

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245453	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Lb Broen Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on observation, interview and document review, the facility failed to implement appropriate donning/doffing of personal protective equipment (PPE) practices to prevent the spread of infection for 3 of 5 residents (R2, R16, R34) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). In addition, the facility failed to ensure equipment was sanitized between 2 of 2 residents (R24, R34) observed during transfers by nursing staff. Further, the facility failed to implement hand hygiene for 5 of 5 residents (R1, R29, R32, R37, R43) observed during medication administration.</p> <p>Findings include:</p> <p>Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated examples of high-contact resident care activities requiring gown and glove use for EBP included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.</p> <p>R16</p> <p>R16's quarterly Minimum Data Set (MDS) dated [DATE], identified R16 had severe cognitive impairment and had diagnoses which included: hypertension (high blood pressure), dementia, anxiety. Indicated R16 required extensive assistance of staff for transfers and toileting.</p> <p>R16's care plan created 3/21/19, identified R16 required assistance with activities of daily living (ADL's) related to dementia, unsteadiness and anxiety. Indicated staff were to assist with transfers and had interventions of EBP. R16's care plan lacked documentation of a stage three ulcer to the left buttock.</p> <p>R16's resident condition report to physician dated 8/11/24, identified R16 had an area to the left buttock measuring nine centimeters (cm) by seven cm with an open area measuring 0.2 cm with drainage.</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R16's wound assessment dated [DATE], identified R16 had a stage three ulcer to the left buttock measuring 1.5 cm in length by 1 cm in width by 0.5 cm in depth. A stage two ulcer to left buttock measuring 1 cm in length by 0.8 cm in depth. A hard boil/lesion to the left buttock measuring 5 cm in length by 4 cm in width.</p> <p>R16's hospital report dated 8/21/24, identified R16's wound culture grew both Methicillin-resistant Staphylococcus Aureas (MRSA- a type of staph bacteria that's resistant to many antibiotics) and Escherichia coli (E. coli- a bacteria that could cause infections in the gut, urinary tract and other parts of the body). The hospital report further identified the growth of four different organisms and to treat with Bactrim antibiotic along with wound treatments. The report instructed staff to change the dressing every four days or as needed if saturated.</p> <p>R16's nursing progress note dated 8/22/24, identified EBP initiated due to positive wound culture of buttock for MRSA.</p> <p>During an observation on 8/27/24 at 10:57 a.m., nursing assistant (NA)-B applied a gown and gloves outside of R16's room and entered R16's room. Registered nurse (RN)-A was sitting on R16's bed next to R16 applying a gait belt to R16's waist. NA-B and RN-A held onto the gait belt on each side of R16 and assisted R16 to stand and transfer to the wheelchair. RN-A sanitized her hands and left the room. RN-A was not wearing a gown or gloves during the entire observation.</p> <p>During an interview on 8/27/24 at 2:06 p.m., NA-B verified R16 had a wound and was on EBP. NA-B confirmed EBP were in place to prevent the spread of infection.</p> <p>During an interview on 8/27/24 at 11:16 a.m., RN-A verified R16 was on EBP because of a wound on R16's buttock. RN-A stated staff were to wear a gown and gloves when doing cares for residents on EBP.</p> <p>37905</p> <p>R34</p> <p>R34's admission MDS dated [DATE], identified R34 had moderate cognitive impairment and diagnoses which included: Parkinson's disease, arthritis, and anxiety. R34's Indicated R34 required partial/moderate assistance with dressing, personal hygiene and sit to stand transfers.</p> <p>R34's care plan printed 8/27/24, identified R34 had ADL self-performance deficit, and required assistance with dressing, grooming, bathing and transferring. R34's care plan identified R34 had a foley catheter for urination. R34's care plan lacked documentation related to EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 8/27/24, at 8:12 a.m., R34 was lying in bed, while NA-C and NA-B were in R34's room, NA-B wore a gown and gloves, while NA-C had only gloves on. R34's doorway had a sign identifying R34 was on EBP and a covered cart was located outside R34's room which contained gowns and gloves. NA-C gave R34 drinks of water from glass and straw while NA-C stood on the left side of R34's bed. NA-B removed gown and gloves and left R34's room. At 8:16 a.m., NA-B returned to room wearing a gown and gloves, with mechanical lift, and began to attach the sling under R34 to the lift with NA-C, then NA-B and NA-C transferred R34 to his wheelchair. NA-B removed the mechanical lift from the room to the hallway without sanitizing the lift, and returned to the room. NA-B and NA-C continued to assist R34 with dressing and grooming, then NA-C made R34's bed. NA-C remained in R34's room not wearing a gown from 8:12 a.m. until 8:34 a.m., when NA-B transported R34 out of room.</p> <p>During an interview on 8/27/24 at 9:52 a.m., NA-C indicated R34 was on EBP and staff were to wear a gown and gloves when in R34's room performing cares. NA-C stated NA-C had forgotten to wear a gown and when starting to assist NA-B with R34's cares, had then remembered during the cares, however did not want to leave the room. NA-C confirmed NA-C had helped R34 with dressing, grooming, transferring, and made R34's bed while not wearing a gown.</p> <p>During an interview on 8/27/24 at 10:06 a.m., NA-B indicated NA-C did not wear a gown while assisting R34, who was on EBP. NA-B stated following EBP for R34 was important to protect the staff, the resident and the next resident they took care of. NA-B stated they had not sanitized the lift when removed from R34's room, because they had forgotten. NA-B indicated usual process was to sanitize the lift after each resident use to prevent the potential for infection transmission.</p> <p>During an interview on 8/27/24 at 10:38 a.m., licensed practical nurse (LPN)-B, stated all nursing staff were to wear a gown and gloves when working with R34's catheter, or completing transfers or cares. LPN-B confirmed the mechanical lift was not usually sanitized between resident use, however should have been to prevent the potential spread of infection.</p> <p>R24</p> <p>R24's significant change in status MDS dated [DATE], identified R24 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia and arthritis. Indicated R24 was dependent on staff for dressing, personal hygiene and transfers.</p> <p>R24's care plan printed 8/27/24, identified an ADL self-care performance deficit and R24 was dependent on staff for dressing, bathing and transferring with a mechanical lift.</p> <p>During an observation on 8/27/24 at 8:54 a.m., NA-D removed the mechanical lift from room [ROOM NUMBER], then moved the lift to R24's room. NA-D began to attach the sling under R24 to the mechanical lift, and at 8:56 a.m. NA-A entered the room and began to assist NA-D to transfer R24 to bed. NA-D pushed the mechanical lift out to the hallway, then both sanitized hands and NA-D took the garbage to the soiled utility room.</p> <p>During an interview on 8/27/24 at 9:06 a.m., NA-D stated NA-D had taken the lift from room [ROOM NUMBER] and brought to R24's room. NA-D stated the usual process was not to sanitize the lift between residents unless they were on transmission based precautions, and confirmed staff had not sanitized the mechanical lift that day. NA-D stated the night shift usually sanitized the lifts.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/27/24 at 10:26 a.m., NA-A stated NA-A had not sanitized the mechanical lift that day. NA-A indicated housekeeping usually sanitized the lifts.</p> <p>During an interview on 8/27/24 at 10:31 a.m., housekeeper (HSK)-A stated housekeeping staff cleaned lifts when noticed they were soiled. HSK-A indicated housekeeping did not have a routine to sanitize the lifts.</p> <p>During an interview on 8/27/24 at 11:09 a.m., registered nurse unit coordinator (RN)-C stated lifts should have been sanitized between resident use and it was important for infection control purposes.</p> <p>48740</p> <p>R2 EBP</p> <p>R2's quarterly MDS dated [DATE], identified R2 had mildly impaired cognition and diagnoses which included hypertension (high blood pressure), seizure disorder and anxiety.</p> <p>R2's care plan updated 8/22/24 identified R2 was on EBP due to infection control.</p> <p>R2's lab culture results from 8/18/24 revealed that R2 had MRSA, in a wound located on the right breast.</p> <p>During an observation on 8/27/24 at 1:57 p.m., NA-A entered R2's room to answer the bathroom call light. R2 had a sign above her name beside the door indicating R2 was on EBP. A plastic bin was next to the door which had gloves and gowns. NA-A applied gloves, however did not apply a gown. NA-A assisted R2 in standing up and performing perineal cares. NA-A changed gloves and assisted R2 with pulling up her underwear and pants. NA-A removed gloves and washed hands.</p> <p>During an interview on 8/27/24 at 2:03 p.m., NA-A stated she was unaware of R2 being on EBP. NA-A verified there was a EBP sign by R2's door. NA-A stated the process was to wear gowns and gloves when working with a resident on EBP.</p> <p>During an interview on 8/27/24 at 2:12 p.m., RN-A stated R2 was on EBP as R2 had a wound on her breast. RN-A stated she expected staff would wear a gown and gloves when assisting with toileting care.</p> <p>49014</p> <p>HAND HYGIENE/MEDICATION PASS</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 8/26/24 at 6:40 p.m., LPN-A entered the dining room, lifted R29's shirt and administered R29's insulin with her bare hands. LPN-A returned to the medication cart and discarded the insulin pen needle into the sharps container and placed the insulin pen back into the medication cart. LPN-A gathered medications and eye drops for R1, while touching the medication cart, computer mouse, and drawers. LPN-A walked to the sitting area where R1 was seated and administered eye drops to R1 wearing one glove on her left hand, touched both of R1's eyes with gloved left hand, removed glove from left hand and disposed of it into the garbage on the medication cart. LPN-A then put R1's eye drop bottle back in the medication cart and proceeded to gather medications for R32, touching the medication cart drawers, computer mouse, and cups on the medication cart LPN-A handed medications to R32 and noted R32 did not have anything in her glass. LPN-A proceeded to open the refrigerator on the unit and poured a glass of juice and handed it to R32. LPN-A returned to the medication cart to gather medications for R43. LPN-A administered medications to R43, picked up R43's glass and provided a drink of juice between each medication administered. LPN-A returned to the medication cart and gathered R37's medications. LPN-A stated medications needed to be crushed and proceeded to crush seven medications and placed them in a medication cup. Two medications were unable to be crushed; LPN-A opened the two capsules with bare hands and sprinkled them into the medication cup containing the other crushed medications. LPN-A mixed applesauce into the crushed medications. LPN-A handed R37 their glass while administering the crushed medications to R37. LPN-A did not sanitize her hands during the entire medication pass.</p> <p>During an interview on 8/26/24 at 7:27 p.m., LPN-A verified that she had not performed hand hygiene during the medication pass. LPN-A stated it was not her normal process to perform hand hygiene during her medication pass. LPN-A indicated she should have performed hand hygiene after every resident contact and medication pass.</p> <p>During an interview on 8/27/24 at 1:44 p.m., infection preventionist (IP)-A stated her expectation was that staff would have performed hand hygiene before and after medication pass, between resident contact, and entering in and out of resident rooms.</p> <p>During a follow-up interview on 8/27/24 at 1:51 p.m., IP-A indicated the facility had an expectation for all staff to sanitize all lifts with a Sani-wipe (germicidal cleansing wipe) after each use. IP-A stated it was important to sanitize the lifts after each use to prevent cross contamination.</p> <p>During a follow-up interview on 8/27/24 at 1:52 p.m., IP confirmed EBP were utilized for high resident contact cares; toileting, transferring, dressing and bathing or anytime a staff would come in direct contact with a resident. IP verified the expectation of staff were to be wearing a gown and gloves with cares. IP further stated EBP were in place because staff did not know what germs could have been present on clothing and staff wanted to protect our residents.</p> <p>During an interview on 8/27/24 at 3:06 p.m. director of nursing (DON) confirmed the expectation lifts were to be wiped down with Sani-wipes after the lifts were removed from a resident's room to prevent the spread of infection from one resident to another.</p> <p>During a follow-up interview on 8/27/24 at 4:32 p.m., director of nursing DON confirmed EBP were put in place to prevent the spread of potential infections's to other residents and staff. DON verified the expectation of staff was to wear a gown and gloves with any close personal contact with residents on EBP. DON confirmed it was important to stop the transmission of infections from staff and residents and from room to room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a follow-up interview on 8/27/24 at 4:48 p.m., DON stated her expectation was staff would have performed hand hygiene prior to administering medications, after administering medication, and after any resident contact to prevent the spread of infection.</p> <p>Review of a facility policy dated April 2024, identified the facility would implement enhanced barrier precautions for prevention of transmission of multidrug-resistant organisms. The policy further identified EBP employed targeted gown and glove use during high contact resident care activities which included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, wound care: any skin opening requiring a dressing. The policy also identified the facility would make gowns and gloves available near or outside of the resident's room; PPE for enhanced barrier precautions were necessary when performing high-contact care activities and EBP would have been used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device was removed.</p> <p>The facility policy titled Standard Precautions: Equipment, Nursing Unit Cleaning Of-Signature sheet, Use Of Form #BMH 689-91 Utensils (Nursing) And Personal Nursing Items, Washing And Sanitizing Of dated 12/2019, identified all shared equipment would be disinfected between residents. The policy also identified Tuesday night staff tasks included mechanical lifts and stands would have all hard surfaces disinfected using gloves and a Professional Disposables International Inc (PDI) Sani-cloth germicidal wipe after gross loose debris had been removed.</p> <p>A policy titled Hand Hygiene Policy dated 10/2020, indicated when to perform hand hygiene, before having direct contact with patients, after contact with a patient's intact skin, after contact with mucous membranes, after contact with inanimate objects (including medical equipment in the immediate vicinity of the patient, and after removing gloves.</p>		