



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 18, 2025

Administrator
LB BROEN HOME

824 SOUTH SHERIDAN STREET
FERGUS FALLS, MN 56537

RE: CCN: 245453

Cycle Start Date: July 9, 2025

Dear Administrator:

On July 9, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseeth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseeth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 September 9, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by December 9, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

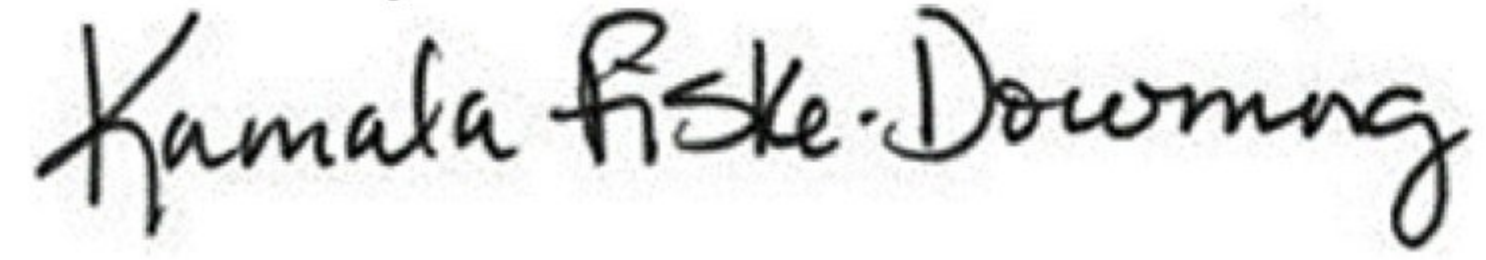
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor

Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 18, 2025

Administrator

LB BROEN HOME

824 SOUTH SHERIDAN STREET

FERGUS FALLS, MN 56537

Re: State Nursing Home Licensing Orders

Event ID: W39311

Dear Administrator:

The above facility was surveyed on July 7, 2025 through July 9, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

LeAnn Huseh, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseh@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
E0000	Initial Comments On 7/7/25 to 7/9/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			07/18/2025	
F0000	INITIAL COMMENTS On 7/7/25 to 7/9/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000			07/18/2025	
F0580 SS = D	Notify of Changes (Injury/Delirium/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,		F0580	The facility failed to notify resident representative, of R5, of diagnosis of UTI and ordered antibiotic treatment prior to administration of the medication on 6/20/25. Resident Representative was notified of the completion of the antibiotic 6/25/25. Resident representative of R5 will be notified, in the future, of all changes in treatment plan and staff will document this notification in the resident record.		08/07/2025	

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0580 SS = D	Continued from page 1 consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F0580	Continued from page 1 All residents within the facility have the potential to be affected by this deficient practice when a change in treatment plan is ordered. BH # 1050-7-95, Acute Care Plan #7, Urinary Tract Infection/Transient Urinary Incontinence,has been revised to include the initials of the staff notifying a resident representative of a change in condition/treatment, and the date of this notification. LB Homes Nursing Care Audit: Acute Care Plan Notification Documentation,BH #1389-25 was created. This audit reviews acute care plans currently in progress for timely completion of notification of the resident, resident representative, and the physician. This audit will be completed weekly x 4 weeks on all units within the facility and quarterly ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance improvement (QAPI). All Nursing Staff Meeting is scheduled for July 29, 2025. The revised form, and new audit as identified above, will be presented to all nursing staff. All facility LPN's and RN's will be reeducated on the requirement to notify the resident representative of a change in condition and/or altered treatment plan and to document notification attempts in the resident progress notes. 08/07/2025 and ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0580 SS = D	Continued from page 2 This REQUIREMENT is NOT MET as evidenced by: Based on interview, and document review, the facility failed to notify the resident representative promptly following provider order changes for 1 of 1 residents (R5) who received an order for antibiotics for a urinary tract infection (UTI). Findings include: R5's quarterly Minimum Data Set (MDS) dated 5/22/25, indicated R5's cognition was severely impaired. R5 had diagnoses that included cancer, Alzheimer's disease (cause of dementia), and arthritis. R5 needed maximal assistance for transferring, personal hygiene, and dressing. R5's care plan, last revised on 7/8/25, indicated R5 had an activities of daily living (ADL) self-care performance deficit related to Alzheimer's dementia, and a right hip fracture. Interventions included: Toileting schedule every two hours and check on nights, continent and incontinent of both bowel and bladder. R5's signed physician order dated 6/20/25, indicated Cipro (antibiotic for bacterial infections) 500 milligrams (mg) twice a day (BID) for five days. R5's medication administration record (MAR) dated June 2025 identified R5 received Cipro 500 mg starting 6/20/25 at 8:00 p.m., and received the last dose on 6/25/25 at 8:00 a.m. R5's progress notes lacked the resident representative being notified of R5's order for Cipro 500 mg for five days. During an interview on 7/7/25 at 11:25 a.m., R5's family member (FM)-A indicated there was no notification that R5 started on an antibiotic. FM-A indicated the clinical manager only provided an update when the antibiotic was completed. During an interview on 7/9/25 at 7:59 a.m., clinical manager (CM)-A indicated the normal practice would be to update family representatives of clinic visits,			F0580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0580 SS = D	Continued from page 3 changes in conditions, and antibiotic orders. CM-A normal practice was to make a note of the update to the family representative in the progress notes. CM-A confirmed that R5's family representative had not been updated before the administration of the antibiotic. During an interview on 7/9/25 at 9:57 a.m., director of nursing (DON) indicated her expectation would be for the family to be aware of the start of antibiotics, as it was important for the continuity of care. Review of the policy titled change in condition, physician notification: "physician notification of resident change in condition guidelines" Resident, Legal Representative or Interested Family Member Notification, dated 11/19, identified LB Broen Home would notify Physicians, residents and legal representatives or interested family members of change in condition according to regulation.	F0580		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty	F0641	The facility failed to accurately code the use of Ativan and the Hospice status of a resident on the MDS. A modification of R17's MDS's dated 2/13/25 and 5/15/25, items N0415B and O0110 K1, were modified and locked on 7/9/25 and accepted on 7/14/25. Modifications include corrected information regarding Ativan use and receipt of Hospice services within the assessment reference periods. The "Order Listing report" was run by Medication Class to include all residents with an order for Ativan/Lorazepam. No additional residents were identified as having been coded inaccurately on the MDS. The PCC Detailed Census Report was run to identify all residents currently receiving Hospice Care. No additional residents were identified as having been coded inaccurately on the MDS. RN's who are responsible for MDS completion will be retrained on MDS completion using the American Association of Post-Acute Care Nursing (AAPACN), MDS Essentials courses. BMH # 1187-06, Nursing Care Audit: Assessment/Care Planning and Implementation was revised to include the addition of Hospice – coded on MDS and Care Plan and the addition of Meds Reviewed if used, coded correctly on the MDS, to ensure the accuracy of MDS completion. This audit will be completed on one resident weekly on all resident care units x 4 weeks and quarterly	08/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0641 SS = D	Continued from page 4 of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) correctly for 2 of 2 residents (R17, R) reviewed for resident assessment. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2023, identified Section N, record the number of days during the 7-day look-back period that the resident received any type of medication, antigen, vaccine, etc., by subcutaneous, intramuscular, or intradermal injection. Check B, antianxiety: if anxiolytic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Section O Hospice care: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licenses by the state as a hospice provider and/or certified under the Medicare Program as a hospice provider. R17's significant change MDS dated 8/14/24, identified R17 on hospice serves under the section O for hospice care. R17's quarterly MDS dated 2/13/25 and quarterly MDS dated 11/14/24 , failed to identify R17 receiving hospice care under section O for hospice care.. R17's MDS dated 2/13/25 identified a diagnosis of anxiety disorder, Section N, which covers medications received during the assessment period, identified R17 was not given an antianxiety medication during the look back period. R17's Signed provider order dated 1/13/25 , identified an order for Ativan 0.5 milligrams (mg) every three			F0641	Continued from page 4 ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit item findings are an agenda item reported to the Resident Care and Customer Relations committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance Improvement (QAPI). All Nursing Staff Meeting is scheduled for July 29, 2025. Revisions to the Assessment/Care Planning and Implementation audit reviewed. 08/07/2025 and ongoing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
F0641 SS = D	Continued from page 5 hours as needed for agitation/ restlessness and scheduled every Wednesday at 7:00 a.m., for comfort during bath and hygiene, give at 7:00 a.m., before bath. Start date 11/27/25 with no end date. Orders also identified as R17 admit to Knute Nelson Hospice state date 8/6/24 with no end date. R17's Signed provider order dated 3/20/25 , identified an order for Ativan 0.5 milligrams (mg) every three hours as needed for agitation/ restlessness for 365 days, and scheduled every Wednesday at 7:00 a.m., for comfort during bath and hygiene, give at 7:00 a.m., before bath. Start date 11/27/25 with no end date. Orders also identified as R17 admit to Knute Nelson Hospice state date 8/6/24 with no end date. R17's signed provider orders dated 7/8/25, identified R17 Admit to Knute Nelson Hospice start date 8/6/24 with no end date. R17's orders also included resident to have bed bath only, no tub baths, one time a day every Wednesday. Attain 0.5mg by mouth every three hours as needed for restlessness/anxiety start date 4/11/25 end date 4/11/26. R17's January 2025 medical administration record (MAR) identified R17 received Ativan 0.5mg of Ativan every Wednesday morning at 7:00 a.m. Start date of the order 11/27/25 and was discontinued 4/11/25. R17's February 2025 MAR identified R17 received Ativan 0.5mg of Ativan every Wednesday morning at 7:00 a.m. Start date of the order 11/27/25 and was discontinued 4/11/25. R17's MAR identified R17 received Ativan 0.5 mg every Wednesday during the month of February. Start date of the order 11/27/25 and was discontinued 4/11/25. R17's significant change CAA dated 8/14/24 indicated R17had a Terminal illness, CAA lacked information regarding receiving an antianxiety medication. R17's care plan revived on 7/8/25, identified Coordination of care needs with Vivie (formerly Knute Nelson) Hospice, admitted to Knute Nelson or Vivie hospice services on 8/6/24. Interventions listed Vivie hospice contact information. Care plan identified R17 uses antidepressant medication related to depression and anxiety and receives Remeron and citalopram daily, Interventions are to notify hospice of any medication changes.		F0641				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0641 SS = D	Continued from page 6 During an interview on 7/8/25 at 2:14 p.m., trained medical assistant (TMA) verified R17 was on hospice. The hospice nursing assistant would come in two to three times a week in the morning around breakfast time. During an interview on 7/8/25 at 22:22 p.m., nursing assistant (NA)-D verifieid R17 was on hospice. During an interview on 7/8/25 at 8:39 a.m., licensed practical nurse (LPN)-A verified R17 was on hospice. During an interview on 7/9/25 at 7:49 a.m.,clinical manager (CM)-A verified R17 was on hospice and had been admitted to hospice 8/6/24. DON verified the quarterly MDS dated 2/13/25 and quarterly MDS dated 11/14/24 , failed to identify R17 receiving hospice care under section O for hospice care. CM-A verified the MDS for 11/14/24 and 3/13/25 should have been marked as receiving hospice under section O. CM-A verified R17 has an order for Ativan and was receiving Ativan once a week before baths from 11/27/24 until 4/11/25. CM-A indicated Section N, was coded correctly as Ativan was being used for anxiety but needed to coded as the classification on medication and Ativan was classified as an antidepressant. During an interview on 7/9/25 at 8:47 a.m., pharmacy consultant vifeifed Ativan would be considered as a benzodiapine, which would be put on an anxiety anxiety classification. Pharmacy consultant indicated a psychotropic medication sheet was given to the facility with a list of medications and classifications to post in the facility. Pharmacy consultant gave surveyor a copy of psychotropicd medication date sheet. The pharmacy consultant indicated she would resend the sheet to the facility and will review it with the facility. During an interview on 7/9/25 at 9:56 a.m., director of nursing (DON) indicated Ativan would be coded as an antianxiety on the MDS. DON's expectation would be for corrections to be made to the MDS for 11/14/24 and 3/13/25 to capture what was going on with the resident during the look back time to ensure the case mix was correct. Psychotropic medications data sheet dated 2022 had Lorazepam/Ativan listed under the anxiolytics category. Policy titled MDS assessment dated 2010, indicated all dependents/ disciplines involved in MDS completion and care planning conferences will be trained in the use of			F0641			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
F0641 SS = D	Continued from page 7 software, be responsible for completing MDS's sections according to deadlines in procedure, participating in care planning conferences as assigned.	F0641					
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a pressure relieving device was implemented to prevent skin breakdown for 1 of 3 residents (R25) reviewed for pressure ulcers. Findings include: R25's quarterly Minimum Data Set (MDS) dated 4/24/25, identified R22 had severe cognitive impairment and diagnoses which included stroke, dementia, and arthritis. Identified R25 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Identified R25 was at risk for pressure ulcers. R25's annual Care Area Assessment (CAA) dated 7/5/24, identified R25 required total assistance from staff with repositioning and was at risk for skin breakdown. Identified R22 was incontinent of bowel and bladder. R25's care plan dated 4/29/22, identified R22 had self care deficits and was at risk for skin breakdown related to stroke, history of pressure ulcers and need	F0686	The facility failed to ensure pressure relieving devices were implemented for R25 per Care Plan direction. R25's Hospice provider was consulted regarding resident's frequent removal of pressure relieving devices to feet. No changes were made by Hospice. R25 is currently trying Derma Saver Stay-Put Heel protectors to bilateral feet when in bed. Two additional residents in the facility were identified to have treatment orders for pressure relieving devices to their heels and have the potential to be affected by the same deficient practice. Resident care plans, nursing assistant worksheets, and e-TAR records have been updated to ensure pressure relieving devices are in use as ordered. It is the responsibility of the team leader to ensure that the pressure-relieving devices are in use prior to signing the e-TAR. LB Homes Nursing Care Audit: Preventative Skin Care Relieving Devices, BH #1390-25 was created. Auditing that resident care plans, nursing assistant worksheets, and e-TAR records have been updated to ensure pressure relieving devices are recorded consistently, and that the ordered device is in use. This audit will be completed weekly x 4 weeks, on all shifts, on all units within the facility and quarterly ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit findings are an agenda item reported to the Resident Care and Customer Relations committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance improvement (QAPI). All Nursing Staff Meeting is scheduled for July 29, 2025. The new audit as identified above will be presented to all nursing staff. Team leaders will be reminded of their responsibility to ensure pressure relieving devices are in use as ordered prior to signing the e-TAR record. 08/07/2025 and ongoing.			08/07/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0686 SS = D	Continued from page 8 for staff assistance with repositioning in bed and wheelchair. Identified R25 was to wear bilateral heel protectors when in bed. R25's Braden Scale for Predicting Pressure Ulcer Risk dated 5/9/25, identified R25 was at high risk of developing a pressure ulcer. R25's treatment administration record (TAR) for the month of July 2025, identified R25 was to wear bilateral heel protectors while in bed. During an observation on 7/7/25 at 1:10 p.m., R25 was lying in bed on her back wearing a heel protector on her left foot and only a gripper sock on her right foot. R25's right heel was lying directly on the mattress. During an observation on 7/8/25 at 8:05 a.m., R25 was lying on her right side with only gripper socks on her feet. Both of R25's heels were lying directly on the mattress. One heel protector was lying on a bedside table across the room. During a joint interview on 7/8/25 at 8:15 a.m., nursing assistant (NA)-A and registered nurse (RN)-A verified R25 was at risk for pressure ulcers and was to have heel protectors on both feet while in bed. NA-A stated she was unsure why R25's heel protectors were not on her feet. RN-A stated the expectation was R25 should have had heel protectors on both feet to prevent pressure ulcers. During an interview on 7/8/25 at 3:11 p.m., director of nursing (DON) verified R25 was at risk for skin breakdown. DON stated her expectation was that staff would have applied the heel protectors on R25's feet when in bed per the care plan to prevent skin breakdown. Review of a facility policy titled Skin Care program dated 7/24, identified a resident who entered the facility without pressure sores did not develop pressure sores unless the individuals clinical condition demonstrated that they were unavoidable. Identified preventative skin care used individualized approaches specific to the condition. Identified the			F0686			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0686 SS = D	Continued from page 9 interventions. Identified residents with pressure ulcer risk would have identified preventative interventions placed on their care plan.			F0686			
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, attempt alternatives, ensure dimensions were appropriate and follow manufacturer's recommendations for installing prior to use of bed rails for 1 of 2 residents (R41) reviewed who were observed to have bed rails. Findings Include: R41's quarterly Minimum Data Set (MDS) dated 6/20/25, identified R41 was cognitively intact and had diagnoses which included: diabetes mellitus, arthritis and anxiety. R41's MDS further identified R41 was independent to roll left and right, and required supervision or touching assistance for lying to sitting, sit to stand and chair and bed transfers.			F0700	The facility failed to comprehensively assess the use of a positioning rail on a resident's consumer bed, including following manufacturer's recommendations for installation. The rail provided by and installed by family on R41's bed was removed by maintenance staff 7/9/25 following receipt of the manufacturer's recommendations from family that included under ADDITIONAL WARNINGS 'Do not use on adjustable beds unless otherwise specified in ASSEMBLY INSTRUCTIONS. ASSEMBLY INSTRUCTIONS 'Compatibility: Not intended for use on adjustable beds.' To date, the positioning rail has not been returned to use on R41's adjustable bed. Five additional resident's consumer beds are used within the facility. Of these five, two are using a bedrail/bed positioning device. One of the two is a hospital bed owned by the resident. This rail has been assessed using BMH #1214-07, LB Broen Homes hospital bed assessment. The second is a consumer bed that has been assessed using BMH #1214-07 and is in use according to manufacturer's recommendations. Manufacturer's recommendations for each rail used on a consumer bed at LB Broen Home have been scanned into the resident record. LB Broen Homes Bedrail/Bed Positioning Device, Use of policy and procedure was revised to include procedure for both hospital beds and consumer beds if used within the facility. LB Broen Homes Bedrail/Bed Positioning Device Assessment and Informed Consent form, BMH #1214-07 was revised to include directions for both hospital and consumer beds if used within the facility. LB Homes Nursing Care Audit: Bedrail/Bed Positioning Device, BH #1391-25 was created. This audit requires staff to identify residents using bedrails/bed positioning devices, identify bed type (consumer or hospital), completion of the Bedrail/Bed Positioning Device Assessment and Informed Consent form, BMH #1214-07, ensure the resident Care Plan is current, and for consumer beds that a copy of the manufacturer's guidelines for bedrail use is included in the resident record. This audit will be completed weekly x 4 weeks on all units within the facility and quarterly ongoing. The		08/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0700 SS = D	Continued from page 10 R41's care plan dated 7/9/25, identified R41 had an activities of daily living (ADL) self-care performance deficit and indicated R41 was able to turn self and sit up in bed on own. R41's care plan interventions included to assist with transfers with gait belt and front wheeled walker. R41's care plan identified R41 had positioning rails bilaterally to assist with bed mobility. R41's Bedrail/Bed Positioning Device Assessment And Informed Consent form dated 9/22/23, identified R41 had bilateral positioning rails to aide in bed mobility and define parameters of bed. R41's Bedrail/Positioning Device Assessment dated 6/20/25, identified R41 had ¼ positioning rails on both sides of bed. R41's medical record lacked a comprehensive assessment of R41's bed rail including: appropriate use and installation of bed rail, measurements to assure safety and attempted alternatives prior to the use of the bed rail. During observation on 7/7/25 at 4:34 p.m., R41 had a personal twin bed with a black round bed rail on the right side. R41 indicated she had purchased the bed from a friend, and her family had installed the bed rail. R41 stated she used the bed rail to get in and out of bed. During observation on 7/8/25 at 10:47 a.m., R41's bed continued to have a black round bed rail on the right side of her bed towards the door. During interview on 7/8/25 at 3:09 p.m., nursing assistant (NA)-F indicated R41 often transferred herself to her bed. NA-F stated when assisting R41, she used a gait belt for transfers. NA-F indicated R41 did use her bed rail. NA-F stated R41 had her own bed, that her family had brought in for her. During interview on 7/8/24 at 3:17 p.m., licensed practical nurse (LPN)-B indicated R41 had her own bed for about the last month or two. During interview on 7/8/25 at 3:45 p.m., maintenance assistant (MA)-A verified R41 had a bed rail on her bed. MA-A stated family installed the bed rail. MA-A stated he was present the day they brought the bed and bed rail in, but did not assist with installation. During interview on 7/9/25 at 8:21 a.m., maintenance engineer (ME)-A stated the beds used by the facility			F0700	Continued from page 10 DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit findings are an agenda item reported to the Resident Care and Customer Relations committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance improvement (QAPI). All Nursing Staff Meeting is scheduled for July 29, 2025. The revised P&Ps, revised form, and new audit as identified above, will be presented to all nursing staff. Maintenance and Housekeeping staff were also educated on the revisions and of the importance of identifying and reporting to the charge nurse the presence of positioning rails in use within the facility. 08/07/2025 and ongoing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0700 SS = D	Continued from page 11 all were the same and had the same bed rails. ME-A stated they had inspected the bed rails a few years ago. ME-A stated they do not routinely check bed rails, but if it became loose or a problem, the nursing staff would write a ticket for them to inspect it. ME-A confirmed he was not aware R41 had a different bed or bed rail. ME-A stated they had not obtained the manufacturer's instructions for R41's bed rail and was not aware if R41's bed rail was installed correctly. ME-A indicated he would inspect R41's bed and bed rail. During interview on 7/9/25 at 8:49 a.m., unit coordinator registered nurse (RN)-B stated the facility's usual practice was to inspect the bed rails to assure they were safe and inform the resident or representative of risks and benefits of their use. RN-B stated she completed the assessment and risk versus benefit consent form on admission. RN-B stated they completed quarterly bed rail assessments also. RN-B confirmed R41's Bedrail/Positioning Device Assessment dated 6/20/25, was not accurate and needed to be modified, because R41 had obtained a new bed in May 2025. RN-B stated R41 had not been happy with mattresses they tried, so family brought in a bed for R41. RN-B confirmed she had not completed an assessment for R41's new bed rail, and they had not obtained the manufacturer's instructions for the bed rail. R41 stated R41's Bedrail/Bed Positioning Device Assessment And Informed Consent form should also be updated. During interview on 7/9/25 at 9:25 a.m., director of nursing (DON) stated her expectation was that when a resident was admitted, they ask residents if they would like a positioning rail. DON indicated they then completed the Bedrail/Bed Positioning Devise Assessment And Informed Consent form. DON stated they usually did not attempt alternatives first. DON stated her expectation would be that R41's bed rail would be assessed to assure it was safe and appropriate. DON confirmed an assessment had not been completed yet of R41's new bed rail. The facility's Bedrail/Bed Positioning Device policy dated 2/2017, identified a bedrail/bed positioning device would not be used without assessment and informed consent. The policy identified the facility would attempt to use appropriate alternatives prior to installing a bedrail/bed positioning devise, and an assessment and informed consent would be completed.	F0700		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880	The facility failed to ensure staff were using personal protective equipment (PPE) according to the Centers for Disease Control for two residents who had tested positive for COVID-19.	08/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0880 SS = E	Continued from page 12 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with			F0880	Continued from page 12 R36 and R13 were in isolation precautions following testing positive for COVID-19. Two staff caring for these residents incorrectly used an N95 respirator when providing this care. Reuse of N95 respirators was not implemented, as there was no shortage of N95 respirators at the time. One staff caring for these residents incorrectly wore the N95 respirator over a surgical mask. There are currently no residents in isolation precautions in the facility. All residents who were and will be placed in isolation precautions have the potential to be affected by the same deficient practice if they require personal protective equipment when providing care to them while residing at LB Broen Home. BH#1340-20 LB Broen Home Nursing Care Audit, Donning/Doffing PPE will be completed weekly x 4 weeks, on all shifts, on all units within the facility and quarterly ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit items findings are an agenda item reported to the Safety and Infection Control Committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance Improvement (QAPI). All Nursing Staff Meeting is scheduled for July 29, 2025. A knowledge check regarding the use of N95 respirators was prepared and will be completed with all staff who may enter the rooms of a resident in isolation precautions that require N95 respirators. LB Broen Home policy and procedure, COVID-19 Infection Prevention and Control, was revised to include directions on when an N95 respirator should be changed: "If they are used during the care of patient for which a NIOSH Approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during care of a patient on Droplet Precautions), they should be removed and discarded after the patient care encounter and a new one should be donned." BH#1340-20 LB Broen Home Nursing Care Audit, Donning/Doffing PPE, was reviewed with no content changes indicated. 08/07/2025 and ongoing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0880 SS = E	Continued from page 13 residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were using personal protective equipment (PPE) according to the Centers for Disease Control for 2 of 2 residents R35, R13 who tested positive for COVID -19. Findings include: The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated May 8, 2023, identified when using a NIOSH approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on droplet precautions), they should be removed and disgarded after the patient care encounter and a new one should be donned. FACILITY Infection Control Laundry tour			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
F0880 SS = E	Continued from page 14 07/08/25 10:02 AM Don Mollerud Supervisor - laundry comes down in carts. we wear yellow gowns and gloves and goggles when sorting laundry. Any infectious bags are sent out to west central linen. One washer broken . 2 gas dryers . dryer vents get cleaned every shift. Use a covered cart to deliver laundry. Yellow gowns are reusabel and gets washed in hot water. 07/08/25 05:27 PM Destiny Morris - LPN I checked the res blood sugar and then washed it with alchohol and sani wipe - Reviewed IC policies no concerns Reviewed IP credentials no concerns 07/09/25 09:39 AM Rita Wickline NA/TMA - we get tested for Covid every day that we work. 07/08/25 02:00 PM Samantha Finch RN IP - I use the Mcgeers criteria the nurses alert me to infections charge nurses can right in infection - Amy the DON is my back up as well. I email staff and post things in nurses station or through mass text to educate and do in person a well. We do antibiotic stewardship we do antibiotic timeout that alerts the charge nurse. If uc comes back and its not an infection we alert the MD's. Laureu is on a phrophalactic and its reviewed with primary and risk verus benefits gets done every 6 months. Covid outbreak - started on 6/27/25 a res tested positive he was on hospice and passed since. That day we contact traced all staff that had worked with him the prior 48 hrs . Then we got a second res positive the next day so we started to test everyone. Then that sunday 3 more residents. Staff get tested everyday. Residents get tested twice a week. We have signs on the door of what PPE to wear and should remove PPE before they leave the roo. Should wear a gown, N95, gloves and face shield or the goggles. When Doffing they should be throwing away the N95's. Staff should be throwing away the N95's not reusing. Verified we are not in crisis PPE and staff should not be reusing the N95's Expectation is they should not be reusing the N95. Staff should not be putting the N95 over a face mask. Reviewed infection log no concerns. 07/08/25 03:22 PM Amy Nelson DON - Verified res had		F0880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0880 SS = E	Continued from page 15 covid N95's staff should be disposing of the masks after each use. Not in shortage of masks. Staff should only be using the N95 Staff should not be wearing 2 masks. area to hang stuff to dry 07/07/25 11:42 AM 2 staff are gowning. glove for EBP in room 359 07/07/25 11:44 AM 2 staff are gowning, glove, N95 and face shield. to go in room 379 Covid positive room. Hand hygiene very good removing PPE 07/07/25 01:44 PM Passing laundry cart is covered delivered a hanger with pants and a07/07/25 01:45 PM bin with personal items closed cover on the cart and placed clothes in room sanitized hands 07/07/25 07:31 PM Harmony Jenson Robin Cannon NA-gowned gloved to go in EBP room 07/08/25 08:27 AM NA put on gown, gloves, N95 eyewear on and delivered room tray to room 373 covid positive resident 07/08/25 08:34 AM NA came out of room and put used N95 mask in a brown paper bag. 07/08/25 09:14 AM Savanna ha noel Na took N95 out of brown paper bag put on a gown, gloves and eyewear after sanitizing hands, and entered Res room07/08/25 0918 am verified used the same N95 just for that res thats why the brown paper bags are by their room . Immunizations: 1.) Otis Anderson Covid 10/2/24 and 4/3/25, influenza 10/2/24, PCV 13 = 01/13/2016Pneumo-PCV 20 (Pneumo-conj) 4/3/25, step 1 mantouz = 01/03/2025 step 2 = 1/13/25 2.) Susan Hill Covid dose 1= 01/05/2021Dose 2 = 02/02/2021Dose 3 = 09/15/2022 Dose 4 = 04/03/2025			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0880 SS = E	Continued from page 16 influenza = 10/14/2024 PCV 13 = 10/13/2016 PCV 20 =04/04/2024 mantouz step 1 = 12/19/2017 Negative (0 mm) System mantouz step 2 = 12/31/2017 Negative (0 mm) 3.) Gladys Hanson Covid dose 1 = 03/19/2024 Dose 2 = 10/14/2024 dose 3 = 04/03/2025 influenza = 10/17/2023 PcV20 = 03/19/2024 mantoux step 1 = 04/02/2024 Negative (0 mm) System Step 2 =04/02/2024 4.) Alice Monson Covid dose 1 = 09/27/2023 dose 2 = 04/04/2024 Dose 3 = 10/14/2024 refused covid = 4/3/25 influenza = 10/14/2024 was education done Pneumo 13 = 10/08/2015 pneumo 23 refused on 1/30/23 pnumo 20 done 04/04/2024 mantoux 1st step = 11/22/2019 Negative (0 mm) second step = 12/01/2019 Negative (0 mm) I called her cousin and She wants her to take vaccine. I gave education. 5.) Irene McCormick covid dose 1 = 02/02/2021 dose 2 = 10/14/2022 dose 3 = 05/19/2023 dose 4 = 04/03/2025 influenza = 10/14/2024 pneumo 23 = 10/10/2005 pneumo 13 = 07/22/2015 pneumo 20 = 04/04/2024 MAntouz step 1 = 10/25/2022 negative step 2 = 11/04/2022 negative 07/08/25 05:37 PM Sarah MDH - it is not ok to wait up to 12 months to do the second step . We do a 2 step TST instead of 1 step first step boosts the immune system so you get a more accurate result on the fist step. If negative test in past 12 months then they only need to do the one step . All I say if they dont come back in the 3 weeks they just dont need to start over. Most should be done in the 3 weeks after the first step.			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0880 SS = E	Continued from page 17 R13 R13's quarterly MDS dated 6/19/25, identified R13 was cognitively intact, and had diagnoses which included: end stage renal disease (kidney failure), chronic obstructive pulmonary disease (lung disease that limits airflow) and diabetes mellitus. R13's care plan dated 7/9/25, identified R13 had limited physical mobility and required assistance with dressing, grooming and transferring with a EZ stand mechanical lift. R13's care plan also identified R13 had COVID-19, and staff were to observe for signs and symptoms of COVID-19 and implement infection control measures. R13's Point Of Care (POC) Test Result Reporting form dated 7/1/25, identified R13's test of SARS-CoV-2 (COVID-19) was positive. During observation on 7/7/25 at 4:45 p.m., NA-E assisted R13 to transfer from her wheelchair to her recliner using the EZ stand mechanical lift. NA-E wore a gown, gloves, eye protection and wore a N95 mask, over the top of a blue medical mask. NA-E removed her gown, gloves, then sanitized her hands and left R13's room. During interview on 7/7/25 at 7:19 p.m. NA-E indicated R13 had COVID, and they were expected to wear a gown, gloves, N95 mask and protective glasses or face shield. NA-E verified she had worn the N95 mask over her blue medical mask. NA-E stated she had observed others wear their masks that way, so she did it too. NA-E indicated they kept their N95 mask and eye protection glasses in a brown paper bag. NA-E stated they reused their N95 masks and glasses, one for each resident, one for each shift. NA-E showed surveyor the bags with her name on them, outside resident's rooms who were COVID positive. The bags contained a pair of protective glasses and a N-95 mask. NA-E indicated she wiped off the glasses before and after they were worn. During an interview on 7/8/25 at 2:00 p.m., infection preventionist (IP) verified eight residents including R36 and R13 on the third floor had tested positive for			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0880 SS = E	Continued from page 18 COVID-19 which placed the facility in an outbreak. IP verified the facility had adequate PPE supplies and was not in a shortage. IP stated her expectation was that staff would use a clean N95 each time they entered a Covid-19 positive room and then dispose of the N95 after each use. IP further stated staff should only be wearing an N95 when they entered a Covid-19 positive room to ensure they had a proper seal of the N95. During an interview on 7/8/25 at 3:22 p.m., director of nursing (DON) verified R36 and R13 had tested positive for COVID-19. DON stated her expectation was staff would use a clean N95 each time they entered a positive Covid -19 room. DON further stated staff should not be wearing a face mask with the N95 to ensure a proper seal of the N95. Review of a facility policy titled COVID-19 Infection Prevention and Control revised 6/24, identified the facility would adhere to Federal and State/Local recommendations to minimize the spread of COVID-19. Identified. Health Care Personnel(HCP) who entered the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or PAPR, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).Policy lacked information regarding when an N95 should be changed.	F0880		
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident's call light was within reach from the bathroom floor in a resident	F0919	The facility failed to ensure a resident's bathroom call cord was within reach of the bathroom floor. R7's bathroom call light cord was not accessible from the floor as is required by both State and Federal regulation. R7's bathroom call light cord was replaced with one long enough to be reached from the floor on 7/8/25. All additional bathroom call light cords were of an appropriate length within the facility. LB Broen Home Call Light Accessibility Policy and Procedure was created to ensure a communication system in compliance with 483.90 (g), and MN 4658.35 B. Environmental Services, Housekeeping policy and procedure titled Housekeeping Tasks, Routine Daily was updated to include I. M. 8. Bathroom call light a. ensure call light cord is within reach of the floor. LB Broen Home Nursing Care Audit titled Call light	08/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
F0919 SS = D	Continued from page 19 bathroom for 1 of 1 residents (R7) reviewed for call light accessibility. Findings include: R7's quarterly Minimum Data Set (MDS) dated 5/8/25, identified R7 was cognitively intact and had diagnoses which included: diabetes mellitus, arthritis and anxiety. R7's MDS further identified R7 used a walker and was independent with walking, transferring and toilet hygiene. R7's care plan dated 7/8/25, identified R7 had an activities of daily living (ADL) self-care performance deficit with interventions that included, ensure call light was within reach. R7 was independent with toileting. During observation on 7/7/25 at 11:27 a.m., R7's bathroom call light box was on the wall approximately three feet off the floor. It had a short blue string attached with a knot on the end. The string hung approximately three to four inches below the call light box. R7 indicated she used the bathroom independently. During observation on 7/8/25 at 12:31 p.m., R7's bathroom call light box continued to have a short blue string, approximately three to four inches hanging from the call light box. R7 indicated she used her bathroom independently and if she fell on the floor, she would not be able to reach the call light. R7 stated she had fallen one time before in the bathroom. During observation on 7/8/25 at 2:14 p.m., maintenance assistant (MA)-A confirmed R7's bathroom call light was not accessible from the floor and was approximately three feet off the floor. MA-A did not know the actual length the call light cord should be. During interview on 7/8/25 at 2:27 p.m., administrator indicated she had been notified of R7's short call light cord in R7's bathroom. Administrator stated her expectation was that they be about two to three inches off the floor so the resident would be able to reach it from the floor. Administrator stated MA-A was replacing it now.		F0919	Continued from page 19 Response/Accessibility, BMH#1160-04 was revised to include 'Bathroom pull cord within reach of floor?' column to Section I "Call light within reach check". This audit will be completed weekly x 4 weeks on all units within the facility and quarterly ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit findings are an agenda item reported to the Resident Care and Customer Relations committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance improvement (QAPI). All Nursing Staff Meeting is scheduled for July 29, 2025. The revised policy and procedure, and revised audit as identified above, will be presented to all nursing staff. Environmental Services - Housekeeping staff were updated on the revisions to Housekeeping Tasks Routine Daily policy and procedure as described above. All facility staff were educated on Call Light Accessibility Policy and Procedure. 08/07/2025 and ongoing.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0919 SS = D	Continued from page 20 During interview maintenance engineer (ME)-A stated call light cords must be accessible from the floor. ME-A stated this was important because if a resident fell on the floor and needed help, they needed to be able to reach the call light. ME-A indicated he was made aware R7's bathroom call light cord was too short. ME-A stated some of the cords become worn or break. ME-A stated he ordered a spool of cord and will be inspecting all the call light cords and replacing them as needed. On 7/8/25 at 8:48 p.m., health information manager (HIM)-A's e-mail indicated the facility did not have a specific call light policy.			F0919			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
E0000	Initial Comments On 7/7/25 to 7/9/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			07/18/2025	
F0000	INITIAL COMMENTS On 7/7/25 to 7/9/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000			07/18/2025	
F0580 SS = D	Notify of Changes (Injury/Delirium/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,		F0580	The facility failed to notify resident representative, of R5, of diagnosis of UTI and ordered antibiotic treatment prior to administration of the medication on 6/20/25. Resident Representative was notified of the completion of the antibiotic 6/25/25. Resident representative of R5 will be notified, in the future, of all changes in treatment plan and staff will document this notification in the resident record.		08/07/2025	

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0580 SS = D	Continued from page 1 consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F0580	Continued from page 1 All residents within the facility have the potential to be affected by this deficient practice when a change in treatment plan is ordered. BH # 1050-7-95, Acute Care Plan #7, Urinary Tract Infection/Transient Urinary Incontinence,has been revised to include the initials of the staff notifying a resident representative of a change in condition/treatment, and the date of this notification. LB Homes Nursing Care Audit: Acute Care Plan Notification Documentation,BH #1389-25 was created. This audit reviews acute care plans currently in progress for timely completion of notification of the resident, resident representative, and the physician. This audit will be completed weekly x 4 weeks on all units within the facility and quarterly ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance improvement (QAPI). All Nursing Staff Meeting is scheduled for July 29, 2025. The revised form, and new audit as identified above, will be presented to all nursing staff. All facility LPN's and RN's will be reeducated on the requirement to notify the resident representative of a change in condition and/or altered treatment plan and to document notification attempts in the resident progress notes. 08/07/2025 and ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
F0580 SS = D	Continued from page 2 This REQUIREMENT is NOT MET as evidenced by: Based on interview, and document review, the facility failed to notify the resident representative promptly following provider order changes for 1 of 1 residents (R5) who received an order for antibiotics for a urinary tract infection (UTI). Findings include: R5's quarterly Minimum Data Set (MDS) dated 5/22/25, indicated R5's cognition was severely impaired. R5 had diagnoses that included cancer, Alzheimer's disease (cause of dementia), and arthritis. R5 needed maximal assistance for transferring, personal hygiene, and dressing. R5's care plan, last revised on 7/8/25, indicated R5 had an activities of daily living (ADL) self-care performance deficit related to Alzheimer's dementia, and a right hip fracture. Interventions included: Toileting schedule every two hours and check on nights, continent and incontinent of both bowel and bladder. R5's signed physician order dated 6/20/25, indicated Cipro (antibiotic for bacterial infections) 500 milligrams (mg) twice a day (BID) for five days. R5's medication administration record (MAR) dated June 2025 identified R5 received Cipro 500 mg starting 6/20/25 at 8:00 p.m., and received the last dose on 6/25/25 at 8:00 a.m. R5's progress notes lacked the resident representative being notified of R5's order for Cipro 500 mg for five days. During an interview on 7/7/25 at 11:25 a.m., R5's family member (FM)-A indicated there was no notification that R5 started on an antibiotic. FM-A indicated the clinical manager only provided an update when the antibiotic was completed. During an interview on 7/9/25 at 7:59 a.m., clinical manager (CM)-A indicated the normal practice would be to update family representatives of clinic visits,		F0580				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0580 SS = D	Continued from page 3 changes in conditions, and antibiotic orders. CM-A normal practice was to make a note of the update to the family representative in the progress notes. CM-A confirmed that R5's family representative had not been updated before the administration of the antibiotic. During an interview on 7/9/25 at 9:57 a.m., director of nursing (DON) indicated her expectation would be for the family to be aware of the start of antibiotics, as it was important for the continuity of care. Review of the policy titled change in condition, physician notification: "physician notification of resident change in condition guidelines" Resident, Legal Representative or Interested Family Member Notification, dated 11/19, identified LB Broen Home would notify Physicians, residents and legal representatives or interested family members of change in condition according to regulation.	F0580		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty	F0641	The facility failed to accurately code the use of Ativan and the Hospice status of a resident on the MDS. A modification of R17's MDS's dated 2/13/25 and 5/15/25, items N0415B and O0110 K1, were modified and locked on 7/9/25 and accepted on 7/14/25. Modifications include corrected information regarding Ativan use and receipt of Hospice services within the assessment reference periods. The "Order Listing report" was run by Medication Class to include all residents with an order for Ativan/Lorazepam. No additional residents were identified as having been coded inaccurately on the MDS. The PCC Detailed Census Report was run to identify all residents currently receiving Hospice Care. No additional residents were identified as having been coded inaccurately on the MDS. RN's who are responsible for MDS completion will be retrained on MDS completion using the American Association of Post-Acute Care Nursing (AAPACN), MDS Essentials courses. BMH # 1187-06, Nursing Care Audit: Assessment/Care Planning and Implementation was revised to include the addition of Hospice – coded on MDS and Care Plan and the addition of Meds Reviewed if used, coded correctly on the MDS, to ensure the accuracy of MDS completion. This audit will be completed on one resident weekly on all resident care units x 4 weeks and quarterly	08/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0641 SS = D	Continued from page 4 of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) correctly for 2 of 2 residents (R17, R) reviewed for resident assessment. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2023, identified Section N, record the number of days during the 7-day look-back period that the resident received any type of medication, antigen, vaccine, etc., by subcutaneous, intramuscular, or intradermal injection. Check B, antianxiety: if anxiolytic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Section O Hospice care: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licenses by the state as a hospice provider and/or certified under the Medicare Program as a hospice provider. R17's significant change MDS dated 8/14/24, identified R17 on hospice serves under the section O for hospice care. R17's quarterly MDS dated 2/13/25 and quarterly MDS dated 11/14/24 , failed to identify R17 receiving hospice care under section O for hospice care.. R17's MDS dated 2/13/25 identified a diagnosis of anxiety disorder, Section N, which covers medications received during the assessment period, identified R17 was not given an antianxiety medication during the look back period. R17's Signed provider order dated 1/13/25 , identified an order for Ativan 0.5 milligrams (mg) every three			F0641	Continued from page 4 ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit item findings are an agenda item reported to the Resident Care and Customer Relations committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance Improvement (QAPI). All Nursing Staff Meeting is scheduled for July 29, 2025. Revisions to the Assessment/Care Planning and Implementation audit reviewed. 08/07/2025 and ongoing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
F0641 SS = D	Continued from page 5 hours as needed for agitation/ restlessness and scheduled every Wednesday at 7:00 a.m., for comfort during bath and hygiene, give at 7:00 a.m., before bath. Start date 11/27/25 with no end date. Orders also identified as R17 admit to Knute Nelson Hospice state date 8/6/24 with no end date. R17's Signed provider order dated 3/20/25 , identified an order for Ativan 0.5 milligrams (mg) every three hours as needed for agitation/ restlessness for 365 days, and scheduled every Wednesday at 7:00 a.m., for comfort during bath and hygiene, give at 7:00 a.m., before bath. Start date 11/27/25 with no end date. Orders also identified as R17 admit to Knute Nelson Hospice state date 8/6/24 with no end date. R17's signed provider orders dated 7/8/25, identified R17 Admit to Knute Nelson Hospice start date 8/6/24 with no end date. R17's orders also included resident to have bed bath only, no tub baths, one time a day every Wednesday. Attain 0.5mg by mouth every three hours as needed for restlessness/anxiety start date 4/11/25 end date 4/11/26. R17's January 2025 medical administration record (MAR) identified R17 received Ativan 0.5mg of Ativan every Wednesday morning at 7:00 a.m. Start date of the order 11/27/25 and was discontinued 4/11/25. R17's February 2025 MAR identified R17 received Ativan 0.5mg of Ativan every Wednesday morning at 7:00 a.m. Start date of the order 11/27/25 and was discontinued 4/11/25. R17's MAR identified R17 received Ativan 0.5 mg every Wednesday during the month of February. Start date of the order 11/27/25 and was discontinued 4/11/25. R17's significant change CAA dated 8/14/24 indicated R17had a Terminal illness, CAA lacked information regarding receiving an antianxiety medication. R17's care plan revived on 7/8/25, identified Coordination of care needs with Vivie (formerly Knute Nelson) Hospice, admitted to Knute Nelson or Vivie hospice services on 8/6/24. Interventions listed Vivie hospice contact information. Care plan identified R17 uses antidepressant medication related to depression and anxiety and receives Remeron and citalopram daily, Interventions are to notify hospice of any medication changes.		F0641				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0641 SS = D	Continued from page 6 During an interview on 7/8/25 at 2:14 p.m., trained medical assistant (TMA) verified R17 was on hospice. The hospice nursing assistant would come in two to three times a week in the morning around breakfast time. During an interview on 7/8/25 at 22:22 p.m., nursing assistant (NA)-D verifieid R17 was on hospice. During an interview on 7/8/25 at 8:39 a.m., licensed practical nurse (LPN)-A verified R17 was on hospice. During an interview on 7/9/25 at 7:49 a.m.,clinical manager (CM)-A verified R17 was on hospice and had been admitted to hospice 8/6/24. DON verified the quarterly MDS dated 2/13/25 and quarterly MDS dated 11/14/24 , failed to identify R17 receiving hospice care under section O for hospice care. CM-A verified the MDS for 11/14/24 and 3/13/25 should have been marked as receiving hospice under section O. CM-A verified R17 has an order for Ativan and was receiving Ativan once a week before baths from 11/27/24 until 4/11/25. CM-A indicated Section N, was coded correctly as Ativan was being used for anxiety but needed to coded as the classification on medication and Ativan was classified as an antidepressant. During an interview on 7/9/25 at 8:47 a.m., pharmacy consultant vifeifed Ativan would be considered as a benzodiapine, which would be put on an anxiety anxiety classification. Pharmacy consultant indicated a psychotropic medication sheet was given to the facility with a list of medications and classifications to post in the facility. Pharmacy consultant gave surveyor a copy of psychotropicd medication date sheet. The pharmacy consultant indicated she would resend the sheet to the facility and will review it with the facility. During an interview on 7/9/25 at 9:56 a.m., director of nursing (DON) indicated Ativan would be coded as an antianxiety on the MDS. DON's expectation would be for corrections to be made to the MDS for 11/14/24 and 3/13/25 to capture what was going on with the resident during the look back time to ensure the case mix was correct. Psychotropic medications data sheet dated 2022 had Lorazepam/Ativan listed under the anxiolytics category. Policy titled MDS assessment dated 2010, indicated all dependents/ disciplines involved in MDS completion and care planning conferences will be trained in the use of			F0641			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0641 SS = D	Continued from page 7 software, be responsible for completing MDS's sections according to deadlines in procedure, participating in care planning conferences as assigned.			F0641			
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a pressure relieving device was implemented to prevent skin breakdown for 1 of 3 residents (R25) reviewed for pressure ulcers. Findings include: R25's quarterly Minimum Data Set (MDS) dated 4/24/25, identified R22 had severe cognitive impairment and diagnoses which included stroke, dementia, and arthritis. Identified R25 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Identified R25 was at risk for pressure ulcers. R25's annual Care Area Assessment (CAA) dated 7/5/24, identified R25 required total assistance from staff with repositioning and was at risk for skin breakdown. Identified R22 was incontinent of bowel and bladder. R25's care plan dated 4/29/22, identified R22 had self care deficits and was at risk for skin breakdown related to stroke, history of pressure ulcers and need			F0686	The facility failed to ensure pressure relieving devices were implemented for R25 per Care Plan direction. R25's Hospice provider was consulted regarding resident's frequent removal of pressure relieving devices to feet. No changes were made by Hospice. R25 is currently trying Derma Saver Stay-Put Heel protectors to bilateral feet when in bed. Two additional residents in the facility were identified to have treatment orders for pressure relieving devices to their heels and have the potential to be affected by the same deficient practice. Resident care plans, nursing assistant worksheets, and e-TAR records have been updated to ensure pressure relieving devices are in use as ordered. It is the responsibility of the team leader to ensure that the pressure-relieving devices are in use prior to signing the e-TAR. LB Homes Nursing Care Audit: Preventative Skin Care Relieving Devices, BH #1390-25 was created. Auditing that resident care plans, nursing assistant worksheets, and e-TAR records have been updated to ensure pressure relieving devices are recorded consistently, and that the ordered device is in use. This audit will be completed weekly x 4 weeks, on all shifts, on all units within the facility and quarterly ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit findings are an agenda item reported to the Resident Care and Customer Relations committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance improvement (QAPI). All Nursing Staff Meeting is scheduled for July 29, 2025. The new audit as identified above will be presented to all nursing staff. Team leaders will be reminded of their responsibility to ensure pressure relieving devices are in use as ordered prior to signing the e-TAR record. 08/07/2025 and ongoing.		08/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0686 SS = D	Continued from page 8 for staff assistance with repositioning in bed and wheelchair. Identified R25 was to wear bilateral heel protectors when in bed. R25's Braden Scale for Predicting Pressure Ulcer Risk dated 5/9/25, identified R25 was at high risk of developing a pressure ulcer. R25's treatment administration record (TAR) for the month of July 2025, identified R25 was to wear bilateral heel protectors while in bed. During an observation on 7/7/25 at 1:10 p.m., R25 was lying in bed on her back wearing a heel protector on her left foot and only a gripper sock on her right foot. R25's right heel was lying directly on the mattress. During an observation on 7/8/25 at 8:05 a.m., R25 was lying on her right side with only gripper socks on her feet. Both of R25's heels were lying directly on the mattress. One heel protector was lying on a bedside table across the room. During a joint interview on 7/8/25 at 8:15 a.m., nursing assistant (NA)-A and registered nurse (RN)-A verified R25 was at risk for pressure ulcers and was to have heel protectors on both feet while in bed. NA-A stated she was unsure why R25's heel protectors were not on her feet. RN-A stated the expectation was R25 should have had heel protectors on both feet to prevent pressure ulcers. During an interview on 7/8/25 at 3:11 p.m., director of nursing (DON) verified R25 was at risk for skin breakdown. DON stated her expectation was that staff would have applied the heel protectors on R25's feet when in bed per the care plan to prevent skin breakdown. Review of a facility policy titled Skin Care program dated 7/24, identified a resident who entered the facility without pressure sores did not develop pressure sores unless the individuals clinical condition demonstrated that they were unavoidable. Identified preventative skin care used individualized approaches specific to the condition. Identified the			F0686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0686 SS = D	Continued from page 9 interventions. Identified residents with pressure ulcer risk would have identified preventative interventions placed on their care plan.			F0686			
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, attempt alternatives, ensure dimensions were appropriate and follow manufacturer's recommendations for installing prior to use of bed rails for 1 of 2 residents (R41) reviewed who were observed to have bed rails. Findings Include: R41's quarterly Minimum Data Set (MDS) dated 6/20/25, identified R41 was cognitively intact and had diagnoses which included: diabetes mellitus, arthritis and anxiety. R41's MDS further identified R41 was independent to roll left and right, and required supervision or touching assistance for lying to sitting, sit to stand and chair and bed transfers.			F0700	The facility failed to comprehensively assess the use of a positioning rail on a resident's consumer bed, including following manufacturer's recommendations for installation. The rail provided by and installed by family on R41's bed was removed by maintenance staff 7/9/25 following receipt of the manufacturer's recommendations from family that included under ADDITIONAL WARNINGS 'Do not use on adjustable beds unless otherwise specified in ASSEMBLY INSTRUCTIONS. ASSEMBLY INSTRUCTIONS 'Compatibility: Not intended for use on adjustable beds.' To date, the positioning rail has not been returned to use on R41's adjustable bed. Five additional resident's consumer beds are used within the facility. Of these five, two are using a bedrail/bed positioning device. One of the two is a hospital bed owned by the resident. This rail has been assessed using BMH #1214-07, LB Broen Homes hospital bed assessment. The second is a consumer bed that has been assessed using BMH #1214-07 and is in use according to manufacturer's recommendations. Manufacturer's recommendations for each rail used on a consumer bed at LB Broen Home have been scanned into the resident record. LB Broen Homes Bedrail/Bed Positioning Device, Use of policy and procedure was revised to include procedure for both hospital beds and consumer beds if used within the facility. LB Broen Homes Bedrail/Bed Positioning Device Assessment and Informed Consent form, BMH #1214-07 was revised to include directions for both hospital and consumer beds if used within the facility. LB Homes Nursing Care Audit: Bedrail/Bed Positioning Device, BH #1391-25 was created. This audit requires staff to identify residents using bedrails/bed positioning devices, identify bed type (consumer or hospital), completion of the Bedrail/Bed Positioning Device Assessment and Informed Consent form, BMH #1214-07, ensure the resident Care Plan is current, and for consumer beds that a copy of the manufacturer's guidelines for bedrail use is included in the resident record. This audit will be completed weekly x 4 weeks on all units within the facility and quarterly ongoing. The		08/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0700 SS = D	Continued from page 10 R41's care plan dated 7/9/25, identified R41 had an activities of daily living (ADL) self-care performance deficit and indicated R41 was able to turn self and sit up in bed on own. R41's care plan interventions included to assist with transfers with gait belt and front wheeled walker. R41's care plan identified R41 had positioning rails bilaterally to assist with bed mobility. R41's Bedrail/Bed Positioning Device Assessment And Informed Consent form dated 9/22/23, identified R41 had bilateral positioning rails to aide in bed mobility and define parameters of bed. R41's Bedrail/Positioning Device Assessment dated 6/20/25, identified R41 had ¼ positioning rails on both sides of bed. R41's medical record lacked a comprehensive assessment of R41's bed rail including: appropriate use and installation of bed rail, measurements to assure safety and attempted alternatives prior to the use of the bed rail. During observation on 7/7/25 at 4:34 p.m., R41 had a personal twin bed with a black round bed rail on the right side. R41 indicated she had purchased the bed from a friend, and her family had installed the bed rail. R41 stated she used the bed rail to get in and out of bed. During observation on 7/8/25 at 10:47 a.m., R41's bed continued to have a black round bed rail on the right side of her bed towards the door. During interview on 7/8/25 at 3:09 p.m., nursing assistant (NA)-F indicated R41 often transferred herself to her bed. NA-F stated when assisting R41, she used a gait belt for transfers. NA-F indicated R41 did use her bed rail. NA-F stated R41 had her own bed, that her family had brought in for her. During interview on 7/8/24 at 3:17 p.m., licensed practical nurse (LPN)-B indicated R41 had her own bed for about the last month or two. During interview on 7/8/25 at 3:45 p.m., maintenance assistant (MA)-A verified R41 had a bed rail on her bed. MA-A stated family installed the bed rail. MA-A stated he was present the day they brought the bed and bed rail in, but did not assist with installation. During interview on 7/9/25 at 8:21 a.m., maintenance engineer (ME)-A stated the beds used by the facility			F0700	Continued from page 10 DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit findings are an agenda item reported to the Resident Care and Customer Relations committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance improvement (QAPI). All Nursing Staff Meeting is scheduled for July 29, 2025. The revised P&Ps, revised form, and new audit as identified above, will be presented to all nursing staff. Maintenance and Housekeeping staff were also educated on the revisions and of the importance of identifying and reporting to the charge nurse the presence of positioning rails in use within the facility. 08/07/2025 and ongoing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0700 SS = D	Continued from page 11 all were the same and had the same bed rails. ME-A stated they had inspected the bed rails a few years ago. ME-A stated they do not routinely check bed rails, but if it became loose or a problem, the nursing staff would write a ticket for them to inspect it. ME-A confirmed he was not aware R41 had a different bed or bed rail. ME-A stated they had not obtained the manufacturer's instructions for R41's bed rail and was not aware if R41's bed rail was installed correctly. ME-A indicated he would inspect R41's bed and bed rail. During interview on 7/9/25 at 8:49 a.m., unit coordinator registered nurse (RN)-B stated the facility's usual practice was to inspect the bed rails to assure they were safe and inform the resident or representative of risks and benefits of their use. RN-B stated she completed the assessment and risk versus benefit consent form on admission. RN-B stated they completed quarterly bed rail assessments also. RN-B confirmed R41's Bedrail/Positioning Device Assessment dated 6/20/25, was not accurate and needed to be modified, because R41 had obtained a new bed in May 2025. RN-B stated R41 had not been happy with mattresses they tried, so family brought in a bed for R41. RN-B confirmed she had not completed an assessment for R41's new bed rail, and they had not obtained the manufacturer's instructions for the bed rail. R41 stated R41's Bedrail/Bed Positioning Devise Assessment And Informed Consent form should also be updated. During interview on 7/9/25 at 9:25 a.m., director of nursing (DON) stated her expectation was that when a resident was admitted, they ask residents if they would like a positioning rail. DON indicated they then completed the Bedrail/Bed Positioning Devise Assessment And Informed Consent form. DON stated they usually did not attempt alternatives first. DON stated her expectation would be that R41's bed rail would be assessed to assure it was safe and appropriate. DON confirmed an assessment had not been completed yet of R41's new bed rail. The facility's Bedrail/Bed Positioning Device policy dated 2/2017, identified a bedrail/bed positioning device would not be used without assessment and informed consent. The policy identified the facility would attempt to use appropriate alternatives prior to installing a bedrail/bed positioning devise, and an assessment and informed consent would be completed.	F0700		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880	The facility failed to ensure staff were using personal protective equipment (PPE) according to the Centers for Disease Control for two residents who had tested positive for COVID-19.	08/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0880 SS = E	Continued from page 12 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with			F0880	Continued from page 12 R36 and R13 were in isolation precautions following testing positive for COVID-19. Two staff caring for these residents incorrectly used an N95 respirator when providing this care. Reuse of N95 respirators was not implemented, as there was no shortage of N95 respirators at the time. One staff caring for these residents incorrectly wore the N95 respirator over a surgical mask. There are currently no residents in isolation precautions in the facility. All residents who were and will be placed in isolation precautions have the potential to be affected by the same deficient practice if they require personal protective equipment when providing care to them while residing at LB Broen Home. BH#1340-20 LB Broen Home Nursing Care Audit, Donning/Doffing PPE will be completed weekly x 4 weeks, on all shifts, on all units within the facility and quarterly ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit items findings are an agenda item reported to the Safety and Infection Control Committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance Improvement (QAPI). All Nursing Staff Meeting is scheduled for July 29, 2025. A knowledge check regarding the use of N95 respirators was prepared and will be completed with all staff who may enter the rooms of a resident in isolation precautions that require N95 respirators. LB Broen Home policy and procedure, COVID-19 Infection Prevention and Control, was revised to include directions on when an N95 respirator should be changed: "If they are used during the care of patient for which a NIOSH Approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during care of a patient on Droplet Precautions), they should be removed and discarded after the patient care encounter and a new one should be donned." BH#1340-20 LB Broen Home Nursing Care Audit, Donning/Doffing PPE, was reviewed with no content changes indicated. 08/07/2025 and ongoing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
F0880 SS = E	Continued from page 13 residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were using personal protective equipment (PPE) according to the Centers for Disease Control for 2 of 2 residents R35, R13 who tested positive for COVID -19. Findings include: The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated May 8, 2023, identified when using a NIOSH approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on droplet precautions), they should be removed and disgarded after the patient care encounter and a new one should be donned. FACILITY Infection Control Laundry tour		F0880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
F0880 SS = E	Continued from page 14 07/08/25 10:02 AM Don Mollerud Supervisor - laundry comes down in carts. we wear yellow gowns and gloves and goggles when sorting laundry. Any infectious bags are sent out to west central linen. One washer broken . 2 gas dryers . dryer vents get cleaned every shift. Use a covered cart to deliver laundry. Yellow gowns are reusabel and gets washed in hot water. 07/08/25 05:27 PM Destiny Morris - LPN I checked the res blood sugar and then washed it with alchohol and sani wipe - Reviewed IC policies no concerns Reviewed IP credentials no concerns 07/09/25 09:39 AM Rita Wickline NA/TMA - we get tested for Covid every day that we work. 07/08/25 02:00 PM Samantha Finch RN IP - I use the Mcgeers criteria the nurses alert me to infections charge nurses can right in infection - Amy the DON is my back up as well. I email staff and post things in nurses station or through mass text to educate and do in person a well. We do antibiotic stewardship we do antibiotic timeout that alerts the charge nurse. If uc comes back and its not an infection we alert the MD's. Laureu is on a phrophalactic and its reviewed with primary and risk verus benefits gets done every 6 months. Covid outbreak - started on 6/27/25 a res tested positive he was on hospice and passed since. That day we contact traced all staff that had worked with him the prior 48 hrs . Then we got a second res positive the next day so we started to test everyone. Then that sunday 3 more residents. Staff get tested everyday. Residents get tested twice a week. We have signs on the door of what PPE to wear and should remove PPE before they leave the roo. Should wear a gown, N95, gloves and face shield or the goggles. When Doffing they should be throwing away the N95's. Staff should be throwing away the N95's not reusing. Verified we are not in crisis PPE and staff should not be reusing the N95's Expectation is they should not be reusing the N95. Staff should not be putting the N95 over a face mask. Reviewed infection log no concerns. 07/08/25 03:22 PM Amy Nelson DON - Verified res had		F0880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0880 SS = E	Continued from page 15 covid N95's staff should be disposing of the masks after each use. Not in shortage of masks. Staff should only be using the N95 Staff should not be wearing 2 masks. area to hang stuff to dry 07/07/25 11:42 AM 2 staff are gowning. glove for EBP in room 359 07/07/25 11:44 AM 2 staff are gowning, glove, N95 and face shield. to go in room 379 Covid positive room. Hand hygiene very good removing PPE 07/07/25 01:44 PM Passing laundry cart is covered delivered a hanger with pants and a07/07/25 01:45 PM bin with personal items closed cover on the cart and placed clothes in room sanitized hands 07/07/25 07:31 PM Harmony Jenson Robin Cannon NA- gowned gloved to go in EBP room 07/08/25 08:27 AM NA put on gown, gloves, N95 eyewear on and delivered room tray to room 373 covid positive resident 07/08/25 08:34 AM NA came out of room and put used N95 mask in a brown paper bag. 07/08/25 09:14 AM Savanna ha noel Na took N95 out of brown paper bag put on a gown, gloves and eyewear after sanitizing hands, and entered Res room07/08/25 0918 am verified used the same N95 just for that res thats why the brown paper bags are by their room . Immunizations: 1.) Otis Anderson Covid 10/2/24 and 4/3/25, influenza 10/2/24, PCV 13 = 01/13/2016Pneumo-PCV 20 (Pneumo-conj) 4/3/25, step 1 mantouz = 01/03/2025 step 2 = 1/13/25 2.) Susan Hill Covid dose 1= 01/05/2021Dose 2 = 02/02/2021Dose 3 = 09/15/2022 Dose 4 = 04/03/2025			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0880 SS = E	Continued from page 16 influenza = 10/14/2024 PCV 13 = 10/13/2016 PCV 20 =04/04/2024 mantouz step 1 = 12/19/2017 Negative (0 mm) System mantouz step 2 = 12/31/2017 Negative (0 mm) 3.) Gladys Hanson Covid dose 1 = 03/19/2024 Dose 2 = 10/14/2024 dose 3 = 04/03/2025 influenza = 10/17/2023 PcV20 = 03/19/2024 mantoux step 1 = 04/02/2024 Negative (0 mm) System Step 2 =04/02/2024 4.) Alice Monson Covid dose 1 = 09/27/2023 dose 2 = 04/04/2024 Dose 3 = 10/14/2024 refused covid = 4/3/25 influenza = 10/14/2024 was education done Pneumo 13 = 10/08/2015 pneumo 23 refused on 1/30/23 pnumo 20 done 04/04/2024 mantoux 1st step = 11/22/2019 Negative (0 mm) second step = 12/01/2019 Negative (0 mm) I called her cousin and She wants her to take vaccine. I gave education. 5.) Irene McCormick covid dose 1 = 02/02/2021 dose 2 = 10/14/2022 dose 3 = 05/19/2023 dose 4 = 04/03/2025 influenza = 10/14/2024 pneumo 23 = 10/10/2005 pneumo 13 = 07/22/2015 pneumo 20 = 04/04/2024 MAntouz step 1 = 10/25/2022 negative step 2 = 11/04/2022 negative 07/08/25 05:37 PM Sarah MDH - it is not ok to wait up to 12 months to do the second step . We do a 2 step TST instead of 1 step first step boosts the immune system so you get a more accurate result on the fist step. If negative test in past 12 months then they only need to do the one step . All I say if they dont come back in the 3 weeks they just dont need to start over. Most should be done in the 3 weeks after the first step.			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
F0880 SS = E	Continued from page 17 R13 R13's quarterly MDS dated 6/19/25, identified R13 was cognitively intact, and had diagnoses which included: end stage renal disease (kidney failure), chronic obstructive pulmonary disease (lung disease that limits airflow) and diabetes mellitus. R13's care plan dated 7/9/25, identified R13 had limited physical mobility and required assistance with dressing, grooming and transferring with a EZ stand mechanical lift. R13's care plan also identified R13 had COVID-19, and staff were to observe for signs and symptoms of COVID-19 and implement infection control measures. R13's Point Of Care (POC) Test Result Reporting form dated 7/1/25, identified R13's test of SARS-CoV-2 (COVID-19) was positive. During observation on 7/7/25 at 4:45 p.m., NA-E assisted R13 to transfer from her wheelchair to her recliner using the EZ stand mechanical lift. NA-E wore a gown, gloves, eye protection and wore a N95 mask, over the top of a blue medical mask. NA-E removed her gown, gloves, then sanitized her hands and left R13's room. During interview on 7/7/25 at 7:19 p.m. NA-E indicated R13 had COVID, and they were expected to wear a gown, gloves, N95 mask and protective glasses or face shield. NA-E verified she had worn the N95 mask over her blue medical mask. NA-E stated she had observed others wear their masks that way, so she did it too. NA-E indicated they kept their N95 mask and eye protection glasses in a brown paper bag. NA-E stated they reused their N95 masks and glasses, one for each resident, one for each shift. NA-E showed surveyor the bags with her name on them, outside resident's rooms who were COVID positive. The bags contained a pair of protective glasses and a N-95 mask. NA-E indicated she wiped off the glasses before and after they were worn. During an interview on 7/8/25 at 2:00 p.m., infection preventionist (IP) verified eight residents including R36 and R13 on the third floor had tested positive for		F0880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0880 SS = E	Continued from page 18 COVID-19 which placed the facility in an outbreak. IP verified the facility had adequate PPE supplies and was not in a shortage. IP stated her expectation was that staff would use a clean N95 each time they entered a Covid-19 positive room and then dispose of the N95 after each use. IP further stated staff should only be wearing an N95 when they entered a Covid-19 positive room to ensure they had a proper seal of the N95. During an interview on 7/8/25 at 3:22 p.m., director of nursing (DON) verified R36 and R13 had tested positive for COVID-19. DON stated her expectation was staff would use a clean N95 each time they entered a positive Covid -19 room. DON further stated staff should not be wearing a face mask with the N95 to ensure a proper seal of the N95. Review of a facility policy titled COVID-19 Infection Prevention and Control revised 6/24, identified the facility would adhere to Federal and State/Local recommendations to minimize the spread of COVID-19. Identified. Health Care Personnel(HCP) who entered the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or PAPR, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).Policy lacked information regarding when an N95 should be changed.	F0880		
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident's call light was within reach from the bathroom floor in a resident	F0919	The facility failed to ensure a resident's bathroom call cord was within reach of the bathroom floor. R7's bathroom call light cord was not accessible from the floor as is required by both State and Federal regulation. R7's bathroom call light cord was replaced with one long enough to be reached from the floor on 7/8/25. All additional bathroom call light cords were of an appropriate length within the facility. LB Broen Home Call Light Accessibility Policy and Procedure was created to ensure a communication system in compliance with 483.90 (g), and MN 4658.35 B. Environmental Services, Housekeeping policy and procedure titled Housekeeping Tasks, Routine Daily was updated to include I. M. 8. Bathroom call light a. ensure call light cord is within reach of the floor. LB Broen Home Nursing Care Audit titled Call light	08/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0919 SS = D	Continued from page 19 bathroom for 1 of 1 residents (R7) reviewed for call light accessibility. Findings include: R7's quarterly Minimum Data Set (MDS) dated 5/8/25, identified R7 was cognitively intact and had diagnoses which included: diabetes mellitus, arthritis and anxiety. R7's MDS further identified R7 used a walker and was independent with walking, transferring and toilet hygiene. R7's care plan dated 7/8/25, identified R7 had an activities of daily living (ADL) self-care performance deficit with interventions that included, ensure call light was within reach. R7 was independent with toileting. During observation on 7/7/25 at 11:27 a.m., R7's bathroom call light box was on the wall approximately three feet off the floor. It had a short blue string attached with a knot on the end. The string hung approximately three to four inches below the call light box. R7 indicated she used the bathroom independently. During observation on 7/8/25 at 12:31 p.m., R7's bathroom call light box continued to have a short blue string, approximately three to four inches hanging from the call light box. R7 indicated she used her bathroom independently and if she fell on the floor, she would not be able to reach the call light. R7 stated she had fallen one time before in the bathroom. During observation on 7/8/25 at 2:14 p.m., maintenance assistant (MA)-A confirmed R7's bathroom call light was not accessible from the floor and was approximately three feet off the floor. MA-A did not know the actual length the call light cord should be. During interview on 7/8/25 at 2:27 p.m., administrator indicated she had been notified of R7's short call light cord in R7's bathroom. Administrator stated her expectation was that they be about two to three inches off the floor so the resident would be able to reach it from the floor. Administrator stated MA-A was replacing it now.	F0919	Continued from page 19 Response/Accessibility, BMH#1160-04 was revised to include 'Bathroom pull cord within reach of floor?' column to Section I "Call light within reach check". This audit will be completed weekly x 4 weeks on all units within the facility and quarterly ongoing. The DON will monitor audit findings and ensure prompt follow-up of concerns identified. Audit findings are an agenda item reported to the Resident Care and Customer Relations committee, a sub-committee of the Quality Assessment and Assurance Committee and Quality Assurance and Performance improvement (QAPI). All Nursing Staff Meeting is scheduled for July 29, 2025. The revised policy and procedure, and revised audit as identified above, will be presented to all nursing staff. Environmental Services - Housekeeping staff were updated on the revisions to Housekeeping Tasks Routine Daily policy and procedure as described above. All facility staff were educated on Call Light Accessibility Policy and Procedure. 08/07/2025 and ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
F0919 SS = D	Continued from page 20 During interview maintenance engineer (ME)-A stated call light cords must be accessible from the floor. ME-A stated this was important because if a resident fell on the floor and needed help, they needed to be able to reach the call light. ME-A indicated he was made aware R7's bathroom call light cord was too short. ME-A stated some of the cords become worn or break. ME-A stated he ordered a spool of cord and will be inspecting all the call light cords and replacing them as needed. On 7/8/25 at 8:48 p.m., health information manager (HIM)-A's e-mail indicated the facility did not have a specific call light policy.			F0919			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
K0000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted on 07/10/2025 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, LB Broen Home Bldg 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. 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. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us			K0000			

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
K0000	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. LB Broen Memorial Home is a 2-story building with a partial basement. The building was constructed at three 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 northwest of the 1969 building is 1-story without a basement and was determined to be Type II (000). The facility was surveyed as two buildings. The building is completely protected by an automatic fire sprinkler system installed and also has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 74 beds and a census of 49 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET.			K0000			
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/10/2025. At the time of this			K0000			07/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
K0000	Continued from page 2 survey, LB Broen Home Building 05 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies and the 2012 edition of NFPA 99, the Health Care Facilities Code. This addition is a single-story building of type II (000) construction and is fully sprinkled. It includes areas for a cooler and freezer for the main kitchen as well as a loading dock. There is a 3-hour fire curtain separating the addition from the existing building. At the time of the addition several HVAC roof top units were replaced with the addition of a new unit for the kitchen. The facility has a capacity of 74 beds and had a census of 49 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET:		K0000				
K0321 SS = E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms		K0321	K0321 1) 1. 2N West Wing rooms storing combustible items without self-closure door devices will be cleared of stored combustible items. 2. Maintenance staff re-educated on the storage of combustible items and the requirements for a self-closing door on all areas of storage. 3. Combustible items will be stored only in designated storage locations with self-closing doors. Monitoring of non-storage areas will be ongoing by maintenance and facility staff.		08/29/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
K0321 SS = E	Continued from page 3 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.6.3.5, and 8.7.1.3. These violations could have a patterned impact on residents within the facility. Findings include: On 07/10/2025 at 11:34 AM, it was revealed by observation that several rooms in the 2N West Wing were being used to store combustible items and the doors did not have a self-closing device on them.On 7/10/2025 at 11:40 AM, it was revealed by observation that the door for Storage Room X5 in the 1969 building basement did not positively latch when the door was closed using the self-closing device. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0321	Continued from page 3 4. Sam Davids, Facilities Manager, will be responsible for the corrective action and monitoring of compliance. 5. Date of completion August 29. 2025. 2) 1. Door closer on door to hazardous area Storage Room x5 in the 1969 building basement noted not to latch properly during inspection will be adjusted to latch properly per code. 2. Staff education provided to all LB Homes staff to submit repair requests, via the LB Homes Ticket System, for all doors noted not to latch properly. 3. Ongoing monitoring of the Ticket System with timely follow up on concerns will ensure solutions are sustained. 4. Sam Davids, Facilities Manager, will be responsible for the corrective action and monitoring of compliance. 5. Date of completion is August 29, 2025		
K0353 SS = E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.			K0353	K0353 1) 1. IT storage items noted on top shelf too close to the fire sprinkler head were removed from top shelf storage and a permanent sign placed reading NO STORAGE ABOVE THIS POINT.		08/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
K0353 SS = E	Continued from page 4 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2010 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.1(5), and 5.2.1.2. These deficient findings could have a patterned impact on residents within the facility. Findings include:On 07/10/2025 at 11:00 AM, it was revealed by observation that items were being stored on the top shelf close to the ceiling in the IT Storage room that would prevent the fire sprinkler from operating properly in the event of a sprinkler activation.On 07/10/2025 at 11:15 AM, it was revealed by observation that the sprinkler head in 1 South Kitchenette area was covered with lint and debris.On 07/10/2025 at 11:26 AM, it was revealed by observation that items were being stored to close to the sprinkler deflector in the storage closet next to the 2nd Floor Nurse's Station.An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0353	Continued from page 4 2. Staff education provided to all LB Broen Home staff regarding maintenance of the Water-Based Fire Protection Systems identified in sections 5.2.1.1.1(5) and 5.2.1.2. 3. Ongoing monitoring of compliance with sprinkler head obstruction will occur with all facility employees and reported to maintenance if noted. 4. Sam Davids, Facilities Manager, will be responsible for the corrective action and monitoring of compliance. 5. Date of completion July 31,2025. 2) 1. Sprinkler head covered with lint and debris in the 1 South Kitchenette will be cleaned. 2. Staff education provided to all LB Homes staff to submit sprinkler head cleaning requests via the LB Homes Ticket System. 3. Ongoing monitoring of the Ticket System with timely follow up on concerns will ensure solutions are sustained. 4. Sam Davids, Facilities Manager, will be responsible for the corrective action and monitoring of compliance. 5. Date of completion July 31, 2025. 3) 1. Storage closet in the hallway between 2S and 2N			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
K0353 SS = E			K0353	Continued from page 5 where items were stored on a shelf within 18 inches of a sprinkler head have been removed and a permanent sign placed reading NO STORAGE ABOVE THIS POINT. 2. Staff education provided to all LB Broen Home staff regarding maintenance of the Water-Based Fire Protection Systems identified in sections 5.2.1.1.1(5) and 5.2.1.2. 3. Ongoing monitoring of compliance with sprinkler head obstruction will occur with all facility employees and reported to maintenance if noted. 4. Sam Davids, Facilities Manager, will be responsible for the corrective action and monitoring of compliance. 5. Date of completion July 31,2025.			
K0363 SS = D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device		K0363	The door leading to the stairway at the end of the 2N West Wing hallway will have the hinges adjusted to ensure compliance with NFPA 101 (2012 edition), Life Safety Code section 19.3.6.3.5. Staff education provided to all LB Homes staff to submit repair requests, via the LB Homes Ticket System, for all doors noted to not positively latch upon closure. Ongoing monitoring of the Ticket System with timely follow up on concerns will ensure solutions are sustained. Sam Davids, Facilities Manager, will be responsible for the corrective action and monitoring of compliance. Date of completion August 29, 2025.		08/29/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
K0363 SS = D	Continued from page 6 capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/10/2025 at 11:35 AM, it was revealed by observation that the door leading to the stairway at the end of the 2N West Wing hallway did not positively latch when it was closed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0363				
K0751 SS = D	Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1		K0751	1. The curtain hanging from the ceiling in the Activity Room (2N dining room) that would interfere with the ability of the fire s sprinkler to effectively extinguish a fire and without tag indicating it meets the requirements at NFPA 701, has been removed. 2. Staff education provided to all LB Broen Home staff to enhance		08/29/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
K0751 SS = D	Continued from page 7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install curtains and loosely hanging fabrics per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.11, 19.7.5.1, and 10.3.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 07/10/2025 at 11:48 AM, it was revealed by observation that a large curtain was hanging from the ceiling in the Activity Room that would interfere with the ability of the fire sprinkler to effectively extinguish a fire in the room upon activation. The curtain also did not have a tag indicating that it meets the requirements NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0751	Continued from page 7 awareness of fire sprinkler location and avoiding restrictions. 3. Ongoing monitoring of compliance will occur with all facility employees and reported to maintenance if noted. 4. Sam Davids, Facilities Manager, will be responsible for the corrective action and monitoring of compliance. 5. Date of completion, July 18, 2025.			
K0761 SS = E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire and smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections		K0761	K 0761 1) 1. The Dish Room fire door in the Main Kitchen has been adjusted to ensure compliance with NFPA 101 (2012 edition), Life Safety Code section 19.7.6 and 4.6.21.1. 2. Staff education provided to all LB Homes staff to submit repair requests, via the LB Homes Ticket System, for all doors noted to not positively latch upon closure. 3. Ongoing monitoring of the Ticket System with timely follow up on concerns will ensure solutions are sustained. 4. Sam Davids, Facilities Manager, will be responsible		08/29/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
K0761 SS = E	Continued from page 8 19.7.6, and 4.6.12.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.4.2(7) and (8). These deficient findings could have a patterned impact on residents within the facility. Findings include:On 07/10/2025 at 11:54 AM, it was revealed by observation that the Dish Room fire door in the Main Kitchen did not latch and secure the door in the closed position.On 07/10/2025 at 11:59 AM, it was revealed by observation that the coordinator above the smoke barrier doors leading into the 3N West Wing was not adjusted properly preventing the doors from closing as designed. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0761	Continued from page 8 for the corrective action and monitoring of compliance. 5. Date of completion July 31, 2025. 2) 1. The coordinator above the smoke barrier doors leading into the 3N West Wing has been adjusted to ensure proper closure. 2. Staff education provided to all LB Homes staff to submit repair requests via the LB Homes Ticket System, for all doors noted not to latch properly. 3. Ongoing monitoring of the Ticket System with timely follow up on concerns will ensure solutions are sustained. 4. Sam Davids, Facilities Manager, will be responsible for the corrective action and monitoring of compliance. 5. Date of completion is August 29, 2025		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
20000	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: On 7/7/25 to 7/9/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		20000			07/18/2025	

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin The State licensing orders are delineated on the attached Minnesota 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. 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.		20000				
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) correctly for 1 of 1 residents (R17) reviewed for resident assessment.		20550	Corrected		08/07/2025	

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
20550	Continued from page 2 Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2023, identified Section N, record the number of days during the 7-day look-back period that the resident received any type of medication, antigen, vaccine, etc., by subcutaneous, intramuscularly, or intradermal injection. Check B, antianxiety: if antianxiety medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Section O: special treatments, procedures, and programs. K1. Hospice care: Code residents identified as being in a hospice program for terminally ill persons, where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare Program as a hospice provider. R17's significant change MDS dated 8/14/24, identified R17 was on hospice services under the section O for hospice care. R17 's significant change CAA dated 8/14/24 indicated R 17 had a Terminal illness, CAA lacked information regarding receiving an antianxiety medication. R17's quarterly MDS dated 2/13/25 and quarterly MDS dated 11/14/24, failed to identify R17 receiving hospice care under section O for hospice care. R17's MDS dated 2/13/25, identified a diagnosis of anxiety disorder, Section N, which covers medications received during the assessment period, but failed to identify that R17 was not given an antianxiety medication during the look-back period. R17's signed provider order dated 1/13/25, identified an order for Ativan (a benzodiazepine used to treat anxiety) 0.5 milligrams (mg) every three hours as needed for agitation/ restlessness and scheduled every Wednesday at 7:00 a.m., for comfort during bath and hygiene, give at 7:00 a.m., before bath. Start date 11/27/24, with no end date. Orders also identified as R17 admitted to Knute Nelson Hospice start date, 8/6/24, with no end date.			20550			

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
20550	Continued from page 3 R17's Signed provider order dated 3/20/25, identified an order for Ativan 0.5 milligrams (mg) every three hours as needed for agitation/ restlessness for 365 days, and scheduled every Wednesday at 7:00 a.m., for comfort during bath and hygiene, give at 7:00 a.m., before bath. Start date 11/27/24, with no end date. Orders also identified as R17 admit to Knute Nelson Hospice, start date 8/6/24, with no end date. R17's signed provider orders dated 7/8/25, identified R17 admitted to Knute Nelson Hospice start date 8/6/24, with no end date. R17's orders also included the resident to have a bed bath only, no tub baths, one time a day, every Wednesday. Ativan 0.5 mg by mouth every three hours as needed for restlessness/anxiety, start date 4/11/25, end date 4/11/26. R17's January 2025 medical administration record (MAR) identified that R17 received Ativan 0.5 mg every Wednesday morning at 7:00 a.m. The start date of the order was 11/27/24, and was discontinued 4/11/25. R17's February 2025 MAR identified R17 received Ativan 0.5 mg of Ativan every Wednesday morning at 7:00 a.m. The start date of the order was 11/27/24, and was discontinued 4/11/25. R17's MAR identified R17 received Ativan 0.5 mg every Wednesday during the month of February. The start date of the order was 11/27/24, and was discontinued 4/11/25. R1 's care plan revised on 7/8/25, identified Coordination of care needs with Vivie (formerly Knute Nelson) Hospice, admitted to Knute Nelson or Vivie hospice services on 8/6/24. Interventions listed the Vivie hospice contact information. Care plan identified R17 received antidepressant medication related to depression and anxiety, and received Remeron (depression) and Citalopram (antidepressant) daily. Interventions were to notify the hospice of any medication changes. The care plan lacked information regarding Ativan as an antianxiety medication. During an interview on 7/8/25 at 2:14 p.m., trained medical assistant (TMA)-A verified R17 was on hospice. The hospice nursing assistant would come in two to		20550				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
20550	Continued from page 4 three times a week in the morning around breakfast time. During an interview on 7/8/25 at 22:22 p.m., nursing assistant (NA)-D verified R17 was on hospice. During an interview on 7/8/25 at 8:39 a.m., licensed practical nurse (LPN)-A verified R17 was on hospice. During an interview on 7/9/25 at 7:49 a.m., clinical manager (CM)-A verified R17 was on hospice and had been admitted to hospice on 8/6/24. DON verified the quarterly MDS dated 2/13/25, and the quarterly MDS dated 11/14/24, lacked documentation R17 received hospice care under section O for hospice care. CM-A verified that the MDS for 11/14/24, and 3/13/25, should have been marked as receiving hospice under section O. CM-A verified R17 had an order for Ativan and was receiving Ativan once a week before baths from 11/27/24, until 4/11/25. CM-A indicated Section N was not coded for an antianxiety, as CM-A classified Ativan as an antidepressant. CM-A indicated she was under the impression that Ativan was an antidepressant medication and not an antianxiety medication. During an interview on 7/9/25 at 8:47 a.m., the pharmacy consultant verified that Ativan would be considered a benzodiazepine, which would be put in an antianxiety classification. The pharmacy consultant indicated that a psychotropic medication sheet was given to the facility with a list of medications and classifications to post in the facility. The pharmacy consultant gave the surveyor a copy of the psychotropic medication date sheet that was given to the facility. The pharmacy consultant indicated she would resend the sheet to the facility and would review it with the facility. During an interview on 7/9/25 at 9:56 a.m., director of nursing (DON) indicated Ativan would be coded as an antianxiety on the MDS. DON's expectation would be for corrections to be made to the MDS for 11/14/24, and 3/13/25, to capture the accurate assessment information during the look-back time frame to ensure the case mix was correct. Review of the Psychotropic medications data sheet dated 2022, provided by the pharmacy consultant identified		20550				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
20550	Continued from page 5 Lorazepam/Ativan listed under the anxiolytics (medications to treat anxiety symptoms or disorders). Policies titled MDS assessment dated 2010, and Resident Assessment and Care Planning dated 11/19, lacked information on how to accurately complete the MDS for sections N and O. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20550				
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a pressure relieving device was implemented to prevent skin breakdown for 1 of 3 residents (R25) reviewed for pressure ulcers. Findings include:		20900	Corrected		08/07/2025	

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
20900	Continued from page 6 R25's quarterly Minimum Data Set (MDS) dated 4/24/25, identified R22 had severe cognitive impairment and diagnoses which included stroke, dementia, and arthritis. Identified R25 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Identified R25 was at risk for pressure ulcers. R25's annual Care Area Assessment (CAA) dated 7/5/24, identified R25 required total assistance from staff with repositioning and was at risk for skin breakdown. Identified R22 was incontinent of bowel and bladder. R25's care plan dated 4/29/22, identified R22 had self care deficits and was at risk for skin breakdown related to stroke, history of pressure ulcers and need for staff assistance with repositioning in bed and wheelchair. Identified R25 was to wear bilateral heel protectors when in bed. R25's Braden Scale for Predicting Pressure Ulcer Risk dated 5/9/25, identified R25 was at high risk of developing a pressure ulcer. R25's treatment administration record (TAR) for the month of July 2025, identified R25 was to wear bilateral heel protectors while in bed. During an observation on 7/7/25 at 1:10 p.m., R25 was lying in bed on her back wearing a heel protector on her left foot and only a gripper sock on her right foot. R25's right heel was lying directly on the mattress. During an observation on 7/8/25 at 8:05 a.m., R25 was lying on her right side with only gripper socks on her feet. Both of R25's heels were lying directly on the mattress. One heel protector was lying on a bedside table across the room. During a joint interview on 7/8/25 at 8:15 a.m., nursing assistant (NA)-A and registered nurse (RN)-A verified R25 was at risk for pressure ulcers and was to have heel protectors on both feet while in bed. NA-A stated she was unsure why R25's heel protectors were			20900			

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
20900	Continued from page 7 not on her feet. RN-A stated the expectation was R25 should have had heel protectors on both feet to prevent pressure ulcers. During an interview on 7/8/25 at 3:11 p.m., director of nursing (DON) verified R25 was at risk for skin breakdown. DON stated her expectation was that staff would have applied the heel protectors on R25's feet when in bed per the care plan to prevent skin breakdown. Review of a facility policy titled Skin Care program dated 7/24, identified a resident who entered the facility without pressure sores did not develop pressure sores unless the individuals clinical condition demonstrated that they were unavoidable. Identified preventative skin care used individualized approaches specific to the condition. Identified the interventions. Identified residents with pressure ulcer risk would have identified preventative interventions placed on their care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20900				
21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.		21385	Corrected		08/07/2025	

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
21385	Continued from page 8 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were using personal protective equipment (PPE) according to the Centers for Disease Control for 2 of 2 residents (R36, R13) who tested positive for COVID -19 reviewed for transmission based precautions. Findings include: R36 The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personal During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated May 8, 2023, identified when using a NIOSH approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on droplet precautions), they should be removed and discarded after the patient care encounter and a new one should be donned. R36's quarterly Minimum Data Set (MDS) dated 4/3/25, identified R36 had severe cognitive impairment and diagnoses which included renal insufficiency, arthritis and hypertension (elevated blood pressure). Identified R36 required extensive assistance with activities of daily living (ADL's) which included bed mobility, toileting, and transferring. R36's care plan dated 12/2/24, identified R36 had a self care deficit related to confusion, dementia and pain. care plan directed staff to assist R36 with ADL's. Care plan lacked evidence R36 had Covid-19 and was on airborne precautions. R36's point of care (POC) test for Covid-19 dated 6/28/25, identified R36 was positive for Covid-19. During an observation on 7/7/25 at 11:20 a.m., R36's door was closed and a sign on the door stated anyone entering this room must wear a gown, gloves, N95 mask and eye protection. Identified R36 was on Airborne precautions.		21385				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
21385	Continued from page 9 During observations on 7/7/25 and 7/8/25, brown paper bags with goggles and N95 masks were sitting on the railing outside of R36 and R13's room. During an observation on 7/8/25 at 8:27 a.m., nursing assistant (NA)-B sanitized hands removed face mask and placed it in her back pocket, put on a gown, gloves, new 95, and eyewear and entered R36's room with a breakfast tray. -at 8:34 NA-B exited R36's room, sanitized hands and removed her N95 mask and eyewear and placed them in a brown paper bag on the railing outside of R36's room. NA-B removed her surgical mask from her back pocket and placed it on her face. During an observation on 7/8/25 at 9:14 a.m., NA-B sanitized hands, put on a gown, removed face mask and placed it in her back pocket, removed the eyewear and the used N95 from the brown paper bag, put them on and entered R36's room. -at 9:18 a.m., NA-B exited R26's room, sanitized hands and room, removed her N95 mask and eyewear and placed them in a brown paper bag on the railing outside of R36's room. NA-B removed her surgical mask from her back pocket and placed it on her face. During an interview on 7/8/25 at 9:20 a.m., NA-B verified R36 was positive for COVID-19. NA-B further verified she had placed her N95 in a brown paper bag after entering R36's room and then reused it to re-enter R36's room. NA-B stated her usual practice was to place the N95 in a brown paper bag and place it on the railing and re-use it for that resident her entire shift. NA-B stated she did this for all residents who were positive for COVID-19. NA-B stated she was unsure why staff were re-using the N95's. R13 R13's quarterly MDS dated 6/19/25, identified R13 was cognitively intact, and had diagnoses which included: end stage renal disease (kidney failure), chronic obstructive pulmonary disease (lung disease that limits		21385				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
21385	Continued from page 10 airflow) and diabetes mellitus. R13's care plan dated 7/9/25, identified R13 had limited physical mobility and required assistance with dressing, grooming and transferring with a EZ stand mechanical lift. R13's care plan also identified R13 had COVID-19, and staff were to observe for signs and symptoms of COVID-19 and implement infection control measures. R13's Point Of Care (POC) Test Result Reporting form dated 7/1/25, identified R13's test of SARS-CoV-2 (COVID-19) was positive. During observation on 7/7/25 at 4:45 p.m., NA-E assisted R13 to transfer from her wheelchair to her recliner using the EZ stand mechanical lift. NA-E wore a gown, gloves, eye protection and wore a N95 mask, over the top of a blue medical mask. NA-E removed her gown, gloves, then sanitized her hands and left R13's room. During interview on 7/7/25 at 7:19 p.m. NA-E indicated R13 had COVID, and they were expected to wear a gown, gloves, N95 mask and protective glasses or face shield. NA-E verified she had worn the N95 mask over her blue medical mask. NA-E stated she had observed others wear their masks that way, so she did it too. NA-E indicated they kept their N95 mask and eye protection glasses in a brown paper bag. NA-E stated they reused their N95 masks and glasses, one for each resident, one for each shift. NA-E showed surveyor the bags with her name on them, outside resident's rooms who were COVID positive. The bags contained a pair of protective glasses and a N-95 mask. NA-E indicated she wiped off the glasses before and after they were worn. During an interview on 7/8/25 at 2:00 p.m., infection preventionist (IP) verified eight residents including R36 and R13 on the third floor had tested positive for COVID-19 which placed the facility in an outbreak. IP verified the facility had adequate PPE supplies and was not in a shortage. IP stated her expectation was that staff would use a clean N95 each time they entered a Covid-19 positive room and then dispose of the N95 after each use. IP further stated staff should only be wearing an N95 when they entered a Covid-19 positive room to ensure they had a proper seal of the N95.		21385				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
21385	Continued from page 11 During an interview on 7/8/25 at 3:22 p.m., director of nursing (DON) verified R36 and R13 had tested positive for COVID-19. DON stated her expectation was staff would use a clean N95 each time they entered a positive Covid -19 room. DON further stated staff should not be wearing a face mask with the N95 to ensure a proper seal of the N95. Review of a facility policy titled COVID-19 Infection Prevention and Control revised 6/24, identified the facility would adhere to Federal and State/Local recommendations to minimize the spread of COVID-19. Identified. Health Care Personnel(HCP) who entered the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or PAPR, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).Policy lacked information regarding when an N95 should be changed. SUGGESTED METHOD OF CORRECTION: The infection preventionist (IP) or designee could develop additional teaching and methods to mitigate the risk of spread of infection. She could ensure all staff are trained on the importance and proper use of PPE. Audits could be done to ensure that PPE use and other infection control practices are routinely followed. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21385			
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid	21426	Corrected	08/07/2025	

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
21426	Continued from page 12 employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure two-step tuberculin skin tests (TST) were completed for 2 of 5 employees. Findings include: According to Centers for Disease Control (CDC) Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019 dated 5/17/2019 identified anyone who works in a healthcare setting should be tested for Tuberculosis (TB). a first step Tuberculin skin test (TST) (injection under the skin should be completed prior to working and read 48-72 hrs later. A second step TST should be done 1-3 weeks after the first step TST unless there is evidence of a negative TST 90 days prior to employment. Nursing assistant (NA)-G's employment start date was 5/21/25. NA-A received the first step TST on 5/21/25. NA-G had not received the second-step TST, and had not provided evidence of a negative TST dated within 90 days prior to date of hire. NA-H's employment start date was 4/3/25. NA-G received the fist step TST on 4/3/25. NA-H had not received the second-step TST, and had not provided evidence of a negative TST dated within 90 days prior to date of hire. During an interview on 7/8/25 at 2:15 p.m., Infection preventionist (IP) verified NA-G and NA-H had not received a second step TST. IP stated as long as staff had a fist step TST they had up to 12 months to do the second step TST. IP stated going forward she would ensure all new employees received a two step TST.		21426				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
21426	Continued from page 13 During an interview on 7/9/25 at 8:00 a.m.,director of nursing (DON) verified NA-G and NA-H had not received a second step TST. DON stated her expectation was that staff would receive TST per CDC guidelines to protect the residents. Review of a facility policy titled Infection Control Policies and Procedures dated 9/23, identified facility was to complete TST for all new employees according to CDC guidelines. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or her designee could develop systems to ensure TB screenings for staff are completed according to the Center for Disease Control recommendations. The DON or her designee could educate all appropriate staff on these systems. The DON or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.		21426				
21830	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 10 Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing		21830	Corrected		08/07/2025	

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
21830	Continued from page 14 that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper			21830			

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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	
21830	Continued from page 15 or violated the patient's privacy rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, and document review, the facility failed to notify the resident representative promptly following provider order changes for 1 of 1 residents (R5) who received an order for antibiotics for a urinary tract infection (UTI). Findings include: R5's quarterly Minimum Data Set (MDS) dated 5/22/25, indicated R5's cognition was severely impaired. R5 had diagnoses that included cancer, Alzheimer's disease (cause of dementia), and arthritis. R5 needed maximal assistance for transferring, personal hygiene, and dressing. R5's care plan, last revised on 7/8/25, indicated R5 had an activities of daily living (ADL) self-care performance deficit related to Alzheimer's dementia, and a right hip fracture. Interventions included: Toileting schedule every two hours and check on nights, continent and incontinent of both bowel and bladder. R5's signed physician order dated 6/20/25, indicated Cipro (antibiotic for bacterial infections) 500 milligrams (mg) twice a day (BID) for five days. R5's medication administration record (MAR) dated June 2025 identified R5 received Cipro 500 mg starting 6/20/25 at 8:00 p.m., and received the last dose on 6/25/25 at 8:00 a.m. R5's progress notes lacked the resident representative being notified of R5's order for Cipro 500 mg for five days. During an interview on 7/7/25 at 11:25 a.m., R5's family member (FM)-A indicated there was no notification that R5 started on an antibiotic. FM-A indicated the clinical manager only provided an update when the antibiotic was completed. During an interview on 7/9/25 at 7:59 a.m., clinical manager (CM)-A indicated the normal practice would be		21830				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER LB BROEN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 824 SOUTH SHERIDAN STREET , FERGUS FALLS, Minnesota, 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
21830	Continued from page 16 to update family representatives of clinic visits, changes in conditions, and antibiotic orders. CM-A normal practice was to make a note of the update to the family representative in the progress notes. CM-A confirmed that R5's family representative had not been updated before the administration of the antibiotic. During an interview on 7/9/25 at 9:57 a.m., director of nursing (DON) indicated her expectation would be for the family to be aware of the start of antibiotics, as it was important for the continuity of care. Review of the policy titled change in condition, physician notification: "physician notification of resident change in condition guidelines" Resident, Legal Representative or Interested Family Member Notification, dated 11/19, identified LB Broen Home would notify Physicians, residents and legal representatives or interested family members of change in condition according to regulation. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement measure to ensure timely notification to the resident's representative. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The facility should perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21830			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 14, 2025

Administrator
LB BROEN HOME
824 SOUTH SHERIDAN STREET
FERGUS FALLS, MN 56537

RE: CCN: 245453
Cycle Start Date: July 9, 2025

Dear Administrator:

On September 30, 2025, the Minnesota Department of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 14, 2025

Administrator
LB BROEN HOME
824 SOUTH SHERIDAN STREET
FERGUS FALLS, MN 56537

Re: Reinspection Results
Event ID: W393-H2

Dear Administrator:

On August 15, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 9, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

An equal opportunity employer.