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	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lb Broen Home	824 South Sheridan Street Fergus Falls, MN 56537

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] at 6:30 p.m. The immediate jeopardy was removed on [DATE] 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 [DATE], identified R1 was admitted to the facility on [DATE], 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 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: [DATE].R1's 5/2026, electronic medication administration record (EMAR) identified O2 use was documented starting on evening shift on [DATE] through [DATE] night shift (all three shifts) set at 2L to 2.5L with SaO2 ranging from 92 to 98%. Additionally, on [DATE] during day shift R1 was documented as using oxygen at 2L with SaO2 at 96%.R1's St. Louis University Mental Status (SLUMS) (examination used to detect mild cognitive impairment and dementia) dated [DATE], 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 [DATE], identified R1 (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 [DATE], 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: [DATE].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: [DATE].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: [DATE].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: [DATE].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: [DATE].Nursing assistant (NA) worksheet, undated, received printed copy on [DATE], 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 [DATE], 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 [DATE] at 11:45 a.m., identified transfers with 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 [DATE] through [DATE], identified: On [DATE] 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 [DATE] at 7:56 p.m., received phone call from local hospital. They are keeping R1 overnight for observation, he was looking better.On [DATE] at 10:25 p.m., received phone call and updated on resident status.On [DATE] at 12:04 p.m., (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	failure or compromise.Hospital admission note dated [DATE] 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) (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 [DATE] 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 [DATE] at 9:55 p.m. from ED and discharged on [DATE] 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 [DATE] 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 ([DATE]). 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 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 [DATE] 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 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 [DATE] at 12:58 p.m., EMS operations manager (OM) stated on [DATE] 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 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 [DATE] 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 [DATE] 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 [DATE] at 1:52 p.m., licensed practical nurse (LPN)-B stated she had worked on [DATE]. 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 3/4 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 [DATE] at 3:11 p.m., NA-D stated the last time she saw R1 on [DATE], 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 (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 [DATE] 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 [DATE]. 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 [DATE] at 5:00 p.m., the DON stated R1 was hospitalized three times: [DATE] through [DATE], for acute carbon dioxide (CO2) retention; [DATE], for chronic hypoxic respiratory failure and [DATE] through [DATE], 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 [DATE] to [DATE], 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 R1 had of pneumonia prior to the [DATE] 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 ha