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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QAEX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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) **BROEN MEMORIAL 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 **05/08/2017** (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):

17. SURVEYOR SIGNATURE — Date :
Sandra Tatro, HFE NE II — 06/01/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/09/2017 (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
05/09/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245453
June 9, 2017

Ms. Andrea Zeta, Administrator
Broen Memorial 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 June 1, 2017 the above facility is certified for or recommended for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 16, 2017

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

RE: Project Number S5453028

Dear Ms. Zeta:

On March 27, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 9, 2017. 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 8, 2017, 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 March 9, 2017. We presumed, based on your plan of correction, that your facility will correct these deficiencies as of June 1, 2017. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on March 9, 2017.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the March 9, 2017 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard extended survey 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.

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 June 9, 2017. (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 June 9, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 9, 2017. 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, Broen Memorial Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 9, 2017. 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.

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 September 9, 2017 (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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245453	A. Building B. Wing	5/8/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROEN MEMORIAL HOME	824 SOUTH SHERIDAN FERGUS FALLS, MN 56537

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0334 Reg. # 483.80(d)(1)(2) LSC	Correction Completed 04/17/2017	ID Prefix F0441 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 04/17/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	**REVIEWED BY (INITIALS)** GA/KJ	**DATE** 06/09/2017	**SIGNATURE OF SURVEYOR** 28034	**DATE** 05/08/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/9/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245453	A. Building 01 - MAIN BUILDING 01 B. Wing	6/1/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROEN MEMORIAL HOME	824 SOUTH SHERIDAN FERGUS FALLS, MN 56537

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 03/30/2017	ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 03/30/2017	ID Prefix Reg. # NFPA 101 LSC K0364	Correction Completed 06/01/2017
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 06/09/2017	SIGNATURE OF SURVEYOR 36536	DATE 06/01/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/9/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QAEX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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) **BROEN MEMORIAL 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 **03/09/2017** (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:
A. In Compliance With
Program Requirements
Compliance Based On:
X 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: **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):

17. SURVEYOR SIGNATURE — Date :
Christina Martinson, NE II — 04/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/09/2017 (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)

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
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 27, 2017

Ms. Andrea Zeta, Administrator
Broen Memorial Home
824 South Sheridan
Fergus Falls, Minnesota 56537

RE: Project Number S5453028

Dear Ms. Zeta:

On March 9, 2017, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

Informal Dispute Resolution - 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 a "F" 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
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 April 18, 2017, 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 June 9, 2017 (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 September 9, 2017 (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.

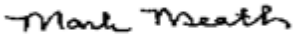
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROEN MEMORIAL 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 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable 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 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334		4/17/17

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

Electronically Signed | 03/31/2017

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 334	Continued From page 1 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 334		

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F 334	Continued From page 2 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R94, R95) reviewed for immunizations were offered and provided the pneumococcal conjugate vaccine (PCV13), or the pneumococcal polysaccharide vaccine 23 (PPSV23). Findings include: The Center for Disease Control and Prevention (CDC) identified, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." R94 was identified by the facility form titled Admission Record as admitted to the facility on 11/10/16, and was 91 years old. R94's Pre-admission Care Needs Assessment, dated 11/2/16, included a section for documented immunization dates. The form included a date the influenza vaccine had been given, however, the form lacked documentation of any pneumococcal vaccine which had been given. Review of R94's computerized clinical record lacked any documented evidence the PPSV23, or the PCV13, had been received or offered. R95 was identified by the facility form titled Admission Record as re-admitted to the facility on 2/25/17, and was 93 years old. R95's undated History and physical form identified R95 had received a pneumococcal vaccination in 2007.	F 334	R94's MIIC was reviewed, showing Pneumo-PCV 13 had been administered 5/22/2015. LRHC clinic record showed Pneumo-PPSV 23 had been administered in 2007. LB Broen Home's Immunization Record updated to reflect these two historically administered immunizations. R94's pneumococcal immunization schedule was complete 5/22/2015. Date completed: 3/29/2017 R95's MIIC was reviewed, showing Pneumo-PCV 13 had been administered 12/03/2015. According to the Immunization Action Coalition Pneumococcal vaccine pocket guide, Pneumo-PPSV 23 is due to be administered. R95 was discharged from LB Broen Home 3/15/2017. R95's primary physician was notified of the need for PPSV 23 via FAX so that she can review the clinic record and offer the immunization at R95's next physician clinic visit. Date completed: 3/30/2017. All LB Broen Home resident's MIIC's and clinic records were reviewed and each resident due to receive pneumococcal immunization, either PCV 13 or PPSV 23, will be educated on benefits and potential risks and offered the needed immunization. Immunization is scheduled to be completed in the facility by Thrifty White Drug Pharmacy staff for all resident's requesting to receive the	

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F 334	Continued From page 3 R95's Vaccination Record dated 2/25/17, identified R95 had received a pneumococcal vaccine on 12/13/15. R95's forms did not identify which pneumococcal vaccination R95 had received, the PCV13, or the PPSV23. The pneumococcal vaccination had not been documented in the computerized immunization section. Review of R95's computerized chart lacked any documented evidence the facility had provided or offered R95 the needed pneumococcal vaccination. On 3/08/2017, at 2:06 p.m. The infection control nurse (ICN)-A indicated the nurse who completed the admission process reviewed immunizations and charted the findings on the admission form and the immunization sheet. ICN-A identified she expected the admission nurse to ensure resident immunizations were current. On 3/08/2017, at 2:19 p.m. the clinical manager (CM)-B verified R95's clinical record identified a pneumococcal vaccination had been administered in 2007; however, did not identify which pneumococcal vaccination R95 had received, the PCV13, or the PPSV23. CM-B identified the facility offered the vaccinations one time a year usually in October and indicated when the medical doctors reviewed resident immunization records, needed immunizations would be ordered. On 3/08/2017, at 2:29 p.m. CM-A identified she had not aware which pneumococcal vaccine R95 had received. CM-A indicated the resident immunizations were reviewed at care conference and she understood the nurse practitioner reviewed the vaccinations also.	F 334	offered immunization 04/10/2017. For those resident's not yet due for immunization, their e-TAR will be updated to alert staff on the future due date in order to assure immunization is completed when due. Date completed: 4/10/2017. Facility policy titled Subject: Vaccination, Influenza and Pneumococcal, dated February 2017, was updated and retitled Immunization, Influenza and Pneumococcal. This policy was updated to include: use of CDC Vaccine Information Statements; Influenza, Pneumococcal Conjugate Vaccine (PCV 13) and Pneumococcal Polysaccharide Vaccine (PPSV 23), to provide education to resident/resident representative regarding the benefits and potential side effects of immunization, and detailed procedure steps including: review of the resident's MIIC entry prior to the first provider visit at LB Broen Home, complete documentation of immunizations using the Point Click Care Immunization Record and review of the resident immunization status by the RNUC with each scheduled MDS. CDC Vaccine Information Statements are included in the Resident Handbook reviewed with each resident upon admission to LB Broen Home. LB Broen Home's Point Click Care Immunization tab drop down immunization type choice was updated to include PCV 13 and PPSV 23. Date Completed: 3/30/2017 RN Unit Coordinator, Unit Clerk and	

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F 334	Continued From page 4 On 3/08/2017, at 2:39 p.m. a follow up interview with ICN-A was conducted. ICN-A identified pneumococcal immunizations were offered to residents anytime through out the year. ICN verified the nurse who completed the admission process should have followed up with R94 and R95 to identify which pneumococcal immunization R95 had received and to offer the needed vaccinations to R94 and R95. On 3/09/2017, at 1:33 p.m. the director of nursing (DON) indicated immunization records were reviewed when a resident was admitted to the facility and then added to the electronic record program Point Click Care (PCC). The DON indicated the clinical manager was responsible to follow up with needed immunizations and would expect this to be completed by the time the resident had their first care conference. The DON indicated R94 and R95's immunization records had not been reviewed to ensure their immunization status was current. A facility policy titled Subject: Vaccination, Influenza and Pneumococcal, dated February, 2017. The policy identified immunization against Pneumococcal Disease will be offered to resident or the residents' representative unless the immunization is medically contraindicated or the resident has already been immunized. The policy directed to ensure the pneumococcal vaccine was offered according to the Immunization Action Coalition PCV13/PPSV23 schedule.	F 334	Charge Nurse Meeting scheduled for 4/12/2017, will include review of updates to the Immunization, Influenza and Pneumococcal Policy and Procedure, demonstration of use of the MIIC system to gather immunization information and use of the Nursing Care Audit: Influenza and Pneumococcal Immunization. Date completed: 4/12/2017. Nursing Care Audit: Influenza and Pneumococcal Immunization was created and includes: the review of four resident Immunization records in Point Click Care for provision of education regarding the benefits and potential side effects of the immunization, offering the immunization unless the immunization is medically contraindicated or the resident has already received the immunization or the resident refused the immunization and whether or not the resident had received the immunization. Nursing Care Audit Influenza and Pneumococcal Immunization will be completed on each unit weekly x four weeks. This audit is competed 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 line item reported to the Resident Care and Customer Relations Committee, a subcommittee of the Quality Assessment and Assurance Committee. Date completed: 4/08/2017 and on-going.	

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F 441	Continued From page 5	F 441		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (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:	F 441		4/17/17

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F 441	Continued From page 6 (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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 handle soiled incontinent products in a sanitary manner to prevent the potential for cross contamination for 1 of 4 residents (R83) observed during perineal cares. Findings include: During observation 3/7/17 at 2:04 p.m. R83 was	F 441	R83 Areas of potential cross contamination were sanitized by NA-A immediately following the MDH surveyor observed provision of perineal cares 3/07/2017. NA-A was educated and counseled regarding providing dignified cares, and proper use of gloves and completion of hand washing. Date completed: 3/30/2017.	

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F 441	Continued From page 7 lying on her back, in bed with nursing assistant (NA)-B and NA-A present in R83's room to assist R83 with personal cares. NA-A opened R83's incontinent brief, checked for incontinence and stated the brief was "dirty." NA-A removed her gloves, obtained a clean incontinent brief from a storage area and container of disposable wash clothes from the top drawer of the night stand and applied clean disposable gloves to both hands. After NA-A and NA-B had assisted R83 to reposition onto her back, NA-A removed the front of R83's incontinent brief, picked up a disposable wash cloth and proceeded to provide perineal cares. NA-B assisted R83 to reposition to her right side and a large white incontinent pad was under R83's buttocks area which had a small amount of dried bowel movement on the pad. NA-A removed the incontinent soiled brief from between R83's legs and a very loose, watery, brown bowel movement with foul odor was noted in her incontinent brief, on her anal area and buttocks area. NA-A proceeded to repeatedly wipe R83's buttocks and anal area with disposable cloths and place the soiled disposable cloths in the brief until R83's buttocks area was clean. -At 2:09 p.m. NA-A removed the soiled brief and wipes soiled with loose, watery, brown stool from under R83's buttocks and laid the soiled brief and cloths next to R83's head on th bed. With her soiled gloved hands, NA-A immediately reached out, opened the top drawer of R83's night stand, picked up a tube of barrier cream and proceeded to apply the barrier cream to R83 buttocks and anal area. NA-A picked up the soiled brief and disposable cloths next to R83's head and proceeded to place the soiled brief and clothes in the open, top drawer of the night stand, on top of	F 441	All resident's who are incontinent of stool and require staff assistance to change incontinent products have the potential to be affected by NA-A's unsatisfactory performance of glove use and hand washing during perineal care/brief change. Education and counseling provided to NA-A including: satisfactory completion of the Checklist for Aseptic Glove use: Perineal Care/Brief Changes/Indwelling Catheter Care/Empty Urine Drainage Bag, stressing the importance of proper hand washing, glove use and importance of dignity while providing perineal care. Date completed: 3/30/2017. All Nursing Staff Meeting scheduled 4/11/2017 will include: 1) re-education on and demonstration of proper aseptic glove use for perineal care and brief changes, 2) re-education on proper handling and transportation of soiled incontinent products from the resident room with emphasis on use of trash bag collection of soiled products when fecal material is not contained in the brief and, 3) emphasis on caregiver dignity while providing perineal cares. A black light and glow solution will be used to further demonstrate how germs are spread in the environment when gloves are not used properly and hands are not washed at appropriate times during the provision of perineal cares and brief changes. Date completed: 4/11/2017. Checklist for Aseptic Glove Use: Perineal Care/Brief changes/Indwelling Catheter	

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F 441	Continued From page 8 R83's personal supplies. The drawer held two tubes of mouth moisturizer, one bottle of oral spray, one tube of nasal saline gel, one tube of lip balm, one alcohol prep pad, and approximately eleven toothettes. -At 2:10 p.m. NA-A removed her soiled gloves from both hands, and proceeded to apply a clean incontinent brief under R83's buttocks and fastened the brief tabs. NA-A immediately reached out with her bare hands and picked up the soiled brief and clothes and approximately four toothettes from R83's top night stand drawer and threw the items in the garbage. -At 2:12 p.m. NA-A and NA-B transferred R83 via a mechanical lift from her bed to her wheelchair, then covered R83 up with a blanket and tucked the blanket around R83. NA-A proceeded to reach out and briefly hold both sides of R83's face/cheeks with her soiled hands. -At 2:15 p.m. NA-A exited R83's room with R83's soiled bed linens in her bare right hand and proceeded to walk approximately 50 feet down the entire length of the hallway and placed the soiled linen in a bin in the soiled utility room. NA-A immediately returned to R83's room, and assisted NA-B to make R83's bed with fresh linen. NA-A had not washed or sanitized her hands during the entire observation. On 3/7/17 at 2:16 p.m. NA-A confirmed she had placed the soiled incontinent brief and clothes next to R83's head, then placed the soiled incontinent brief and clothes in R83 top night stand drawer and stated "contamination big time." NA-A indicated she should not of placed the soiled brief and disposable clothes in these areas	F 441	Care/Empty Urine Drainage Bag was completed by NA-A 3/30/17 with satisfactory performance observed and documented by the Evaluator. NA-A will be re-evaluated using this checklist weekly x four weeks. The Checklist for Aseptic Glove Use: Perineal Care/Brief Changes/Indwelling Catheter Care/Empty Urine Drainage Bag is an on-going part of Annual and New Employee Evaluation with each employee required to have a satisfactory performance at the time of their annual employee review and each new employee required to have a satisfactory performance prior to completion of their on-the-job training period. This checklist will also be completed weekly x 4 weeks on all shifts on all units. This checklist has been added to the Quarterly Nursing Care Audit system for completion on each shift on each unit quarterly on-going. DON will monitor audit findings and assure prompt follow-up of potential concerns. Audit findings are an agenda item reported to the Infection Control Committee - a sub-committee of the Quality Assessment and Assurance Committee. Date completed: 4/08/2017 and on-going.	

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F 441	Continued From page 9 and stated the soiled brief should of been placed in the garbage. NA-A stated the soiled brief and clothes had been placed on top of R83's personal supplies in the drawer such as: two tubes of mouth moisturizer, one bottle of oral spray, one tube of nasal saline gel, one tube of lip balm, one alcohol prep pad, and approximately eleven toothettes. On 3/9/17 at 1:30 p.m. clinical manager (CM)-C stated she would expect staff to wash their hands before providing cares, after removing gloves and should be following standard precautions. CM-C also indicated staff should avoid cross contamination, going from dirty to clean during cares. CM-C indicated staff should not of placed the soiled brief and disposable clothes next to R83 head and in R83's top night stand drawer on top of her personal care supplies. CM-C indicated she did not feel the findings of the above observation was good infection control practice and also did not feel this practice was dignified experience for R83. She indicated the soiled brief and disposable clothes should of been placed immediately into the garbage can. On 3/9/17 at 8:23 a.m. director of nursing (DON) stated he would expect staff to follow the facility infection control procedures. The DON indicated he would expect staff to take their gloves off when going from dirty to clean and to wash their hands and stated "the dirty brief should go in the garbage." The DON indicated it was not acceptable or dignified to place the soiled brief and clothes next to R83's head during cares. DON also indicated staff should of disposed of the soiled brief and clothes appropriately to prevent contamination of R83's personal supplies.	F 441		

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	245453	A. BUILDING _____ B. WING _____	03/09/2017

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F 441	Continued From page 10 Review of the facility policy titled Standard Precautions: Handwashing and Hand Antisepsis, dated 1/2011, directed staff to handwash/use hand sanitizer before and after contact with resident, including after glove removal. Review of the facility policy titled Checklist for Aseptic Glove Use: Perineal Care/Brief Changes/Indwelling Catheter Care/Empty Urine Drainage Bag, revised 7/2014, indicated staff should use the soiled brief as the container for the soiled disposable wash cloth, or toilet paper, by folding and using the tabs to secure. If the fecal material was not contained in the brief, place the brief into the trash either in the resident's waste basket or in a plastic bag brought in the room. Further, the checklist listed staff were to remove gloves used for perineal care when handling siderails, call light, furniture, etc. Review of the facility policy titled Standard Precautions: Work Place Controls, dated 1/2015, directed staff to use standard precautions when handling contaminated laundry and included the use of plastic bags for collection of disposable briefs, disposable washcloths.	F 441		

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	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/09/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	EPOC	

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

Electronically Signed | 03/30/2017

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

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K 000	Continued From page 1 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 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	K 000		

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K 000	Continued From page 2 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 85 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing 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 STANDARD 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	K 353	The two sprinkler heads covered with dust in the physical therapy room were cleaned and the dust was removed on	3/30/17

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K 353	Continued From page 3 (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect 6 of the 85 resident and an undetermined amount of staff and visitors. Findings include: On the facility tour between 7:45 am to 12:15 pm on 03/09/2017 observations and staff interview revealed 2 sprinkler heads covered with dust in the physical therapy room. This deficient condition was confirmed by the Facility Engineer.	K 353	3/10/2017. Kevin Rogness, Facilities Engineer, was responsible for the correction and will monitor to prevent the re-occurrence of this deficiency.	
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or	K 363		3/30/17

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K 363	Continued From page 4 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to provide two sets of corridor doors with a means suitable for keeping the door closed in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in case of a fire, affecting 37 of the 85 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 7:45 am to 12:15 pm on 03/09/2017 observations and staff interview revealed roller latches on corridor doors located on the second floor south in the admin corridor and on the 3rd floor, north nurses station. This deficient condition was confirmed by the Facility Engineer .	K 363	The roller latches on corridor doors on 2 South and on 3 North will be removed and replaced with a means suitable for keeping the door closed in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.5. Our proposed completion date is June 1, 2017. Kevin Rogness, Facilities Engineer, will be responsible for the correction and will monitor to prevent the re-occurrence of this deficiency.	
K 364 SS=D	NFPA 101 Corridor - Openings	K 364		6/1/17

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K 364	Continued From page 5 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to control the openings in a corridor wall in accordance with the 2012 of the Life Safety Code (NFPA 101) section 19.3.6.4.1. This deficient practice could allow for smoke to enter the corridor and make in untenable, affecting the exiting of all staff and visitors in the lower level. Findings include: On the facility tour between 7:45 am to 12:15 pm on 03/09/2017 observations and staff interview revealed louvered transfer ducts in the corridor wall from the elevator equipment room in the south basement. This deficient condition was confirmed by the Facility Engineer.	K 364	The louvered transfer ducts in the corridor wall from the elevator equipment room in the south basement will be removed and the remaining holes will be filled in with code appropriate material. Our proposed completion date is June 1, 2017. Kevin Rogness, Facilities Engineer, will be responsible for the correction and will monitor to prevent re-occurrence of this deficiency.	