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: Q7HK
Facility ID: 00862

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245453**
2. STATE VENDOR OR MEDICAID NO. (L2) **678740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LB BROEN HOME**
(L4) **824 SOUTH SHERIDAN**
(L5) **FERGUS FALLS, MN** (L6) **56537**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **07/26/2018** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **04/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **107** (L18)
13. Total Certified Beds **107** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 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
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	107			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE - NE II 08/20/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/13/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/05/2018** (L33)

DETERMINATION APPROVAL

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.

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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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.

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.

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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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

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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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

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

Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On July 26, 2018, I, Andrea Zetah, Administrator, received
(Name)(Please Print) (Title)(Please Print)
the Notice of Penalty Assessment dated July 26, 2018 and licensing orders issued to:

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 July 26, 2018, Denise Erickson HFE II HFE II
I, Andrea Zetah, Administrator, 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

The Notice of Penalty Assessment was handed to Andrea Zetah,
(Name)(Please Print)
Administrator, Date 7-26-18
(Title)(Please Print)

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

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: Q7HK
Facility ID: 00862

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245453**

2. STATE VENDOR OR MEDICAID NO. (L2) **678740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LB BROEN HOME**
(L4) **824 SOUTH SHERIDAN**
(L5) **FERGUS FALLS, MN** (L6) **56537**

4. TYPE OF ACTION: 7 (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/20/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **04/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **107** (L18)

13.Total Certified Beds **107** (L17)

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 Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 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
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	107			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susan Bachleitner, HFE -NE II 07/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/12//2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/05/2018** (L33)

DETERMINATION APPROVAL

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.

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 https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

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 Tamika.Brown@cms.hhs.gov .

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING ______ B. WING ______	R 06/20/2018

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

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{E 000}	Initial Comments No deficiencies were noted at the time of the survey 06/20/2018	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 6/19/18 and 6/20/18. The certification tags that were corrected can be found on the CMS2567B. Also there are tags that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	{F 000}		
{F 688} SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	{F 688}		7/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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{F 688}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide exercises to maintain range of motion (ROM) services for 4 of 4 residents (R67, R28, R15 and R66) reviewed with a restorative nursing program. Findings include: R67 R67's quarterly Minimum Data Set (MDS) dated 3/29/18, indicated R67 had moderate cognitive impairment, had diagnoses which included anemia, heart dysrhythmia and end stage renal disease. The MDS identified R67 required total staff assistance with all activities of daily living (ADL's). The MDS further indicated R67 was not steady moving from a seated to standing position, moving on and off the toilet and surface to surface transfers (transfer between bed and chair or wheelchair). R67's care plan revised 4/19/18, indicated R67 had an ADL self care performance deficit related to disease process, limited mobility and pain. The care plan listed various interventions which included restorative program services. - R67's Therapy to Nursing Communication form, dated 10/26/17, identified the following instructions: Stand by edge of bed: with front wheeled walker (FWW), shoes on, gait belt, CGA (contact guard assistance), from elevated bed. Stand Time to pt's tolerance, 3x per week. - R67's Therapy to Nursing Communication form, dated 2/15/17, identified the following	{F 688}	Nursing Rehabilitation is completed as ordered for R15. Date completed: 7/19/18 Nursing Rehabilitation is completed as ordered for R67. Date completed: 7/19/18 Nursing Rehabilitation is completed as ordered for R66. Date completed: 7/19/18 R28 died on 6/21/18, the day following exit. Date completed: 6/21/18 All residents with a Nursing Rehabilitative program will be reviewed by the RN Unit Coordinator (RNUC), evaluating completion and documentation of provided Rehabilitative Nursing services. Date completed: 7/17/18. RNUCs and Charge Nurses will be re-educated on their responsibility to manage the Rehabilitative Program on their unit and to assure rehabilitative services are being completed as ordered. A review of policy and procedure Rehabilitative Nursing, Charting Code and Reporting Requirements will be completed with the RNUCs and Charge Nurses. Date completed: 7/19/18 Rehabilitation Assistant assignments will be reviewed and adjusted on all units to ensure proper time and completion of the restorative nursing program. Date completed: 7/17/18 The Rehabilitation Assistant (RA)	

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{F 688}	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. 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, 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 period and began to stand and sit repeatedly x 3 and stated "that's all I can do". R67 attempted to stand one more time then sat back on his bed and indicated he wanted to stop. RA-A transferred R67 from his bed to his wheelchair via mechanical lift. R67 indicated he did pretty good	{F 688}	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 Rehabilitative Nursing, Charting Code and Reporting Requirements. A review of the 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 quarterly Nursing Care Audit system for each unit. DON will monitor and audit findings and assure prompt follow up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of the Quality and	

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{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 remained seated in his wheelchair. RA-A was not observed to perform any yellow theraband exercise to include 1) external rotation 15 x 2 (hip height), 2) punch downs 15 x 2 and 3) curls 15 x 2 per therapies recommendations. R67's Rehab Nursing Record (RNR) dated 6/1/18 to 6/30/18, indicated R67's standing by the edge of bed exercise program was completed only 3 out of 9 opportunities for the month, exercises which included: 1 x 15 seated: hip flexion, abduction, adduction, long arch quads and ankle planter/dorsal flexion bilaterally, AAROM bilaterally shoulder flexion 10 x 2 and hand grippers 15 x 2 were completed 6 out of 9 opportunities for the month and R67's RNR lacked evidence of the use of the yellow theraband for 1) external rotation 15 x 2 (hip	{F 688}	Assessment and Assurance Committee and QAPI. Date completed: 7/19/18.	

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{F 688}	Continued From page 4	{F 688}		

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 repositioned and toileted.

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{F 688}	Continued From page 5 R28 R28's quarterly MDS dated 5/17/18, indicated R28 had severe cognitive impairment, had diagnoses which included hemiplegia or hemiparesis (paralysis of one entire side of the body), cerebral vascular accident (CVA) (stroke). and seizure disorder. R28's MDS further identified R28 required total assistance with ADLs and had range of motion impairment on one side that affected her lower and upper extremities. R28's care plan revised 6/19/18, indicated R28 had an ADL self care performance deficit related to stroke. The care plan listed several intervention which included rehab interventions which instructed staff to see rehab book and therapy recommendations in chart. 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. During observation on 6/20/18 at 9:40 a.m. R28 was in her room lying in bed, on her back, with head of bed elevated, fully clothed, with pressure relieving boots on her feet bilaterally and was receiving feeding via gastrostomy tube while she looked out the window. R28's RNR dated 6/1/18 to 6/20/18, indicated R28 had received restorative and ROM exercises 6 out of 9 opportunities for the month. Review of R28's nursing progress notes from 6/4/18 to 6/20/18, lacked any notation of R28's	{F 688}		

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{F 688}	Continued From page 6	{F 688}		

restorative nursing program participation.

On 6/20/18 at 12:38 p.m. RA-A confirmed R28 was to receive ROM exercises 3x/week. RA-A confirmed R28 had not been receiving ROM services as per therapies recommendations and had only received ROM exercises in the last couple of days so far this week.

On 6/20/18 at 2:38 p.m. RA-B confirmed R28 was to receive ROM exercises routinely. RA-B indicated restorative staff would get pulled to the floor sometimes to help with cares. RA-B indicated she had voiced her concerns about the restorative program and indicated management instructed the restorative staff resident cares come first, then the restorative program. RA-B indicated each concerns had been voiced to the RN's and management in the recent past and they were all aware of the problem with the restorative program not getting done.

On 6/20/18 at 2:44 p.m. RN-C confirmed R28 was to receive ROM exercises routinely and she was not receiving ROM as recommended. RN-C was not sure why her ROM did not get done. RN-C indicated the restorative program had gotten better, but her floor had not had a RA until recently and indicated every floor was supposed to have a RA. RN-C indicated she was aware of staff complaints about the restorative program and had reported the complaints to the director of nursing (DON.)

R15

R15's quarterly MDS dated 5/3/18, indicated R15 had intact cognition, had diagnoses which included anxiety disorder, osteoarthritis and

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{F 688}	Continued From page 7	{F 688}		

Continued From page 7

systemic lupus. The MDS identified R15 required extensive assistance of one staff with all activities of ADL's. The MDS further indicated R15 was not steady moving from a seated to standing position, moving on and off the toilet and surface to surface transfers (transfer between bed and chair or wheelchair).

R15's care plan revised on 5/12/18, indicated R15 had an ADL self care performance deficit related to disease process, limited mobility weakness pain in right knee, recent falls, systemic lupus, erythematous, asthma hypothyroidism and osteoporosis.. The care plan listed several intervention which included restorative program as set up.

R15's Therapy to Nursing Communication form , dated 3/24/17, identified the following: dark blue theraband (she has in her room) 1) horizontal 20 x 2, 2) tricep punch outs 20 x 2, 3) shoulder checks 20 x 2, 4) external rotation 20 x 2 (elbows tucked), 3 to 4 x per week or as patient tolerates. Lower extremity seated: hip flexion, abduction, adduction, long arch quads and ankle planter/dorsi flexion and blue theraband hamstring curls 1 x 20 bilaterally. 3 x per week or as patient tolerates.

During observations on 6/20/18 at 9:20 a.m. R15 was in her room, seated in her recliner with her feet elevated up on the foot rest of the recliner.

-at 10:06 a.m. RA-C entered R15's room with her cart which contained several items for exercising such as theraband's, weights and other equipment. RA-C sat down on a foot stool and proceeded to complete upper arm exercises with the blue theraband, applied weights her ankles

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{F 688}	Continued From page 8	{F 688}		

and completed lower extremity exercises. R15 was able to participate and complete both upper extremity and lower extremity exercises.

R15's RNR dated 6/1/18 to 6/30/18, documented R15 had completed her restorative and ROM exercises 5 out of 9 opportunities for the month.

Review of R15's nursing progress notes from 6/4/18 to 6/20/18, lacked any notation of R15's restorative nursing program participation.

On 6/20/18 at 11:52 a.m. R15 indicated she received restorative program maybe two times a week. R15 indicated she did not believe she was receiving restorative exercise and ROM three times a week.

R66

R66's quarterly MDS, dated 3/29/18, identified R66 was severely cognitively impaired and had diagnoses which included dementia, depression and Parkinson's disease. The MDS indicated R66 required extensive assistance of two staff with all ADL's and needed ext assistance of one for grooming. The MDS further indicated R66 was not steady moving from a seated to standing position, walking, turning around facing the opposite direction while walking, moving on and off the toilet and surface to surface transfers (transfer between bed and chair or wheelchair).

R66's care plan revised on 3/28/18, identified R66 had ADL self care performance deficit related to dementia, disease process: parkinsonism, depression, acute kidney injury and generalized weakness. The care plan listed various interventions which included restorative nursing

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 688}	Continued From page 9 program in place. R66's Therapy to Nursing Communication form, dated 1/16/18, identified the follows: bilateral LE AAROM, hip flexion, hip abduction, knee flexion/extensions, ankle planter/dorsi flexion, ankle IV/EV 1 x 10. R66's Therapy to Nursing Communication form, dated 4/27/18, identified the following: AAROM or AROM upper extremities 1 to 2 sets 10 reps, shoulders-flex, extension abduction/adduction, elbow-flex, extension, no weights, wrists- flex, extension, supination and pronation, 3 times per week or as tolerated. During observations on 6/20/18 at 10:35 a.m. R66 was lying in bed on his back and RA-C was present in his room. RA-C indicated she had just laid R66 down so she could complete his exercises. RA-C indicated R66 did better with his exercises when he laid down. RA-C proceeded to complete upper extremity and lower extremity exercises with R66. R66 was cooperative throughout the exercises. R66's RNR dated 6/1/18 to 6/30/18, indicated R66 had received his restorative and ROM exercises 6 times out of 9 opportunities for the month. Review of R66's nursing progress notes from 6/4/18 to 6/20/18, lacked any notation of R66's restorative nursing program participation. On 6/20/18 at 11:55 a.m. RA-C confirmed R15 and R66 was to receive restorative and ROM exercises 3x/week. RA-C indicated it was a	{F 688}		

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{F 688}	Continued From page 10 struggle to get the restorative program done and completed daily. RA-C indicated she had noticed R15 only had her exercises done one time last week and indicated it was a struggle of bouncing back and forth between restorative nursing programs and helping other staff on the floor. On 6/20/18 at 2:27 p.m. RN-D confirmed R15 and R66 were to receive restorative and ROM exercises 3x/week. RN-D verified R15 and R66 were not receiving restorative and ROM exercises 3x/week per therapies recommendations. RN-D indicated the RA were trying prioritize their work and if the resident was to receive therapy 3 times a week that's what the facility wanted to see done. RN-D indicated staff were struggling getting restorative exercises done and stated "work in progress." RN-D indicated RA's had voiced their concerns about the restorative program not getting done and indicated this concern had been reported to the DON. On 6/20/18 at 2:54 p.m. DON reviewed and confirmed findings regarding the restorative program not being completed consistently for residents as recommended. The DON indicated moving forward, the RN's would be looking at the program weekly to see what adjustments and changes need be done. The DON indicated she had not received any complaints from staff in regards to the restorative program not getting done properly. The DON indicated she would expect staff to make sure the restorative program was getting completed as ordered. The DON indicated she was aware of one time when restorative was not staffed on one floor to do the restorative program and education was given to the staff involved at the time and it was	{F 688}		

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{F 688}	Continued From page 11 addressed. The DON indicated she was not aware of any other concerns since this one time. A facility policy titled, Restorative Nursing, Charting Code and Reporting Requirements, revised 9/2003, revealed the purpose of the policy was to record resident's compliance with rehab care plan. The policy directed facility staff to record resident's participation and refusals on the facility Rehab Nursing Care Record. The policy revealed if a resident refuses or was unable to perform for three or more scheduled days the restorative aid should report to the RN coordinator for follow up. The RA shall report to the RN or substitute any anticipated inability to complete ordered modalities before the end of each shift so that assignments can be adjusted to assure completion.	{F 688}		

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{E 000}	Initial Comments No deficiencies were noted at the time of the survey 06/20/2018	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 6/19/18 and 6/20/18. The certification tags that were corrected can be found on the CMS2567B. Also there are tags that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	{F 000}		
{F 688} SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	{F 688}		7/19/18

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

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{F 688}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide exercises to maintain range of motion (ROM) services for 4 of 4 residents (R67, R28, R15 and R66) reviewed with a restorative nursing program. Findings include: R67 R67's quarterly Minimum Data Set (MDS) dated 3/29/18, indicated R67 had moderate cognitive impairment, had diagnoses which included anemia, heart dysrhythmia and end stage renal disease. The MDS identified R67 required total staff assistance with all activities of daily living (ADL's). The MDS further indicated R67 was not steady moving from a seated to standing position, moving on and off the toilet and surface to surface transfers (transfer between bed and chair or wheelchair). R67's care plan revised 4/19/18, indicated R67 had an ADL self care performance deficit related to disease process, limited mobility and pain. The care plan listed various interventions which included restorative program services. - R67's Therapy to Nursing Communication form, dated 10/26/17, identified the following instructions: Stand by edge of bed: with front wheeled walker (FWW), shoes on, gait belt, CGA (contact guard assistance), from elevated bed. Stand Time to pt's tolerance, 3x per week. - R67's Therapy to Nursing Communication form, dated 2/15/17, identified the following	{F 688}	Nursing Rehabilitation is completed as ordered for R15. Date completed: 7/19/18 Nursing Rehabilitation is completed as ordered for R67. Date completed: 7/19/18 Nursing Rehabilitation is completed as ordered for R66. Date completed: 7/19/18 R28 died on 6/21/18, the day following exit. Date completed: 6/21/18 All residents with a Nursing Rehabilitative program will be reviewed by the RN Unit Coordinator (RNUC), evaluating completion and documentation of provided Rehabilitative Nursing services. Date completed: 7/17/18. RNUCs and Charge Nurses will be re-educated on their responsibility to manage the Rehabilitative Program on their unit and to assure rehabilitative services are being completed as ordered. A review of policy and procedure Rehabilitative Nursing, Charting Code and Reporting Requirements will be completed with the RNUCs and Charge Nurses. Date completed: 7/19/18 Rehabilitation Assistant assignments will be reviewed and adjusted on all units to ensure proper time and completion of the restorative nursing program. Date completed: 7/17/18 The Rehabilitation Assistant (RA)	

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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. 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, 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 period and began to stand and sit repeatedly x 3 and stated "that's all I can do". R67 attempted to stand one more time then sat back on his bed and indicated he wanted to stop. RA-A transferred R67 from his bed to his wheelchair via mechanical lift. R67 indicated he did pretty good

{F 688}

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 Rehabilitative Nursing, Charting Code and Reporting Requirements. A review of the 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 quarterly Nursing Care Audit system for each unit. DON will monitor and audit findings and assure prompt follow up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of the Quality and

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{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 remained seated in his wheelchair. RA-A was not observed to perform any yellow theraband exercise to include 1) external rotation 15 x 2 (hip height), 2) punch downs 15 x 2 and 3) curls 15 x 2 per therapies recommendations. R67's Rehab Nursing Record (RNR) dated 6/1/18 to 6/30/18, indicated R67's standing by the edge of bed exercise program was completed only 3 out of 9 opportunities for the month, exercises which included: 1 x 15 seated: hip flexion, abduction, adduction, long arch quads and ankle planter/dorsal flexion bilaterally, AAROM bilaterally shoulder flexion 10 x 2 and hand grippers 15 x 2 were completed 6 out of 9 opportunities for the month and R67's RNR lacked evidence of the use of the yellow theraband for 1) external rotation 15 x 2 (hip	{F 688}	Assessment and Assurance Committee and QAPI. Date completed: 7/19/18.	

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{F 688}	Continued From page 4	{F 688}		

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 repositioned and toileted.

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{F 688}	Continued From page 5	{F 688}		

R28

R28's quarterly MDS dated 5/17/18, indicated R28 had severe cognitive impairment, had diagnoses which included hemiplegia or hemiparesis (paralysis of one entire side of the body), cerebral vascular accident (CVA) (stroke). and seizure disorder. R28's MDS further identified R28 required total assistance with ADLs and had range of motion impairment on one side that affected her lower and upper extremities.

R28's care plan revised 6/19/18, indicated R28 had an ADL self care performance deficit related to stroke. The care plan listed several intervention which included rehab interventions which instructed staff to see rehab book and therapy recommendations in chart.

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.

During observation on 6/20/18 at 9:40 a.m. R28 was in her room lying in bed, on her back, with head of bed elevated, fully clothed, with pressure relieving boots on her feet bilaterally and was receiving feeding via gastrostomy tube while she looked out the window.

R28's RNR dated 6/1/18 to 6/20/18, indicated R28 had received restorative and ROM exercises 6 out of 9 opportunities for the month.

Review of R28's nursing progress notes from 6/4/18 to 6/20/18, lacked any notation of R28's

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{F 688}	Continued From page 6	{F 688}		

restorative nursing program participation.

On 6/20/18 at 12:38 p.m. RA-A confirmed R28 was to receive ROM exercises 3x/week. RA-A confirmed R28 had not been receiving ROM services as per therapies recommendations and had only received ROM exercises in the last couple of days so far this week.

On 6/20/18 at 2:38 p.m. RA-B confirmed R28 was to receive ROM exercises routinely. RA-B indicated restorative staff would get pulled to the floor sometimes to help with cares. RA-B indicated she had voiced her concerns about the restorative program and indicated management instructed the restorative staff resident cares come first, then the restorative program. RA-B indicated concerns had been voiced to the RN's and management in the recent past and they were all aware of the problem with the restorative program not getting done.

On 6/20/18 at 2:44 p.m. RN-C confirmed R28 was to receive ROM exercises routinely and she was not receiving ROM as recommended. RN-C was not sure why her ROM did not get done. RN-C indicated the restorative program had gotten better, but her floor had not had a RA until recently and indicated every floor was supposed to have a RA. RN-C indicated she was aware of staff complaints about the restorative program and had reported the complaints to the director of nursing (DON.)

R15

R15's quarterly MDS dated 5/3/18, indicated R15 had intact cognition, had diagnoses which included anxiety disorder, osteoarthritis and

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{F 688}	Continued From page 7	{F 688}		

systemic lupus. The MDS identified R15 required extensive assistance of one staff with all activities of ADL's. The MDS further indicated R15 was not steady moving from a seated to standing position, moving on and off the toilet and surface to surface transfers (transfer between bed and chair or wheelchair).

R15's care plan revised on 5/12/18, indicated R15 had an ADL self care performance deficit related to disease process, limited mobility weakness pain in right knee, recent falls, systemic lupus, erythematous, asthma hypothyroidism and osteoporosis.. The care plan listed several intervention which included restorative program as set up.

R15's Therapy to Nursing Communication form , dated 3/24/17, identified the following: dark blue theraband (she has in her room) 1) horizontal 20 x 2, 2) tricep punch outs 20 x 2, 3) shoulder checks 20 x 2, 4) external rotation 20 x 2 (elbows tucked), 3 to 4 x per week or as patient tolerates. Lower extremity seated: hip flexion, abduction, adduction, long arch quads and ankle planter/dorsi flexion and blue theraband hamstring curls 1 x 20 bilaterally. 3 x per week or as patient tolerates.

During observations on 6/20/18 at 9:20 a.m. R15 was in her room, seated in her recliner with her feet elevated up on the foot rest of the recliner.

-at 10:06 a.m. RA-C entered R15's room with her cart which contained several items for exercising such as theraband's, weights and other equipment. RA-C sat down on a foot stool and proceeded to complete upper arm exercises with the blue theraband, applied weights her ankles

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and completed lower extremity exercises. R15 was able to participate and complete both upper extremity and lower extremity exercises.

R15's RNR dated 6/1/18 to 6/30/18, documented R15 had completed her restorative and ROM exercises 5 out of 9 opportunities for the month.

Review of R15's nursing progress notes from 6/4/18 to 6/20/18, lacked any notation of R15's restorative nursing program participation.

On 6/20/18 at 11:52 a.m. R15 indicated she received restorative program maybe two times a week. R15 indicated she did not believe she was receiving restorative exercise and ROM three times a week.

R66

R66's quarterly MDS, dated 3/29/18, identified R66 was severely cognitively impaired and had diagnoses which included dementia, depression and Parkinson's disease. The MDS indicated R66 required extensive assistance of two staff with all ADL's and needed ext assistance of one for grooming. The MDS further indicated R66 was not steady moving from a seated to standing position, walking, turning around facing the opposite direction while walking, moving on and off the toilet and surface to surface transfers (transfer between bed and chair or wheelchair).

R66's care plan revised on 3/28/18, identified R66 had ADL self care performance deficit related to dementia, disease process: parkinsonism, depression, acute kidney injury and generalized weakness. The care plan listed various interventions which included restorative nursing

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 688}	Continued From page 9	{F 688}		

program in place.

R66's Therapy to Nursing Communication form, dated 1/16/18, identified the follows: bilateral LE AAROM, hip flexion, hip abduction, knee flexion/extensions, ankle planter/dorsi flexion, ankle IV/EV 1 x 10.

R66's Therapy to Nursing Communication form, dated 4/27/18, identified the following: AAROM or AROM upper extremities 1 to 2 sets 10 reps, shoulders-flex, extension abduction/adduction, elbow-flex, extension, no weights, wrists- flex, extension, supination and pronation, 3 times per week or as tolerated.

During observations on 6/20/18 at 10:35 a.m. R66 was lying in bed on his back and RA-C was present in his room. RA-C indicated she had just laid R66 down so she could complete his exercises. RA-C indicated R66 did better with his exercises when he laid down. RA-C proceeded to complete upper extremity and lower extremity exercises with R66. R66 was cooperative throughout the exercises.

R66's RNR dated 6/1/18 to 6/30/18, indicated R66 had received his restorative and ROM exercises 6 times out of 9 opportunities for the month.

Review of R66's nursing progress notes from 6/4/18 to 6/20/18, lacked any notation of R66's restorative nursing program participation.

On 6/20/18 at 11:55 a.m. RA-C confirmed R15 and R66 was to receive restorative and ROM exercises 3x/week. RA-C indicated it was a

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	245453	A. BUILDING ______ B. WING ______	R 06/20/2018

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{F 688}	Continued From page 10 struggle to get the restorative program done and completed daily. RA-C indicated she had noticed R15 only had her exercises done one time last week and indicated it was a struggle of bouncing back and forth between restorative nursing programs and helping other staff on the floor. On 6/20/18 at 2:27 p.m. RN-D confirmed R15 and R66 were to receive restorative and ROM exercises 3x/week. RN-D verified R15 and R66 were not receiving restorative and ROM exercises 3x/week per therapies recommendations. RN-D indicated the RA were trying prioritize their work and if the resident was to receive therapy 3 times a week that's what the facility wanted to see done. RN-D indicated staff were struggling getting restorative exercises done and stated "work in progress." RN-D indicated RA's had voiced their concerns about the restorative program not getting done and indicated this concern had been reported to the DON. On 6/20/18 at 2:54 p.m. DON reviewed and confirmed findings regarding the restorative program not being completed consistently for residents as recommended. The DON indicated moving forward, the RN's would be looking at the program weekly to see what adjustments and changes need be done. The DON indicated she had not received any complaints from staff in regards to the restorative program not getting done properly. The DON indicated she would expect staff to make sure the restorative program was getting completed as ordered. The DON indicated she was aware of one time when restorative was not staffed on one floor to do the restorative program and education was given to the staff involved at the time and it was	{F 688}		

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{F 688}	Continued From page 11 addressed. The DON indicated she was not aware of any other concerns since this one time. A facility policy titled, Restorative Nursing, Charting Code and Reporting Requirements, revised 9/2003, revealed the purpose of the policy was to record resident's compliance with rehab care plan. The policy directed facility staff to record resident's participation and refusals on the facility Rehab Nursing Care Record. The policy revealed if a resident refuses or was unable to perform for three or more scheduled days the restorative aid should report to the RN coordinator for follow up. The RA shall report to the RN or substitute any anticipated inability to complete ordered modalities before the end of each shift so that assignments can be adjusted to assure completion.	{F 688}		

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

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K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 5/22/18 following a Minnesota Department of Health survey on 4/24/18. At this Comparative Federal Monitoring Survey, LB Broen Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.90(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition. LB Broen Home is composed of a two story building ("1969 Building) with partial basement constructed in 1969 of Type II (222) construction with addition of the "1984 Building" in 1984 of Type II (222) and the "Auditorium" in 1996 of Type II (000). For the purposes of this survey, the facility was surveyed as a single building of Type II (000) construction. The building is fully sprinklered and there is supervised smoke detection located in the corridors, spaces open to the corridor, and some resident rooms. The facility has 107 dually certified beds. At the time of the survey, the census was 75. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		6/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/11/2018

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.

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K 353	Continued From page 1 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ______________________ b) Who provided system test _____________________________ c) Water system supply source ___________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain clearances around sprinklers in accordance with NFPA 101 - 2012 edition, Sections 19.3.5, 9.7 and NFPA 25 - 2010 edition, Sections 5.1.1, 5.2.1, and 5.4.1. This deficient practice could affect approximately 10 of the 75 residents. Findings include: On 5/22/18 at 3:00pm, observation in room 279 revealed a wall mounted television installed directly in front of and within 18 inches of the sidewall sprinkler. This finding was confirmed by the Facilities Engineer at the time of discovery.	K 353	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.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		6/30/18

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K 372	Continued From page 2 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.3.7, 19.3.7.1, 19.3.7.3, 8.5, 8.5.2 and 8.5.6. This deficient practice could affect approximately 20 of the 75 residents. Findings include: 1. On 5/22/18 at 2:10pm, observation at the smoke barrier leading to the dining room in the "Two South" corridor revealed a conduit penetration that was not firestopped leaving an approximate one inch diameter gap in the smoke barrier. 2. On 5/22/18 at 3:20pm, observation at the smoke barrier in the "Three North" corridor near room 371 revealed an approximate one inch diameter cutout that was not firestopped leaving a gap in the smoke barrier. These findings were confirmed by the Facilities Engineer at the time of discovery.	K 372	1) Approved firestop will be installed in the approximate one-inch diameter gap near the conduit penetration in the smoke barrier leading to the dining room in the "Two South" corridor. This correction shall be completed by June 15, 2018. The Facilities Engineer is responsible for the correction and will monitor to prevent the re-occurrence of this deficiency. 2) Approved firestop will be installed in the approximate one-inch diameter cutout in the smoke barrier in the "Three North" corridor near room 371. This correction shall be completed by June 15, 2018. The Facilities Engineer is responsible for the correction and will monitor to prevent 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 will also be inspected after or during any work performed on or around all smoke barriers. The Facilities Engineer is responsible for the correction and will	

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K 372	Continued From page 3	K 372	monitor to prevent re-occurrence of this deficiency.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have a written fire safety plan that addressed all of the items required by NFPA 101 - 2012 edition, Section 19.7.2.2. This deficient practice could affect all of the 75 residents. Findings include: On 5/22/18 at 1:33pm, review of the document titled "Emergency Fire Plan" (dated December 2013) revealed the plan did not include information on preparation of floors and building for evacuation. This finding was confirmed by the Administrator and the Facilities Engineer at the exit conference.	K 711	"Emergency Fire Plan" will be updated by June 15, 2018 to include information on preparing a floor and building evacuation. The Facilities Engineer is responsible for the correction and will monitor to prevent the re-occurrence of this deficiency.	6/15/18
K 923	Gas Equipment - Cylinder and Container Storag	K 923		6/6/18

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K 923 SS=D	Continued From page 4 CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	K 923		

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K 923	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store oxygen cylinders in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.3.2.4, 8.7 and NFPA 99 - 2012 edition, Section 11.3. This deficient practice could affect an isolated number of residents, staff, and visitors. Findings include: On 5/22/18 at 2:00pm, observation in the oxygen room revealed oxygen cylinders were stored in a holder made of combustible material (wood). This finding was confirmed by the Facilities Engineer at the time of discovery.	K 923	On June 6, 2018, the oxygen cylinder holder made of combustible material was removed and metal racks installed for oxygen cylinder storage. The Facilities Engineer is responsible for the correction and will monitor to prevent the re-occurrence of this deficiency.	

Minnesota Department of Health

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{2 000}	Initial Comments	{2 000}		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
An onsite follow-up visit was completed on June 19th and 20th, 2018. During this visit it was determined that the following correction order, #0895, was NOT corrected.

The uncorrected order will remain in effect and will be reviewed at the next onsite visit. To be

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{2 000}	Continued From page 1 reviewed for possible penalty assessment.	{2 000}		
{2 895}	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 4/26/18 will remain in effect. Penalty assessment issued. Based on observation, interview and document review the facility failed to provide exercises to maintain range of motion (ROM) services for 4 of 4 residents (R67, R28, R15 and R66) reviewed with a restorative nursing program. Findings include: R67 R67's quarterly Minimum Data Set (MDS) dated 3/29/18, indicated R67 had moderate cognitive impairment, had diagnoses which included anemia, heart dysrhythmia and end stage renal	{2 895}	Correct.	7/26/18

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{2 895}	Continued From page 2	{2 895}		

disease. The MDS identified R67 required total staff assistance with all activities of daily living (ADL's). The MDS further indicated R67 was not steady moving from a seated to standing position, moving on and off the toilet and surface to surface transfers (transfer between bed and chair or wheelchair).

R67's care plan revised 4/19/18, indicated R67 had an ADL self care performance deficit related to disease process, limited mobility and pain. The care plan listed various interventions which included restorative program services.

- R67's Therapy to Nursing Communication form, dated 10/26/17, identified the following instructions:
Stand by edge of bed: with front wheeled walker (FWW), shoes on, gait belt, CGA (contact guard assistance), from elevated bed. Stand Time to pt's tolerance, 3x per week.

- R67's Therapy to Nursing Communication form, dated 2/15/17, identified the following 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

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{2 895}	Continued From page 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, 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 period and began to stand and sit repeatedly x 3 and stated "that's all I can do". R67 attempted to stand one more time then sat back on his bed and indicated he wanted to stop. RA-A transferred R67 from his bed to his wheelchair via mechanical lift. R67 indicated he did pretty good 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

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	00862	A. BUILDING: ______ B. WING ______	R 06/20/2018

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

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{2 895}	Continued From page 4	{2 895}		

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 remained seated in his wheelchair. RA-A was not observed to perform any yellow theraband exercise to include 1) external rotation 15 x 2 (hip height), 2) punch downs 15 x 2 and 3) curls 15 x 2 per therapies recommendations.

R67's Rehab Nursing Record (RNR) dated 6/1/18 to 6/30/18, indicated R67's standing by the edge of bed exercise program was completed only 3 out of 9 opportunities for the month, exercises which included: 1 x 15 seated: hip flexion, abduction, adduction, long arch quads and ankle planter/dorsal flexion bilaterally, AAROM bilaterally shoulder flexion 10 x 2 and hand grippers 15 x 2 were completed 6 out of 9 opportunities for the month and R67's RNR lacked evidence of the use of the yellow theraband for 1) external rotation 15 x 2 (hip 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,

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{2 895}	Continued From page 5	{2 895}		

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 repositioned and toileted.

R28

R28's quarterly MDS dated 5/17/18, indicated R28 had severe cognitive impairment, had diagnoses which included hemiplegia or hemiparesis (paralysis of one entire side of the body), cerebral vascular accident (CVA) (stroke). and seizure disorder. R28's MDS further identified R28 required total assistance with ADLs and had range of motion impairment on one side that affected her lower and upper extremities.

R28's care plan revised 6/19/18, indicated R28 had an ADL self care performance deficit related to stroke. The care plan listed several intervention which included rehab interventions which instructed staff to see rehab book and therapy recommendations in chart.

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{2 895}	Continued From page 6 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. During observation on 6/20/18 at 9:40 a.m. R28 was in her room lying in bed, on her back, with head of bed elevated, fully clothed, with pressure relieving boots on her feet bilaterally and was receiving feeding via gastrostomy tube while she looked out the window. R28's RNR dated 6/1/18 to 6/20/18, indicated R28 had received restorative and ROM exercises 6 out of 9 opportunities for the month. Review of R28's nursing progress notes from 6/4/18 to 6/20/18, lacked any notation of R28's restorative nursing program participation. On 6/20/18 at 12:38 p.m. RA-A confirmed R28 was to receive ROM exercises 3x/week. RA-A confirmed R28 had not been receiving ROM services as per therapies recommendations and had only received ROM exercises in the last couple of days so far this week. On 6/20/18 at 2:38 p.m. RA-B confirmed R28 was to receive ROM exercises routinely. RA-B indicated restorative staff would get pulled to the floor sometimes to help with cares. RA-B indicated she had voiced her concerns about the restorative program and indicated management instructed the restorative staff resident cares come first, then the restorative program. RA-B indicated concerns had been voiced to the RN's and management in the recent past and they were all aware of the problem with the restorative	{2 895}		

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{2 895}	Continued From page 7 program not getting done. On 6/20/18 at 2:44 p.m. RN-C confirmed R28 was to receive ROM exercises routinely and she was not receiving ROM as recommended. RN-C was not sure why her ROM did not get done. RN-C indicated the restorative program had gotten better, but her floor had not had a RA until recently and indicated every floor was supposed to have a RA. RN-C indicated she was aware of staff complaints about the restorative program and had reported the complaints to the director of nursing (DON.) R15 R15's quarterly MDS dated 5/3/18, indicated R15 had intact cognition, had diagnoses which included anxiety disorder, osteoarthritis and systemic lupus. The MDS identified R15 required extensive assistance of one staff with all activities of ADL's. The MDS further indicated R15 was not steady moving from a seated to standing position, moving on and off the toilet and surface to surface transfers (transfer between bed and chair or wheelchair). R15's care plan revised on 5/12/18, indicated R15 had an ADL self care performance deficit related to disease process, limited mobility weakness pain in right knee, recent falls, systemic lupus, erythematous, asthma hypothyroidism and osteoporosis.. The care plan listed several intervention which included restorative program as set up. R15's Therapy to Nursing Communication form , dated 3/24/17, identified the following: dark blue theraband (she has in her room) 1) horizontal 20 x 2, 2) tricep punch outs 20 x 2, 3) shoulder	{2 895}		

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{2 895}	Continued From page 8	{2 895}		

checks 20 x 2, 4) external rotation 20 x 2 (elbows tucked), 3 to 4 x per week or as patient tolerates. Lower extremity seated: hip flexion, abduction, adduction, long arch quads and ankle planter/dorsi flexion and blue theraband hamstring curls 1 x 20 bilaterally. 3 x per week or as patient tolerates.

During observations on 6/20/18 at 9:20 a.m. R15 was in her room, seated in her recliner with her feet elevated up on the foot rest of the recliner.

-at 10:06 a.m. RA-C entered R15's room with her cart which contained several items for exercising such as theraband's, weights and other equipment. RA-C sat down on a foot stool and proceeded to complete upper arm exercises with the blue theraband, applied weights her ankles and completed lower extremity exercises. R15 was able to participate and complete both upper extremity and lower extremity exercises.

R15's RNR dated 6/1/18 to 6/30/18, documented R15 had completed her restorative and ROM exercises 5 out of 9 opportunities for the month.

Review of R15's nursing progress notes from 6/4/18 to 6/20/18, lacked any notation of R15's restorative nursing program participation.

On 6/20/18 at 11:52 a.m. R15 indicated she received restorative program maybe two times a week. R15 indicated she did not believe she was receiving restorative exercise and ROM three times a week.

R66

R66's quarterly MDS, dated 3/29/18, identified R66 was severely cognitively impaired and had

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{2 895}	Continued From page 9 diagnoses which included dementia, depression and Parkinson's disease. The MDS indicated R66 required extensive assistance of two staff with all ADL's and needed ext assistance of one for grooming. The MDS further indicated R66 was not steady moving from a seated to standing position, walking, turning around facing the opposite direction while walking, moving on and off the toilet and surface to surface transfers (transfer between bed and chair or wheelchair). R66's care plan revised on 3/28/18, identified R66 had ADL self care performance deficit related to dementia, disease process: parkinsonism, depression, acute kidney injury and generalized weakness. The care plan listed various interventions which included restorative nursing program in place. R66's Therapy to Nursing Communication form, dated 1/16/18, identified the follows: bilateral LE AAROM, hip flexion, hip abduction, knee flexion/extensions, ankle planter/dorsi flexion, ankle IV/EV 1 x 10. R66's Therapy to Nursing Communication form, dated 4/27/18, identified the following: AAROM or AROM upper extremities 1 to 2 sets 10 reps, shoulders-flex, extension abduction/adduction, elbow-flex, extension, no weights, wrists- flex, extension, supination and pronation, 3 times per week or as tolerated. During observations on 6/20/18 at 10:35 a.m. R66 was lying in bed on his back and RA-C was present in his room. RA-C indicated she had just laid R66 down so she could complete his exercises. RA-C indicated R66 did better with his exercises when he laid down. RA-C proceeded to complete upper extremity and lower extremity	{2 895}		

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{2 895}	Continued From page 10	{2 895}		

exercises with R66. R66 was cooperative throughout the exercises.

R66's RNR dated 6/1/18 to 6/30/18, indicated R66 had received his restorative and ROM exercises 6 times out of 9 opportunities for the month.

Review of R66's nursing progress notes from 6/4/18 to 6/20/18, lacked any notation of R66's restorative nursing program participation.

On 6/20/18 at 11:55 a.m. RA-C confirmed R15 and R66 was to receive restorative and ROM exercises 3x/week. RA-C indicated it was a struggle to get the restorative program done and completed daily. RA-C indicated she had noticed R15 only had her exercises done one time last week and indicated it was a struggle of bouncing back and forth between restorative nursing programs and helping other staff on the floor.

On 6/20/18 at 2:27 p.m. RN-D confirmed R15 and R66 were to receive restorative and ROM exercises 3x/week. RN-D verified R15 and R66 were not receiving restorative and ROM exercises 3x/week per therapies recommendations. RN-D indicated the RA were trying prioritize their work and if the resident was to receive therapy 3 times a week that's what the facility wanted to see done. RN-D indicated staff were struggling getting restorative exercises done and stated "work in progress." RN-D indicated RA's had voiced their concerns about the restorative program not getting done and indicated this concern had been reported to the DON.

On 6/20/18 at 2:54 p.m. DON reviewed and

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{2 895}	Continued From page 11	{2 895}		

confirmed findings regarding the restorative program not being completed consistently for residents as recommended. The DON indicated moving forward, the RN's would be looking at the program weekly to see what adjustments and changes need be done. The DON indicated she had not received any complaints from staff in regards to the restorative program not getting done properly. The DON indicated she would expect staff to make sure the restorative program was getting completed as ordered. The DON indicated she was aware of one time when restorative was not staffed on one floor to do the restorative program and education was given to the staff involved at the time and it was addressed. The DON indicated she was not aware of any other concerns since this one time.

A facility policy titled, Restorative Nursing, Charting Code and Reporting Requirements, revised 9/2003, revealed the purpose of the policy was to record resident's compliance with rehab care plan. The policy directed facility staff to record resident's participation and refusals on the facility Rehab Nursing Care Record. The policy revealed if a resident refuses or was unable to perform for three or more scheduled days the restorative aid should report to the RN coordinator for follow up. The RA shall report to the RN or substitute any anticipated inability to complete ordered modalities before the end of each shift so that assignments can be adjusted to assure completion.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

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: Q7HK
Facility ID: 00862

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245453**

2. STATE VENDOR OR MEDICAID NO. (L2) **678740100**

3. 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
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/26/2018** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **04/30**

11. LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

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 Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 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
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

12. Total Facility Beds **107** (L18)

13. Total Certified Beds **107** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	107			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date:
Susan Bachleitner, HFE NE II 05/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/31/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
___ 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above:

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - 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;
>
> Potential Consequences - 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department’s informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

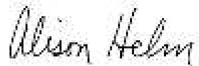
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING ______ B. WING ______	04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/23/18, through 4/26/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements	E 000		
F 000	INITIAL COMMENTS On 4/23/18, through 4/26/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		6/4/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE: | (X6) DATE: 05/23/2018

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.

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 1 of 1 resident (R66) observed during the supper meal in the second	F 550	R19 recliner cushion and wheelchair cushion have been thoroughly cleaned and white incontinent padding has been removed from use. Recliner cushion has	

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F 550	Continued From page 2 floor dining room. In addition the facility failed to ensure dignity was maintained for 1 of 1 resident (R19) who utilized an incontinent pad. Findings include; R66's quarterly Minimum Data Set (MDS), dated 3/29/18, identified R66 was severely cognitively impaired and had diagnoses which included dementia, depression and Parkinson's disease. The MDS indicated R66 required extensive assistance of two staff with bed mobility, transfers, dressing and toileting and one staff for eating. R66's care plan dated 2/2/18, identified R66 had an activities of daily living self care performance deficit and potential unplanned /unexpected weight gain or loss related to diagnoses and disease process and varying intakes. The care plan listed various interventions which included regular diet, provide dignity, and one staff to feed R66. During continual observations of the supper meal on 4/23/18 at 6:26 p.m. on the second floor north dining room R66 was sleeping at the dining room table and his food sat in front of him which consisted of turkey sandwich, soup, tator tots and fruit salad with whip cream. Nursing assistant (NA)-E approached R66, sat down next to him and began talking to R66. --at 6:39 p.m. NA-E continued talking to R66 and when he opened his eyes she started to assist him to eat his soup. -at 6:45 p.m. NA-E got up from feeding R66 his food and started walking around from table to table asking other residents if they would like ice cream. NA-F walked over from the other end of	F 550	been covered with a more discreet colored pad with R19 approval. eTAR entry to change recliner and w/c pads 3x/week. Date Completed: 5/18/18 All resident rooms were evaluated for odor and use of incontinent padding in recliners and wheelchairs. Those wanting/requiring incontinent padding were provided with discreet colored padding. Date completed: 5/30/2018 Housekeeping Tasks, Routine Daily was updated to include maintenance of a clean, orderly, odor free and comfortable interior& and I. Routine Room Cleaning Protocol was updated to expand M. Make visual inspection of privacy curtains, walls, ceilings, registers, lighting, personal fans, and furnishings to include specific directions for resident furnishing: chairs/recliners, bed, expectations of odor free and if covered, covered in a dignified manner. ie. with discreet incontinent padding. Date completed: 5/22/2018 An Audit titled Nursing Care Audit Dignity, BH #1296-18, was created. This audit will monitor the dignity of the resident environment including monitoring of: incontinent care items being visible in the room and in the residents seating locations, room odor, and staff interventions with residents to assure staff are addressing residents by their preferred name as indicated on the Care Plan. Nursing Care Audit Dignity will be completed on each unit by 6/4/2018 and then weekly x 4 weeks on each unit. This audit is completed on an on-going basis and is included in a quarterly Nursing Care system for each unit. DON will	

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F 550	Continued From page 3 the table and gave R66 a bite of his vegetable soup while she stood on the left side of him. NA-F briefly walked away from the table and then returned and sat down next to R66 and assisted him to eat. -at 6:49 p.m. NA-F got up from assisting R66 to eat and began to pick up the soiled clothing protectors from the other tables in the ding room. -at 6:50 p.m. NA-E approached R66, sat down next to him, and stated "hi buddy" and began to feed him a bite of his vegetable soup using a sliver spoon. -at 6:51 p.m. NA-E gave R66 a bite of his vegetable soup and said "here ya go buddy." -at 6:53 p.m. NA-E cut R66's turkey sandwich in half, tried handing it to him while she stated "there ya go buddy I cut it into a smaller piece." -at 6:58 p.m. NA-E gave R66 a bite of his fruit dessert and stated "here ya go buddy." -at 7:09 NA-E gave R66 a bite of his turkey sandwich and stated "here ya go buddy you almost ate all of your sandwich." -at 7:11 p.m. NA-E gave R66 a drink of his milk and said "it's ok buddy you can let go of it (glass of milk)." NA-E took the glass from R66's hand and sat it on the table. -at 7:15 p.m. R66 was done eating his supper meal, NA-E got up from sitting next to R66 and stated "here we go buddy" and wheeled R66 out of the dining room via his wheel chair to the living room area. On 4/26/18 at 2:30 p.m. NA-E confirmed she was using nicknames while she was assisting R66 with his supper meal. NA-E confirmed the usual facility practice was for staff to remain seated next to the resident while they were eating and not to interrupt their meal time by getting up and leaving. NA-E verified staff should not be using	F 550	monitor and audit findings and assure prompt follow up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of the Quality Assessment and Assurance Committee and QAPI. Date Completed: 6/4/2018 and ongoing. Nursing Staff meeting scheduled May 30, 2018 to include review of updated policy and procedure and Nursing Care Audit Dignity. Further information was provided to staff regarding availability of discreet colored padding and that visibility of incontinence padding and products is not dignified. Date completed: 5/30/2018 Housekeeping staff updated with review of policy and procedure Housekeeping Tasks, Routine Daily and expectations of odor free and dignified interior environment. Date completed: 5/29/2018 2 dozen additional discreet colored incontinent pads have been ordered for facility use. Date completed: 5/18/2018 R66 is experiencing a dignified dining experience at every meal. Date completed: 5/31/2018 All residents in the dining room served by NA-E have the potential for an undignified dining room experience. NA-E was counselled on the important of maintaining a dignified experience for all residents by addressing them by their preferred name. NA-E verbalized understanding. All staff were educated on the importance of maintaining dignity of all residents by addressing them by their preferred name as identified on their Care Plan at the Nursing Staff meeting held	

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F 550	Continued From page 4 pet names unless the resident preferred to be called by the nickname. NA-E indicated she felt it was better to use the residents name to get their attention more. On 4/26/18 at 1:12 p.m. director of nursing (DON) confirmed the usual facility practice while staff were assisting residents to eat, was for staff to stay with the resident until they are done eating and let them have a good hot meal. The DON verified staff should not be interrupting the residents meal and she did not like the staff to rotate while they were assisting a resident, because that staff member knew how the resident was eating. The DON confirmed staff should not be using pet names or nicknames and indicated staff had been trained on this in dementia training. The DON verified staff should only being using the residents name, unless the resident preferred a different name and stated "buddy should not be used." R19 R19's quarterly MDS, dated 2/15/18, identified R19 was moderately cognitively impaired and had diagnoses which included dementia, hemiplegia and depression. The MDS indicated R19 required extensive assistance of two staff with bed mobility, transfers and one staff for dressing, toileting, personal hygiene and eating. Further review of the MDS indicated R19 was always incontinent of urine and was not on a toileting program. R19's care plan dated 5/18/17, identified R19 had an activities of daily living self care performance deficit related to stroke, dementia hemiplegia and depression. The care plan listed various	F 550	5/30/2018. Date completed: 5/30/2018 LB Broen Home Competency Checklist: Assisting a Resident to Eat, BH #1275-17, was updated to include 1. Check resident s Care Plan for diet order, eating assistance needed and preferred name, 7. Sit beside the resident during feeding and remain with resident as able throughout the meal, and 17. Did not address resident by a pet name. Date Completed: 5/22/2018 LB Broen Home Competency Checklist: Assisting a Resident to Eat will be completed with all NA/R s at LB Broen Home by 6/4/2018. Date completed: 6/4/2018 LB Broen Home Food/Dining Service Audit Tool, BMH #691-94 was updated to include Food Service: 5. Staff were seated while feeding (did not stand) and remained with the resident as able throughout the meal, and Atmosphere: 6. Residents are addressed by their preferred name as identified on their Care Plan. LB Broen Home Food/Dining Service Audit Tool was completed on all units, at all meals by 6/4/2018 and then weekly on all units, at all meals x 4 weeks. This audit is completed on an on-going basis and is included in a quarterly Nursing Care audit system for each unit. DON will monitor audit findings and assure prompt follow up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of the Quality Assessment and Assurance Committee and QAPI. Date completed: 6/4/2018 and ongoing.	

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F 550	Continued From page 5 interventions which included provide privacy, dignity and required physical assistance of one to two staff with all perineal care, adjusting of clothing and changing of incontinent padding. During observations on 4/24/18 at 1:16 p.m. R19 was in her room lying in bed sleeping. A brown cloth covered recliner was present in R19's room and the seat of the recliner was covered with a white incontinent pad. R19's room had a strong odor of urine noted permeating through out the room. During observations on 4/25/18 at 7:04 a.m., R19 was seated in her room in her brown cloth reclining chair with her feet up on the foot rest of the recliner. R19's brown reclining chair was covered with a white incontinent pad on the seat of the recliner. The white incontinent pad was visible to the public on the left side of R19's recliner while the edge of it hung from the front of the reclining chair. -at 7;38 a.m. R19 remained seated in her recliner with the white incontinent pad visibly hanging on the left side of her recliner. -at 7:53 a.m. remained seated in her recliner with the white incontinent pad visibly hanging on the left side of her recliner. -at 8:07 a.m. registered nurse (RN)-B wheeled R19 out of her room via her black wheelchair into the dining room area for breakfast and handed her a menu to look at. R19's wheel chair seat was covered with a white incontinent pad and was hanging partially out of the back and the left side of her wheel chair, while the rest of it was tucked under the seat of the wheel chair but was visible on all sides of the seat cushion. -at 8:22 a.m. R19 was seated in her wheel chair at the dining room table drinking a container of	F 550	Nursing Staff meeting held 5/30/2018 included review of Competency Checklist: Assisting a Resident to Eat and LB Broen Home Food/Dining Service Audit Tool updates. The correct way to address a resident by their preferred name was demonstrated. Date Completed: 5/30/2018	

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F 550	Continued From page 6 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	F 550		

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F 550	Continued From page 7	F 550		

tucked under the seat of the wheel chair but still visible on all sides.
-at 12:30 p.m. R19 remained seated in her wheel chair at the dining room table while NA-F sat on the right side of her assisting her to eat her lunch. R19 continued to have a white incontinent pad still visible on all sides of the wheelchair seat.
-at 12:42 p.m. R19 remained seated in her wheel chair at the dining room table while NA-F sat on the right side of her assisting her to eat her lunch. R19 continued to have a white incontinent pad visible on the seat and sides of the wheelchair.

On 4/25/18 at 11:14 a.m. NA-H confirmed R19 was incontinent of bowel/bladder, wore a brief and needed staff assistance to be toileted and changed. NA-H indicated R19 had incontinent pads on the seats of her recliner and wheel chair due R19 being incontinent and to protect the furniture from being soiled with urine. NA-H indicated staff tried to take the incontinent pads off the recliner but does not always happen if they are in a hurry.

On 4/25/18 at 1:30 p.m. licensed practical nurse (LPN)-C confirmed R19 was incontinent of bowel/bladder, wore a brief and needed staff assistance to be toileted and changed. LPN-C indicated R19 had incontinent pads on the seats of her recliner and wheel chair in case she had an accident and so they don't ruin the furniture from being soiled with urine. LPN-C indicated the facility had brown incontinent pads staff normally used, but indicated the supply was limited and not always available.

On 4/26/18 at 1:06 p.m. director of nursing (DON) confirmed R19 was incontinent of bowel/bladder, wore a brief and needed staff assistance to be

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F 550	Continued From page 8 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	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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	F 584		6/4/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review the facility failed to maintain windows in good repair to prevent the elements from entering in resident personal rooms in 12 of 12 resident rooms(rm 350, rm 357, rm 365, rm369, rm368, rm 366, rm 364, rm 361, rm 360, rm 359, rm 358, rm 356), and in common areas on the second and third floor of the facility. Findings include: On 4/25/18, at 11:30 a.m. an environmental tour	F 584	R29 s window is repaired and is in good, weather tight and safe operating condition. Date Completed: 5/22/2018. Windows in rooms 350, 356, 357, 358, 359, 360, 361, 364, 365, 366, 368 and 369 will be repaired and in good, weather tight and safe operating condition. Date Completed: 6/4/2018 Second floor north (2N) windows are repaired and in good weather tight and safe operating condition. Date Completed: 6/4/2018	

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	245453	A. BUILDING ______ B. WING ______	04/26/2018

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F 584	Continued From page 10 of the facility was conducted with the facilities engineer (FE)A , and he confirmed the following findings: 3rd floor: -Room 350-the wooden edges of the three paned window were soft, cracked; -Room 357- the wooden edges of the three paned window were soft, cracked and crumbled when touched; -Room 365-the wooden edges of the three paned window were soft, cracked and crumbled when touched; -Room 369-the wooden edges of the window were soft, cracked and crumbled when touched. There was white duct tape on the bottom edge of the smaller window; -Room 368-the middle windowpane had tape on the lower edge of the window that had been painted over with brown paint. This taped area was soft when touched; -Room 366-the middle windowpane had tape on the lower edge of the window that had been painted over with brown paint. This taped area was soft when touched; -Room 364-the small window to the left of the larger middle window had soft, cracked edges; -Room 361-the wooden edges of the three paned window were soft, cracked and gave way to pressure when touched. Cold air flow was felt by the edges of the window; -Room 360-the wooden edges of the three paned window were soft, cracked and gave way to pressure when touched. Cold air flow was felt by the edges of the window; -Room 359-the wooden edges of the three paned window were soft, cracked and gave way to pressure when touched. Cold air flow was felt by the edges of the window; -Room 358-the wooden edges of the three paned	F 584	All facility windows inspected by the facility maintenance team using the Window Inspection Checklist, BH # 6116-18 and Guidelines, BH # 6117-18, to identify windows in need of repair or replacement. Date Completed: 6/4/2018 A Window Inspection Checklist, BH # 6116-18, has been added to the Environmental Inspection Checklist which is completed quarterly. Date Completed: 5/22/2018 Environmental Services Audit, Resident Safe Environment Window Inspection, BH # 6118-18 was created. This audit will monitor the inspection, condition and repair of facility windows. Date Completed: 5/22/2018 Environmental Services Audit, Resident Safe Environment Window Inspection, BH # 6118-18, will be completed on all units by 6/4/2018 and then weekly x 4 weeks on all units. This audit is completed on an on-going basis and is included in a quarterly maintenance audit system. Director of Support Services will monitor findings and assure prompt follow up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of the Quality Assessment and Assurance Committee and QAPI. Date Completed: 6/4/2018 and ongoing. Education provided to Maintenance team on addition of Window Inspection Checklist to the quarterly Environmental Inspection Checklist and Environmental Services Audit, Resident Safe Environment Window Inspection. Date	

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F 584	Continued From page 11 window were soft, cracked and gave way to pressure when touched; -Room 356-the wooden edges of the window were soft and cracked -The five large windows in the common area on the third floor were in poor repair. The edges of the window were made of particle board with a laminate overlay. The laminate was warped and missing in some areas. The large window near the snack area had sign taped to the window, "do not open this window it is broken." -The large window at end of hall was missing the laminate on the lower edge and the exposed particle board was broken and moved when touched. The top of the window frame bowed down. -One of the three dining room windows had an area along the lower edge which was soft to touch and air was felt coming through the window. 2nd floor: The windows at the end of both halls had warped and missing the laminate with exposed and ill fitting particle board which did not create a tight seal with the window and wall. R29's quarterly minimum data set (MDS) dated 2/15/18, indicated R29 had intact cognition. On 4/25/18, at 11:37 a.m. R29 indicated this past winter, snow had come in through the lower edges of the window near R29's chair this winter. R29 indicated staff screwed the window shut and were able to stop the snow from coming in, however; R29 indicated the wind continued to come in through the window. On 4/26/18, at 12:52 p.m. FE-A verified the	F 584	Completed: 5/31/2018	

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F 584	Continued From page 12 above findings. FE-A indicated the facility did not have plans to replace the windows, however; thought window replacements would be done in the future. FE-A indicated the facility had obtained an estimate for the cost of replacing windows on one floor, in order to get a ball park number of the cost to plan how to pay for the window replacements. FE-A indicated the best plan would be to repair the current windows to make them functional and then replace the windows as the facility is able. The facility provided a estimate for window replacement dated 1/16/18. The estimate had not been signed as accepted and no purchasing order was provided. On 4/26/18, at 3:22 p.m. the director of nursing (DON) verified she expected the environment to be clean, presentable, and functional, in order to provide a safe and comfortable environment for each resident. The requested facility policy was not provided.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and	F 637		6/4/18

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F 637	Continued From page 13 requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) when two or more areas of change in resident status were noted on the Minimum Data Set (MDS) for 2 of 3 residents (R33, R59) reviewed for a decline in health status. Findings include: R33's quarterly MDS dated 11/23/17, identified R33's diagnosis of dementia, had severe cognitive impairment and required extensive assistance with areas of daily living (ADL)s of one staff with bed mobility, transfers, toileting, dressing, personal hygiene and bathing. The MDS further identified R33 had no range of motion (ROM) limitation of the upper or lower extremities and had occasional bowel incontinence. R33's quarterly MDS dated 2/22/18, identified R33 had severe cognitive impairment, required total ADL assistance of two staff with bed mobility, transfers, toileting, dressing, personal hygiene and bathing, had limited ROM of both sides of the upper or lower extremities and always incontinent of bowel. Review of the above assessments indicated R33 had a decline in ADL's performance from extensive assistance of one staff to total assistance of two staff, a decline in ROM from no limitation to limited ROM of both sides of the upper or lower extremities and a decline in bowel	F 637	A Significant Change in Status MDS Assessment was completed on 5/15/2018 for R33. Date Completed: 5/15/2018 A Significant Change in Status MDS Assessment was completed on 5/15/2018 for R59. Date Completed: 5/15/2018 IDT reviewed each resident in the facility to determine if a significant change in status had been met. Date Completed: 5/22/2018 Nursing Care Audit Resident Assessment/Care Planning and Implementation, BMH# 1187-06, was updated to include: IDT reviewed for significant change, by comparing previous and current MDS. Date completed: 5/22/2018 Nursing Resident Assessment/Care Planning and Implementation Checklist, BMH# 1142-03, updated to include: IDT reviewed for significant change, by comparing previous and current MDS. Date completed: 5/22/2018 Nursing Care Audit Resident Assessment/Care Planning and Implementation will be completed on all units by 6/4/18 and then weekly x 4 weeks on all units. This audit is completed on an on-going basis and is included in a quarterly Nursing Care Audit system for each unit. DON will monitor and audit the findings and assure prompt follow up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee,	

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F 637	Continued From page 14 continence from occasional to always incontinent of bowel. R59's annual MDS dated 12/21/17, identified R59 had diagnoses which included Alzheimer's disease and dementia, had severe cognitive impairment, required extensive ADL assistance of staff with bed mobility, transfers, dressing, eating, toileting, bathing, had occasional bladder incontinence and a PHQ-9 score of 00, which indicated no signs or symptoms of depression. R59's quarterly MDS dated 3/22/18, identified R59 had severe cognitive impairment, required total ADL assistance from staff with bed mobility, transfers, dressing, eating, toileting, bathing, had frequent bladder incontinence and a PHQ-9 score of 03, which indicated minimal signs and symptoms of depression. Review of the above assessments indicated R59 had a decline in ADL's performance from extensive assistance of staff to total assistance of staff, a decline in bladder continence from occasional to frequent, and a PHQ-9 score which indicated a decline in mood from no signs or symptoms of depression to minimal signs and symptoms of depression. 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. 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	F 637	a subcommittee of the Quality and Assessment and Assurance Committee and QAPI. Date Completed: 6/4/2018 an ongoing. DON will monitor (CM)-B s completed MDS s weekly beginning 6/4/18 and then weekly x 4 weeks to evaluate understanding of significant change in status assessment needs and provide follow up as needed with (CM)-B. Date Completed: 6/4/2018 and ongoing Education provided to the IDT, consisting of RNUC s, Social Services, Activities and Dietician, on updates to Nursing Resident Assessment/Care Planning and Implementation Checklist and Nursing Care Audit Resident Assessment/Care Planning and Implementation Checklist. Reeducation on definition of a significant change in status, IDT s responsibility for recognizing a significant change in status has occurred and scheduling of the Significant Change in Status completed. Date Completed: 5/29/2018 (CM)-B reeducated and counseled on use of Nursing Resident Assessment/Care Planning and Implementation Checklist as (CM)-B completes the assignments, identification of Significant Change in status and communication of identified changes with IDT. Date Completed: 5/22/18	

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F 637	Continued From page 15 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 637		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F 676		6/4/18

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§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

§483.24(b) Activities of daily living.
The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document

R31 is encouraged to ambulate to all

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F 676	Continued From page 17 review, the facility failed to implement therapy recommendations and routinely provide ambulation services to maintain function for 1 of 1 resident (R31) reviewed for ambulation. Findings include: R31's admission Minimum Data Set (MDS) dated 2/16/18, identified R31 was cognitively intact and had diagnoses which included depression, anxiety, obesity and hypertension. The MDS identified R31 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers and walking with assistance of two facility staff. The MDS revealed R31 was not able to maintain his balance without staff assistance, had no impairments of his range of motion (ROM) and had received five days of both physical therapy (PT) and occupational therapy (OT) services during the seven day look back period. R31's admission Care Area Assessment (CAA) dated 2/16/18, identified R31 required extensive assistance with ADL's including walking. The CAA identified R31 had received both OT and PT services with the goal to improve his independence and to prevent further decline in his strength. R31's 14-day prospective payment system (PPS) MDS dated 2/22/18, identified R31 required extensive assistance with ADL's including bed mobility and transfers. The MDS identified R31 had ambulated less than three times within the seven day look back period. The MDS further identified R31 received both PT and OT services five out of seven days.	F 676	meals. eTAR updated to include: Encourage to ambulate to all meals with 4 wheeled walker and w/c following behind. Date Completed: 5/18/2018 All resident records were reviewed for presence of a PT Therapist Program and Discharge Summary form. Discharge Plans and Instructions section to assure all ambulation recommendations have been transcribed. Date Completed: 5/30/2018 Policy and Procedure, Therapy Recommendations for Restorative Nursing Program created to assure all therapy recommendations are clearly communicated to Nursing staff and direction for completion of Form, Therapy Recommendations for Restorative Nursing Program, BH 1297-18. Date Completed: 5/18/2018 Form, Therapy Recommendations for Restorative Nursing Program, BH # 1297-18, created and includes communication of recommendations for all modalities upon discharge from contracted therapy services to restorative nursing. Date Completed: 5/18/2018 Transcribing Orders Master File, THERAPY: Physical, Occupational, Speech updated to include use of eTAR for therapy recommendations occurring outside of Rehabilitative Nursing hours. Date Completed: 5/22/2018 Nursing Care Audit Transcription of Orders, BH# 1190-06, (#5. Only) will be completed on three residents on each unit by 6/4/2018 and then weekly on three residents x 4 weeks on all units. This audit is completed on an on-going basis	

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F 676	Continued From page 18 R31's care plan revised 4/13/18, revealed R31 required assistance from staff with bed mobility, transfers with one assist and ambulation with a walker and transfer belt. The care plan directed facility staff to encourage R31 to ambulate and to assist R31 to ambulate with a wheelchair to follow behind. The care plan further directed facility staff to encourage R31 to participate in activities that promoted exercise, physical activity for strengthening and improved mobility such as: walking with assistance, using NuStep. R31's end of therapy discharge plan and instructions dated 3/2/18, revealed R31 was assist of one with transfers and ambulation. The instructions directed nursing staff to ambulate with meals with a four wheeled walker and a gait belt. R31 was to be added to the facility restorative nursing program with the NuStep machine. The discharge plan revealed R31 had ambulated up to 90 feet with a four wheeled walked at the time of discharge from skilled therapy services. On 4/24/18, at 8:53 a.m. R31 stated he used to 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.	F 676	and is included in a quarterly Nursing Care Audit system for each unit. DON will monitor and audit findings and assure prompt follow up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of the Quality and Assessment and Assurance Committee and QAPI. Date Completed: 6/4/2018 and ongoing. Contracted Therapy group staff educated on of Policy and Procedure changes and updates to Therapy Recommendations for Restorative Nursing Program. Date Completed: 5/23/2018 Unit Clerks, RNUC s and Charge Nurses educated on new Policy and Procedure titled Therapy Recommendations for Restorative Nursing Program, updates to the Transcribing Master Orders File titled THERAPY: Physical, Occupational, Speech and Therapy Recommendations for Restorative Nursing Program, BH 1297-18 at May 30, 2018 Nursing Staff meeting. Date Completed: 5/30/2018	

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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 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 exercises.

On 4/25/18, at 12:36 p.m.. R31 was seated in a wheelchair in the dining room and had propelled himself with both of his feet approximately 30

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feet. At that time NA-B offered to wheel R31 back to his room. NA-B did not offer to ambulate with R31.

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 rehab nursing record from 3/3/18, to 4/26/18, revealed:

March, 2018, R31 had completed the NuStep machine 4 times, had refused one time out of 28 opportunities. The record revealed R31 had not received ROM exercises.

April, 3108, R31 had completed the NuStep machine 3 times, had refused one time out of 26 opportunities. The record revealed R31 had received ROM exercises once.

R31's rehab nursing record lacked documentation of R31's ambulation to and from meals.

On 4/26/18, at 8:24 a.m. R31's restorative program was reviewed with registered nursing manager (NM)-B. NM-S confirmed R31's had not routinely received his restorative program on a routine basis. NM-B confirmed R31's medical record lacked documentation of R31's ambulation to and from meals. She stated there was no formal program for R31's ambulation, therefore would not be documented in the restorative record. NM-B stated any nursing staff could ambulate with R31, however different NA's had received training in restorative programs, which

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included ROM and the NuStep machine. NS-B confirmed R31's medical record lacked documentation of R31 refusing to ambulate with nursing staff and did not routinely reveal R31's refusals of restorative 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.

On 4/26/18, at 9:54 a.m. NA-B stated R31 would occasionally use the NuStep and had routinely refused to ambulate. NA-B stated he could not 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.

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F 676	Continued From page 22 On 4/26/18, at 2:59 p.m. the director of nursing (DON) stated she would expect R31 to be offered to walk to and from meals, assist with the NuStep machine and ROM exercises. She stated she was not aware R31 had not routinely received restorative nursing services and indicated she would expect to be informed if staff were having difficulty routinely offering restorative services. A facility policy titled, Restorative Nursing, Charting Code and Reporting Requirements, dated 9/2003, revealed the purpose of the policy was to record resident's compliance with rehab care plan. The policy directed facility staff to record resident's participation and refusals on the facility Rehab Nursing Care Record. The policy revealed if a resident refuses or was unable to perform for three or more scheduled days the restorative aid should report to the RN coordinator for follow up.	F 676		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		6/4/18

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F 688	Continued From page 23 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to routinely provide restorative exercises for 2 of 3 residents (R67 and R31) reviewed with a restorative nursing program. In addition the facility failed to provide range of motion services for 1 of 2 residents (R28) who were reviewed for limited range of motion. Findings include: R67's quarterly Minimum Data Set (MDS) dated 3/29/18, indicated R67 had moderate cognitive impairment, had diagnoses included anemia, heart dysrythmia and end stage renal disease. The MDS identified R67 required total staff assistance with all activities of daily living (ADL's). On 4/24/18, at 9:10 a.m. R67 stated staff were to assist him to stand but this service was not being offered and if it was, it was only for a short time. R67 indicated the worry of no longer being able to stand if he was not allowed to stand often or long enough. R67's care plan revised 4/12/18, indicated R67 had an ADL self care performance deficit r/t (related to) disease process, limited mobility and pain. The care plan identified a restorative program was in place. A facility document titled Therapy to Nursing Communication, dated 10/26/17, identified the	F 688	R67 nursing rehabilitation is completed as ordered. Date Completed: 6/4/2018 R31 nursing rehabilitation is completed as ordered. Date Completed: 6/4/2018 R 28 nursing rehabilitation is completed as ordered. Date Completed: 6/4/2018 All residents with a Nursing Rehabilitative program have been reviewed by the RNUC evaluating completion and documentation of provided Rehabilitative Nursing Services. Date Completed: 5/30/2018 Rehabilitative Nursing, Charting Code and Reporting Requirements Policy and Procedure reviewed and updated to increase frequency of RNUC monitoring of completion and documentation of the nursing rehab program. Date Completed: 5/23/2018 Rehab Assistants reeducated regarding the importance of completion and documentation of therapy services as ordered, the need to communicate any anticipated inability to complete ordered modalities before the end of the shift so that assignments can be adjusted to assure completion. Date Completed: 5/31/2018 RNUC s and Charge Nurses reeducated on their responsibility to manage the Rehabilitation program on their unit and to assure rehabilitative services are being completed as ordered. Policy and Procedure Rehabilitative Nursing,	

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F 688	Continued From page 24 following: Goal area; Maintain LE (lower extremity) strength and standing ability 3x (three times) per week or as pt. (patient). Suggested approaches; Stand by edge of bed: with FWW (front wheeled walker), shoes on, gait belt, CGA (Contact Guard Assistance), from elevated bed. Stand Time to pt's tolerance. One time 3x per week. On 4/25/18, at 11:17 a.m. R67 was observed in his room seated on the front edge of the wheel chair leaning back to rest on the back of the chair. R67 informed nursing assistant (NA)-C he was sliding out of the wheel chair and needed help to scoot back onto the seat. With the use of a EZ stand lift (mechanical lift to standing position), NA-C stood R67 and repositioned him to sit farther back onto the wheel chair seat. On 4/25/18, at 11:53 a.m. R67 self propelled the wheel chair to the dining room. On 4/26/18, at 9:48 a.m. R 67 participated with 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.	F 688	Charting Code and Reporting Requirements reviewed. Date Completed: 5/31/2018 Nursing Care Audit Rehabilitative Nursing , BH # 1298 - 18, created. This audit monitors the completion and documentation of the Nursing Rehabilitative program. Date Completed: 5/23/2018 Nursing Care Audit Rehabilitative Nursing will be completed on all units by 6/4/18 and then weekly x 4 weeks on all units. This audit is completed on an on-going basis and is included in a quarterly Nursing Care Audit system for each unit. DON will monitor and audit findings and assure prompt follow up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of the Quality and Assessment and Assurance Committee and QAPI. Date completed: 6/4/2018 an ongoing.	

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Review of the facility form titled Rehab Nursing Record dated April 2018, lacked documentation of R67's participation or refusal of the sit to stand program with exception of 4/11/18, which indicated the program had been completed on that date.

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.

On 4/26/18, at 9:55 a.m. clinical manager (CM)-B indicated a binder was available with direction for all resident restorative nursing programs. CM-B indicated R67 wanted to regain the ability to walk and was seen by therapy. CM-B indicated R67 was not able to walk after therapy was completed but was able to stand and the program to stand by the bed with a walker and staff was started. CM-B verified a note in the binder directed R67's programs be provided by a specific nursing assistant. CM-B indicated often on dialysis days R67 is too weak to participate in the sit to stand program.

On 4/26/18, at 10:42 a.m. NA-C indicated he/she had not completed R67's restorative programs. NA-C verified the documentation in the restorative binder indicated the sit to stand program was only completed on the 11th. NA-C verified the program was supposed to be completed three times a week.

On 4/26/18, at 10:51 a.m. NA-B indicated he/she was responsibile to provide R67's restorative program. NA-B indicated if R67 did not participate with the restorative sit to stand program he/she would inform the nurse and the

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F 688	Continued From page 26 restorative aid. On 4/26/18, at 10:56 a.m. licensed practical nurse (LPN)-B indicated refusals to participate with the restorative nursing program would be reported to her, however; NA-B would also report the refusal to the restorative aid who would be responsible to document the refusal. On 4/26/18, at 11:12 a.m. clinical manager (CM)A indicated she expected staff to document the reason residents did not receive the rehab services (for example because of refusals or illness). CM-A indicated she did not review the restorative nursing documentation throughout the month. On 4/26/18, at 1:19 p.m. NA-B placed the EZ stand lift belt around R67's back, attached the lift belt loops to the hooks on the lift, stood R67 with the assistance of the EZ stand and transferred R67 onto the bed. NA-B placed a gait belt around R67's waist and with CGA and the use of a walker, R67 stood from the bed for two minutes and then sat down. R67 stood and sat a total of 10 times, with the time standing between two minutes and 60 seconds. On 4/26/18, at 3:22 p.m. the director of nursing (DON) indicated she expected staff to follow the restorative nursing programs as they were set up by therapy to maintain strength and ability. The DON indicated documentation should have been completed whether or not the program was completed. If the restorative program was not completed, the clinical manager should be informed. The DON indicated communication should be made in order to ensure the program was provided as ordered.	F 688		

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R31
R31's admission MDS, dated 2/16/18, identified R31 was cognitively intact and had diagnoses which included depression, anxiety, obesity and hypertension. The MDS identified R31 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers and walking with assistance of two facility staff. The MDS revealed R31 was not able to maintain his balance without staff assistance, had no impairments of his range of motion (ROM) and had received five days of both physical therapy (PT) and occupational therapy (OT) services during the seven day look back period.

R31's admission Care Area Assessment (CAA) dated 2/16/18, identified R31 required extensive assistance with ADL's including walking. The CAA identified R31 had received both OT and PT services with the goal to improve his independence and to prevent further decline in his strength.

R31's 14-day prospective payment system (PPS) MDS dated 2/22/18, identified R31 required extensive assistance with ADL's including bed mobility and transfers. The MDS identified R31 had ambulated less than three times within the seven day look back period. The MDS further identified R31 received both PT and OT services five out of seven days.

R31's care plan dated 3/16/18, revealed R31 required assistance from staff with bed mobility,

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transfers with one assist and ambulation with a walker and transfer belt. The care plan further directed facility staff to encourage R31 to participate in activities that promoted exercise, physical activity for strengthening and improved mobility such as: walking with assistance, using NuStep.

R31's current physician orders signed 4/5/18, revealed an order dated 3/2/18, for NuStep level 8 for 20 minutes or as tolerated, may set up NuStep then let resident use machine with supervision and aid for safety getting off and on the machine, one time a day for five times a week or as resident tolerated.

R31's physician orders revealed an order dated 3/2/18, for seated or supine arm exercises with four pound weight bar or green Thera band (large band used for strengthening) shoulder flexion, extension, abduction/adduction and elbow flexion/extension, one set for 20 repetitions, one time a day for 3 times a week as resident tolerated.

R31's end of therapy discharge plan and instructions dated 3/2/18, revealed R31 was assist of one with transfers and ambulation. The instructions directed R31 was to be added to the facility restorative nursing program with the NuStep machine and nursing staff to ambulate with meals with a four wheeled walker and a gait belt. The discharge plan revealed R31 had ambulated up to 90 feet with a four wheeled walked at the time of discharge from skilled therapy services.

On 4/24/18, at 8:53 a.m. R31 stated he used to walk with the facility staff when he first came to

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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 or arm exercises. 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, 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

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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 exercises.

On 4/25/18, at 12:36 pm. R31 was seated in a wheelchair in the dining room and had propelled himself with both of his feet approximately 30 feet. At that time NA-B offered to wheel R31 back to his room. NA-B did not offer to ambulate with R31.

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 rehab nursing record from 3/3/18, to 4/26/18, revealed:

March, 2018, R31 had completed the NuStep machine 4 times, had refused one time out of 28 opportunities. The record revealed R31 had not received ROM exercises.

April, 3108, R31 had completed the NuStep machine 3 times, had refused one time out of 26 opportunities. The record revealed R31 had received ROM exercises once.

On 4/26/18, at 8:24 a.m. R31's restorative

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F 688	Continued From page 31 program was reviewed with registered nursing manager (NM)-B. NM-S confirmed R31's had not routinely received his restorative program on a routine basis. NM-B confirmed R31's medical record lacked documentation of R31's ambulation to and from meals. She stated there was no formal program for R31's ambulation, therefore would not be documented in the restorative record. NM-B stated any nursing staff could ambulate with R31, however different NA's had received training in restorative programs, which included ROM and the NuStep machine. Further, NS-B confirmed R31's medical record lacked documentation of R31 refusing to ambulate with nursing staff and did not routinely reveal R31's refusals of restorative 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. On 4/26/18, at 9:54 a.m. NA-B stated R31 would occasionally use the NuStep and had routinely refused to ambulate. NA-B stated he could not 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	F 688		

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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.

On 4/26/18, at 2:59 p.m. the director of nursing (DON) stated she would expect R31 to be offered to walk to and from meals, assist with the NuStep machine and ROM exercises. She stated she was not aware R31 had not routinely received restorative nursing services and indicated she would expect to be informed if staff were having difficulty routinely offering restorative services.

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R28

R28's annual MDS dated 2/15/18, indicated R28 had diagnosis which included hemiplegia or hemiparesis (paralysis of one entire side of the body), arthritis and seizure disorder. R28's MDS further identified R28 required total assistance with ADLs and had range of motion impairment on one side. R28's quarterly MDS identified R28 had diagnosis of Cerebral Vascular Accident (CVA) (stroke).

R28's care plan last revised 2/26/18, indicated R28 had an ADL self care performance deficit r/t (related to) Stroke. Interventions included rehab interventions which instructed staff to see rehab book and therapy recommendations in chart.

On 4/23/18, at 7:16 p.m. R28 was lying on her bed in her room on her back. Her head of bed was elevated, and she wore pink pajamas and was covered by her sheet and blanket. Her left hand was observed resting on her left side, on a pillow, and her fingers were curled into a loose fist.

On 4/24/18, at 8:41 a.m. R28 was observed in her recliner in her room. Her feet were elevated and her eyes were closed. R28's left hand was resting on a pillow and her fingers were curled into a loose fist.

On 4/25/18, at 7:12 a.m. R28 was sitting in her recliner in her room with her eyes closed and her feet elevated. She was dressed and had her left hand resting on a pillow. Her left fingers were curled into a loose fist.

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On 4/26/18, at 10:37 a.m. NA-A indicated R28 required total assistance with all her cares. NA-A indicated the facility had rehabilitation staff who performed the rehabilitation nursing program. NA-A indicated the rehabilitation staff tried to complete the program daily.

R28's physician orders signed 3/13/18 included orders for PROM to bilateral upper extremities one time a day for 5 times a week, initiated on 3/31/17. R28's orders also included PROM to lower extremities 1 time/ times 10; hip flexion (bending movement), abduction (movement away from body) /adduction (movement toward body), knee flexion/extension (straightening movement). Ankle Planter flexion (movement downward) /dorsi flexion (movement of the foot upward), IV (inversion-tilt towards the body)/EV (eversion-tilt away from the body). One time a day for 5 times a week.

R28's facility form titled physical therapy plan of care (evaluation only) dated 3/27/17, signed by physician 3/30/17, identified R28 was to be discharged to the same SNF (skilled nursing facility) for RNP (rehabilitation nursing program).

R28's facility form titled occupational therapy plan of care (evaluation only) dated 3/28/17, signed by physician 3/30/17, identified R28 was to be discharged to the same SNF, and R28 was appropriate for RNP of UE (upper extremity) PROM.

R28's facility form titled Therapy to Nursing Communication, dated 3/28/17, signed 3/30/17, by restorative coordinator included R28's goal areas were to maintain UE PROM for cares and contracture prevention and Maintain B (bilateral)

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LE ROM 5 times a week or as patient tolerates. Suggested approaches included PROM to B UE and PROM 1 x 10 hip flexion, abduction, adduction, knee flexion/extension, ankle PF (plantar flexion)/ DF (dorsal flexion), IV/EV.

R28's Rehab Nursing Records dated 4/1/17, to 4/26/18, all included instructions for: PROM to bilateral upper extremities. One time a day for 5 X/week, start date 3/31/17. PROM to Lower extremities; 1 x 10 hip flexion, abduction/adduction, knee flexion/extension. Ankle Planter flexion/dorsi flexion, IV/EV. One time a day for 5 x /week.

Review of R28's Rehab Nursing Records dated 11/1/17, to 4/26/18 identified by staff initials the following:

-11/1/17, to 11/30/17, R28 received UE PROM exercises and LE PROM exercises 6 days out of 22 opportunities.

-12/1/17, to 12/31/17, R28 received UE PROM exercises and LE PROM exercises 7 days out of 23 opportunities.

-1/1/18, to 1/31/18, R28 received UE PROM exercises and LE PROM exercises 11 days out of 24 opportunities.

-2/1/18, to 2/28/18, R28 received UE PROM exercises and LE PROM exercises 11 days out of 20 opportunities.

-3/1/18, to 3/31/18, R28 received UE PROM exercises and LE PROM exercises 4 days out of 23 opportunities.

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-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.

On 4/26/18, at 1:07 p.m. physical therapist (PT)-A indicated the facility's usual practice for the restorative nursing program began with therapy staff educating the nursing staff for the program and ROM exercises. PT-A indicated she would expect R28 to receive the exercises 5 times a week, as ordered. PT-A indicated she would expect them to notify her if something had prevented the nursing staff from completing the

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exercises, such as pain or decreased tolerance. PT-A evaluated R28 as requested by surveyor to R28's upper and lower body. PT-A indicated she felt R28's ROM to her upper and lower extremeties had not changed and identified R28's left pointer finger had a small distal contracture, which she felt was an arthritic change, not muscle shortening.

On 4/26/18, at 1:26 p.m. TMA-A confirmed the facility did not have restorative nursing staff scheduled on the unit that day. TMA-A indicated the facility's usual practice was for the restorative nursing staff to do extra programs when working if behind and to get caught up by the end of the week. TMA-A indicated restorative nursing staff were specially trained and not all nursing assistants were trained. TMA indicated she had never completed the rehabilitation programs for the facility. TMA-A indicated the restorative nursing staff assisted on the floor in the morning by helping get residents up and feed residents during breakfast. During lunch they helped on the floor and covered breaks. Staff completed the resident's restorative programs in the morning and after lunch. TMA-A indicated by the end of the week the restorative nursing staff usually got caught up with the resident's rehabilitation scheduled exercises.

On 4/26/18, at 1:35 p.m. staffing coordinator (SC)-A indicated the facility did not schedule restorative nursing every day for every unit. SC-A indicated the facility scheduled 0-3 restorative nursing staff daily. SC-A indicated the restorative nursing staff were expected to work ahead or catch up to complete a resident's exercise program of 3 to 5 times a week. SC-A indicated more staff were scheduled on the weekends, and

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they usually got caught up then. SC-A indicated 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.

On 4/26/18, at 1:44 p.m. DON indicated the therapy department completed evaluations and set up the restorative nursing program. DON indicated the facility then obtained orders from the resident's primary physician for the restorative program. DON indicated the clinical managers were responsible to over see the cares for the residents on their unit, which included the restorative nursing programs. DON indicated she would expect residents to receive exercises the number of days they were ordered to receive them. DON confirmed R28 had not received exercises 5 times a week as ordered in April. DON indicated she would expect the CM to review the rehab nursing records to assure the exercises were completed. DON indicated she did not know why R28 had not been receiving her scheduled exercises as ordered. DON indicated if the staff were unable to perform the exercises she would expect them to report to the NM and document why the exercises were not completed.

The facility policy titled Rehabilitative Nursing Care Policy and Procedure, revised 10/86, instructed the rehabilitation assistant (RA) shall record the completion of modalities by entering his/her initials on the BMH (Broen Memorial Home) Rehab Nursing Care Record in the appropriate date and time position. If it was not completed the RA shall enter their initials and circle them on the record in the appropriate date and time position with a letter indicating the

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F 688	Continued From page 39 reason the resident did not receive the modality ordered. R=Refused, U=Unable due to illness or other inability to perform the tasks. The policy further instructed the RA to report to the RN UC for follow-up. The policy also indicated the RA to report to the RN UC or charge nurse any anticipated inability to complete ordered modalities before the end of the shift so assignments could be adjusted to assure completion. A facility policy titled, Restorative Nursing, Charting Code and Reporting Requirements, dated 9/2003, revealed the purpose of the policy was to record resident's compliance with rehab care plan. The policy directed facility staff to record resident's participation and refusals on the facility Rehab Nursing Care Record. The policy revealed if a resident refuses or was unable to perform for three or more scheduled days the restorative aid should report to the RN coordinator for follow up.	F 688		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		6/4/18

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F 880	Continued From page 40 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 41 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure clean personal laundry was covered and transported to prevent contamination for 4 of 4 resident units served by the facility laundry. Findings include: On 4/24/18, at 10:27 a.m. on the Second floor North unit, an uncovered metal cart which held resident clean folded clothes was observed in the hall. On 4/24/18, at 8:43 a.m. on the Third floor North unit an uncovered metal laundry cart held hanging shirts and dresses and folded pajamas, stockings and under clothing on shelves, was observed against a wall in the hall way. On 4/25/18, at 8:06 a.m. on the Second floor North unit a facility staff pushed an uncovered metal cart with resident personal clothing past residents, staff and visitors. On 4/26/18, at 8:09 a.m. laundry staff (LS)E	F 880	All residents on all units have clean personal laundry covered during transportation from the facility laundry to the unit. Date completed: 6/4/2018 Covers for all personal laundry carts were ordered. Date Completed: 5/22/2018 Policy and Procedure Standard Precautions: Work Place Controls, Laundry Practices was updated to include: I.B.1. f. Clean personal laundry shall be transported to the units from the facility laundry in enclosed personal clothing carts. Date Completed: 5/22/2018 Infection Control Committee Departmental Surveillance Checklist was updated to include: Task Transportation of clean personal clothing and Standard of Measure Clean personal clothing is transported from the facility laundry to the nursing units in an enclosed personal clothing cart. Infection Control Committee Departmental Surveillance	

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stood at the elevator with an uncovered cart of resident personal clothing in the basement level of the facility. The cart had a hanging rack of clothing on hangers and shelves with folded clothing, including stockings, under clothing, and pajamas.

On 4/26/18, at 8:21 a.m. LS-E verified the usual facility practice was to deliver resident personal laundry uncovered, from the basement laundry room to each resident unit. LS-E indicated each resident unit received a cart with clean resident clothing daily. The carts were placed in a designated spot in a hall on each wing. LS-E indicated the uncovered carts with personal resident clothing remained in the halls for the floor staff to return the clothing to the resident rooms.

On 4/26/18, at 8:25 a.m. on the Third floor North unit, an uncovered cart with resident clothing on hangers and folded clothing on shelves was observed.

On 4/26/18, at 9:25 a.m. on the Second floor South unit, two uncovered carts with resident clothing on hangers and folded clothing on shelves were observed. The carts held shirts, dresses, pajamas, stockings, and under garments.

On 4/26/18, at 9:14 a.m. LS-E identified each resident unit had designated laundry carts to transport resident personal clothing which did not have covers and were not covered in transport.

Second floor south and north wings:

F 880

Checklist is completed annually. Date completed: 5/22/2018

Nursing Care Audit entitled Infection Control Laundry Transport, BH# 1299-18, was developed and includes monitoring of delivery of clean personal laundry in an enclosed cart. Date completed: 5/22/2018

Nursing Care Audit Infection Control Laundry Transport, BH# 1299-18, will be completed on all units by 6/4/2018 and then weekly x 4 weeks on all units. This audit is completed on an on-going basis and is included in a quarterly Nursing Care Audit system for each unit. DON will monitor audit findings and assure prompt follow up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a subcommittee of the Quality Assessment and Assurance Committee. Date Completed: 6/4/2018 and ongoing.

Nursing Staff meeting, May 30, 2018, will include review of newly developed Nursing Care Audit Infection Control Laundry Transport, updates to Standard Precautions: Work Place Controls, Laundry Practices and Infection Control Committee Departmental Surveillance Checklist Laundry. Date completed: 5/30/2018

Education provided to Laundry staff on Policy and Procedure Standard Precautions: Work Place Controls,

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F 880	Continued From page 43 During observation on 4/24/18 at 8:42 a.m., a metal clothes hanging rack was sitting next to the wall adjacent from the dining room area, which had clean pants, shirts and jacket hanging on it. A silver metal cart with shelves was parked next to the clothes hanging rack, which contained clean personal articles folded up such as underwear, bras, socks and pajama's. The metal clothing rack and the silver metal cart with shelf's containing clean clothes were not covered to prevent contamination during transportation. -at 8:44 a.m. on the second floor north wing a metal clothes hanging rack was parked next to the wall adjacent from the dining room area which had clean pants, shirts and jacket hanging on it. A silver metal cart with shelves was also parked next to the clothes hanging rack, which contained clean personal articles folded up such as underwear, bras, socks and pajama's. The metal clothing rack and the silver metal cart with shelf containing clean clothes were not covered to prevent contamination during transportation. -at 9:20 a.m. on the second floor south and north wings the metal clothes hanging racks continued to be parked next to the walls adjacent from the dining room areas which had clean pants, shirts and jacket hanging on it. A silver metal cart with shelves was also parked next to the clothes hanging racks, which contained clean personal articles folded up folded up such as underwear, bras, socks and pajama's. The metal clothing racks and the silver metal carts with shelf continued to be uncovered to prevent contamination. -at 9:45 a.m. registered nurse (RN)-B and trained	F 880	Laundry Practices and requirement that resident personal laundry is delivered from the facility laundry to the resident units covered. Date completed: 5/29/2018	

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medication aid (TMA)-B began to take the metal hanging clothes rack and the metal cart with clean clothes down the second floor south hallway. RN-B and TMA-B began delivering the clean clothing to the resident rooms as they moved down the hallway until they were done at 9:58 a.m.

On 4/24/18 at 9:58 a.m. TMA-B confirmed laundry staff brought the clean linen up on the hanging clothes rack and the metal cart for the nursing staff to deliver to the resident rooms every day. TMA-B verified the clean linen had never been covered as far as she knew and indicated they only cover the dirty laundry during transportation to prevent contamination.

During observations on 4/25/18 at 8:27 a.m. laundry staff brought clean laundry off the elevator from the basement to the second floor south wing. The laundry staff brought a metal clothes hanging rack that had clean pants, shirts and jackets hanging on it and parked in adjacent from the dining room area next to the wall. The laundry staff also brought a silver metal cart with shelves, which contained clean personal articles folded up such as underwear, bras, socks and pajama's and parked it next to the clothing rack against the wall. The metal clothes rack and the silver metal cart with shelf containing clean clothes were not covered to prevent contamination during transportation from the basement.

-at 8:47 a.m. on the second floor north wing a metal clothes hanging rack was parked next to the wall adjacent from the dining room area which had clean pants, shirts and jacket hanging on it. A silver metal cart with shelves was also parked

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45	F 880		

next to the clothes hanging rack, which contained clean personal articles folded up such as underwear, bras, socks and pajama's. The metal clothing rack and the silver metal cart with shelf containing clean clothes was not covered to prevent contamination during transportation.

-at 9:47 a.m. license practical, nurse (LPN)-D began to take the metal hanging clothes rack with clean clothes down the second floor south hallway and began delivering the clean clothing to the resident rooms as she moved down the hallway with the rack until she was done delivering the clothes while the silver metal cart remained adjacent from the dining room area and was uncovered.

On 4/26/18, at 8:44 a.m. the clinical manager (CM)/infection preventionist (IP) indicated all soiled linen and personal clothing was covered during transport to the basement laundry facility. CM/IP indicated the facility linens were sent from the units in covered carts, however; was unaware if the clean items were covered when returned to the resident units. CM/IP indicated the laundry was transported in the elevators used by residents, staff and visitors and agreed clean clothing should be covered during transport from the laundry to the units.

On 4/26/18, at 3:22 p.m. the director of nursing (DON) verified the linens sent out of the building to be laundered returned in covered bins, however; the personal laundry washed in the facility was not covered when returned from the laundry room to the resident rooms. The DON indicated the resident personal clean laundry had the potential to become contaminated if not covered when transported through the building

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING ______ B. WING ______	04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 46 and in the elevators with staff visitors and residents. The facility policy titled Laundry practices revised 3/20/16, identified "Linens storage on resident units is on enclosed line carts or closets."	F 880		

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

F5453026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**04/24/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY Building 1 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Broen Memorial Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Healthcare Fire Inspections	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/23/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

Or by email to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Broen Memorial Home is a 2-story building with a partial basement. The building was constructed at 3 different times. The Main building was built in 1969 and is 2-stories with a partial basement that was determined to be Type II (222) construction. In 1984 a 2- story addition was built to the south of the 1969 building, with a partial basement, and was determined to be Type II (222) construction. This building is separated from the 1969 building with a 2-hour fire barrier. In 1996 a chapel addition was built to the north west of the 1969 building is 1-story without a basement and was determined to be Type II (000). The facility was surveyed as one building.

The building has an automatic sprinkler system

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 installed throughout in accordance with NFPA 13 Standard for Installation of Automatic Sprinkler Systems . The facility has a fire alarm system with smoke detection throughout the corridor system and in the common spaces. The fire alarm system is monitored for automatic fire department notification and is installed in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a capacity of 107 beds and had a census of 76 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to properly identify an exit door in the path of egress as required in The Life Safety Code NFPA 101 2012 edition section 7.10.8.3. This deficient condition could affect the exiting of an undetermined amount of residents, staff and visitors.	K 293	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 correction and will monitor to prevent the recurrence of this deficiency. Date Completed: 5/31/2018	6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 3 Findings include: On the facility tour between 8:00 am to 12:00 pm on 04/24/2018 observations revealed the 3rd floor north dining room door did not have an exit sign above it. This deficient condition was confirmed by the Facility Engineer	K 293		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ______ b) Who provided system test ______ c) Water system supply source ______ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler	K 353	The sprinkler head with paint on the head in the closet of resident room 379 was replaced by contractor NOVA Fire Protection, Inc. on May 15th, 2018. Facilities Engineer was responsible for the	6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/24/2018**

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

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K 353	Continued From page 4 systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect 28 of the 107 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 04/24/2018 observations revealed paint on a sprinkler head in the closet of resident room 379. This deficient condition was confirmed by the Facility Engineer	K 353	correction and will monitor to prevent the recurrence of this deficiency. Date Completed: 5/15/2018	

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

F5453026

PRINTED: 05/30/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **05 - FREEZER/HVAC ADDITION** B. WING	**04/24/2018**

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

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K 000	INITIAL COMMENTS Building 5 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Broen Memorial Home was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Facilities and the 2012 edition of NFPA 99, Health Care Facilities Code. This addition is a single story building of type II (000) construction and is fully sprinkled. It includes areas for a cooler and freezer for the main kitchen as well as a loading dock. There is a 3 hour fire curtain separating the addition from the existing building. At the time of the addition several HVAC roof top units were replaced with the addition of a new unit for the kitchen. The facility has a capacity of 107 beds and had a census of 76 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/23/2018

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.

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

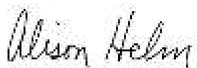
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00862	A. BUILDING: ________ B. WING ________	04/26/2018

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

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00862	A. BUILDING: ______ B. WING ______	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/23/18 -4/26/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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	00862	A. BUILDING: ______ B. WING ______	04/26/2018

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) when two or more areas of change in resident status were noted on the Minimum Data Set (MDS) for 2 of 3 residents (R33, R59) reviewed for a decline in health status. Findings include: R33's quarterly MDS dated 11/23/17, identified R33's diagnosis of dementia, had severe cognitive impairment and required extensive assistance with areas of daily living (ADL)s of one staff with bed mobility, transfers, toileting, dressing, personal hygiene and bathing. The MDS further identified R33 had no range of motion (ROM) limitation of the upper or lower extremities and had occasional bowel incontinence.	2 545	Corrected.	6/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00862	A. BUILDING: ______ B. WING ______	04/26/2018

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2 545		2 545		

Continued From page 3

R33's quarterly MDS dated 2/22/18, identified R33 had severe cognitive impairment, required total ADL assistance of two staff with bed mobility, transfers, toileting, dressing, personal hygiene and bathing, had limited ROM of both sides of the upper or lower extremities and always incontinent of bowel.

Review of the above assessments indicated R33 had a decline in ADL's performance from extensive assistance of one staff to total assistance of two staff, a decline in ROM from no limitation to limited ROM of both sides of the upper or lower extremities and a decline in bowel continence from occasional to always incontinent of bowel.

R59's annual MDS dated 12/21/17, identified R59 had diagnoses which included Alzheimer's disease and dementia, had severe cognitive impairment, required extensive ADL assistance of staff with bed mobility, transfers, dressing, eating, toileting, bathing, had occasional bladder incontinence and a PHQ-9 score of 00, which indicated no signs or symptoms of depression.

R59's quarterly MDS dated 3/22/18, identified R59 had severe cognitive impairment, required total ADL assistance from staff with bed mobility, transfers, dressing, eating, toileting, bathing, had frequent bladder incontinence and a PHQ-9 score of 03, which indicated minimal signs and symptoms of depression.

Review of the above assessments indicated R59 had a decline in ADL's performance from extensive assistance of staff to total assistance of staff, a decline in bladder continence from occasional to frequent, and a PHQ-9 score which indicated a decline in mood from no signs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00862	A. BUILDING: ______ B. WING ______	04/26/2018

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

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or symptoms of depression to minimal signs and symptoms of depression.

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.

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 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:

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2 545	Continued From page 5 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. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures for comprehensive significant change assessments. Nursing staff could be educated as necessary to the importance of significant change comprehensive assessments. The DON or designee, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 545		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion.	2 895		6/4/18

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This MN Requirement is not met as evidenced by:
Based on observation, interview and document review the facility failed to routinely provide restorative exercises for 2 of 3 residents (R67 and R31) reviewed with a restorative nursing program. In addition the facility failed to provide range of motion services for 1 of 2 residents (R28) who were reviewed for limited range of motion.

Corrected.

Findings include:

R67's quarterly Minimum Data Set (MDS) dated 3/29/18, indicated R67 had moderate cognitive impairment, had diagnoses included anemia, heart dysrythmia and end stage renal disease. The MDS identified R67 required total staff assistance with all activities of daily living (ADL's).

On 4/24/18, at 9:10 a.m. R67 stated staff were to assist him to stand but this service was not being offered and if it was, it was only for a short time. R67 indicated the worry of no longer being able to stand if he was not allowed to stand often or long enough.

R67's care plan revised 4/12/18, indicated R67 had an ADL self care performance deficit r/t (related to) disease process, limited mobility and pain. The care plan identified a restorative program was in place.

A facility document titled Therapy to Nursing Communication, dated 10/26/17, identified the following:
Goal area; Maintain LE (lower extremity) strength

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and standing ability 3x (three times) per week or as pt. (patient).
Suggested approaches; Stand by edge of bed: with FWW (front wheeled walker), shoes on, gait belt, CGA (Contact Guard Assistance), from elevated bed. Stand Time to pt's tolerance. One time 3x per week.

On 4/25/18, at 11:17 a.m. R67 was observed in his room seated on the front edge of the wheel chair leaning back to rest on the back of the chair. R67 informed nursing assistant (NA)-C he was sliding out of the wheel chair and needed help to scoot back onto the seat. With the use of a EZ stand lift (mechanical lift to standing position), NA-C stood R67 and repositioned him to sit farther back onto the wheel chair seat.

On 4/25/18, at 11:53 a.m. R67 self propelled the wheel chair to the dining room.

On 4/26/18, at 9:48 a.m. R 67 participated with 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.

Review of the facility form titled Rehab Nursing Record dated April 2018, lacked documentation of R67's participation or refusal of the sit to stand

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program with exception of 4/11/18, which indicated the program had been completed on that date.

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.

On 4/26/18, at 9:55 a.m. clinical manager (CM)-B indicated a binder was available with direction for all resident restorative nursing programs. CM-B indicated R67 wanted to regain the ability to walk and was seen by therapy. CM-B indicated R67 was not able to walk after therapy was completed but was able to stand and the program to stand by the bed with a walker and staff was started. CM-B verified a note in the binder directed R67's programs be provided by a specific nursing assistant. CM-B indicated often on dialysis days R67 is too weak to participate in the sit to stand program.

On 4/26/18, at 10:42 a.m. NA-C indicated he/she had not completed R67's restorative programs. NA-C verified the documentation in the restorative binder indicated the sit to stand program was only completed on the 11th. NA-C verified the program was supposed to be completed three times a week.

On 4/26/18, at 10:51 a.m. NA-B indicated he/she was responsibile to provide R67's restorative program. NA-B indicated if R67 did not participate with the restorative sit to stand program he/she would inform the nurse and the restorative aid.

On 4/26/18, at 10:56 a.m. licensed practical nurse (LPN)-B indicated refusals to participate

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with the restorative nursing program would be reported to her, however; NA-B would also report the refusal to the restorative aid who would be responsible to document the refusal.

On 4/26/18, at 11:12 a.m. clinical manager (CM)A indicated she expected staff to document the reason residents did not receive the rehab services (for example because of refusals or illness). CM-A indicated she did not review the restorative nursing documentation throughout the month.

On 4/26/18, at 1:19 p.m. NA-B placed the EZ stand lift belt around R67's back, attached the lift belt loops to the hooks on the lift, stood R67 with the assistance of the EZ stand and transferred R67 onto the bed. NA-B placed a gait belt around R67's waist and with CGA and the use of a walker, R67 stood from the bed for two minutes and then sat down. R67 stood and sat a total of 10 times, with the time standing between two minutes and 60 seconds.

On 4/26/18, at 3:22 p.m. the director of nursing (DON) indicated she expected staff to follow the restorative nursing programs as they were set up by therapy to maintain strength and ability. The DON indicated documentation should have been completed whether or not the program was completed. If the restorative program was not completed, the clinical manager should be informed. The DON indicated communication should be made in order to ensure the program was provided as ordered.

R31
R31's admission MDS, dated 2/16/18, identified R31 was cognitively intact and had diagnoses which included depression, anxiety, obesity and

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hypertension. The MDS identified R31 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers and walking with assistance of two facility staff. The MDS revealed R31 was not able to maintain his balance without staff assistance, had no impairments of his range of motion (ROM) and had received five days of both physical therapy (PT) and occupational therapy (OT) services during the seven day look back period.

R31's admission Care Area Assessment (CAA) dated 2/16/18, identified R31 required extensive assistance with ADL's including walking. The CAA identified R31 had received both OT and PT services with the goal to improve his independence and to prevent further decline in his strength.

R31's 14-day prospective payment system (PPS) MDS dated 2/22/18, identified R31 required extensive assistance with ADL's including bed mobility and transfers. The MDS identified R31 had ambulated less than three times within the seven day look back period. The MDS further identified R31 received both PT and OT services five out of seven days.

R31's care plan dated 3/16/18, revealed R31 required assistance from staff with bed mobility, transfers with one assist and ambulation with a walker and transfer belt. The care plan further directed facility staff to encourage R31 to participate in activities that promoted exercise, physical activity for strengthening and improved mobility such as: walking with assistance, using NuStep.

R31's current physician orders signed 4/5/18, revealed an order dated 3/2/18, for NuStep level

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8 for 20 minutes or as tolerated, may set up NuStep then let resident use machine with supervision and aid for safety getting off and on the machine, one time a day for five times a week or as resident tolerated.

R31's physician orders revealed an order dated 3/2/18, for seated or supine arm exercises with four pound weight bar or green Thera band (large band used for strengthening) shoulder flexion, extension, abduction/adduction and elbow flexion/extension, one set for 20 repetitions, one time a day for 3 times a week as resident tolerated.

R31's end of therapy discharge plan and instructions dated 3/2/18, revealed R31 was assist of one with transfers and ambulation. The instructions directed R31 was to be added to the facility restorative nursing program with the NuStep machine and nursing staff to ambulate with meals with a four wheeled walker and a gait belt. The discharge plan revealed R31 had ambulated up to 90 feet with a four wheeled walked at the time of discharge from skilled therapy services.

On 4/24/18, at 8:53 a.m. R31 stated he used to 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 or arm exercises. 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

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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 exercises.

On 4/25/18, at 12:36 pm. R31 was seated in a

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wheelchair in the dining room and had propelled himself with both of his feet approximately 30 feet. At that time NA-B offered to wheel R31 back to his room. NA-B did not offer to ambulate with R31.

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 rehab nursing record from 3/3/18, to 4/26/18, revealed:

March, 2018, R31 had completed the NuStep machine 4 times, had refused one time out of 28 opportunities. The record revealed R31 had not received ROM exercises.

April, 3108, R31 had completed the NuStep machine 3 times, had refused one time out of 26 opportunities. The record revealed R31 had received ROM exercises once.

On 4/26/18, at 8:24 a.m. R31's restorative program was reviewed with registered nursing manager (NM)-B. NM-S confirmed R31's had not routinely received his restorative program on a routine basis. NM-B confirmed R31's medical record lacked documentation of R31's ambulation to and from meals. She stated there was no formal program for R31's ambulation, therefore would not be documented in the restorative record. NM-B stated any nursing staff could ambulate with R31, however different NA's had received training in restorative programs, which included ROM and the NuStep machine. Further, NS-B confirmed R31's medical record lacked

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documentation of R31 refusing to ambulate with nursing staff and did not routinely reveal R31's refusals of restorative 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.

On 4/26/18, at 9:54 a.m. NA-B stated R31 would occasionally use the NuStep and had routinely refused to ambulate. NA-B stated he could not 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.

On 4/26/18, at 2:59 p.m. the director of nursing (DON) stated she would expect R31 to be offered to walk to and from meals, assist with the NuStep machine and ROM exercises. She stated she

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was not aware R31 had not routinely received restorative nursing services and indicated she would expect to be informed if staff were having difficulty routinely offering restorative services.

R28

R28's annual MDS dated 2/15/18, indicated R28 had diagnosis which included hemiplegia or hemiparesis (paralysis of one entire side of the body), arthritis and seizure disorder. R28's MDS further identified R28 required total assistance with ADLs and had range of motion impairment on one side. R28's quarterly MDS identified R28 had diagnosis of Cerebral Vascular Accident (CVA) (stroke).

R28's care plan last revised 2/26/18, indicated R28 had an ADL self care performance deficit r/t (related to) Stroke. Interventions included rehab interventions which instructed staff to see rehab book and therapy recommendations in chart.

On 4/23/18, at 7:16 p.m. R28 was lying on her bed in her room on her back. Her head of bed was elevated, and she wore pink pajamas and was covered by her sheet and blanket. Her left hand was observed resting on her left side, on a pillow, and her fingers were curled into a loose fist.

On 4/24/18, at 8:41 a.m. R28 was observed in her recliner in her room. Her feet were elevated and her eyes were closed. R28's left hand was resting on a pillow and her fingers were curled into a loose fist.

On 4/25/18, at 7:12 a.m. R28 was sitting in her recliner in her room with her eyes closed and her feet elevated. She was dressed and had her left

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hand resting on a pillow. Her left fingers were curled into a loose fist.

On 4/26/18, at 10:37 a.m. NA-A indicated R28 required total assistance with all her cares. NA-A indicated the facility had rehabilitation staff who performed the rehabilitation nursing program. NA-A indicated the rehabilitation staff tried to complete the program daily.

R28's physician orders signed 3/13/18 included orders for PROM to bilateral upper extremities one time a day for 5 times a week, initiated on 3/31/17. R28's orders also included PROM to lower extremities 1 time/ times 10; hip flexion (bending movement), abduction (movement away from body) /adduction (movement toward body), knee flexion/extension (straightening movement). Ankle Planter flexion (movement downward) /dorsi flexion (movement of the foot upward), IV (inversion-tilt towards the body)/EV (eversion-tilt away from the body). One time a day for 5 times a week.

R28's facility form titled physical therapy plan of care (evaluation only) dated 3/27/17, signed by physician 3/30/17, identified R28 was to be discharged to the same SNF (skilled nursing facility) for RNP (rehabilitation nursing program).

R28's facility form titled occupational therapy plan of care (evaluation only) dated 3/28/17, signed by physician 3/30/17, identified R28 was to be discharged to the same SNF, and R28 was appropriate for RNP of UE (upper extremity) PROM.

R28's facility form titled Therapy to Nursing Communication, dated 3/28/17, signed 3/30/17, by restorative coordinator included R28's goal

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areas were to maintain UE PROM for cares and contracture prevention and Maintain B (bilateral) LE ROM 5 times a week or as patient tolerates. Suggested approaches included PROM to B UE and PROM 1 x 10 hip flexion, abduction, adduction, knee flexion/extension, ankle PF (plantar flexion)/ DF (dorsal flexion), IV/EV.

R28's Rehab Nursing Records dated 4/1/17, to 4/26/18, all included instructions for: PROM to bilateral upper extremities. One time a day for 5 X/week, start date 3/31/17. PROM to Lower extremities; 1 x 10 hip flexion, abduction/adduction, knee flexion/extension. Ankle Planter flexion/dorsi flexion, IV/EV. One time a day for 5 x /week.

Review of R28's Rehab Nursing Records dated 11/1/17, to 4/26/18 identified by staff initials the following:

-11/1/17, to 11/30/17, R28 received UE PROM exercises and LE PROM exercises 6 days out of 22 opportunities.

-12/1/17, to 12/31/17, R28 received UE PROM exercises and LE PROM exercises 7 days out of 23 opportunities.

-1/1/18, to 1/31/18, R28 received UE PROM exercises and LE PROM exercises 11 days out of 24 opportunities.

-2/1/18, to 2/28/18, R28 received UE PROM exercises and LE PROM exercises 11 days out of 20 opportunities.

-3/1/18, to 3/31/18, R28 received UE PROM exercises and LE PROM exercises 4 days out of 23 opportunities.

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-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.

On 4/26/18, at 1:07 p.m. physical therapist (PT)-A indicated the facility's usual practice for the restorative nursing program began with therapy staff educating the nursing staff for the program and ROM exercises. PT-A indicated she would expect R28 to receive the exercises 5 times a week, as ordered. PT-A indicated she would expect them to notify her if something had prevented the nursing staff from completing the

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exercises, such as pain or decreased tolerance. PT-A evaluated R28 as requested by surveyor to R28's upper and lower body. PT-A indicated she felt R28's ROM to her upper and lower extremeties had not changed and identified R28's left pointer finger had a small distal contracture, which she felt was an arthritic change, not muscle shortening.

On 4/26/18, at 1:26 p.m. TMA-A confirmed the facility did not have restorative nursing staff scheduled on the unit that day. TMA-A indicated the facility's usual practice was for the restorative nursing staff to do extra programs when working if behind and to get caught up by the end of the week. TMA-A indicated restorative nursing staff were specially trained and not all nursing assistants were trained. TMA indicated she had never completed the rehabilitation programs for the facility. TMA-A indicated the restorative nursing staff assisted on the floor in the morning by helping get residents up and feed residents during breakfast. During lunch they helped on the floor and covered breaks. Staff completed the resident's restorative programs in the morning and after lunch. TMA-A indicated by the end of the week the restorative nursing staff usually got caught up with the resident's rehabilitation scheduled exercises.

On 4/26/18, at 1:35 p.m. staffing coordinator (SC)-A indicated the facility did not schedule restorative nursing every day for every unit. SC-A indicated the facility scheduled 0-3 restorative nursing staff daily. SC-A indicated the restorative nursing staff were expected to work ahead or catch up to complete a resident's exercise program of 3 to 5 times a week. SC-A indicated more staff were scheduled on the weekends, and they usually got caught up then. SC-A indicated

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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.

On 4/26/18, at 1:44 p.m. DON indicated the therapy department completed evaluations and set up the restorative nursing program. DON indicated the facility then obtained orders from the resident's primary physician for the restorative program. DON indicated the clinical managers were responsible to over see the cares for the residents on their unit, which included the restorative nursing programs. DON indicated she would expect residents to receive exercises the number of days they were ordered to receive them. DON confirmed R28 had not received exercises 5 times a week as ordered in April. DON indicated she would expect the CM to review the rehab nursing records to assure the exercises were completed. DON indicated she did not know why R28 had not been receiving her scheduled exercises as ordered. DON indicated if the staff were unable to perform the exercises she would expect them to report to the NM and document why the exercises were not completed.

The facility policy titled Rehabilitative Nursing Care Policy and Procedure, revised 10/86, instructed the rehabilitation assistant (RA) shall record the completion of modalities by entering his/her initials on the BMH (Broen Memorial Home) Rehab Nursing Care Record in the appropriate date and time position. If it was not completed the RA shall enter their initials and circle them on the record in the appropriate date and time position with a letter indicating the reason the resident did not receive the modality ordered. R=Refused, U=Unable due to illness or

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2 895	Continued From page 21 other inability to perform the tasks. The policy further instructed the RA to report to the RN UC for follow-up. The policy also indicated the RA to report to the RN UC or charge nurse any anticipated inability to complete ordered modalities before the end of the shift so assignments could be adjusted to assure completion. A facility policy titled, Restorative Nursing, Charting Code and Reporting Requirements, dated 9/2003, revealed the purpose of the policy was to record resident's compliance with rehab care plan. The policy directed facility staff to record resident's participation and refusals on the facility Rehab Nursing Care Record. The policy revealed if a resident refuses or was unable to perform for three or more scheduled days the restorative aid should report to the RN coordinator for follow up. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide a resident restorative nursing program, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of the restorative nursing program to ensure the residents programs are completed consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate	2 915		6/4/18

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2 915	Continued From page 22 treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement therapy recommendations and routinely provide ambulation services to maintain function for 1 of 1 resident (R31) reviewed for ambulation. Findings include: R31's admission Minimum Data Set (MDS) dated 2/16/18, identified R31 was cognitively intact and had diagnoses which included depression, anxiety, obesity and hypertension. The MDS identified R31 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers and walking with assistance of two facility staff. The MDS revealed R31 was not able to maintain his balance without staff assistance, had no impairments of his range of motion (ROM) and had received five days of both physical therapy (PT) and occupational therapy (OT) services during the seven day look		Corrected.	

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back period.

R31's admission Care Area Assessment (CAA) dated 2/16/18, identified R31 required extensive assistance with ADL's including walking. The CAA identified R31 had received both OT and PT services with the goal to improve his independence and to prevent further decline in his strength.

R31's 14-day prospective payment system (PPS) MDS dated 2/22/18, identified R31 required extensive assistance with ADL's including bed mobility and transfers. The MDS identified R31 had ambulated less than three times within the seven day look back period. The MDS further identified R31 received both PT and OT services five out of seven days.

R31's care plan revised 4/13/18, revealed R31 required assistance from staff with bed mobility, transfers with one assist and ambulation with a walker and transfer belt. The care plan directed facility staff to encourage R31 to ambulate and to assist R31 to ambulate with a wheelchair to follow behind. The care plan further directed facility staff to encourage R31 to participate in activities that promoted exercise, physical activity for strengthening and improved mobility such as: walking with assistance, using NuStep.

R31's end of therapy discharge plan and instructions dated 3/2/18, revealed R31 was assist of one with transfers and ambulation. The instructions directed nursing staff to ambulate with meals with a four wheeled walker and a gait belt. R31 was to be added to the facility restorative nursing program with the NuStep machine. The discharge plan revealed R31 had

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ambulated up to 90 feet with a four wheeled walked at the time of discharge from skilled therapy services.

On 4/24/18, at 8:53 a.m. R31 stated he used to 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.

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 indicated there were times when she felt it was challenging to assist R31 with his restorative

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2 915	Continued From page 25 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 exercises. On 4/25/18, at 12:36 p.m.. R31 was seated in a wheelchair in the dining room and had propelled himself with both of his feet approximately 30 feet. At that time NA-B offered to wheel R31 back to his room. NA-B did not offer to ambulate with R31. 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 rehab nursing record from 3/3/18, to 4/26/18, revealed: March, 2018, R31 had completed the NuStep machine 4 times, had refused one time out of 28 opportunities. The record revealed R31 had not received ROM exercises. April, 3108, R31 had completed the NuStep machine 3 times, had refused one time out of 26 opportunities. The record revealed R31 had received ROM exercises once.	2 915		

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R31's rehab nursing record lacked documentation of R31's ambulation to and from meals.

On 4/26/18, at 8:24 a.m. R31's restorative program was reviewed with registered nursing manager (NM)-B. NM-S confirmed R31's had not routinely received his restorative program on a routine basis. NM-B confirmed R31's medical record lacked documentation of R31's ambulation to and from meals. She stated there was no formal program for R31's ambulation, therefore would not be documented in the restorative record. NM-B stated any nursing staff could ambulate with R31, however different NA's had received training in restorative programs, which included ROM and the NuStep machine. NS-B confirmed R31's medical record lacked documentation of R31 refusing to ambulate with nursing staff and did not routinely reveal R31's refusals of restorative 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.

On 4/26/18, at 9:54 a.m. NA-B stated R31 would occasionally use the NuStep and had routinely refused to ambulate. NA-B stated he could not

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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.

On 4/26/18, at 2:59 p.m. the director of nursing (DON) stated she would expect R31 to be offered to walk to and from meals, assist with the NuStep machine and ROM exercises. She stated she was not aware R31 had not routinely received restorative nursing services and indicated she would expect to be informed if staff were having difficulty routinely offering restorative services.

A facility policy titled, Restorative Nursing, Charting Code and Reporting Requirements, dated 9/2003, revealed the purpose of the policy was to record resident's compliance with rehab care plan. The policy directed facility staff to record resident's participation and refusals on the facility Rehab Nursing Care Record. The policy revealed if a resident refuses or was unable to perform for three or more scheduled days the restorative aid should report to the RN coordinator for follow up.

SUGGESTED METHOD OF CORRECTION:
The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on

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2 915	Continued From page 28 residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure clean personal laundry was covered and transported to prevent contamination for 4 of 4 resident units served by the facility laundry. Findings include: On 4/24/18, at 10:27 a.m. on the Second floor North unit, an uncovered metal cart which held resident clean folded clothes was observed in the hall. On 4/24/18, at 8:43 a.m. on the Third floor North unit an uncovered metal laundry cart held hanging shirts and dresses and folded pajamas, stockings and under clothing on shelves, was observed against a wall in the hall way. On 4/25/18, at 8:06 a.m. on the Second floor	21375	Corrected.	6/4/18

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North unit a facility staff pushed an uncovered metal cart with resident personal clothing past residents, staff and visitors.

On 4/26/18, at 8:09 a.m. laundry staff (LS)E stood at the elevator with an uncovered cart of resident personal clothing in the basement level of the facility. The cart had a hanging rack of clothing on hangers and shelves with folded clothing, including stockings, under clothing, and pajamas.

On 4/26/18, at 8:21 a.m. LS-E verified the usual facility practice was to deliver resident personal laundry uncovered, from the basement laundry room to each resident unit. LS-E indicated each resident unit received a cart with clean resident clothing daily. The carts were placed in a designated spot in a hall on each wing. LS-E indicated the uncovered carts with personal resident clothing remained in the halls for the floor staff to return the clothing to the resident rooms.

On 4/26/18, at 8:25 a.m. on the Third floor North unit, an uncovered cart with resident clothing on hangers and folded clothing on shelves was observed.

On 4/26/18, at 9:25 a.m. on the Second floor South unit, two uncovered carts with resident clothing on hangers and folded clothing on shelves were observed. The carts held shirts, dresses, pajamas, stockings, and under garments.

On 4/26/18, at 9:14 a.m. LS-E identified each resident unit had designated laundry carts to transport resident personal clothing which did not have covers and were not covered in transport.

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21375	Continued From page 30 Second floor south and north wings: During observation on 4/24/18 at 8:42 a.m., a metal clothes hanging rack was sitting next to the wall adjacent from the dining room area, which had clean pants, shirts and jacket hanging on it. A silver metal cart with shelves was parked next to the clothes hanging rack, which contained clean personal articles folded up such as underwear, bras, socks and pajama's. The metal clothing rack and the silver metal cart with shelf's containing clean clothes were not covered to prevent contamination during transportation. -at 8:44 a.m. on the second floor north wing a metal clothes hanging rack was parked next to the wall adjacent from the dining room area which had clean pants, shirts and jacket hanging on it. A silver metal cart with shelves was also parked next to the clothes hanging rack, which contained clean personal articles folded up such as underwear, bras, socks and pajama's. The metal clothing rack and the silver metal cart with shelf containing clean clothes were not covered to prevent contamination during transportation. -at 9:20 a.m. on the second floor south and north wings the metal clothes hanging racks continued to be parked next to the walls adjacent from the dining room areas which had clean pants, shirts and jacket hanging on it. A silver metal cart with shelves was also parked next to the clothes hanging racks, which contained clean personal articles folded up folded up such as underwear, bras, socks and pajama's. The metal clothing racks and the silver metal carts with shelf continued to be uncovered to prevent contamination.	21375		

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-at 9:45 a.m. registered nurse (RN)-B and trained medication aid (TMA)-B began to take the metal hanging clothes rack and the metal cart with clean clothes down the second floor south hallway. RN-B and TMA-B began delivering the clean clothing to the resident rooms as they moved down the hallway until they were done at 9:58 a.m.

On 4/24/18 at 9:58 a.m. TMA-B confirmed laundry staff brought the clean linen up on the hanging clothes rack and the metal cart for the nursing staff to deliver to the resident rooms every day. TMA-B verified the clean linen had never been covered as far as she knew and indicated they only cover the dirty laundry during transportation to prevent contamination.

During observations on 4/25/18 at 8:27 a.m. laundry staff brought clean laundry off the elevator from the basement to the second floor south wing. The laundry staff brought a metal clothes hanging rack that had clean pants, shirts and jackets hanging on it and parked in adjacent from the dining room area next to the wall. The laundry staff also brought a silver metal cart with shelves, which contained clean personal articles folded up such as underwear, bras, socks and pajama's and parked it next to the clothing rack against the wall. The metal clothes rack and the silver metal cart with shelf containing clean clothes were not covered to prevent contamination during transportation from the basement.

-at 8:47 a.m. on the second floor north wing a metal clothes hanging rack was parked next to the wall adjacent from the dining room area which had clean pants, shirts and jacket hanging on it. A silver metal cart with shelves was also parked

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next to the clothes hanging rack, which contained clean personal articles folded up such as underwear, bras, socks and pajama's. The metal clothing rack and the silver metal cart with shelf containing clean clothes was not covered to prevent contamination during transportation.

-at 9:47 a.m. license practical, nurse (LPN)-D began to take the metal hanging clothes rack with clean clothes down the second floor south hallway and began delivering the clean clothing to the resident rooms as she moved down the hallway with the rack until she was done delivering the clothes while the silver metal cart remained adjacent from the dining room area and was uncovered.

On 4/26/18, at 8:44 a.m. the clinical manager (CM)/infection preventionist (IP) indicated all soiled linen and personal clothing was covered during transport to the basement laundry facility. CM/IP indicated the facility linens were sent from the units in covered carts, however; was unaware if the clean items were covered when returned to the resident units. CM/IP indicated the laundry was transported in the elevators used by residents, staff and visitors and agreed clean clothing should be covered during transport from the laundry to the units.

On 4/26/18, at 3:22 p.m. the director of nursing (DON) verified the linens sent out of the building to be laundered returned in covered bins, however; the personal laundry washed in the facility was not covered when returned from the laundry room to the resident rooms. The DON indicated the resident personal clean laundry had the potential to become contaminated if not covered when transported through the building and in the elevators with staff visitors and

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21375	Continued From page 33 residents. The facility policy titled Laundry practices revised 3/20/16, identified "Linens storage on resident units is on enclosed line carts or closets." SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents personal clothing is handled and delivered in a sanitary manner. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation interview and document review the facility failed to maintain windows in good repair to prevent the elements from entering in resident personal rooms in 12 of 12 resident rooms(rm 350, rm 357, rm 365, rm369, rm368, rm 366, rm 364, rm 361, rm 360, rm 359, rm 358, rm 356), and in common areas on the second and third floor of the facility.	21665	Corrected.	6/4/18

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Findings include:

On 4/25/18, at 11:30 a.m. an environmental tour of the facility was conducted with the facilities engineer (FE)A , and he confirmed the following findings:
3rd floor:
-Room 350-the wooden edges of the three paned window were soft, cracked;
-Room 357- the wooden edges of the three paned window were soft, cracked and crumbled when touched;
-Room 365-the wooden edges of the three paned window were soft, cracked and crumbled when touched;
-Room 369-the wooden edges of the window were soft, cracked and crumbled when touched. There was white duct tape on the bottom edge of the smaller window;
-Room 368-the middle windowpane had tape on the lower edge of the window that had been painted over with brown paint. This taped area was soft when touched;
-Room 366-the middle windowpane had tape on the lower edge of the window that had been painted over with brown paint. This taped area was soft when touched;
-Room 364-the small window to the left of the larger middle window had soft, cracked edges;
-Room 361-the wooden edges of the three paned window were soft, cracked and gave way to pressure when touched. Cold air flow was felt by the edges of the window;
-Room 360-the wooden edges of the three paned window were soft, cracked and gave way to pressure when touched. Cold air flow was felt by the edges of the window;
-Room 359-the wooden edges of the three paned window were soft, cracked and gave way to pressure when touched. Cold air flow was felt by

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the edges of the window;
-Room 358-the wooden edges of the three paned window were soft, cracked and gave way to pressure when touched;
-Room 356-the wooden edges of the window were soft and cracked
-The five large windows in the common area on the third floor were in poor repair. The edges of the window were made of particle board with a laminate overlay. The laminate was warped and missing in some areas. The large window near the snack area had sign taped to the window, "do not open this window it is broken."
-The large window at end of hall was missing the laminate on the lower edge and the exposed particle board was broken and moved when touched. The top of the window frame bowed down.
-One of the three dining room windows had an area along the lower edge which was soft to touch and air was felt coming through the window.

2nd floor:
The windows at the end of both halls had warped and missing the laminate with exposed and ill fitting particle board which did not create a tight seal with the window and wall.

R29's quarterly minimum data set (MDS) dated 2/15/18, indicated R29 had intact cognition.

On 4/25/18, at 11:37 a.m. R29 indicated this past winter, snow had come in through the lower edges of the window near R29's chair this winter. R29 indicated staff screwed the window shut and were able to stop the snow from coming in, however; R29 indicated the wind continued to come in through the window.

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On 4/26/18, at 12:52 p.m. FE-A verified the above findings. FE-A indicated the facility did not have plans to replace the windows, however; thought window replacements would be done in the future. FE-A indicated the facility had obtained an estimate for the cost of replacing windows on one floor, in order to get a ball park number of the cost to plan how to pay for the window replacements. FE-A indicated the best plan would be to repair the current windows to make them functional and then replace the windows as the facility is able.

The facility provided a estimate for window replacement dated 1/16/18. The estimate had not been signed as accepted and no purchasing order was provided.

On 4/26/18, at 3:22 p.m. the director of nursing (DON) verified she expected the environment to be clean, presentable, and functional, in order to provide a safe and comfortable environment for each resident.

The requested facility policy was not provided.

The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 1 of 1 resident (R66) observed during the supper meal in the second floor dining room. In addition the facility failed to ensure dignity was maintained for 1 of 1 resident (R19) who utilized an incontinent pad. Findings include; R66's quarterly Minimum Data Set (MDS), dated 3/29/18, identified R66 was severely cognitively impaired and had diagnoses which included dementia, depression and Parkinson's disease. The MDS indicated R66 required extensive assistance of two staff with bed mobility, transfers, dressing and toileting and one staff for eating. R66's care plan dated 2/2/18, identified R66 had an activities of daily living self care performance deficit and potential unplanned /unexpected weight gain or loss related to diagnoses and disease process and varying intakes. The care plan listed various interventions which included regular diet, provide dignity, and one staff to feed R66.	21805	Corrected.	6/4/18

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During continual observations of the supper meal on 4/23/18 at 6:26 p.m. on the second floor north dining room R66 was sleeping at the dining room table and his food sat in front of him which consisted of turkey sandwich, soup, tator tots and fruit salad with whip cream. Nursing assistant (NA)-E approached R66, sat down next to him and began talking to R66.
--at 6:39 p.m. NA-E continued talking to R66 and when he opened his eyes she started to assist him to eat his soup.
-at 6:45 p.m. NA-E got up from feeding R66 his food and started walking around from table to table asking other residents if they would like ice cream. NA-F walked over from the other end of the table and gave R66 a bite of his vegetable soup while she stood on the left side of him. NA-F briefly walked away from the table and then returned and sat down next to R66 and assisted him to eat.
-at 6:49 p.m. NA-F got up from assisting R66 to eat and began to pick up the soiled clothing protectors from the other tables in the ding room.
-at 6:50 p.m. NA-E approached R66, sat down next to him, and stated "hi buddy" and began to feed him a bite of his vegetable soup using a sliver spoon.
-at 6:51 p.m. NA-E gave R66 a bite of his vegetable soup and said "here ya go buddy."
-at 6:53 p.m. NA-E cut R66's turkey sandwich in half, tried handing it to him while she stated "there ya go buddy I cut it into a smaller piece."
-at 6:58 p.m. NA-E gave R66 a bite of his fruit dessert and stated "here ya go buddy."
-at 7:09 NA-E gave R66 a bite of his turkey sandwich and stated "here ya go buddy you almost ate all of your sandwich."
-at 7:11 p.m. NA-E gave R66 a drink of his milk and said "it's ok buddy you can let go of it (glass of milk)." NA-E took the glass from R66's hand

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and sat it on the table.
-at 7:15 p.m. R66 was done eating his supper meal, NA-E got up from sitting next to R66 and stated "here we go buddy" and wheeled R66 out of the dining room via his wheel chair to the living room area.

On 4/26/18 at 2:30 p.m. NA-E confirmed she was using nicknames while she was assisting R66 with his supper meal. NA-E confirmed the usual facility practice was for staff to remain seated next to the resident while they were eating and not to interrupt their meal time by getting up and leaving. NA-E verified staff should not be using pet names unless the resident preferred to be called by the nickname. NA-E indicated she felt it was better to use the residents name to get their attention more.

On 4/26/18 at 1:12 p.m. director of nursing (DON) confirmed the usual facility practice while staff were assisting residents to eat, was for staff to stay with the resident until they are done eating and let them have a good hot meal. The DON verified staff should not be interrupting the residents meal and she did not like the staff to rotate while they were assisting a resident, because that staff member knew how the resident was eating. The DON confirmed staff should not be using pet names or nicknames and indicated staff had been trained on this in dementia training. The DON verified staff should only being using the residents name, unless the resident preferred a different name and stated "buddy should not be used."

R19
R19's quarterly MDS, dated 2/15/18, identified R19 was moderately cognitively impaired and had

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diagnoses which included dementia, hemiplegia and depression. The MDS indicated R19 required extensive assistance of two staff with bed mobility, transfers and one staff for dressing, toileting, personal hygiene and eating. Further review of the MDS indicated R19 was always incontinent of urine and was not on a toileting program.

R19's care plan dated 5/18/17, identified R19 had an activities of daily living self care performance deficit related to stroke, dementia hemiplegia and depression. The care plan listed various interventions which included provide privacy, dignity and required physical assistance of one to two staff with all perineal care, adjusting of clothing and changing of incontinent padding.

During observations on 4/24/18 at 1:16 p.m. R19 was in her room lying in bed sleeping. A brown cloth covered recliner was present in R19's room and the seat of the recliner was covered with a white incontinent pad. R19's room had a strong odor of urine noted permeating through out the room.

During observations on 4/25/18 at 7:04 a.m., R19 was seated in her room in her brown cloth reclining chair with her feet up on the foot rest of the recliner. R19's brown reclining chair was covered with a white incontinent pad on the seat of the recliner. The white incontinent pad was visible to the public on the left side of R19's recliner while the edge of it hung from the front of the reclining chair.
-at 7;38 a.m. R19 remained seated in her recliner with the white incontinent pad visibly hanging on the left side of her recliner.
-at 7:53 a.m. remained seated in her recliner with the white incontinent pad visibly hanging on the

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21805	Continued From page 41 left side of her recliner. -at 8:07 a.m. registered nurse (RN)-B wheeled R19 out of her room via her black wheelchair into the dining room area for breakfast and handed her a menu to look at. R19's wheel chair seat was covered with a white incontinent pad and was hanging partially out of the back and the left side of her wheel chair, while the rest of it was tucked under the seat of the wheel chair but was visible on all sides of the seat cushion. -at 8:22 a.m. R19 was seated in her wheel chair at the dining room table drinking a container of 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	21805		

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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 tucked under the seat of the wheel chair but still visible on all sides.
-at 12:30 p.m. R19 remained seated in her wheel chair at the dining room table while NA-F sat on the right side of her assisting her to eat her lunch. R19 continued to have a white incontinent pad still visible on all sides of the wheelchair seat.
-at 12:42 p.m. R19 remained seated in her wheel chair at the dining room table while NA-F sat on the right side of her assisting her to eat her lunch. R19 continued to have a white incontinent pad visible on the seat and sides of the wheelchair.

On 4/25/18 at 11:14 a.m. NA-H confirmed R19 was incontinent of bowel/bladder, wore a brief and needed staff assistance to be toileted and changed. NA-H indicated R19 had incontinent pads on the seats of her recliner and wheel chair due R19 being incontinent and to protect the furniture from being soiled with urine. NA-H indicated staff tried to take the incontinent pads off the recliner but does not always happen if they are in a hurry.

On 4/25/18 at 1:30 p.m. licensed practical nurse (LPN)-C confirmed R19 was incontinent of bowel/bladder, wore a brief and needed staff assistance to be toileted and changed. LPN-C indicated R19 had incontinent pads on the seats

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00862	A. BUILDING: ____ B. WING ____	04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 43	21805		

of her recliner and wheel chair in case she had an accident and so they don't ruin the furniture from being soiled with urine. LPN-C indicated the facility had brown incontinent pads staff normally used, but indicated the supply was limited and not always available.

On 4/26/18 at 1:06 p.m. director of nursing (DON) confirmed R19 was incontinent of bowel/bladder, wore a brief and needed staff assistance to be 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

SUGGESTED METHOD OF CORRECTION:
The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit periodically to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00862	A. BUILDING: ______ B. WING ______	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21805	Continued From page 44 ensure resident(s) dignity are maintained. Audits could be completed, and results of these audits are reviewed by the quality assessment and performance improvement (QAPI) committee could ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		