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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QIE0

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 **05/24/2016** (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 :
Gail Anderson, Unit Supervisor 06/09/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/11/2016 (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
05/20/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245453

July 11, 2016

Ms. Andrea Zeta, Administrator
Broen Memorial Home
824 South Sheridan
Fergus Falls, Minnesota 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 May 31, 2016 the above facility is certified 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,

Mark Meath

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 9, 2016

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

RE: Project Number S5453027

Dear Ms. Zeta:

On April 21, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 7, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 24, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 6, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 7, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 31, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 7, 2016, effective May 31, 2016 and therefore remedies outlined in our letter to you dated April 21, 2016, will not be imposed.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (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	5/24/2016

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 F0412 Reg. # 483.55(b) LSC	Correction Completed 05/17/2016	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) GA/mm	DATE 06/09/2016	SIGNATURE OF SURVEYOR 28034	DATE 05/24/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/7/2016	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245453 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/6/2016 Y3

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	04/14/2016	LSC K0027	05/15/2016	LSC K0029	04/14/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0056	04/14/2016	LSC K0062	05/31/2016	LSC K0144	04/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0147	04/14/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	06/09/2016	36536	06/06/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/6/2016

[ ] 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: QIE0

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 **04/07/2016** (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:
___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):

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 05/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 05/16/2016 (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
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 21, 2016

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

RE: Project Number S5453027

Dear Ms. Zeta:

On April 7, 2016, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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 May 17, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 17, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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 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 7, 2016 (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 7, 2016 (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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

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

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
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 _____	04/07/2016

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'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 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dental services were provided and/or offered for 1 of 3 residents (R84) reviewed with broken/missing natural teeth in poor repair. Findings include:	F 412	R84 was seen at Prairie Dental in Ada, Minnesota by Dr. Resnick 4/14/2016. Date completed: 4/14/2016 All resident□s dental records were reviewed and all residents requesting dental follow-up have been scheduled.	5/17/16

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

Electronically Signed | 04/25/2016

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 _____	04/07/2016

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

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F 412	Continued From page 1 R84's quarterly Minimum Data Set (MDS) dated 1/7/16 indicated R84 had diagnoses which included: Diabetes Mellitus, depression and chronic obstructive pulmonary disease. The MDS indicated R84 had intact cognition, and required extensive assistance for all activities of daily living (ADLs) and supervision or cuing for eating. Further, the MDS indicted R84 had mouth or facial pain, discomfort or difficulty with chewing. R84's annual Minimum Data Set (MDS) dated 7/23/2015, indicated R84 was cognitively intact, required assistance for all activities of daily living (ADL's) and required supervision with set up help from staff for eating. R84's MDS also identified R84 had obvious or likely cavity/broken natural teeth and mouth/facial pain, discomfort or difficulty with chewing. R84's Care Area Assessment (CAA), dated 7/23/15 indicated R84 had obvious or likely cavity or broken natural teeth and mouth or facial pain, discomfort or difficulty with chewing. The CAA indicated R84 had broken and worn natural teeth and remained able to consume foods/ fluids of choice and staff would assist with oral cares. Further, the CAA indicated R84 had Diabetes Mellitus, diabetes was unstable related to oral infection, and indicated the goal was to remain free of infection, and have dental follow up as she allowed. R84's care plan dated 11/12/2012, indicated R84 had oral/dental health problems (broken natural teeth) related to Diabetes Mellitus, and history of smoking. The care plan indicated R84 had her own teeth, in poor repair and was able to brush teeth after staff set up needed supplies. R84 was	F 412	Date completed: 4/19/2016 Nursing Care Audit: Dental Services was created and includes: establishment of oral care plan based on comprehensive assessment including frequency of oral cares and type of assistance needed and presence of natural teeth or dentures, labeling of dentures, review of referral for initial dental examination within 90 days after admission unless resident had an exam six months before admission, annual dental exam offered within one year of previous exam, if resident refused dental services date of refusal, reason for refusal and risk to resident health is documented in resident□s electronic health record. Nursing Care Audit: Dental Services will be completed on each unit weekly x4 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. Date completed: 4/19/2016 and on-going. Care Conference Documentation Record has been updated to include direction to RNUC to complete documentation of date, reason and risk to health in residents electronic health record at each Quarterly Care Conference if resident refuses dental follow-up. Date completed: 5/17/2016	

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F 412	Continued From page 2 independent after meal set up, staff remind/awake to complete meal. The care plan also indicated the facility would coordinate arrangements for dental care, transportation as needed/as ordered, monitor/document/report to medical doctor as needed signs and symptoms of oral/dental problems needing attention such as: pain, (gums, toothache, palate), abscess, debris in mouth, lips cracked, or bleeding, teeth missing, loose, broken, eroded, decayed, tongue (black, coated, inflamed, white, smooth), ulcers in mouth, lesions and provide mouth care as per ADL personal hygiene. Review of the current Nursing Assistant sheets, indicated staff would assist R84 with oral cares in the morning and at bedtime. During observation on 4/5/16 at 2:22 p.m. R84 was seated in a wheelchair, watching television in her room. R84 was observed to have several natural teeth, both on the top and bottom of her mouth, which were a gray/black hewn color, with some of R84's natural teeth broken off at the gum line/ missing or cracked, decayed, and in very poor condition. On 4/5/16 at 2:22 p.m. R84 indicated she really needs to concentrate when she chews and eats because of the condition of her teeth. R84 stated she was not sure when the last time she had seen a dentist and indicated the facility had talked to her about seeing Apple Tree Dental in the very distant past, but she never heard any follow up and seeing a dentist had not been discussed again. Review of R84's Progress Notes from 6/1/15 to 4/5/16, lacked documentation of any oral exams	F 412	Admission Nursing Assessment, completed upon admission for each new resident, has been expanded to include a diagram of upper and lower dentition and more detailed description of appearance of missing teeth, broken/fractured teeth, darkened areas/decay, fillings/crowns and condition of oral mucosa. Date completed: 5/17/2016 Education and counseling provided to RNUC responsible for R84□s care, including review of updated Dental Services system stressing the importance of assurance of dental examination of all residents requesting an examination. Date completed: 5/17/2016 All Nursing Staff Meeting 4/27/16, included review of updates to Dental Services Policy and Procedure and the addition of Nursing Care Audit: Dental Services and review of MDH video, Growing Old With a Smile: Oral Care for Older Adults in Long Term Care. Date completed: 4/27/16 RN Unit Coordinator and Charge Nurse meeting 5/10/2016, included review of updates to Dental Services Policy and Procedure, addition of Nursing Care Audit: Dental Services, update to the Care Conference Documentation Record and the expansion of the Oral Assessment section of the Admission Nursing Assessment. Date completed: 5/10/2016	

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F 412	Continued From page 3	F 412		

noted, identification of missing, broken, cracked, decayed teeth or dental services completed, offered or discussed with R84.

Review of R84's Care Conference Documentation Record (CCDR) from 8/5/15 to 1/20/16 revealed on 8/5/15 was on the waiting list for dental services, and had potential for dentures. On 10/28/15 and 1/20/16, the record indicated R84 remained on the waiting list for dental services, however, the record lacked documentation of the status of R84's teeth, and chewing/eating status.

On 4/6/16 at 10:58 a.m. registered nurse (RN)-A confirmed R84 was on the waiting list for Apple Tree Dental services and "waiting for them to send the paper work back to say they have a opening." RN-A stated she has not heard back from Apple Tree Dental regarding a dental appointment for R84 and stated "she has not seen a dentist since she has been admitted that I am aware of."

On 4/6/16 at 11:16 a.m. nursing support staff (NSS) confirmed R84 had not had a dental appointment since she was admitted to the facility in 2013. NSS indicated it's hard to get an appointment with Apple Tree Dental if the person was not a previous patient of Apple Tree Dental. The NSS indicated the usual facility practice was if the facility could not get the resident an appointment Apple Tree Dental, then they refer them to their consultant doctor Drake.

On 4/6/16 at 11:43 a.m. via telephone interview, clinical coordinator (CC) from Apple Tree Dental confirmed R84 was prospect and on the waiting list for dental services and stated "we are

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F 412	Continued From page 4	F 412		

currently not taking patients at this time." The CC indicated the dental office had hundreds of patients on the waiting list and currently had patients on the waiting list all the way back to 2010. The CC also indicated the office saw the patients that have been on the waiting list the longest first.

On 4/6/16 at 11:57 a.m. director of nursing (DON) confirmed R84's oral cavity, which had some natural teeth on the top and bottom of her mouth, a gray/black hewn color to them, with some of her natural teeth broken off at the gum line/missing and was noted to be broken, cracked, decayed, fragile and in very poor condition. The DON verified on admission staff were to screen and assess the residents oral cavity and to see if they need dental work or if they have dentures, pain and if they need anything for oral care. The DON indicated the usual practice was for R84's oral cavity to be assessed on a quarterly basis and if there was any concerns or problems, then staff would notify the team lead or the unit coordinator of any issues. DON stated he would expect them (staff) to follow the protocol within the facility. The DON also indicated if they could not get a resident into Apple Tree Dental, then the facility would set up an appointment for the resident with their consultant doctor Drake. The DON verified Apple Tree Dental was currently not taking new patients and was not sure if doctor Drake had even been contacted or notified and stated "we have protocol and it needs to be followed." The DON verified the facility policy which directed a resident should be referred to a dentist 90 days after admission and seen annually there after. DON was not aware if or where R84 had been on the waiting in 2014 prior to being on the waiting list for Apple tree Dental and stated "she (R84)

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F 412	Continued From page 5 has not seen a dentist." On 4/7/16, at 8:38 a. am., during follow up interview with the DON, he stated he had talked with R84 and after discussion regarding dental evaluation, R84 agreed to an appointment with a out of town dentist appointment made for the following week. During follow up interview with R84 on 4/7/16 at 9:12 a.m. R84 indicated she did not currently have pain in her mouth, but her teeth were sensitive to hot and cold things when she eats. R84 also indicated she had a hard time eating because of the condition of her teeth and stated her teeth were "so chipped and broken." R84 stated she had to move the food around in her mouth so she could chew her food and stated "it takes along time to eat." R84 stated she had been told yesterday of an upcoming dental appointment in the near future and stated she was "glad" she had finally gotten an appointment to see the dentist. Review of the facility policy titled, Dental Services Routine, revised on 11/91, indicated each resident or his/her responsible party will have an opportunity to identify a private dentist. A current list of dentists will be available to the resident as needed. Within 90 days after admission the resident must be referred for an initial dental examination unless the resident has received a dental examination within six months before admission. After the initial dental examination the RNUC must ask the resident if the resident wants to see a dentist and provide any necessary help to make the appointment on least an annual basis. This opportunity/ or an annual dental checkup must be provided within one year from	F 412		

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F 412	Continued From page 6 the date of the initial dental examination or within one year from the date of the examination done within six months before admission.	F 412		

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	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/06/2016**

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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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 Or by email to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 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 (1999 edition). 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	K 000		

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K 000	Continued From page 2 accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 107 beds and had a census of 83 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 7 resident room doors according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 45 of the 83 residents and an undetermined amount of staff	K 018	The door frames, doors, latches, and/or strikes in need of adjustment for rooms listed that failed to latch or fit tightly to the door frame where fixed to correct the violation. These fixes were performed within one week of the observations.	4/14/16

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K 018	Continued From page 3 and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 8:15 am to 1:30 pm on 04/06/2016 observations and staff interview revealed the following resident room doors either did not fit tight in the frame or latch to provide smoke resistance. 1. Rooms that did not latch: 266, 120, 119, 107, 115, 104 2. Rooms that did not fit tight in the frame: 352 This deficient condition was verified by the the Maintenance Supervisor.	K 018	Kevin Rogness, Facilities Engineer, was responsible for the correction and will monitor to prevent the re-occurrence of the deficiency.	
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect 61 of the 83 residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another.	K 027	Door coordinators will be ordered and installed for the areas noted in the observations. Our proposed completion date is no later than two weeks from May 1st, 2016. Kevin Rogness, Facilities Engineer, was responsible for the correction and will monitor to prevent the re-occurrence of the deficiency.	5/15/16

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K 027	Continued From page 4 Findings include: On the facility tour between 8:15 am to 1:30 pm on 04/06/2016 observations and staff interview revealed on the North and South 2nd and third floor wings, the smoke barrier doors across the corridors swung in the same direction and did not have coordinators. This deficient condition was verified by the the Maintenance Supervisor.	K 027		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the corridor and adjacent areas making them untenable, which could negatively affect the exiting capabilities for 15 of the 83 of residents and an undetermined amount of staff and visitors.	K 029	The automatic closer on the door to the soiled utility noted in the observation was adjusted and now the door closes completely. This fix was performed within one week of the observations. Kevin Rogness, Facilities Engineer, was responsible for the correction and will monitor to prevent the re-occurrence of the deficiency.	4/14/16

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K 029	Continued From page 5 Findings include: On the facility tour between 8:15 am to 1:30 pm on 04/06/2016 observations and staff interview revealed a soiled utilities room on the second floor near resident room 263, has an automatic closer that does not close the door completely. This deficient condition was verified by the Maintenance Supervisor	K 029		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99) section 5-13.6.3. The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow fire and smoke to spread throughout the areas served by the elevater and could affect all 83 residents and an undetermined amount of visitors and staff of the facility. Findings include: On the facility tour between 8:15 am to 1:30 pm	K 056	The elevator shaft noted in the observation in the deficiency does contain a sprinkler head, it was not observed by Mr. Baumann or confirmed by the Facilities Engineer on 4/6/16. The sprinkler head was installed at the time when the entire building had work performed to meet the requirement of fully sprinkled.	4/14/16

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	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/06/2016**

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

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K 056	Continued From page 6 on 04/06/2016 observations and staff interview revealed the elevator shaft did not have a sprinkler head at the top or bottom. This deficient condition was verified by the Maintenance Supervisor	K 056		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 21 of the 83 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:15 am to 1:30 pm on 04/06/2016 observations and staff interview revealed the sprinkler system was not being maintained for the following reasons. 1. In room E63, the Activity Directors office, paint covered the sprinkler head. 2. The phone room on the 2nd floor was missing an escutcheon on a sprinkler head. 3. One sprinkler head in the kitchen near the	K 062	The paint covered sprinkler head in room E63 will be replaced and the missing escutcheon found in the phone room will be installed by our fire suppression contractor. Our fire suppression contractor, NOVA Fire Protection, Inc., has been contacted and will perform the work noted above on their quarterly inspection which takes place in the month of May, 2016. The sprinkler heads covered with dirt and lint noted in the observation were cleaned within one week of the observation. Kevin Rogness, Facilities Engineer, was responsible for the correction and will monitor to prevent the re-occurrence of the deficiency.	5/31/16

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	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/06/2016**

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K 062	Continued From page 7 cooking line and 3 heads in the beauty salon were covered with dirt and lint. This deficient condition was verified by the Maintenance Supervisor	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all 83 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:15 am to 1:30 pm on 04/06/2016 record review and staff interview revealed the generator cool down was not being logged. This deficient condition was verified by the Maintenance Supervisor	K 144	Generator cool down will be logged on all future records. Kevin Rogness, Facilities Engineer, was responsible for the correction and will monitor to prevent the re-occurrence of the deficiency.	4/25/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observations and an email recieved by the MDH surveryors it was revealed that the	K 147	Extension cord was removed from room 371 and non-protected power strips were	4/14/16

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	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/06/2016**

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K 147	Continued From page 8 facility failed to maintain the facilitys electrical wiring per NFPA 101 (99) section 9.1.2 and NFPA 70. This deficient practice could affet 3 of the 83 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:15 am to 1:30 pm on 04/06/2016 observations and staff interview revealed an extension cord being used in resident room 371 and non-protected power strips being used in resident rooms 277 and 259. This deficient condition was verified by the Maintenance Supervisor	K 147	replaced with protected power strips within one week of the observation. The Maintenance Dept. and IT Dept. reviewed the CMS ref: S&C: 14-46-LSC provided by Mr. Baumann. Kevin Rogness, Facilities Engineer, was responsible for the correction and will monitor to prevent the re-occurrence of the deficiency.	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 25, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5453027

Dear Ms. Zeta:

The above facility was surveyed on April 4, 2016 through April 7, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 at (218) 332-5140 or email: 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.

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

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
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
	00862	A. BUILDING: _____ B. WING _____	04/07/2016

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BROEN MEMORIAL HOME	824 SOUTH SHERIDAN FERGUS FALLS, MN 56537

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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	2 000		

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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 April 4, 5, 6, and 7, 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health 1505 Pebble Lke Road, Suite 300 Fergus Falls, MN 56537 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	2 000		

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2 000	Continued From page 2 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.	2 000		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dental services were provided and/or offered for 1 of 3 residents (R84) reviewed with broken/missing natural teeth in poor repair. Findings include: R84's quarterly Minimum Data Set (MDS) dated 1/7/16 indicated R84 had diagnoses which	21325	Corrected.	5/17/16

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21325	Continued From page 3	21325		

included: Diabetes Mellitus, depression and chronic obstructive pulmonary disease. The MDS indicated R84 had intact cognition, and required extensive assistance for all activities of daily living (ADLs) and supervision or cuing for eating. Further, the MDS indicted R84 had mouth or facial pain, discomfort or difficulty with chewing.

R84's annual Minimum Data Set (MDS) dated 7/23/2015, indicated R84 was cognitively intact, required assistance for all activities of daily living (ADL's) and required supervision with set up help from staff for eating. R84's MDS also identified R84 had obvious or likely cavity/broken natural teeth and mouth/facial pain, discomfort or difficulty with chewing.

R84's Care Area Assessment (CAA), dated 7/23/15 indicated R84 had obvious or likely cavity or broken natural teeth and mouth or facial pain, discomfort or difficulty with chewing. The CAA indicated R84 had broken and worn natural teeth and remained able to consume foods/ fluids of choice and staff would assist with oral cares. Further, the CAA indicated R84 had Diabetes Mellitus, diabetes was unstable related to oral infection, and indicated the goal was to remain free of infection, and have dental follow up as she allowed.

R84's care plan dated 11/12/2012, indicated R84 had oral/dental health problems (broken natural teeth) related to Diabetes Mellitus, and history of smoking. The care plan indicated R84 had her own teeth, in poor repair and was able to brush teeth after staff set up needed supplies. R84 was independent after meal set up, staff remind/awake to complete meal. The care plan also indicated the facility would coordinate arrangements for dental care, transportation as

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21325	Continued From page 4	21325		

needed/as ordered, monitor/document/report to medical doctor as needed signs and symptoms of oral/dental problems needing attention such as: pain, (gums, toothache, palate), abscess, debris in mouth, lips cracked, or bleeding, teeth missing, loose, broken, eroded, decayed, tongue (black, coated, inflamed, white, smooth), ulcers in mouth, lesions and provide mouth care as per ADL personal hygiene.

Review of the current Nursing Assistant sheets, indicated staff would assist R84 with oral cares in the morning and at bedtime.

During observation on 4/5/16 at 2:22 p.m. R84 was seated in a wheelchair, watching television in her room. R84 was observed to have several natural teeth, both on the top and bottom of her mouth, which were a gray/black hewn color, with some of R84's natural teeth broken off at the gum line/ missing or cracked, decayed, and in very poor condition.

On 4/5/16 at 2:22 p.m. R84 indicated she really needs to concentrate when she chews and eats because of the condition of her teeth. R84 stated she was not sure when the last time she had seen a dentist and indicated the facility had talked to her about seeing Apple Tree Dental in the very distant past, but she never heard any follow up and seeing a dentist had not been discussed again.

Review of R84's Progress Notes from 6/1/15 to 4/5/16, lacked documentation of any oral exams noted, identification of missing, broken, cracked, decayed teeth or dental services completed, offered or discussed with R84.

Review of R84's Care Conference

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21325	Continued From page 5	21325		

Documentation Record (CCDR) from 8/5/15 to 1/20/16 revealed on 8/5/15 was on the waiting list for dental services, and had potential for dentures. On 10/28/15 and 1/20/16, the record indicated R84 remained on the waiting list for dental services, however, the record lacked documentation of the status of R84's teeth, and chewing/eating status.

On 4/6/16 at 10:58 a.m. registered nurse (RN)-A confirmed R84 was on the waiting list for Apple Tree Dental services and "waiting for them to send the paper work back to say they have a opening." RN-A stated she has not heard back from Apple Tree Dental regarding a dental appointment for R84 and stated "she has not seen a dentist since she has been admitted that I am aware of."

On 4/6/16 at 11:16 a.m. nursing support staff (NSS) confirmed R84 had not had a dental appointment since she was admitted to the facility in 2013. NSS indicated it's hard to get an appointment with Apple Tree Dental if the person was not a previous patient of Apple Tree Dental. The NSS indicated the usual facility practice was if the facility could not get the resident an appointment Apple Tree Dental, then they refer them to their consultant doctor Drake.

On 4/6/16 at 11:43 a.m. via telephone interview, clinical coordinator (CC) from Apple Tree Dental confirmed R84 was prospect and on the waiting list for dental services and stated "we are currently not taking patients at this time." The CC indicated the dental office had hundreds of patients on the waiting list and currently had patients on the waiting list all the way back to 2010. The CC also indicated the office saw the patients that have been on the waiting list the

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21325	Continued From page 6 longest first. On 4/6/16 at 11:57 a.m. director of nursing (DON) confirmed R84's oral cavity, which had some natural teeth on the top and bottom of her mouth, a gray/black hewn color to them, with some of her natural teeth broken off at the gum line/missing and was noted to be broken, cracked, decayed, fragile and in very poor condition. The DON verified on admission staff were to screen and assess the residents oral cavity and to see if they need dental work or if they have dentures, pain and if they need anything for oral care. The DON indicated the usual practice was for R84's oral cavity to be assessed on a quarterly basis and if there was any concerns or problems, then staff would notify the team lead or the unit coordinator of any issues. DON stated he would expect them (staff) to follow the protocol within the facility. The DON also indicated if they could not get a resident into Apple Tree Dental, then the facility would set up an appointment for the resident with their consultant doctor Drake. The DON verified Apple Tree Dental was currently not taking new patients and was not sure if doctor Drake had even been contacted or notified and stated "we have protocol and it needs to be followed." The DON verified the facility policy which directed a resident should be referred to a dentist 90 days after admission and seen annually there after. DON was not aware if or where R84 had been on the waiting in 2014 prior to being on the waiting list for Apple tree Dental and stated "she (R84) has not seen a dentist." On 4/7/16, at 8:38 a. am., during follow up interview with the DON, he stated he had talked with R84 and after discussion regarding dental evaluation, R84 agreed to an appointment with a out of town dentist appointment made for the	21325		

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BROEN MEMORIAL HOME	824 SOUTH SHERIDAN FERGUS FALLS, MN 56537

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21325	Continued From page 7 following week. During follow up interview with R84 on 4/7/16 at 9:12 a.m. R84 indicated she did not currently have pain in her mouth, but her teeth were sensitive to hot and cold things when she eats. R84 also indicated she had a hard time eating because of the condition of her teeth and stated her teeth were "so chipped and broken." R84 stated she had to move the food around in her mouth so she could chew her food and stated "it takes along time to eat." R84 stated she had been told yesterday of an upcoming dental appointment in the near future and stated she was "glad" she had finally gotten an appointment to see the dentist. Review of the facility policy titled, Dental Services Routine, revised on 11/91, indicated each resident or his/her responsible party will have an opportunity to identify a private dentist. A current list of dentists will be available to the resident as needed. Within 90 days after admission the resident must be referred for an initial dental examination unless the resident has received a dental examination within six months before admission. After the initial dental examination the RNUC must ask the resident if the resident wants to see a dentist and provide any necessary help to make the appointment on least an annual basis. This opportunity/ or an annual dental checkup must be provided within one year from the date of the initial dental examination or within one year from the date of the examination done within six months before admission. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures	21325		

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 _____	04/07/2016

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

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21325	Continued From page 8 related to dental services. Responsible personnel could be re-educated on these policies and procedures. Appropriate provision of dental services could be re-assessed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate provision of dental services. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21325		