Electronically delivered
November 30, 2021

Administrator
Lb Broen Home
824 South Sheridan
Fergus Falls, MN 56537

RE: CCN: 245453
Cycle Start Date: November 17, 2021

Dear Administrator:

On November 17, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 17, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 17, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 17, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial

compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 17, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lb Broen Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 17, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 17, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING _____ B. WING _____	C 11/17/2021

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

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F 000	INITIAL COMMENTS On 11/16/21, to 11/17/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED, H5453043C (MN62796) H5453046C (MN57959) however NO deficiencies were cited due to actions implemented by the facility prior to survey. AND The following complaints were found to be UNSUBSTANTIATED, however related deficiencies were cited. H5453040C (MN56897), with no deficiencies. H5453041C (MN59198), with no deficiencies. H5453042C (MN61252), with no deficiencies. H5453044C (MN63288), with no deficiencies H5453045C (MN72927), with a deficiency cited at F609. Additionally, during the course of the survey, F880 was cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F 000		

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

Electronically Signed | 12/10/2021

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		12/21/21

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F 609	Continued From page 2 by: Based on interview and document review, the facility failed to ensure incidents of injury of unknown origin were immediately reported to the State Agency (SA), no later than 24 hours after knowledge of a major injury with an unknown cause, for 1 of 2 residents (R1) reviewed for allegations of abuse. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/9/21, identified R1 had diagnoses which included: end stage renal disease, osteoarthritis, anemia and depression. The MDS identified R1 was cognitively intact and required extensive assistance with activities of daily living (ADL's.) R1's current care plan revised, 10/4/21, revealed R1 was alert, oriented, a vulnerable adult and had a behavior problem of making inappropriate comments to staff and stating untrue stories. The care plan revealed R1 was to have male caregivers, would use two staff if only female staff were available and any new reports of complaints or "stories" would be reported to the charge nurse, social services or unit coordinator for investigation. The care plan further revealed R1 had limited mobility, pain, had a hip replacement and required extensive assistance with ADL's. R1's progress note dated 5/11/21, revealed during a follow up orthopaedic appointment, R1 had x-rays which found his right hip was dislocated. R1 had been transferred to the local emergency room and was subsequently transferred to Sanford in Fargo (out of state hospital) where R1 had his right hip replaced the prior month.	F 609	R1 Expired on 10/3/2021. All current residents are considered to be vulnerable adults and have the potential to have an injury of unknown source. All resident□s records will be reviewed for the past 3 months to identify any potential injuries of unknown source. Any identified unreported events will be reported immediately to the Administrator and the state agency per policy. LB Broen Home□s Vulnerable Adult Abuse Prevention Program was reviewed, and the following changes made: 1. Adverse Event Report reviewed and updated to include a section on injuries of unknown source, including definitions and requiring a yes/no answer for Does this fit the definition of an injury of unknown source. 2. The LB Broen Home Vulnerable Adult Act: Internal Investigation Record BMH #5014-02 was reviewed and updated to include a section on injuries of unknown source definitions and requiring a yes/no answer for Does this fit the definition of an injury of unknown source. 3. The Vulnerable Adult: Recognizing and Reporting Abuse, Neglect, Exploitation, or Mistreatment Audit, BH # 1329-20 was updated to include additional examples of injuries of unknown source. 4. The Daily Progress Note Review by the Night Charge Nurse Form #1332-20 was updated to include residents who had been discharged that day. 5. Daily Progress Note Review by the Night Charge Nurse was reviewed and unchanged.	

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F 609	Continued From page 3 R1's progress note dated 5/14/21, revealed R1 returned to the facility following right hip replacement for his dislocated hip. R1's medical record lacked any information of the SA report submitted on 5/16/21, in which R1's family member reported R1 had told her, therapy had dislocated his hip a week prior. The facility SA report reviewed identified an allegation of abuse was made on 5/16/21, at 3:40 p.m. in which R1's family member alleged physical therapy had not followed instructions and pulled R1's hip out of its socket which resulted in a hip dislocation, which was noted upon a follow up orthopedic appointment on 5/11/21. On 11/17/21, at 8:47 a.m. R1's medical record was reviewed with the director of nursing (DON). The DON confirmed R1 had been found to have a dislocated right hip on 5/11/21, during a follow up orthopedic appointment which required surgical intervention. The DON confirmed she was not aware of how R1's hip dislocated and indicated the source of R1's major injury was not known. The DON confirmed a report should have been submitted to the SA on 5/11/21, when R1's hip dislocation was first noted. The DON confirmed prior to his appointment on 5/11/21, R1 had no new falls, no reports of increased pain and had not verbalized any concerns with therapy staff. The DON stated R1's last day of therapy had actually been on 4/29/21, and he had refused restorative therapy with nursing staff. Review of the facility policy Vulnerable Adult Act/Abuse Prevention Plans last revised 2/2019, indicated all alleged violations involving abuse,	F 609	6. The Vulnerable Adult Reporting Requirements Audit BH #1321-19 was reviewed for comprehensiveness and unchanged. Education, counseling, and disciplinary action was issued to individuals related to this event that was not reported within the timeliness of reporting the event, RN Unit Coordinator and DON, regarding timeliness of reporting potential injuries of unknown source, following prescribed policy and procedure, regardless of whether the resident is currently within the facility. Re-education occurred using the Freedom from Abuse, Neglect, Misappropriation, and Exploitation Power Point presentation on 12/8/2021. Competency was successfully completed by these staff members following re-education. They will also participate in the Survey Correction education, competencies, and audits. All Staff Meeting scheduled 12/10/21 will include 1. Re-education on identification and reporting requirements of potential abuse, neglect, exploitation, and maltreatment incidents 2. Will review updates to the Vulnerable Adult Abuse Prevention Program Forms and emphasize the identification and reporting requirements of injuries of unknown source and reporting requirements for all abuse, neglect, misappropriation, and exploitation. Audits will be completed to assure compliance: 1. The Vulnerable Adult: Recognizing and Reporting Abuse, Neglect,	

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F 609	Continued From page 4 neglect, exploitation, injury of unknown source or mistreatment were to be reported immediately but not later than 2 hours after the allegations are made. The facility will thoroughly investigate all alleged violations and prevent further potential abuse while the investigation is in process.	F 609	Exploitation, or Mistreatment Audit form BH #1329-20 will be completed on all units, on all shifts, weekly x 4 weeks. 2. The Vulnerable Adult Reporting Requirements Audit BH#1321-19 will occur on all units, on all shifts, weekly x 4 weeks. 3. The Daily Progress Note Review by the Night Charge Nurse Audit, form BH #1333-20 will be completed weekly x 4 weeks. These Audits will remain on the nursing audit system for completion on all units quarterly ongoing. The DON will monitor audit findings and assure prompt follow up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations subcommittee of the Quality Assessment and Assurance Committee and QAPI. 12-21-2021 and ongoing.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		12/21/21

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F 880	Continued From page 5 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 6 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 source control personal protective equipment (PPE) was worn properly. This deficient practice had the potential to affect all 28 residents who resided on the third floor of the facility. Findings include: On 11/16/21, from 2:34 p.m. to 3:18 p.m. during environmental observations, the following was observed: -at 2:34 p.m. licensed practical nurse (LPN)-A was observed to enter the unit from the elevator, wore a blue surgical mask from her chin to underneath her nose (nares observed) and had eye glasses on with no other eye protection observed. LPN-A approached the nurses station, placed items on the chair, proceeded to one of the medication carts and counted controlled medications with a trained medication aid (TMA) whom made no mention of LPN-A's lack of eye protection. LPN-A proceeded to the second medication cart and counted the controlled medications with another LPN, whom also made	F 880	Please see uploaded attachments for DPOC F880. All current residents are at risk for contracting COVID-19 from staff not wearing source control. All current residents will be served by staff wearing the appropriate PPE in the appropriate manner. All staff will assure understanding of when and how to use source control and/or PPE. LPN-A Counseling with disciplinary action and re-education regarding policies related to Source Control and Use of Surgical Facemask as well as current policies of Wearing of Eye Protection During COVID-19 Pandemic and LBH Handbook policy of no eating when on resident care units. LPN-A will also complete the Survey Correction Education and Competencies. The LPN and TMA that were identified as being at the med cart with LPN-A and did not hold her accountable for wearing her eye protection were counseled regarding accountability of co-workers with the	

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F 880	Continued From page 7 no mention to LPN-A on her lack of eye protection. LPN-A then approached the counter in the common area, grabbed a cookie from a plastic container, removed her mask below her chin and proceeded to walk down the east hallway while she ate the cookie. At that time, three residents were in the common area within six feet of LPN-A when she removed her mask. LPN-A then went to a room with several facility staff for shift change report. -at 2:52 p.m. LPN-A was observed to walk out of the report room, she had no eye protection on and her blue surgical mask covered her mouth however lacked coverage over the nares of her nose. LPN-A walked to the common area, a resident approached her and LPN-A bent down to speak with the resident without eye protection or her face mask covering her nose. LPN-A then moved to the medication cart, adjusted her surgical mask to cover the nares of her nose. -at 3:10 p.m. LPN-A stood at a medication cart, wore a surgical mask which covered her mouth and the lower part of the nares of her nose and continued to have no eye protection on. At that time, LPN-A bent down to speak to an unmasked resident and was within 24 inches of the residents unmasked face. On 11/16/21, at 3:16 p.m. during an interview, registered nurse (RN)-A stated it was expected facility staff wear PPE which included eye protection and a medical grade face mask which covered the mouth and nose at all times while in resident areas for source control to help protect against COVID-19. RN-A confirmed LPN-A was not wearing eye protection and was not wearing the face mask properly.	F 880	Wearing of Eye Protection Policy. Following completion of review of Policies and Procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care; Source control masks; eye protection, proper use of gowns, and standard and transmission-based precautions it was determined that the following policies needed to be updated or revised: 1. PPE, Optimization of During Times of Scarce Resources was updated to include the new updates regarding Conventional, Contingency, and Crisis Capacity Strategies for all PPE 2. Standard Precautions: PPE was updated to include reference to PPE, Strategies for Optimizing Use of During Times of Scarce Resources and referred donning and doffing practices to the PPE Donning/Doffing Competency Checklist 3. Transmission Based Precautions updated to include reference: Appendix A CDC Type and Duration of Precautions Recommended for Selected Infections and Conditions; LB Homes Transmission-Based Precautions Signs; exception to airborne transmission for COVID-19, and the PPE, Strategies for Optimizing Use of during Times of Scarce Resources. 4. Surgical Facemasks, Use of was updated to include the fit of the mask including the areas of the face which should be covered such as the chin, nose, and mouth 5. Suspected or Confirmed Coronavirus,	

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	245453	A. BUILDING _____ B. WING _____	C 11/17/2021

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F 880	Continued From page 8 On 11/16/21, at 3:18 p.m. LPN-A stated she had forgotten to apply eye protection prior to starting her shift and indicated it was her usual process to apply eye protection when she completed her screening prior to starting her shift. LPN-A stated it was not her usual practice to have her facemask placed below her nose and normally would not have eaten in areas where residents resided. On 11/17/21, at 10:43 a.m. the director of nursing (DON) stated she expected all facility staff to wear PPE which consisted of a surgical face mask, worn over the nose and mouth and eye protection for staff who were to have contact with residents as part of the facility's COVID prevention plan. A facility policy titled, LB Homes Eye Protection During COVID-19 Pandemic, Wearing of dated June 2021, identified all healthcare workers were expected to wear an approved form of eye protection while in the facilities of LB Homes. The facility identified staff were to apply eye protection prior to any close contact with staff or residents. A facility policy titled, LB Homes Use of Surgical Facemasks, dated March 2021, identified all healthcare workers were expected to wear a surgical facemask at all times while in the facilities of LB Homes. The facility policy lacked any information on the fit of surgical masks and what areas of the face the facemask should have covered such as the nose and mouth.	F 880	PPE section updated to include fit of surgical masks as source control 6. Screening Procedure: COVID-19 was updated to include updated education to visitors Visitation Risks and Responsibilities, updated References CMS and CDC. It was also determined that there was not a competency for source control and screening procedures. Competency/Skills: Screening and Source Control Form # LBH #1072-21 was created. It was determined that the audit for Donning and Removing PPE was not a real time audit, and the existing audit was being used as a competency. Competency Checklist: Donning and Removing PPE BH# 1281-17 was updated to be inclusive of shoe covers, N95s, and PAPR as well as a well-fitting mask over the chin, mouth, and nose. All Staff Meeting scheduled 12/10/21 will include: 1. Education regarding standards and expectations of source control mask and eye protection-how and when to wear it as well as how to hold all staff accountable to that standard 2. Types of Personal Protective Equipment (PPE) to wear for various transmission-based precautions and how to use PPE including donning and doffing and the difference of conventional, contingency, and crisis capacity strategies. 3. Education regarding the importance and expectations of not eating in the resident care areas 4. How to help prevent COVID fatigue	

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F 880	Continued From page 9	F 880	5. How to help hold each other accountable with the wearing of source control and PPE 6. Education regarding Policy updates, new policies, new audits, and competencies. 7. Post test to assure Competency of education. Competencies: 1. Donning and Doffing PPE BH 1281-17-Will be completed by all nursing staff and housekeeping staff. Other departments will be on an as needed basis. 2. Screening and Source Control Competency Form # LBH 1072-21 will be completed by all staff Audits created to assure appropriate PPE and source control used by all staff: 1. Transmission Based Precautions during Covid-19 Pandemic: Observable use of PPE Audit Form will be completed on all units, all shifts, weekly x 4 2. Source Control during COVID-19 Pandemic: Observable use of PPE Audit Form # 1364-21 will be completed 4 x/week x 1 week, then 2x/wk x 1 wk, audit will continue until 100% compliance is met 3. Source Control during COVID-19 Pandemic: Knowledge of Appropriate PPE Use Audit Form # BH 1363-21 will be completed 4 x/week x 1 week then 2 x/week x 1 week, audit will continue until 100% compliance is met. 4. Aerosolizing Generating Procedures PPE audit will be completed on all units, all shifts weekly x 4. 5. PPE Gown Audit will be completed on all units, all shifts weekly x 4.	

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F 880	Continued From page 10	F 880	These Audits will remain on the nursing audit system for completion on all units quarterly ongoing. The DON will monitor audit findings and assure prompt follow up of potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations subcommittee of the Quality Assessment and Assurance Committee and QAPI. 12-21-2021 and ongoing. See uploaded attachments for DPOC F880	

Electronically delivered
November 30, 2021

Administrator
Lb Broen Home
824 South Sheridan
Fergus Falls, MN 56537

Re: State Nursing Home Licensing Orders
Event ID: 0JLQ11

Dear Administrator:

The above facility was surveyed on November 16, 2021 through November 17, 2021 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 Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00862	A. BUILDING: _____ B. WING _____	C 11/17/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/16/21, to 11/17/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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

Electronically Signed | 12/10/21

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5453043C (MN62796) H5453046C (MN57959) , however, no licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5453045C (MN72927), however, a related licensing order was issued at (S1980). The following complaints were found to be UNSUBSTANTIATED, with no deficiencies. H5453040C (MN56897), with no deficiencies. H5453041C (MN59198), with no deficiencies. H5453042C (MN61252), with no deficiencies. H5453044C (MN63288), with no deficiencies 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 surveyor's 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 14-01, available at https://www.health.state.mn.us/facilities/regulatio	2 000		

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2 000	Continued From page 2 n/infobulletins/ib14_1.html 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to	21980		12/21/21

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21980	Continued From page 3 believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of injury of unknown origin were immediately reported to the State Agency (SA), no later than 24 hours after	21980	Corrected	

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21980	Continued From page 4 knowledge of a major injury with an unknown cause, for 1 of 2 residents (R1) reviewed for allegations of abuse. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/9/21, identified R1 had diagnoses which included: end stage renal disease, osteoarthritis, anemia and depression. The MDS identified R1 was cognitively intact and required extensive assistance with activities of daily living (ADL's.) R1's current care plan revised, 10/4/21, revealed R1 was alert, oriented, a vulnerable adult and had a behavior problem of making inappropriate comments to staff and stating untrue stories. The care plan revealed R1 was to have male caregivers, would use two staff if only female staff were available and any new reports of complaints or "stories" would be reported to the charge nurse, social services or unit coordinator for investigation. The care plan further revealed R1 had limited mobility, pain, had a hip replacement and required extensive assistance with ADL's. R1's progress note dated 5/11/21, revealed during a follow up orthopaedic appointment, R1 had x-rays which found his right hip was dislocated. R1 had been transferred to the local emergency room and was subsequently transferred to Sanford in Fargo (out of state hospital) where R1 had his right hip replaced the prior month. R1's progress note dated 5/14/21, revealed R1 returned to the facility following right hip replacement for his dislocated hip. R1's medical record lacked any information of the	21980		

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21980	Continued From page 5 SA report submitted on 5/16/21, in which R1's family member reported R1 had told her, therapy had dislocated his hip a week prior. The facility SA report reviewed identified an allegation of abuse was made on 5/16/21, at 3:40 p.m. in which R1's family member alleged physical therapy had not followed instructions and pulled R1's hip out of its socket which resulted in a hip dislocation, which was noted upon a follow up orthopedic appointment on 5/11/21. On 11/17/21, at 8:47 a.m. R1's medical record was reviewed with the director of nursing (DON). The DON confirmed R1 had been found to have a dislocated right hip on 5/11/21, during a follow up orthopedic appointment which required surgical intervention. The DON confirmed she was not aware of how R1's hip dislocated and indicated the source of R1's major injury was not known. The DON confirmed a report should have been submitted to the SA on 5/11/21, when R1's hip dislocation was first noted. The DON confirmed prior to his appointment on 5/11/21, R1 had no new falls, no reports of increased pain and had not verbalized any concerns with therapy staff. The DON stated R1's last day of therapy had actually been on 4/29/21, and he had refused restorative therapy with nursing staff. Review of the facility policy Vulnerable Adult Act/Abuse Prevention Plans last revised 2/2019, indicated all alleged violations involving abuse, neglect, exploitation, injury of unknown source or mistreatment were to be reported immediately but not later than 2 hours after the allegations are made. The facility will thoroughly investigate all alleged violations and prevent further potential abuse while the investigation is in process.	21980		

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21980	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review the facility polices in regards to reporting of allegations of mistreatment to the State Agency. The administrator and/or designee could educate staff on ensuring reports are submitted in a timely manner. The administrator or designee could routinely monitor to ensure reports are submitted in a timely manner. TIME PERIOD FOR CORRECTION: Fourteen (14) days	21980		