



*Protecting, Maintaining and Improving the Health of All Minnesotans*

## Revised Letter

Electronically Delivered  
February 3, 2023

Administrator  
MN Veterans Home Fergus Falls  
1821 North Park  
Fergus Falls, MN 56537

RE: CCN: 245636  
Cycle Start Date: January 25, 2023  
Event ID: 00Y511

Dear Administrator:

**This letter will replace the letter dated February 2, 2023. The correct exited date for this survey is January 25, 2023.**

On January 25, 2023, a COVID-19 Focused Infection Control survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. The investigation resulted in no deficiencies being issued.

Electronically attached is your copy of the Federal Form CMS-2567 stating that no violations were noted at the time of this investigation.

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112 Fax: (651) 215-9697  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

February 2, 2023

Administrator  
Mn Veterans Home Fergus Falls  
1821 North Park  
Fergus Falls, MN 56537

RE: CCN: 245636  
Cycle Start Date: January 24, 2023  
Event ID: 00Y511

Dear Administrator

On January 24, 2023, a COVID-19 Focused Infection Control survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. The investigation resulted in no deficiencies being issued.

Electronically attached is your copy of the Federal Form CMS-2567 stating that no violations were noted at the time of this investigation.

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112 Fax: (651) 215-9697  
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/02/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245636</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/24/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MN VETERANS HOME FERGUS FALLS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1821 NORTH PARK FERGUS FALLS, MN 56537</b>
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(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
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E 000	Initial Comments  On 1/24/23, and 1/25/23, COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was found to be IN compliance.	E 000		
F 000	INITIAL COMMENTS  On 1/24/23, and 1/25/23, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.73 Infection Control. The facility was determined to be IN compliance.  Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required the facility acknowledge receipt of the electronic documents.	F 000		

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