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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SBHU

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 **06/18/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
04/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Gail Anderson, HFE NEII — 06/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 08/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/11/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5453

June 24, 2014

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

Dear Ms. Zetah:

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 3, 2014 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.

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 24, 2014

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

RE: Project Number S5453025

Dear Ms. Zetah:

On May 12, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 24, 2014. 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 June 18, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 16, 2014 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 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 3, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 24, 2014, effective June 3, 2014 and therefore remedies outlined in our letter to you dated May 12, 2014, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Enclosure

cc: Licensing and Certification File 5453r14.pdf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245453	A. Building B. Wing	6/18/2014

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0323 Reg. # 483.25(h) LSC	06/03/2014	ID Prefix F0371 Reg. # 483.35(i) LSC	06/03/2014	ID Prefix F0441 Reg. # 483.65 LSC	06/03/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GA	06/23/2014	31593	06/18/2014

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
4/24/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245453	A. Building B. Wing 01 - MAIN BUILDING 01	6/16/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0046	Correction Completed 04/29/2014	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 05/13/2014	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	Date:	Signature of Surveyor:	Date:
	MM/PS	06/24/2014	27200	06/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/23/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SBHU

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 **04/24/2014** (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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Miriam Thornquist, HFE NEII 05/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/06/2014 (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

CCN: 24-5453

On April 24, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed. Post Certification Revisit to follow. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 0327

May 12, 2014

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

RE: Project Number S5453025

Dear Ms. Zetah:

On April 24, 2014, 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:

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537

Telephone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 3, 2014, 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 June 3, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 24, 2014 (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 24, 2014 (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

Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

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 _____	04/24/2014

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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	RECEIVED MAY 21 2014 MN Dept of Health Fergus Falls	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to evaluate/re-assess potential causative factors for ongoing falls for 1 of 3 residents (R42) reviewed with a recent history of falls. Findings Include: R42's quarterly Minimum Data Set (MDS) dated 1/30/14, indicated diagnoses including non-Alzheimer dementia, depression and psychotic disorder. The MDS identified R42 had	F 323	A full MDS assessment with ARD date of 4/29/14 was completed for R42. A Fall Risk Assessment was completed 4/28/14 in conjunction with this MDS with potential casual factors noted to include use of psychotropic medications, memory and recall impairment, incontinence and impaired gait. Collected data was analyzed and determined follow up completed. A Comprehensive Bowel and Bladder assessment with newly developed toileting plan was completed 5/2/14, repeated Pressure Tolerance tests 4/26/14 with updated repositioning plan, Occupational and Physical therapy treatment 4/17-5/9/14,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Zetah, Administrator — TITLE — (X6) DATE: 5-21-14

OK 5/22/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING _____ B. WING _____	04/24/2014

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 323	Continued From page 1 severe cognitive impairment, and required assistance with all activities of daily living. Further, the MDS identified R42 was occasionally incontinent of urine and was not on a scheduled toileting program. The falls Care Area Assessment (CAA) dated 11/17/13, indicated R42 had cognitive impairment, difficulty maintaining a sitting balance and impaired balance during transitions. Review of the facility Incident/Accident Reports for R42 indicated he had fallen seven times from 3/9/14, to 4/15/14. On 4/11/14, the incident report noted sensor alarms were to be placed on R42's chair, bed and wheelchair as a fall prevention intervention. On 4/15/14, R42 was found on the floor in the bathroom doorway. There were no documentation of measures planned to prevent further falls. Review of R42's fall log revealed on 4/15/14, staff were to check on relocating R42 to a different room as a fall prevention intervention. Review of the facility fall risk assessments completed after each fall revealed the fall risk assessment completed on 4/22/14 identified R42 had multiple falls, had consistent problems with memory and recall ability, was frequently incontinent, was unable to independently come to a standing position, had loss of balance while standing and required hands on assistance to move from place to place. However, the assessment lacked documentation of analysis of the data, to determine why he was trying to get out of bed. R42's current plan of care with a print date of 4/19/14, indicated he had a potential for injury, secondary to falls, related to the use of psychotropic medications. The care plan	F 323	Consultant Pharmacy review with change in psychotropic medication administration time 4/22/14 and lab to rule out hyponatremia 4/24/14 were addressed. R42 was moved from room 215 to room 204, closer to the Nurse's Station area of the unit on 4/25/14. 5/14/14 Interdisciplinary Team met to discuss history of R42's falls and determined additional interventions to reduce further falls including addition of anti-rollback brake device added to w/c 5/15/14. All new and changed interventions were added to the Care Plan and communicated to staff per the Care Plan Revisions Communication Sheet. A review of all current residents identified as high risk for falls by the Point Click Care Fall Risk Assessment over the past quarter were reviewed to assess whether current interventions were pertinent, appropriate and effective. Following the assessment, Care Plans	5/9/14 5/15/14

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 _____	04/24/2014

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 323	Continued From page 2 identified that R42 ambulated with an assistive device and directed one to two staff to reposition him every one to two hours and use an EZ stand lift for transfers. The care plan further identified R42 was unable to ambulate, required the use of a wheelchair for mobility and was incontinent of both bowel and bladder. On 4/22/14, at 3:40 p.m. R42 was observed in his resident room, located at the end of the hallway. R42 was lying slightly on his left side, in a low bed, with his feet hanging over the edge of the bed. On 4/23/14, at 12:39 p.m. R42 was observed while in bed. A sensor alarm was noted on R42's bed. R42 sat up in bed, moved both legs over the left side of the bed. R42 then laid back down briefly and then returned to the seated position, with his hip over the edge of the bed. R42 repeatedly sat up, threw his hip and legs over the side of the bed, and repeatedly reached out and pulled on the side rail on the same side of the bed. At 12:44 p.m., R42 sat up on the side of the bed, with his feet touching the floor and continued to push and pull on the side rail. The sensor alarm did not sound through out the entire observation. R42 then laid back down on his left side, with his feet remaining in contact with the floor and hand on the side rail. On 4/23/14, at 5:39 p.m. nursing assistant (NA)-C stated when R42 had to go to the bathroom, he sat up on the edge of the bed or got out of bed. NA-C indicated a lot of R42's falls were because he needed to go to the bathroom or was trying to shut his television off. On 4/23/14, at 10:26 a.m. social worker (SW)-A	F 323	were updated with any new/changed interventions. 6/3/14 Facility Fall Prevention Program reviewed by DON and Administrator. 5/16/14 Accident/Injury/Incident Log Policy and Procedure updated to include RNUC follow up of the Confidential Accident/Injury/Incident report's immediate intervention to assure the intervention was completed and to implement further planning/action if needed. If the report was completed due to a fall, the RNUC will review with the Interdisciplinary Team. 6/3/14 Broen Home Nursing Care Audit, Fall, Acute Care Plan #2 was updated to include assuring the intervention implemented after each fall to minimize risk of similar, future incidents was completed. 6/3/14 Confidential Accident/Injury/Incident Report to include five new or updated line items to address immediate intervention for fall and delineate Charge Nurse and RNUC responsibilities in follow up. Review with Interdisciplinary Team for all fall	

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 _____	04/24/2014

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 323	Continued From page 3 stated they talked about R42 being moved to a different room during daily report. SW-A confirmed there was a room available, but the team did not think that room was going to be an improvement for R42's fall prevention. SW-A confirmed although the room change had been deemed an inappropriate intervention for R42, no further interventions were discussed for consideration in place of this relocation. On 4/23/14, at 10:47 a.m. licensed practical nurse (LPN)-A stated R42 frequently tried to self-transfer and was unsteady. LPN-A said she thought the falls were related to weakness and was in therapy to improve muscle strength. On 4/24/14, at 10:06 a.m. registered nurse (RN)-E said she was not sure why R42 was falling so often. She reported R42 was treated for pneumonia in the past and started falling after that. RN-E verified R42 was at high risk for further falls and stated she was not aware if R42 continued to self transfer. RN-E indicated R42 spent the majority of his time in his room, and had not moved to a different room in several years. RN-E stated the intervention to move R42 had not been implemented and was not aware of any further interventions attempted or considered to attempt to prevent further falls for R42. She confirmed the current facility policy. On 4/24/14, at 10:37 a.m. NA-E indicated R42 was confused, utilized a bed and chair alarm and routinely attempted to self transfer. She stated R42 most recently self transferred two days ago, and confirmed R42 routinely spent the majority of his time in his room. The facility's Fall Prevention Program policy	F 323	incidents will be added. All Nursing Staff meeting will be held 5/27/14 to review changes to the Nursing Care Audit, Fall, Acute Care Plan #2, Confidential Accident/ Injury/Incident Report (Resident) and Accident/Injury/Incident Policy and Procedure. The importance of a pertinent, appropriate and effective immediate intervention and communication of this intervention to direct care staff will be emphasized. Licensed staff will be re-educated on the importance of following approaches on Acute Care Plan direction to guide them in follow up of resident accident, injury or incident. Acute Care Plan #2 Fall, Witnessed/ Unwitnessed updated to include delineation of Charge Nurse and RNUC follow-up responsibilities after a fall. Nursing Care Audit, Fall, Acute Care Plan #2 will be completed on each unit by 6/3/14 and then one on each unit weekly x 4 weeks thereafter.	6/3/14 5/27/14 6/3/14 6/3/14 & on-going

F323 Page 5 (Cont)

Nursing Care Audit, Fall, Acute Care Plan #2 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. on-going

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 _____	04/24/2014

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 323	Continued From page 4 revised 6/13, directed staff to recognize the residents at high risk for falls, promptly begin a prevention plan, and alert staff of residents at high risk for falls.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food and fluid containers were covered/sealed and labeled with the date opened, in 2 of 4 refrigerators located on the units. This had the potential to affect 42 of 42 residents whose food items were stored in the first and third floor refrigerators. The facility also failed to ensure sanitary handling of resident meal plates, for 7 of 35 residents (R20, R33, R64, R75, R80, R98, R99) from the census sample who were observed during the meal service on 4/21/14. This had the potential to affect all 25 of 25 residents who ate in the Two-North dining room. Findings include: During initial tour of the facility on 4/21/14, at 7:10	F 371	Re-education/counseling and demonstration on correct procedure for proper handling of food plates and other serving items during food service was done with Dietary Aide (DA-B) involved in the deficient practice 2N meal service observation. 5/15/14 A policy and procedure developed and implemented entitled Food Service Plates and Other Service Items, Proper Handling of. 6/3/14 An all Dietary staff meeting scheduled for 5/29/14 will include review and re-education on facility policy for proper handling of food service plates and other items. 5/29/14	

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 _____	04/24/2014

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 371	Continued From page 5 a.m. a side-by-side refrigerator/freezer was observed in the dining area, across from the nurse's station on the third floor. The following food items lacked a label to identify the date the item was opened or prepared: One plastic container with a spread-type of food; One half of a meat sandwich in a plastic bag; One small plastic container filled with a thick white substance; One medium plastic container with cut pears, apples, and pineapple that were beginning to turn brown; One small pitcher filled with a clear liquid; One gallon-sized plastic bag which held unidentifiable food items; A cake pan filled with baked eggs and meat; One open 12 ounce (oz.) jar of Picante salsa; One container of Minute Maid raspberry lemonade flavor drops, 1.9 oz. with the top flipped off; One open 46 oz. Sahara Burst grape juice container; Two 48 oz. Hormel, nectar thickened water containers, with 50 to 75% of the water remaining in each; One 48 oz. Hormel honey consistency thickened water, with 50% remaining in the container; One plastic bag, rolled up and secured with duct tape on the shelf in the freezer, resembling fish fillets, and; One plastic, covered cake pan with a four-inch piece of dessert-type food, on top of the stove, next to the refrigerator. During interview on 4/21/14, at 7:24 a.m. dietary aide (DA)-C reported the nursing department was responsible for labeling and dating food items that were located in the refrigerators/freezers on the units. DA-C stated, the only duty the kitchen staff had in relation to the unit refrigerator/freezers, was to place applesauce and bedtime snacks in them. When DA-C was asked to identify the contents of a plastic bag with duct tape in the third floor unit freezer, DA-C replied, it was probably something that belonged to a resident.	F 371	An all Nursing Staff meeting scheduled for 5/27/14 will include review of and re-education on facility policy for proper handling of food service plates and other items. 5/27/14 The Food/Dining Service Audit Tool was updated to include monitoring of clean food service plates and other service items so they are handled in a proper sanitary manner during dishing and plating of food. This audit will be 6/3/14 completed for 3 meals on each unit by 6/3/14; then one on each unit weekly x 4 weeks thereafter. This audit is completed on an on-going basis and is included in a quarterly Nursing Care Audit system for each unit. Dietary staff will also complete one of these audits quarterly per unit. DON and Food Service Director 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 - subcommittee of the Quality Assessment and Assurance 6/3/14 & Committee. on-going	

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 _____	04/24/2014

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 371	Continued From page 6 During interview on 4/21/14, at 7:27 a.m. licensed practical nurse (LPN)-A stated the dietary staff were responsible for the contents of the unit refrigerators. LPN-A confirmed that the refrigerator/freezer was for resident and staff food items. During interview on 4/21/14, at 7:29 a.m. nursing assistant (NA)-B reported that nursing staff were to keep track of items in the refrigerator/freezer and it was for staff and resident use. NA-B then stated, "I know I didn't [did not] label my stuff and I should have." LPN-A joined the interview, both staff were asked if they could identify the contents in the plastic bag, with duct tape. NA-B replied, "I have no idea." NA-B slowly peeled off the duct tape, unrolled the plastic bag and stated, "It looks like fish to me." LPN-A and NA-B confirmed that the food items listed, lacked labeling to identify the food item and the date opened/prepared. LPN-A and NA-B both confirmed the correct practice was to label and date food items when opened. On 4/23/14, at 11:28 a.m. refrigerator/freezer was observed in the first floor dining room. The following food items lacked a label to identify the date the item was opened or prepared: One Styrofoam box, filled with eight mini desserts; One-gallon bucket of chocolate revel ice cream, with 50% remaining in the container. During interview on 4/23/14, at 11:47 a.m. registered nurse (RN)-C confirmed the refrigerator on first floor was used for resident and staff food items. RN-C stated the food items should have been labeled and dated when opened. RN-C indicated it was the nursing staff's	F 371	All unit refrigerators storing food and juice/supplements will be cleaned and items properly labeled with the item description, date, resident name (if applicable) and stored properly. 6/3/14 The policy and procedure entitled Storing of Juices and Nutritional Supplements updated to include directions for: 1) responsibility for on-going management of the unit refrigerators and 2) proper storing of resident items. 6/3/14 Dietary AM Weekly Cleaning Checklist updated to include weekly cleaning of unit refrigerators and monitoring of labeled/dated and stored items. 6/3/14 An all Dietary Staff meeting scheduled for 5/29/14 and all Nursing Staff meeting scheduled for 5/27/14 will include review of updates and re-education on facility policy for Storing of Juices and Nutritional Supplements. Responsibility for cleaning and on-	

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 _____	04/24/2014

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 371	Continued From page 7 responsibility to ensure appropriate storage of the food items in the unit refrigerator/freezers. RN-C then stated, "It's [It is] kinda [kind of] hit and miss. Sometimes residents/families put things in there without telling us." RN-C confirmed staff did not audit the refrigerator/freezer for labeling and dating of food items. During interview on 4/23/14, at 12:15 p.m. RN-D reported it was a joint effort with nursing and dietary to ensure food items were labeled and dated. During interview on 4/23/14, at 1:10 p.m. the dietary director (DD)-C was unsure which department was responsible to ensure items located in the refrigerators/freezers on the nursing units were properly dated and labeled. DD-C stated, "I will have to look at the policy." After reviewing the policy, DD-C confirmed that all food items needed to be labeled and dated, even on the units. DD-C reported there was a cleaning list, but the list did not designate responsibility for maintaining appropriate food storage procedures in the unit refrigerator/freezers. During interview on 4/23/14, at 1:33 p.m. the director of nursing (DON) stated the facility had a policy and procedure regarding labeling and dating food items. The DON reported that all staff were responsible for labeling and dating food items when opened. The DON added, whoever placed the item in the unit refrigerator/freezer, should have labeled and dated the items. The DON reported that all staff had received education regarding the expectations of labeling and dating food items. The facility's Storage of Juices and Nutritional	F 371	going management of the unit refrigerators will be emphasized. A Nursing Care Audit: Unit Refrigerator/Freezer Monitoring developed and implemented for monitoring and auditing of labeled/dated and proper storage of items. This audit will be completed one on each shift on all units by 6/3/14; then one on each unit weekly x 4 weeks thereafter. 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 - subcommittee of the Quality Assessment and Assurance Committee.	5/27/14 5/29/14 6/3/14 6/3/14 & on-going

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 _____	04/24/2014

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 371	Continued From page 8 Supplements, Refrigerated Dietary Snacks on Nursing Stations policy dated 5/04, directed staff to clearly label all food items with the date and time it was opened. During a meal service observation in the facility's Two-North dining room on 4/21/14, at 12:01 p.m. DA-B stood at the steam table, sorting through paper menu sheets with her bare hands. The menu sheets were noted to have been handled by residents and staff, while they made their menu selections, prior to DA-B handling them. A stack of thick, plastic dinner plates was noted to the right side of the steam table. At 12:04 p.m., without washing/sanitizing hands or donning gloves, DA-B reached over and picked up an individual plate, spread her bare fingers on top surface and her bare thumb on the bottom surface of the plate. DA-B's bare fingers were observed to touch the center of the plate, where food was to be placed. DA-B then moved her fingers to the side of the plate and began to fill the plate with a pork chop and vegetables. DA-B again handled one of the paper menus and placed it under the meal plate. The meal was then served to R20. At 12:08 p.m., DA-B continued the same process of handling the paper menu sheets, then picking up individual plates with her bare fingers on the center surface of the plate, before dishing-up the meal and serving the plates. DA-B did not wash/sanitize her hands or donn gloves after handling the menu sheets and before handling the meal plates. Meal plates handled in this manner were subsequently served to R33, R64, R75, R80, R98, and R99. At 12:21 p.m., DA-B had taken all 25 resident meal plates from the stack and handled each of them in the center of the plate, after having handled the paper menus.	F 371		

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 _____	04/24/2014

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 371	Continued From page 9 On 4/21/14, at 12:25 p.m. DA-B confirmed the paper menus had been filled out by various residents and/or facility staff, prior to her handling them during meal service. DA-B verified this was her usual practice when serving resident meals. DA-B indicated she had not realized she had touched the plates in the center, where resident food items were placed. DA-B, further indicated the correct way to handle resident meal plates was to touch only the edge of the plates, if she had bare hands. On 4/23/14, at 1:02 p.m. DD-B confirmed paper menus that had been handled by several staff/residents were to be considered contaminated. DD-B also confirmed the meal plates were contaminated if they were handled in the center of the plate with contaminated hands. DD-B reported the expectation was for staff to handle resident meal plates by touching only the edges of the plate and not where food was to be placed. Review of the facility policy titled, Infection Control-General Practice, dated 9/07, directed care was to be taken when clean dishes were handled, so hands would not come in contact with the food surfaces.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	Infection Preventionist reviewed Infection Surveillance, Resident Log on all units to assure symptoms of infection and organism, if known is recorded. Resident Infection Surveillance will be current as of June 3, 2014.	6/3/14

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

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 _____	04/24/2014

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 441	Continued From page 10 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement a comprehensive infection control program, which included tracking, trending and analyzing resident and employee illnesses/infections in order to evaluate cross contamination of infections. This had the	F 441	Administrator, DON and Infection Preventionist reviewed the Infection Control Program on 5/19/14. An Employee/Resident Infection Correlation Tool developed and added to the Infection Control Program to trend, track, and analyze resident and employee illness/ infections in order to evaluate cross contamination of infections and assure prompt initiation of control measures if/when identified. Updated Permission to Return to Work slip to include gathering of pertinent employee information for tracking and analyzing infections. This information to be included on Employee/Resident Infection Correlation Tool. Permission to Return to Work slips will be reviewed by the Infection Preventionist. Updated Employee Illness/Work Status Guidelines Policy and Procedure to reflect addition of Employee/ Resident Infection Correlation Tool	5/19/14 6/3/14 6/3/14 & on-going

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 _____	04/24/2014

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 441	Continued From page 11 potential to affect all 93 of 93 residents in the facility. In addition, the facility failed to handle soiled incontinent products in a sanitary manner for 1 of 4 residents (R44) observed during perineal cares. This had the potential to affect all 24 of 24 residents who resided on the facility's Two-South unit. Findings include: Review of the facility's resident tracking and trending logs for infection control from 8/11/13, through 4/14/14, revealed no surveillance of resident signs/symptoms of illness. In addition, the resident tracking logs failed to identify specific organisms for the infections. The logs also lacked evidence of employee and resident illnesses having been analyzed for trends. During interview on 4/23/14, at 2:42 p.m. registered nurse (RN)-B said she reviewed the resident tracking log every two weeks, but was not looking for trends or patterns of resident symptoms or infections. RN-B also verified the infectious organisms were not being tracked. RN-B indicated that infection control audits were completed and submitted to the director of nursing (DON), but did not know what follow up was done in response to the audits. RN-B reported she received a summary of employee illnesses from the staffing coordinator twice monthly, but there was no tracking or trending of this information. The facility's Infection Prevention Task Listing policy reviewed 9/12, identified the infection control program was to prevent, recognize and control the spread of infections through data collection, analyzing and ongoing surveillance.	F 441	procedure for use of this tool. Infection Preventionist Task Listing updated to include responsibility of Employee/Resident Infection Correlation Tool. Infection Control Policy and Procedure titled Surveillance - Daily and Monthly updated to include addition of the Employee/Resident Infection Correlation Tool use. Education provided to Infection Preventionist 5/20/14 regarding need for recording of resident symptoms using Infection Criteria Definition List, completion of organism if known column on Infection Surveillance, Resident Log, and use of the Employee/Resident Infection Correlation Tool. All Nursing Staff Meeting 5/27/14 will include: 1) re-education of use of Infection Surveillance, Resident Log to include on-going recording of symptoms	6/3/14 6/3/14 6/3/14 5/20/14

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 _____	04/24/2014

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 441	Continued From page 12 During observation on 4/23/14, at 12:15 p.m. nursing assistant (NA)-A assisted a hospice nurse with changing a soiled incontinent brief for R44. After removing her gloves and donning new gloves to both hands, NA-A retrieved a new incontinent brief for R44 and handed it to the hospice nurse. NA-A then picked up the soiled brief with her right, gloved hand, but failed to contain the brief in a plastic garbage bag. NA-A removed her left glove and proceeded to exit R44's room. NA-A walked approximately 60 feet down the entire length of the hallway, with the soiled incontinent brief uncontained, holding it out in front of her with her arm extended. NA-A then grabbed the door handle of the soiled utility room with her ungloved, left hand and proceeded to throw the soiled incontinent brief in the garbage. NA-A removed the glove from her right hand, threw it in the garbage and washed her hands. During interview on 4/23/14, at 12:16 p.m. NA-A confirmed that she did not have the soiled incontinent brief contained in a garbage bag during transportation from the resident's room to the soiled utility room. At 1:12 p.m. NA-A confirmed that she did routinely transport soiled incontinent products out of resident rooms, without containing it in a garbage bag. NA-A added, "It would be better to put it in a garbage bag." On 4/24/14, at 8:30 a.m. RN-A confirmed that soiled linen and incontinent products with body fluids were to be transported, away from clothing and in a garbage bag. RN-A stated, "This is more sanitary way of doing things and better infection control practice." On 4/24/14, at 1:50 p.m. DON confirmed the	F 441	using Infection Criteria Definition List and recording of organism if known. 2) updates to Permission to Return to Work slip and additional employee expectations for completion. 3) re-education and demonstration of proper handling and transportation of soiled incontinent products from the resident room. Emphasis on if fecal material was not contained in the brief, place the brief into a trash bag either in resident's waste basket or in a plastic bag brought into the room section. 4) Morning Care and Bedtime Care audits will be reviewed with emphasis on soiled clothing/linens/briefs removed from room in a manner that promotes infection control practices. The Infection Preventionist on an on-going monthly basis on each unit, will review/audit Employee and Residents infection symptoms, treatment and utilize documentation/ surveillance/developing trends.	5/27/14 on-going

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 _____	04/24/2014

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 441	Continued From page 13 proper way to handle soiled briefs and linen was to keep it contained in a garbage bag. DON stated, "If it's not properly contained, this is improper infection control measures." Review of facility checklist titled, Checklist For Aseptic Glove Use: Perineal Care/Brief Changes/Indwelling Catheter Care/Empty Urine Drainage Bag, revised on 12/05, directed staff to contain soiled briefs, placing the brief into a trash bag either in the resident's waste basket or in a plastic bag brought into the room.	F 441	The DON will check the system monthly x2 months, to assure symptoms of infection, organism if known and Employee/Resident Infection Correlation Tool is complete, beginning in June, 2014. Infection Preventionist and DON will monitor audit findings and assure prompt follow-up of identified problems or trends. Nursing Care Audits Morning Care and Bedtime Care will be completed on each unit by 6/3/14 and then one on each unit weekly x4 weeks thereafter. Checklist for Aseptic Glove Use: Perineal Care/Brief Changes/Indwelling Catheter Care/Empty Urine Drainage Bag will be completed on each unit by 6/3/14 and then one on each unit weekly x4 weeks thereafter. The facility will continue monthly infection control meetings where a detailed agenda is completed. Monthly meetings are a subcommittee	8/1/14 on-going 6/3/14 & on-going 6/3/14 & on-going

F441 Page 14 (Cont)

of Quality Assessment and Assurance Committee. Employee/Resident Infection Correlation Tool will be added along with the Infection Surveillance Monthly Summary and Infection Surveillance, Resident Log and infection rate reviews by the Infection Control Committee. on-going

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. Nursing Care Audit Bedtime Care and Nursing Care Audit Morning Care are completed on an on-going basis and are 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. on-going

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

F5453022

PRINTED: 05/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/23/2014

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
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 By email to:	K 000	POC OK 5-29-14 Last Date of Correction 5-13-14 RECEIVED MAY 27 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 6-3-14

EXIT: 4-23-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrea Wold	Administrator	5-21-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/23/2014**

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
K 000	Continued From page 1 Marian.Whitney@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 accordance with NFPA 72 "The National Fire	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/23/2014

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
K 000	Continued From page 2 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 91 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and interview with staff, the facility has failed to ensure that 1 of several emergency lights have been maintained in accordance with NFPA LSC (00) Section 7.9, 19.2.9.1. This deficient practice could affect residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 11:00 AM and 3:00 PM on 04/23/2014, it was observed during the facility tour that the battery backup powered emergency light located by the generator in the North Building (1969) basement boiler/generator room, was inoperative when tested at the time of the inspection.	K 046	The back-up battery that powers the emergency light, North building boiler/generator room has been replaced and is now operative. Kevin Rogness, Facilities Engineer, was responsible for the correction and will monitor to prevent re-occurrence of the deficiency.	4/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/23/2014**

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
K 046	Continued From page 3 This deficient practice was verified by the Facilities Engineer (KR).	K 046		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 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). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow a delayed activation of the fire sprinkler system and could affect the residents, visitors and staff of the facility. Findings include: On facility tour between 11:00 AM and 3:00 PM on 04/23/2014, the following deficient conditions were observed:	K 056		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/23/2014

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
K 056	Continued From page 4 1. The sprinkler head that is in the mechanical room A-15 is located above the HVAC duct work and is being blocked by the HVAC duct work that is approximately 4 feet in width. The blocked sprinkler head being blocked is creating an area that will not be protected in the event of a fire. 2. The spare sprinkler head boxes that are located by each of the facility's fire sprinkler risers are not equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the side wall sprinkler heads that are located in the conference/training room in the basement of the South Building and the elevated temperature sprinkler head that is above the South Building's fire sprinkler riser. This deficient practice was verified by the Facilities Engineer (KR).	K 056	An additional sprinkler head was added to the system below the HVAC duct noted in deficiency. The area is now protected in the event of a fire. Kevin Rogness, Facilities Engineer, was responsible for the correction and will monitor to prevent re-occurrence of the deficiency. The appropriate sprinkler heads (at least 2 of every type and style) were obtained from contractor, Nova Fire Protection, Inc., and are now stored in the facility. Kevin Rogness, Facilities Engineer, was responsible for the correction and will monitor to prevent re-occurrence of the deficiency.	5/13/14 5/13/14

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 0327

May 12, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5453025

Dear Ms. Zetah:

The above facility was surveyed on April 21, 2014 through April 24, 2014 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, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to Gail Anderson at Minnesota Department of Health, 1505 Pebble Lake Road #300, Fergus Falls, MN 56537. 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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File