



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 17, 2026

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

RE: CCN: 245453

Cycle Start Date: May 19, 2026

Dear Administrator:

On June 25, 2026, we notified you a remedy was imposed. On August 6, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 31, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 10, 2026, be discontinued as of July 31, 2026. (42 CFR 488.417 (b))

In our letter of June 25, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 4, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

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

June 25, 2026

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

RE: CCN: 245453

Cycle Start Date: May 15, 2026

Dear Administrator:

On May 26, 2026, we informed you that we may impose enforcement remedies.

On June 4, 2026, the Minnesota Department(s) of Health and Public Safety completed a revisit/survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety.

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On June 3, 2026, the situation of immediate jeopardy to potential health and safety cited at F689 - Free of Accident Hazards/Supervision/Devices was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 10, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 10, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 10, 2026.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, LB BROEN HOME is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 4, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 November 19, 2026 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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,



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

June 25, 2026

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

Re: Event ID: 2341D2-H1

Dear Administrator:

The above facility survey was completed on June 4, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 16, 2026

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

RE: CCN: 245453

Cycle Start Date: May 19, 2026

Dear Administrator:

On June 25, 2026, we informed you of imposed enforcement remedies.

On July 6, 2026, the Minnesota Department of Health completed a revisit and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

F689 - Free of Accident Hazards/Supervision/Devices

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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 10, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 10, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 10, 2026.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 \$13,343, 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 July 10, 2026, 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 July 10, 2026.

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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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 November 19, 2026 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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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)

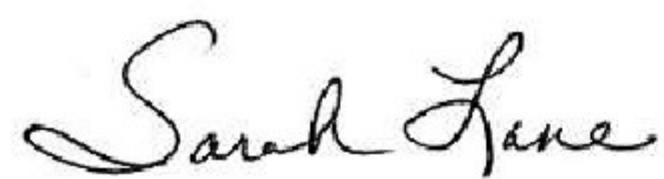
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP

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.

Feel free to contact me if you have questions.

Sincerely,



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

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 06/04/2026	
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
F0000	INITIAL COMMENTS On 6/1/26, through 6/4/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H54532645C (3026884) with a deficiency issued at F689. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to provide adequate supervision for R1 while outside in extreme temperatures without protection and resulted in serious, life-threatening harm when found slumped over with extreme hyperthermia. R1 was sent to the emergency department (ED) via ambulance and admitted to hospital for further management of heat stroke and pneumonia. The IJ began on 5/27/26, and the immediacy was removed on 6/3/26 at 4:50 p.m. The above findings constituted substandard quality of care, and an extended survey was conducted on 6/3/26 and 6/4/26. 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 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.			F0000			06/29/2026
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.			F0689	The facility failed to provide adequate supervision to prevent a hazard over which the facility had control for 1 of 1 resident (R1) while outside in extreme temperatures without protection which resulted in serious, life-threatening harm when R1 was found slumped over in a chair and unresponsive.		07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 1 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to provide adequate supervision to prevent a hazard over which the facility has control for 1 of 1 resident (R1) while outside in extreme temperatures without protection which resulted in serious, life-threatening harm when R1 was found slumped over in a chair and unresponsive. R1 was transferred to a hospital for evaluation and treatment for extreme hyperthermia. The immediate jeopardy began on 5/27/26 at 4:00 p.m., when the facility failed to provide adequate supervision to R1 who notified staff he was going to sit outside at approximately 2:30 p.m. R1 required assistance from staff for ambulation, was allowed to independently ambulate out of the facility, to the pond area. The temperature outside was 95 degrees Fahrenheit (F), sunny, with no cloud coverage, or wind present (accuweather.com). R1 wore long sleeves and pants, without water or a way to call for assistance. R1 was found at approximately 4:15 p.m. slumped over in a chair and unresponsive. R1 was evaluated by emergency services (EMS), findings included: body temperature was 105.8 F, tachycardia (rapid heartrate) 100 to 120 beats per minute, and tachypnea (rapid breathing) respirations 36. R1 was admitted to hospital with diagnoses including heat stroke and pneumonia. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 6/2/26 at 6:30 p.m. The immediate jeopardy was removed on 6/3/26 at 4:50 p.m., but noncompliance remained at the lower scope and severity level D (isolated, scope and severity level) which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's annual Minimum Data Set (MDS) dated 4/30/26, identified R1 was admitted to the facility on 3/1/25, from a hospital. R1 had intact cognition and no behaviors. MDS noted it was very important to R1 to get fresh air when the weather was good. R1 was			F0689	Continued from page 1 R1 was hospitalized 5/27-5/29/2026, returning with OT and PT evaluation orders. R1 had been receiving OT and PT services prior to 5/27/2026 emergency department transfer and required assistance from staff for ambulation as noted on the residents' care plan. Upon R1s hospital return 5/29/2026, Sam Schaefer, RN (identified as LPN-B on the 2567), met with R1 to discuss the pond area as a seating area not recommended for use. R1 was assessed on 6/3/2026 by Amber Volk, DPT, with therapy communication to nursing form reading, "Able to ambulate outside on concrete surfaces, with 4WW (four wheeled walker), in front of Main Entrance independently." R1's care plan was updated to reflect this determination. 6/3/2026 the safety concern notification titled "Safety Concern Identified – Effective Immediately" was delivered to R1 by Amy Nelson, DON, with notification of removal of seating from the area near the outside pond site. R1 was encouraged to use the front entrance seating area to get fresh air when the weather allowed. All residents residing in the facility have the potential to be affected by this deficient practice. Specifically, five additional residents were identified as cognitively intact and capable of independently ambulating or operating a motorized wheelchair, placing them at risk for a similar adverse outcome if adequate supervision and safety measures are not implemented. The safety concern notification titled "Safety Concern Identified – Effective Immediately", as noted above, was delivered to all facility residents on 6/3/2026. The facility has revised and implemented the following policies and procedures and forms to address the identified system failure and prevent recurrence of a serious adverse outcome: Nursing Department Resident Care Communication System Policy (revised to include care plan location), LB Broen Home Nursing Assistant Worksheet, form number BMH #1098-98 (revised to include additional column regarding if resident is able to go outside independently), Therapeutic Leave and Short-Term Leave Policy (updated to LB Broen Home from past verbiage of Broen Memorial Home), Therapeutic Leave and Short-Term Leave, Release of Responsibility, form number BMH #680-94 (updated to LB Broen Home from past verbiage of Broen Memorial Home.) The facility has additionally developed and implemented a new Designated Outside Seating Area Policy that defines the roles and responsibilities of maintenance staff, nursing staff, and residents		07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 2 independent for all cares, transfers, and walked 150 feet once standing in a corridor or similar place independently with a walker. Medical diagnoses included: debility (state of weakness due to illness or old age) due to cardiorespiratory conditions, atrial fibrillation (two upper chambers of the heart beat irregularly, too fast, quivering instead of contracting properly increasing a person's risk of blood clots), congestive heart failure (CHF), hypertension (HTN) (high blood pressure), renal failure/insufficiency, diabetes mellitus (DM) insulin dependent, asthma, macular degeneration (decreased and/or loss of central vision due visual field deficit), and muscle weakness. R1 had dyspnea (shortness of breath or trouble breathing with exertion) (e.g. walking, bathing, transferring), and on oxygen. R1's physician orders identified: -Oxygen (O2) 1 liter (L) in both nostrils every shift to keep SaO2 (arterial oxygen saturation) above 89% (1 to 5 L per nasal cannula (NC)). Titrate as able. Start date: 5/14/26. R1's 5/2026, electronic medication administration record (EMAR) identified O2 use was documented starting on evening shift on 5/14/26 through 5/26/26 night shift (all three shifts) set at 2L to 2.5L with SaO2 ranging from 92 to 98%. Additionally, on 5/27/26 during day shift R1 was documented as using oxygen at 2L with SaO2 at 96%. R1's Saint Louis University Mental Status (SLUMS) (examination used to detect mild cognitive impairment and dementia) dated 4/16/26, identified score of 14 out of 30, to indicate dementia (less than high school education scoring used) (25 to 30 – normal, 20 to 24 mild neurological disorder, and 1 to 19 dementia). R1's Cognitive Area Assessment (CAA) dated 4/25/26, identified R1 had a poor memory, respiratory distress, and was administered diuretics (remove excess fluid and salt from the body by increasing urine production), anticonvulsants (taken for nerve pain). R1's care plan dated 5/17/26, identified: Risk for decreased cardiac output due to heart failure. Staff were directed to evaluate skin color, temperature, and characteristics and provide oxygen as indicated by condition and provider order. Date initiated/created: 4/3/25.			F0689	Continued from page 2 regarding the use of designated outdoor areas deemed safe for independent resident use based on location, access, and protection from direct sun exposure. All LB Homes Staff were notified of the Designated Outside Seating Areas Policy via email 6/03/2026. The LB Homes All Teams Meeting July 1, 2026, will include a review of policy and procedure changes and of the responsibility of all employees for resident supervision and safety. Care plans were updated for residents able to independently ambulate on facility grounds. Detailed education was provided to all nursing staff regarding the revised and newly implemented policies and procedures. Maintenance staff were educated regarding the details of the designated seating areas. Nursing staff education included step-by-step instruction on how to access and review a resident's care plan, including transfer and ambulation status, staff expectations for when a resident chooses to go outside, and the safety measures implemented to ensure resident supervision. Nursing staff education began 6/03/2026 on the day shift, by Amy Nelson, Director of Nursing. Education was provided in person for the day shift staff and continued at the beginning of the evening and night shifts. Charge nurses were educated and continued to educate additional staff when they arrived for their shifts. Staff have or will sign and date an attendance sheet once education is completed. Casual nursing employees, those nursing employees who do not work regularly scheduled shifts, have or will receive education before their next shift worked. All nursing staff have or will complete a knowledge check. The LB Broen Home Resident Safety and Supervision Policy was created and implemented to further support resident safety. This policy addresses the responsibility of the facility and all staff to ensure the resident environment remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistive devices to prevent accidents. NAR-A was reeducated by the DON, 6/3/2026. NAR-A is no longer employed at LB Broen Home. LB Broen Home Nursing Care Audit, form number BH #1396-26, was created and implemented to monitor compliance related to resident outdoor activities. This audit includes review of the following: If a resident wishes to go outside, did staff check the residents care plan or Nursing Assistant Worksheet to determine if the residents can go outside? If able to go outside independently, did the resident sign out on the Therapeutic Leave		07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 3 Activities of daily living (ADLs) self-care performance deficit related to disease process, heart disease and muscle weakness. Staff were directed to provide wheelchair if required continuous oxygen use or experiencing increased weakness. R1 required assistance of one with dressing, transfers, and ambulation. Ensure call light was within reach. Date created/initiated: 6/27/25. R1 was dependent upon staff for activities for cognitive stimulation, social interaction, related to physical limitations. Staff were directed to assure the activities R1 was attending were compatable with physical and mental capabilities. R1 had the potential for fluid deficit related to diuretic use to manage CHF. Staff were instructed to ensure he had access to cold water whenever possible and monitor intake and output. Date initiated/created: 4/3/25. R1 was at risk for ineffective breathing patterns and impaired gas exchange related to chronic obstructive pulmonary disease (COPD) and CHF. Staff were directed to administer/monitor effectiveness of oxygen therapy as ordered and encourage fluid intake. Date initiated/created: 4/3/25. R1 was at moderate risk for falls related to deconditioning and balance problems. Staff were instructed to anticipate and meet R1's needs, be sure R1 had call light within reach and encourage use for assistance. R1 required prompt response to all requests for assistance. Date initiated/created: 5/17/26. Nursing assistant (NA) worksheet, undated, received printed copy on 6/1/26, identified R1 transfer/locomotion: transfer with assist of one, transfer belt, wheelchair as needed (PRN) and ambulation assist of one, transfer belt, wheelchair to follow. Special needs/requests: oxygen (handwritten in black: PRN). Nursing staff shall: revise worksheet whenever care plans are changed and follow worksheet and care plan directions when delivering care. R1's elopement assessment dated 4/28/26, identified low risk for elopement. R1 was able to ambulate independently on and off the unit. During the summer months he often sat outside. He was alert and oriented, made no attempts to leave the facility, and was not at risk for elopement. Occupational Therapy (OT) treatment encounter note dated 5/27/26 at 11:45 a.m., identified transfers with			F0689	Continued from page 3 and Short-term Leave, Release of Responsibility form, BMH #680-94? Did staff offer/provide climate appropriate items (sunscreen, water, coat, hat, gloves, etc.)? Did staff set a timer to ensure completion of 15-20 minute checks? This audit will be completed weekly for four 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). The All Team Meeting, a mandatory all employee semi-annual meeting, is scheduled for Wednesday, July 1, 2026, at 2:00pm. The Resident Safety and Supervision Policy, the Nursing Care Audit, as noted above, and the expectation that it is the responsibility of all staff to ensure the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents will be presented and reinforced by Lisa Vogel, Administrator. July 2, 2026 and ongoing.		07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 4 assist of one and four wheeled walker. R1 had oxygen needs and frequent rest breaks, dyspnea (shortness of breath) with exertion, and low endurance. Instructed in bilateral upper extremity exercises to increase strength for improved performance in ADLs and functional transfers. R1 complained of weakness in bilateral knees and required subsequent verbal/visual cueing throughout exercises due to poor recall of technique. R1's progress notes reviewed 5/27/26 through 6/1/26, identified: On 5/27/26 at 4:30 p.m., writer got a call at 4:06 p.m., R1 was not responding, and she needed to go outside. Writer promptly ran to where R1 sat behind the facility building by the pond in a stationary chair with head down. Resident color was pink and skin was warm to touch. Face appeared to be deep pink in color. R1's pulse was palpated, present and strong but irregular. Writer asked staff to call 9-1-1 and get emergency services on their way. Staff reported R1 was not wearing oxygen correctly and they reapplied it. R1's O2 tank was in the red when writer assessed it and asked staff to grab an O2 tank and oximeter. Writer was unable to get R1 to arouse to verbal stimulation, ineffective. Writer completed sternal rub to try to awake R1, he opened his eyes, moaned to writer, and was unable to talk. R1's SaO2 was 80% on 2.5L and writer titrated O2 up to 5L via NC. Writer called more staff and brought down automated external defibrillator (AED) (portable medical device used to save lives during a sudden cardiac arrest, automatically analyses the heart's rhythm and delivers an electrical shock to help the heart re-establish and effective beat) and cardiac pulmonary resuscitation (CPR) supplies. Emergency services had arrived and took over. Paperwork faxed to local area hospital. Another staff member stated they were going to call family. On 5/27/26 at 7:56 p.m., received phone call from local hospital. They are keeping R1 overnight for observation, he was looking better. On 5/27/26 at 10:25 p.m., received phone call and updated on resident status. On 5/29/26 at 12:04 p.m., R1 was admitted back to the facility. R1 was in good spirits and appeared to be back to baseline and getting up and moving independently from nurse to nurse. Had bowel movement and off O2 since 6:00 a.m. Orders for O2 to be PRN. R1 reported he had received insulin in the hospital one time a day and wanted that here and utilizing O2 at night.			F0689			07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 5 On 5/29/26 at 1:31 p.m., Writer talked to R1 about him going outside without alerting staff and sat out by the pond, he should have alerted staff when leaving the building and was not recommended to sit out by the pond. Resident stated, “maybe I went down there to die.” R1 mentioned he was upset with his family about wanting him to stay here long-term and he wanted to leave and go to Wadena. R1 reported he felt depressed lately. Writer reassured R1 that we were here for him and that we only want the best for him. R1 in agreement to wait to talk to provider about his code status and concerns. On 5/29/26 at 2:43 p.m., DON (director of nursing) discussed with resident his comment made about maybe went down there to die, referring to sitting in the back of the building by the pond. R1 stated he was feeling disgusted and was upset with his family for wanting him to stay here and he wanted to go back to Wadena. When he was questioned further about wanting to die, denied wanting to harm himself and did not have a plan in place to cause himself harm. R1’s electronic medical record vital signs identified on 5/27/26 at 7:04 a.m. R1's oral temperature was 98.0 F., blood pressure was 118/80 (sitting), heart rate was 66 beats per minute, oxygen saturation level (SaO2) was 96%, and respirations were 20 breaths per minute. Facility document, Transportation Drive Scheule dated 5/27/26, identified: resident appointments were scheduled for 6:30 a.m., 8:50 a.m., 9:00 a.m., 10:00 a.m., 10:10 a.m., 10:20 a.m., and 1:00 p.m. The driver returned to the facility around 3:30 p.m. and 4:00 p.m. to transport resident(s) back to facility. Per DON, on 5/27/26 the driver drove the van towards the back parking lot where R1 sat by the pond, to get to the street. Vulnerable Adult Maltreatment Report dated 5/28/26 at 1:15 p.m., identified a male resident [R1] was found alert to voice but unable to follow commands. Nursing staff stated the patient had been sitting outside for the last approximately 90 minutes in 95-degree weather. Staff stated they had driven by the patient a few times and saw him moving but no official checks came until about 4:05 p.m. Patient was unresponsive to all stimuli and slumped in his walker for staff. His eyes were open and attempted to track but showed no motor activity in extremities or core. Patient was extremely hot to touch and red in color. Patient was assisted to standing with EMS			F0689			07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 6 assistance, dead body weight, and moved to the cot. Patient began to move his arms and groan but was unable to make distinct movements or words. While in ambulance, patient would open his eyes when spoken to but had no other motor response to physical stimuli. Stroke assessment was unable to be completed. Crew initiated cooling measures with groin placed in ices packs and cooled air during transporting due to suspected heat stroke. Patient had strong radial pulse through contact, did not appear to be in any respiratory distress but was reported to have an initial SaO2 of 85% for staff. Oxygen was applied by nursing staff prior to EMS arrival which brought his SaO2 up to mid-90's. Patient was transferred to the closest local hospital ED (emergency department) and continually monitored through transport to ED where handoff report was given to nursing staff who were able to take over further evaluation and care. ED visit note dated 5/27/26 at 7:42 p.m., identified R1 had significant cardiopulmonary and metabolic comorbidities (two or more conditions that occur together can interact in ways that affect your approach to managing your health) with acute altered mental status after being found slumped over outdoors with extreme hyperthermia (105.8-degree F temperature), tachycardia, and tachypnea. Clinical picture is most concerning for heat stroke given environmental exposure, markedly elevated temperature and central nervous system (CNS) dysfunction. Broad work up initiated to rule out alternative etiologies (causes or origins of disease or condition) and assess for severe effects of prolonged heat exposure. Aggressive cooling measures initiated including application of ice packs, removal of patient's fluid within, IV fluid boluses, and placement of temperature sensing catheter for close monitoring of core body temperature and accurate tracking of intake/output. Elevated ventricular heart rate likely secondary to hyperthermia. Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: cardiac failure, circulatory failure, and CNS failure or compromise. Hospital admission note dated 5/27/26 at 7:44 p.m., identified R1 presented to emergency room (ER) with heat related illness. He stated he was near a pond for a couple of hours, and staff found him slumped over in the chair. He felt quite unwell and had a decreased level of responsiveness and brought to ER. R1 was quite warm at that point, no fever or chills prior to this incident. R1's initial temperature in ER was 105.8 F, heart rate 100 to 120's in atrial fibrillation in rapid ventricular response (RVR)			F0689			07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 7 (occurs when heart rate was over 100 beats per minute, prevents the heart from filling properly, drastically reducing blood flow, and oxygen delivery resulting in a serious condition that can lead to blood clots, stroke, or heart failure if not managed) hemodynamically stable (blood flow was sufficient in the body). Respirations were tachypneic with initial respiration rate at 36 per minute. All vitals normalized (HR, temperature and respirations) after intravenous fluids (IV) and external cooling with ice packs. R1 was noted to have some diffuse wheezes upon exam. Initial lactic acid (indicate your body tissues are stressed or not receiving enough optimal oxygen) was moderately elevated at 2.5 millimoles per liter (mmol/L) (normal range: 0.7 – 2.1 mmol/L). Chest x-ray showed evidence of left lower lung infiltrate (an abnormal substance such as fluid, pus, or cells) was abnormal. Procalcitonin (a biomarker that spikes rapidly in the blood stream during serious bacterial infections and sepsis) was elevated at 0.51 nanograms per milliliter (ng/ml) (over 0.50 ng/ml: High. Serious bacterial infection, sever sepsis, or septic shock are very likely, indicating a strong need for antibiotic treatment). R1 was admitted for further management of heat stroke and pneumonia and started on Levaquin and Doxycycline (antibiotics) and IV fluids given. In patient treatment required for heat stroke, pneumonia, and COPD. Hospital discharge summary dated 5/29/26 at 9:26 a.m., identified discharge back to facility with discharge diagnoses: hyperthermia likely related to heatstroke, acute heatstroke, left lower lobe pneumonia, acute COPD exacerbation. Hospital problem list: acute kidney injury (AKI), heat stroke and bacterial pneumonia. Admitted on 5/27/26 at 9:55 p.m. from ED and discharged on 5/29/26 at 10:50 a.m. At this time R1 was on room air but will discharge him with 2L O2 per NC on PRN basis (his baseline) and follow-up with primary provider in one week. During an interview on 6/1/26 at 10:50 a.m., nursing assistant (NA)-C stated R1’s memory was good, remembered most things talked about. R1 had no behaviors, accepted assistance with care, required assistance from one staff with transfers and ambulation. R1 was changed to independent with walking with walker this morning (6/1/26). NA-C was unsure if R1 had to be supervised outside, stated she would have to ask someone else. NA-C verified R1’s care plan did not include whether he needed supervision while outside and /or how he could alert staff if he needed help while outside. NA-C stated residents were able to go out and sit by the pond			F0689			07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 8 either by going out through the basement exit door or by exiting the building from the front door, go around to the side of the building and down a slopped road. NA-C stated she had not received any education about residents going outside by the pond. During an interview on 6/1/26 at 11:36 a.m., R1 stated he had lived at this facility since 3/2024, a little over two years. R1 stated he was an outside person no matter what type of weather it was and the other day he passed out by the pond. Staff strapped his oxygen tank onto his walker, and he walked down to the pond from the front door, was down there for about two hours, it was hot out, he was alone and was found slumped over. Staff later told him his oxygen had run out. R1 stated he knew about the pond area because another resident who went there a lot, talked about it. R1 stated, the middle of last week, at 2:30 p.m., he decided to check it out and it was his first time going to the pond. R1 stated he had not been told he could not go down to the pond, was not asked to sign out when he went outside, did not tell anyone he was going, that he remembered, but was aware now he had to let someone know where he was going. R1 stated once he arrived at the pond, he felt warm, and his underarms were sweating with the long-sleeved shirt he had on. R1 stated he had nothing to drink and was not aware he was getting too hot. R1 stated he did not have his cell phone with him, always left it in his room, and had no way to alert staff he needed help. R1 did not remember passing out. R1 stated he remembered NA-B was getting into her car in the parking lot, unsure of what time that was, he waved at her, she waved back. He saw four or five other staff in the parking lot during the time he sat out there but was unsure of their names. R1 stated there were days he felt depressed, wanted to be outside rather than sit around inside, and was lonely. His family did not visit very often, he felt boxed in, isolated, and needed something more to do. R1 stated he was not suicidal, did not want to end his life, and did not need a counselor. During an interview on 6/1/26 at 12:58 p.m., EMS operations manager (OM) stated on 5/27/26 they arrived on scene at approximately 4:30 p.m. Behind the facility, located next to a pond, R1 was in a stationary chair directly in the sun, with a walker next to him. It was 95 degrees outside, sunny without cloud coverage and no breeze. R1 was dressed in a long-sleeved button up shirt and long pants. R1's face, neck, and hands were extremely red and hot to touch. R1 did not appear to have			F0689			07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 9 sunscreen on. OM stated he was not aware of anything near R1 that could be used to contact staff if R1 needed assistance. EMS team was informed by facility staff, R1 had been outside in the sun/heat for at least 90 minutes, staff had driven by him in the parking lot, and no one checked on him. R1 was slumped over in the chair and was unresponsive to verbal stimuli. R1’s eyes were open, he was attempting to track but showed no motor activity in his extremities or core. OM stated he would be concerned about anyone who was found unresponsive out in the heat but it was strange no one physically checked on him. The lack of supervision for almost two hours was concerning to OM. “Anyone can look just fine when someone drove by but they still could have been unresponsive.” OM stated with temperatures in the 90’s, no protection from the sun/heat would have become a health concern within 20 to 30 minutes without access to water. R1 sat by the pond where the reflection of the sun onto the water would have made it even hotter in this situation. R1 was brought into the ER unresponsive, and the cooling process was started. R1 was in serious condition when we arrived, he was close to needing CPR and if it had been a few minutes longer he could have had a cardiac arrest. During an interview on 6/1/26 at 1:20 p.m., NA-B stated she usually parked in the back parking lot. NA-B stated she was very familiar with R1’s past medical concerns such as his respiratory problems, received nebulizer treatments and complained of breathing problems. On 5/27/26 around 3:00 p.m., when she walked to her car, she saw R1 by the pond sitting in a chair in the direct sunlight, alone. NA-B stated she had no idea how long he had been out there, and the sun was hot. Residents should not have been allowed to go outside that day due to extreme heat and if they did staff would be expected to check on them at least every 15 to 20 minutes. She had seen a female resident down by that same pond on other days, thought that resident had the ok to go there. R1 had a history of not telling staff where he was going. NA-B stated it would not have been safe for R1 to walk down the slopped road to the pond area with his walker. NA-B was unsure how he managed to do that safely. NA-B stated she was in her vehicle and drove by R1, he waved at her, she waved back and kept driving. There were no other staff around at the time and she figured the staff on first floor knew he was out there. NA-B stated she should have gone over and checked on him but since he waved, she thought he was ok. During an interview on 6/1/26 at 1:52 p.m., licensed			F0689			07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 10 practical nurse (LPN)-B stated she had worked on 5/27/26. The last time she saw R1 was around lunch time and assumed after that he was in his room napping. She was not made aware R1 went outside and had no idea how long he was out there. LPN-B stated it would have been concerning to have R1 outside in over 90 degrees weather with the sun shining on him. He should not have been allowed outside that day alone in the heat, activities could have sat with him if they were asked. LPN-B did not think R1 had anything to drink while outside that day. LPN-B stated R1 had COPD and was on 2L of oxygen that day. LPN-B checked R1’s oxygen tank levels that morning, was unsure of what time, and the tank was ¾ full. LPN-B stated the tank should have been ok for at least three hours. LPN-B stated she heard it was empty when they found him later that day around 4:00 p.m. LPN-B stated she was sure R1 did not have sunscreen on. R1 was wearing a cap, long sleeved shirt, and shoes or slippers. During an interview on 6/1/26 at 3:11 p.m., NA-D stated the last time she saw R1 on 5/27/26, was in the afternoon walking in the hallway with therapy with his walker. NA-D stated R1 would have been ok to be outside unsupervised, but only right outside the building. NA-D stated she was unaware R1 had gone out of building and down to the pond area. With the temperature outside over 90 degrees, it would not have been safe for him to be out there alone. “It was too hot out. It placed him at risk for a heat stroke. NA-D stated residents are not told to sign the book when they go outside. There should be a way for us to know they are going out there and right now we don’t have anything such as that in place. NA-D stated she was unaware of any interventions or plans in place to help avoid this from happening again. During an interview on 6/2/26 at 10:15 a.m., Oxygen Respiratory Services representative (R) stated a mid-thigh height oxygen tank would last about four to five hours before a resident would run out of oxygen. When the red arrow on the dial was at zero indicated low pressure, less oxygen pushed the patient due to low volume and almost empty. During an interview on 6/2/26 at 11:48 a.m., registered nurse (RN)-B stated on 5/27/26, she had received report by 3:30 p.m. At 4:00 p.m., NA-A informed her R1 was outside. RN-B thought NA-A meant R1 was right outside the front door. “It was the hottest day of the year so far. [R1] had some confusion, was sleepier lately, was not his usual self, was increasingly having shortness of breath (SOB), and was on oxygen.” At 4:15 p.m., RN-B was			F0689			07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 11 informed by LPN-A, R1 was out by the pond in the heat. Staff went to the pond area and 9-1-1 was called. RN-B stated if a resident informed staff they were going outside, they could be monitored through the windows. Those residents, including R1, were considered independent. When outside no one checked on them. The residents were unable to contact staff if they needed assistance while down by the pond or outside anywhere. RN-B stated R1 did not have fluids with him, sat in the sun unprotected, ran out of oxygen, had poor safety awareness and did not realize he needed to stay hydrated in the heat. R1 got heat stroke and was sent to the hospital via ambulance. During an interview on 6/2/26 at 12:50 p.m., the certified occupational therapy assistant director (COTA) stated the residents at this facility do not typically walk on uneven surfaces and are not assessed for that. R1 was assessed as needing supervision while ambulating outside. The COTA stated prior to 6/1/26, R1 required assistance of one staff to walk, with a gait belt and walker and should have had assistance of one when he went out the front door to be outside for safety reasons. R1 was using a four wheeled walker with an oxygen tank attached and placed him at a higher risk for falls. R1 had not been assessed for outdoor ambulation. R1 would not have been safe walking outside alone, on uneven ground, around the building and down to the pond with the walker and oxygen tank. The COTA stated she did not understand how R1 could have gotten around the building and down the slopped road to the pond safely by himself. The slopped road made the COTA nervous due to the speed going down a slope would have pushed him at an angel faster, affected his gait pattern and placed him at a higher risk for falling. Staff would have been expected to be with him, would have expected staff alert therapy of the need to assess R1 for outside ambulation. The COTA stated R1 would not have been safe out in 95-degree weather without shade and no way to call for assistance. During an interview on 6/2/26 at 2:24 p.m., the NA-A stated on 5/267/26 between 2:30 p.m. and 2:45 p.m., R1 was seen walking down the hallway independently without difficulty, “Which was odd because he was supposed to get assistance from one staff. R1 had a white dog on a leash and stated, “I’m going outside to sit by the pond can someone do something with this dog?” R1 handed me the leash and walked out the front door with his walker. This exchange took place near the doorway by the front desk. The NA-A asked no questions of R1, did not have time to ask what pond R1 meant, and			F0689			07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 12 watched him walk out of the front door of the building alone. The NA-A stated her attention was not on R1, the NA-A was more concerned about what she was going to do with the dog and starting her tasks for the day. The NA-A stated normally, if not distracted by a dog and starting her tasks for the day, she would have asked R1 “are you not assist of one?” NA-A recalled R1 was wearing a t-shirt with arms exposed and was unsure of his pants. NA-A stated she was unsure if he had sunscreen on, did not recall if R1 had fluids with him, and R1’s oxygen canister was located on the front of the walker in a holder. NA-A stated she was unaware if R1 was care planned to be outside alone, “Most of the residents on first floor were independent and go out whenever they wanted to. We are expected to check on residents every twenty to thirty minutes through the day.” NA-A stated at 4:00 p.m., the facility transport van driver (TA) approached her and informed her they found R1 sitting down by the pond for a while and it looked like R1 was asleep. The TA informed NA-A, they had driven back and forth through the parking lot between 2:30 p.m. and 4:00 p.m., and saw R1 sitting by the pond numerous times. The NA-A stated she was not sure who was responsible for checking on R1 or if someone was already out there, the NA-A became busy with her tasks and did not think about it. The NA-A verified she did not see anyone go outside with R1 when he left the building but thought there could have been someone waiting outside for him. The NA-A stated it was a hot day and sunny out. As far as the NA-A knew, no one checked on R1. The staff nurse instructed the NA-A and the TA to go down to the pond area, check and see if R1 was ok and tell him to come back into the building. The NA-A and the TA took the van to the back parking lot, where R1 sat by the pond. There were no trees, R1 was in the direct sunlight without protection, with a hat on his head, arms were red, and his oxygen canula was on the back of his neck and not in his nose. NA-A stated R1 did not have a way to contact staff for help while by the pond. The oxygen tank was empty, this was verified by the nurse once she arrived. R1 sat hunched over in a chair located next to the pond and looked like he was sleeping. NA-A rubbed R1’s shoulder and he moved his arm. The NA-A tried to apply the gait belt to get him up and noted he was unable to move and was limp. NA-A stated she checked his pulse on his neck, it was faint. NA-A could hear his irregular breathing; it was slower and louder than normal. R1 had no movement in his shoulder and the rest of his body, his chin was to his chest, and his bottom lip was above top lip. The TA called the staff nurse to come down, indicating R1 was not looking good.			F0689			07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 13 LPN-A came to the pond and started yelling R1's name. LPN-A tried to do a sternal rub to get R1 to respond. R1 moaned like he could hear LPN-A but did not open his eyes. Staff called 9-1-1, NA-A left when the ambulance arrived. NA-A stated staff met at the nurse's station and talked about the incident. NA-A told the LPN-A, R1 informed her he was leaving the building earlier to go to the pond and NA-A was made aware of where he was. During an interview on 6/2/26 at 4:00 p.m. front desk staff/confidential secretary/human resource assistant (HRA) stated she was aware of who R1 was and had seen him go outside without assistance/supervision in the past. The HRA stated she left the front desk frequently to assist staff and residents, the HRA did not remember seeing R1 exit the building on 5/27/26. R1 usually sat outside in front of the building by himself or with other residents. The HRA was expected to stop a resident if they had a wander guard, the HRA was aware those residents could not be left alone or leave the facility. There was not a binder and/or pictures of residents to refer to at the front desk for those residents at risk of elopement or safety concerns going outside. The HRA stated she had not seen staff walking with R1 inside or outside the building for a while now and was unaware of his recent care plan. If R1 came to the front door to exit out of building, the HRA would not have responded unless she saw R1 walk away from the facility. The HRA stated she did not have a good view from the front desk, could only see a small section outside, was unable to see people coming down the parking lot and only a little part of the front entry door. The HRA stated she had never been told which residents were able to go outside without supervision or assistance, aside from those residents with a wander guard bracelet on. The HRA stated she had seen a specific female resident go out the door on several occasions and did not pay attention as to whether she walked around the side of the building or sat out front. During an interview on 6/2/26 at 5:00 p.m., the DON stated R1 was hospitalized three times: 5/1/26 through 5/4/26, for acute carbon dioxide (CO2) retention; 5/9/26, for chronic hypoxic respiratory failure and 5/27/26 through 5/29/26, for heat stroke and pneumonia. R1 was on oxygen due to increased respiratory difficulties due to COPD, CHF, and SOB. Additionally, he was in the hospital for one week 4/4/26 to 4/14/26, with acute hypoxic respiratory failure, exacerbation of COPD, concern for pulmonary embolism (PE), and pneumonia. The DON stated she was unaware of any signs or symptoms			F0689			07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 14 R1 had of pneumonia prior to the 5/27/26 incident. DON stated she was unaware of a facility policy/protocol addressing staff responsibility when a resident wanted to go outside independently. The DON stated all residents who were alert and oriented were allowed to go outside to the pond. If the residents had impaired cognition, staff or activities were expected to be with them to ensure they were safe. R1 had been assessed by therapy prior to 5/27/26 and was identified as needing assistance from one staff for ambulation. R1 had not been assessed to ambulate outside on uneven surfaces. Prior to 5/27/26, R1 had gone outside sitting by front door and was not aware he had ever walked away from the building. The DON stated, “There were some residents living at this facility who were alert, orientated, ambulated without assistance to the pond area behind the building. Nothing has been enforced yet about not allowing residents to go down there independently.” The DON stated the uneven tar on the hill used by residents to get to the pond area would have placed residents at a higher risk for falls, especially if they did not have the endurance to walk up and down a hill and would need to be assessed by therapy. “Those residents who have gone to the pond area, had taken upon themselves and figured out a way to get there.” The DON stated she was worried about their safety, getting down there, being down there, and getting back to the building. R1’s oxygen tank was attached to his walker with straps, placed in a cloth holder and attached to the grab bars of the walker. The weight of the oxygen tank increased R1’s risk for a fall. The DON stated a female resident requested two chairs be placed by the pond and maintenance accommodated her. The DON did not agree with this action. The DON stated she would have discouraged residents from sitting behind the building, by the pond, due to not having a place that was visible/viewable by staff to monitor residents, the ground was uneven, and no one in that parking lot area. R1 left the facility out the front door on 5/27/26 at 2:30 p.m. The DON stated it would have been concerning to be out in over 90-degree weather in the sun without protection. “We do not have a facility policy or plan for how a resident could have contacted staff if they needed assistance while outside. I hope the residents bring their cell phone with.” The DON stated she would have expected staff to check on R1 at least every 30 minutes to see if he was okay. R1 did not have fluids with him and was outside for about 1 hour 40 minutes. The DON state R1 was placed in a life-threatening situation which could have been avoided, “if we had known he was back there, checked on him, and brought him back inside the			F0689			07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 15 building.” The DON stated she had not done anything since the incident on 5/27/26 and thought about not allowing residents to go by the pond, if residents wanted to walk the facility grounds, they should be cleared by therapy. DON stated, “We do not have a specific patient supervision/safety policy and will be something that we will be developing.” During an interview on 6/3/26 at 11:38 a.m., the TA driver stated she drove the facility van on 5/27/26, and at roughly between 2:30 p.m. to 3:00 p.m., she first saw R1 outside sitting up and noted he was alone. The TA did not think anything of R1 being outside. The TA stated around 3:30 p.m., she drove back around and it looked like R1 was sleeping with his head down. Approximately 10 to 15 minutes later she saw his arms fall and decided to check on him. The TA stated she saw him a total of three times. During an interview on 6/4/26 at 8:25 a.m., facility medical doctor (MD) stated R1 had ongoing health issues with chronic hypoxic respiratory failure, CHF, and exacerbation of COPD. R1 had terrible lungs and was a chronic oxygen user. The MD stated it would take 30 to 60 minutes for a 77-year-old man to get heat stroke in 95-degree weather, in the direct sunlight without protection. The MD stated, given R1’s heath issues such as atrial fibrillation, ongoing issues with pneumonia, and heart failure, R1 had difficulty with temperature regulation. R1 had profound electrolyte disturbances from heat expose, his lactic acid lab value was elevated and considered a marker of the heat exposure. The pneumonia could have been related but it was more tachycardia, heart failure exacerbation and atrial fibrillation. The MD stated this was one of the more serious situations for R1 to be in. R1 became overheated and had neurological changes which was an indicator as to how serious it was when he became unresponsive due to heat stroke. The MD stated this was a lift threatening situation for R1 and could have been avoided. The MD stated he did not understand the thought process of the staff to even allow R1 to be in the hot sun, with temperatures that high around 2:00 p.m., it did not make sense for staff to not check on R1. The MD stated he would have expected staff to check on him frequently. The immediate jeopardy that began on 5/27/26, was removed on 6/3/26, when the following actions were taken: 6/2/26 at 6:00 p.m.- facility removed chairs from use at the outside pond area The facility revised and implemented policies and			F0689			07/02/2026

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 06/04/2026	
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
F0689 SS = SQC-J	Continued from page 16 procedures to address identified system failure and prevent recurrence of a serious adverse outcome. The facility developed and implemented a new Designated Outside Seating Areas Policy. Education was provided starting on 6/3/26, to all nursing staff regarding the revised and newly implemented policies and procedures, how to access and review resident’s care plan, transfer status of resident, expectations for when a resident chose to go outside, and safety measures implemented to ensure resident supervision. A knowledge check will be completed with nursing staff on those areas to ensure understanding and staff will sign and date an attendance sheet once education is completed. Education will be provided for maintenance staff regarding the designated seating areas.			F0689			07/02/2026

Minnesota 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 06/04/2026	
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 6/1/26, through 6/4/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaint was reviewed during the survey H54532645C (3026884). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal		20000			06/29/2026	

Office of Primary Care and Health Systems Management

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

Minnesota 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 06/04/2026	
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 software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			06/29/2026