a different name and stated be used."				
		9S, dated 2/15/18, identified ly cognitively impaired and had	1			

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00862	B. WING		04/	26/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
LB BROI	EN HOME		TH SHERIDAN			
			FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 40	21805			
	diagnoses which included dementia, hemi and depression. The MDS indicated R19 required extensive assistance of two staff bed mobility, transfers and one staff for dr toileting, personal hygiene and eating. Fur review of the MDS indicated R19 was alwa incontinent of urine and was not on a toile program.					
	an activities of daily deficit related to str depression. The ca interventions which dignity and required two staff with all pe	ted 5/18/17, identified R19 had v living self care performance oke, dementia hemiplegia and are plan listed various n included provide privacy, d physical assistance of one to rineal care, adjusting of ing of incontinent padding.				
	was in her room lyin cloth covered reclin and the seat of the white incontinent pa	s on 4/24/18 at 1:16 p.m. R19 ng in bed sleeping. A brown her was present in R19's room recliner was covered with a ad. R19's room had a strong permeating through out the				
	was seated in her r reclining chair with the recliner. R19's covered with a whit of the recliner. The visible to the public recliner while the et the reclining chair. -at 7;38 a.m. R19 r with the white incor the left side of her r	s on 4/25/18 at 7:04 a.m., R19 room in her brown cloth her feet up on the foot rest of brown reclining chair was re incontinent pad on the seat white incontinent pad was on the left side of R19's dge of it hung from the front of emained seated in her recliner ntinent pad visibly hanging on recliner. ned seated in her recliner with				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00862	B. WING	B. WING		26/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE. ZIP CODE	• • •	
			TH SHERIDAN			
LB BRO	EN HOME		FALLS, MN 5			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 41	21805			
	R19 out of her room the dining room are her a menu to look covered with a whith hanging partially ou of her wheel chair, under the seat of the on all sides of the s -at 8:22 a.m. R19 v at the dining room Ensure independent have a white incom back and left side of -at 8:42 a.m. R19 v at the dining room independently while white incontinent pa- left side of her whe -at 9:03 a.m. RN-B dining room table a cream of wheat. R ⁻¹ incontinent pad har side of her wheelch -at 9:19 a.m. R19 v when NA-G approa- the dining room via R19 continued to h hanging out of the l wheelchair. NA-G p bathroom via mech incontinent brief do assisted her with re brief, provided peri incontinent brief, as bathroom via mech brown recliner in her recliner was covered	ered nurse (RN)-B wheeled m via her black wheelchair into ea for breakfast and handed at. R19's wheel chair seat was te incontinent pad and was ut of the back and the left side while the rest of it was tucked ne wheel chair but was visible seat cushion. was seated in her wheel chair table drinking a container of ntly while she continued to tinent pad hanging out of the of her wheelchair. was seated in her wheel chair table eating her breakfast e she continued to have a ad hanging out of the back and eelchair. sat down next to R19 at the and assisted R19 to eat her 19 continued to have a white nging out of the back and left	5			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00862	B. WING		04/26/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
B BROI	EN HOME		TH SHERIDAN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21805	recliner listening to incontinent pad visi her recliner. -at 12:14 p.m. R19 at the dining room to independently while chair was covered which hung partially side of her wheel c tucked under the se visible on all sides. -at 12:30 p.m. R19 chair at the dining r the right side of her R19 continued to h still visible on all side -at 12:42 p.m. R19 chair at the dining r the right side of her R19 continued to h still visible on all side -at 12:42 p.m. R19 chair at the dining r the right side of her R19 continued to h visible on the seat a On 4/25/18 at 11:14 was incontinent of I and needed staff as changed. NA-H ind pads on the seats of due R19 being inco furniture from being indicated staff tried	remained seated in her music, with the white bly hanging on the left side of was seated in her wheel chair table eating her dessert e the seat of her black wheel with a white incontinent pad y out of the back and the left hair, while the rest of it was eat of the wheel chair but still remained seated in her wheel toom table while NA-F sat on assisting her to eat her lunch ave a white incontinent pad des of the wheelchair seat. remained seated in her wheel toom table while NA-F sat on assisting her to eat her lunch ave a white incontinent pad des of the wheelchair seat. remained seated in her wheel toom table while NA-F sat on assisting her to eat her lunch ave a white incontinent pad and sides of the wheelchair. 4 a.m. NA-H confirmed R19 powel/bladder, wore a brief ssistance to be toileted and icated R19 had incontinent of her recliner and wheel chair ontinent and to protect the g soiled with urine. NA-H to take the incontinent pads does not always happen if they		DEFICIENCY		
	(LPN)-C confirmed bowel/bladder, wor assistance to be to	p.m. licensed practical nurse R19 was incontinent of e a brief and needed staff ileted and changed. LPN-C incontinent pads on the seats				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00862	B. WING		04/2	26/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
LB BRO	EN HOME		TH SHERIDAN FALLS, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21805	Continued From pa	ge 43	21805			
	of her recliner and wheel chair in case she had accident and so they don't ruin the furniture fro being soiled with urine. LPN-C indicated the facility had brown incontinent pads staff norma used, but indicated the supply was limited and always available.					
	confirmed R19 was wore a brief and ne toileted and change facility had colorful seats/recliners and recliners and the se indicated if staff we pads she would exp them away when no lying out due to dign	p.m. director of nursing (DON) incontinent of bowel/bladder, eded staff assistance to be ed. The DON indicated the incontinent pads to protect the usually used these for the eats of wheel chairs. The DON re using the white incontinent bect them to fold them up, put of in use and should not be hity issues. The DON indicated using the white incontinent rs and recliners.				
	Service Audit Tool r	blicy titled, Food/Dining evised on 5/14, indicated staff in conversation and dignity				
	under resident right	ation revised on 6/16, indicated is: preserve an individuals and promoting privacy and				
	The administrator, of designee could dev care by the interdise residents dignity is could update policie	THOD OF CORRECTION: director of nursing (DON), or relop and implement a plan of ciplinary team to ensure being maintained. The facility es and procedures, educate ges, and audit periodically to				

Minnesota Department of Health STATE FORM

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00862	B. WING		04/26/2018	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
B BROE	EN HOME		TH SHERIDAN FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 44	21805			
	could be completed are reviewed by the performance impro could ensure comp	dignity are maintained. Audits d, and results of these audits e quality assessment and ovement (QAPI) committee liance. R CORRECTION: Twenty-one				
inesota De ATE FORM	epartment of Health		6899	7HK11		on sheet 45 o