Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 19, 2026

Administrator
MN VETERANS HOME FERGUS FALLS
1821 NORTH PARK
FERGUS FALLS, MN 56537

RE: CCN:245636

Cycle Start Date: May 6, 2026

Dear Administrator:

On May 6, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility’s Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 6, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 6, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245636**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/06/2026**
NAME OF PROVIDER OR SUPPLIER **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE **1821 NORTH PARK , 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
E0000	Initial Comments On 5/4/26 through 5/7/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a 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 that the facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 5/4/26 through 5/6/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was in substantial compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed, and no deficiencies were cited as a result of the investigations: H56361717C (2605872) and H56361718C (2605888). The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F0000		
F0641 SS = A	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F0641		

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: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026
NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE: **1821 NORTH PARK , 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
F0641 SS = A	Continued from page 1 §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure Minimum Data Set (MDS) section N was accurately coded for the medications received for 2 of 5 residents (R10, R3) who's medication management was reviewed. Findings include: R10 R10’s quarterly Minimum Data Set dated 3/13/26, identified R10 had severe cognitive impairment and was independent with eating. R10’s diagnoses included Alzheimer’s disease and severe morbid obesity. R10 received insulin injections one time during the assessment period. The assessment did not identify R10 had a diagnosis of diabetes mellitus (DM). R10’s provider orders dated 12/29/26, identified an order for Tirzepitide GLP-1 (a glucagon-like peptide-1, a hormone that regulates blood sugar and appetite) 2.5 mg/0.5 ml injection – inject 2.5 mg subcutaneously in the morning every Wed for morbid obesity/obstructive sleep apnea for 4 weeks.	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026
NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME FERGUS FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE: 1821 NORTH PARK , 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
F0641 SS = A	Continued from page 2 During interview on 5/6/26 at 10:10 a.m., registered nurse (RN)-A stated R10 had morbid obesity because of excessive caloric intake and was pre-diabetic and did not have a diagnosis of DM. R10 was prescribed Tirzepitide to help with weight loss. RN-A stated according to the facilities electronic medical record, GLP-1 medications were considered anti-diabetic medication and for that reason had coded it as a hypoglycemic During interview on 5/6/26 at 11:12 a.m., the director of nursing (DON) stated R10's Tirzepitide was coded as insulin on the most recent MDS. Tirzepitide was classified as a GLP-1 medication and not insulin and should not have been coded as insulin on the MDS. R3 R3's quarterly MDS dated 3/11/26, identified R3 did not have any cognitive impairment. R3 received one insulin injection during the assessment period. R3's diagnosis included diabetes mellitus-type 2 (a chronic metabolic condition where the body develops insulin resistance or fails to produce enough insulin). R3's provider orders dated 4/14/26, identified R3 was receiving semaglutide (a GLP-1 receptor agonist to improve blood sugar control, reduce appetite) subcutaneous solution pen injector 2 mg/3 milliliters (ml) (semaglutide) Inject 2 mg subcutaneously in the morning every Wed related to type 2 diabetes mellitus. The provider's orders dated 4/14/26, and the medication administration record (MAR) from March 2026, did not identify R3 received any insulin injections. During an interview on 5/6/26 at 10:08 a.m. RN-B stated she did identify R3 received insulin on the MDS because R3 received an injectable hypoglycemic medication and thought it was in the same category as insulin. During interview on 5/6/26 at 11:12 a.m., DON stated R3's semaglutide was coded as insulin on the most recent MDS. Semaglutide was classified as a GLP-1 medication and not insulin and should not have been coded as insulin on the MDS.	F0641		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026
NAME OF PROVIDER OR SUPPLIER **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE **1821 NORTH PARK , 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
F0641 SS = A	Continued from page 3 The facilities Resident Assessment – Care Plan policy dated 4/8/26, identified the MDS as a core set of screening, clinical and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The purpose was to establish a process for ensuring all residents received a comprehensive assessment, which was used to develop a comprehensive, culturally competent, trauma-informed, person-centered care plan with written interventions designed to accommodate the resident’s individualized needs and preferences and support the resident’s choices.	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245636**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MN VETS HO...** B. WING	(X3) DATE SURVEY COMPLETED **05/05/2026**
NAME OF PROVIDER OR SUPPLIER **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE **1821 NORTH PARK , 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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/05/2026. At the time of this survey, Minnesota Veterans Home Fergus Falls was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us	K0000		

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: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MN VETS HO... B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME FERGUS FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE: 1821 NORTH PARK , 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
K0000 Bldg. 01	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. MN Veterans Home Fergus Falls was constructed in 1997 with an addition constructed on the west end in 2011. The construction type is II (111). The building is fully sprinkled and a fire alarm system per NFPA 72. There is smoke detection in the corridors, spaces open to the corridor and in resident rooms. There are five 2 hour fire barriers separating the building into 5 smoke compartments and one 2 hour fire barrier separating a clinic. The facility has a capacity of 85 beds and had a census of 80 at the time of the survey.The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0521 SS = F Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread	K0521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MN VETS HO... B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK , 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
K0521 SS = F Bldg. 01	Continued from page 2 impact on the residents within the facility. Findings include: On 05/05/2026 at 11:05am, it was revealed by a review of available documentation that the facility completed a fire damper inspection on 12/30/2025. With in the provided document the damper test paperwork shows that five (5) dampers failed and at the time of inspection that repairs had not been completed. These dampers need to be repaired to show completion of this inspection. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0521		
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/05/2026, at 11:05am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: third shift 05/21/2025 at 11:15pm, 09/25/2025 at 11:35pm, and 12/23/2025 at 11:50pm. second shift 09/30/2025 at 5:46pm and on 12/04/2025 at 5:50pm. These drills do not demon straight varying times. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MN VETS HO... B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK , 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
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a pattered impact on the residents within the facility. Findings include: On 05/05/2026 at the following times, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; 1) at 12:01pm, Refrigerator plugged into multi-plug adapter in room E155 2) at 11:27am, Refrigerator plugged into multi-plug adapter in room D128 3) at 11:31am, Refrigerator plugged into multi-plug adapter in room A139	K0920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MN VETS HO... B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE: **1821 NORTH PARK , 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
K0920 SS = E Bldg. 01	Continued from page 4 4) at 11:37am, Refrigerator plugged into multi-plug adapter in room B119 (lower level) An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0920		
K0372 SS = D Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 05/05/2026, at 12:04pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to W wing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0372		
K0761 SS = D Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.	K0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MN VETS HO... B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME FERGUS FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE: 1821 NORTH PARK , 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
K0761 SS = D Bldg. 01	Continued from page 5 Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/05/2026 at 11:45am, it was revealed by review of available documentation the required annual door inspection documentation the facility failed to comply with the 13 point door inspection by have a decal run the full length of door. This decal obstructs the ability to properly inspect the door. The door in question is located in the South Village (door V141) An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0761		
K0162 SS = A Bldg. 01	Roofing Systems Involving Combustibles CFR(s): NFPA 101 Roofing Systems Involving Combustibles 2012 EXISTING Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. Roof covering meets Class C requirements.	K0162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MN VETS HO... B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME FERGUS FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE: 1821 NORTH PARK , 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
K0162 SS = A Bldg. 01	Continued from page 6 2. Roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2 1/2 inches concrete or gypsum fill. 3. Attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 19.1.6.2*, ASTM E108, ANSI/UL 790 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain non-combustible ceiling in accordance with the NFPA Life Safety Code 101 2012 edition section 19.1.6.3 subsection 1 and 3. This deficient practice could have an isolated impact on the residents within the facility. Findings include: On 5/5/2026 at following times, it was revealed by observation that exit corridor ceiling was missing ceiling a tile. Missing tile was located in exit corridor, lower level by the elevator room (village wing) * Ceiling tiles were replaced at time of survey. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0162		
K0363 SS = A Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open	K0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MN VETS HO... B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME FERGUS FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE: 1821 NORTH PARK , 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
K0363 SS = A Bldg. 01	Continued from page 7 devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/05/2026 at 11:50am, it was revealed by observation that the Soiled Utility (door E112) did not close or latch and time of inspection. * door E112 was repaired at time of survey. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0363		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245636**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MN VETS HO...** B. WING	(X3) DATE SURVEY COMPLETED **05/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	**1821 NORTH PARK , 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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/05/2026. At the time of this survey, Minnesota Veterans Home Fergus Falls was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us	K0000		05/28/2026

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: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MN VETS HO... B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME FERGUS FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE: 1821 NORTH PARK , 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
K0000 Bldg. 01	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. MN Veterans Home Fergus Falls was constructed in 1997 with an addition constructed on the west end in 2011. The construction type is II (111). The building is fully sprinkled and a fire alarm system per NFPA 72. There is smoke detection in the corridors, spaces open to the corridor and in resident rooms. There are five 2 hour fire barriers separating the building into 5 smoke compartments and one 2 hour fire barrier separating a clinic. The facility has a capacity of 85 beds and had a census of 80 at the time of the survey.The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		05/28/2026
K0521 SS = F Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread	K0521	K0521 - HVAC Corrective Action: The five (5) fire dampers identified during the 12/30/2025 inspection as failed were repaired/replaced by the facility’s contracted HVAC vendor. Documentation of completed repairs and operational verification was obtained and maintained on file. Other Potentially Affected Areas: The Maintenance Director reviewed all fire/smoke damper inspection documentation throughout the facility to ensure no additional unresolved deficiencies existed. Systemic Changes: The facility implemented a tracking system for all	06/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245636**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MN VETS HO...** B. WING	(X3) DATE SURVEY COMPLETED **05/05/2026**
NAME OF PROVIDER OR SUPPLIER **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE **1821 NORTH PARK , 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
K0521 SS = F Bldg. 01	Continued from page 2 impact on the residents within the facility. Findings include: On 05/05/2026 at 11:05am, it was revealed by a review of available documentation that the facility completed a fire damper inspection on 12/30/2025. With in the provided document the damper test paperwork shows that five (5) dampers failed and at the time of inspection that repairs had not been completed. These dampers need to be repaired to show completion of this inspection. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0521	Continued from page 2 required fire/smoke damper inspections and repairs to ensure deficiencies identified during inspections are corrected timely and documented upon completion. Maintenance staff were educated regarding required follow-up documentation for all Life Safety inspection deficiencies. Monitoring: The Maintenance Director or designee will audit twenty (20) random smoke/fire dampers for operational verification and completion of supporting documentation, on a quarterly basis for twelve (12) months. Responsible Person: Maintenance Director	06/05/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/05/2026, at 11:05am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: third shift 05/21/2025 at 11:15pm, 09/25/2025 at 11:35pm, and 12/23/2025 at 11:50pm. second shift 09/30/2025 at 5:46pm and on 12/04/2025 at 5:50pm. These drills do not demon straight varying times.	K0712	K0712 - Fire Drills Corrective Action: The facility revised the fire drill schedule to ensure drills are conducted at varying times and under varying conditions for all shifts in accordance with NFPA requirements. Other Potentially Affected Areas: Previous fire drill documentation for all shifts was reviewed to identify any additional concerns related to drill timing variation. Systemic Changes: The Maintenance Director developed a rotating fire drill schedule to ensure drills occur at different times throughout each shift and under varying operational conditions. Education was provided to staff responsible for scheduling and documenting drills. Monitoring: The Maintenance Director or designee will complete the Fire Drill Compliance Audit monthly for six (6) months to ensure drills occur at varying times and under varying conditions. Responsible Person: Maintenance Director	06/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MN VETS HO... B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE: **1821 NORTH PARK , 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
K0712 SS = F Bldg. 01	Continued from page 3 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712		06/10/2026
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a pattered impact on the residents within the facility. Findings include: On 05/05/2026 at the following times, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; 1) at 12:01pm, Refrigerator plugged into multi-plug adapter in room E155 2) at 11:27am, Refrigerator plugged into multi-plug	K0920	K0920 - Electrical Equipment / Power Strips Corrective Action: The multi-plug adapters identified in rooms E155, D128, A139, and B119 were removed immediately. Refrigerators were plugged directly into approved wall receptacles. Other Potentially Affected Areas: A facility-wide inspection was conducted to identify improper use of multi-plug adapters, extension cords, and unauthorized power strips. Any identified issues were corrected at the time of discovery. Systemic Changes: Education was provided to maintenance staff and department managers regarding approved electrical device usage and NFPA requirements prohibiting the use of multi-plug adapters and extension cords as permanent wiring. Routine environmental rounds were updated to include monitoring for improper electrical connections. Monitoring: The Maintenance Director or designee will complete the Electrical Safety Audit on six (6) random rooms/offices monthly for six (6) months. Deficiencies identified during audits will be corrected promptly and documentation maintained for review. Responsible Person: Maintenance Director	05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245636**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MN VETS HO...** B. WING	(X3) DATE SURVEY COMPLETED **05/05/2026**
NAME OF PROVIDER OR SUPPLIER **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE **1821 NORTH PARK , 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
K0920 SS = E Bldg. 01	Continued from page 4 adapter in room D128 3) at 11:31am, Refrigerator plugged into multi-plug adapter in room A139 4) at 11:37am, Refrigerator plugged into multi-plug adapter in room B119 (lower level) An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0920		05/11/2026
K0372 SS = D Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 05/05/2026, at 12:04pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to W wing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0372	K0372 - Smoke Barrier Penetration Corrective Action: The penetration located above the doors leading to the W Wing smoke compartment barrier was sealed using approved fire-rated materials to restore smoke barrier integrity. Other Potentially Affected Areas: The facility conducted an inspection of accessible smoke barrier walls throughout the building to identify additional penetrations requiring repair. Systemic Changes: Maintenance staff were educated regarding maintenance of smoke barrier integrity and requirements for sealing penetrations with approved fire-rated materials. Smoke barrier inspections were added to routine maintenance rounds. Monitoring: The Maintenance Director or designee will complete the Smoke Barrier Inspection Audit every other month for six (6) months to verify smoke barrier integrity is maintained. Responsible Person: Maintenance Director	06/05/2026
K0761 SS = D Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K0761	K0761 - Maintenance, Inspection & Testing – Doors Corrective Action:	06/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245636**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MN VETS HO...** B. WING	(X3) DATE SURVEY COMPLETED **05/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	**1821 NORTH PARK , 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
K0761 SS = D Bldg. 01	Continued from page 5 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/05/2026 at 11:45am, it was revealed by review of available documentation the required annual door inspection documentation the facility failed to comply with the 13 point door inspection by have a decal run the full length of door. This decal obstructs the ability to properly inspect the door. The door in question is located in the South Village (door V141) An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0761	Continued from page 5 The annual fire door inspection documentation was reviewed and corrected to ensure all required inspection elements are completed and documented appropriately. The decal on door V141 was removed to ensure the door can be properly inspected. Other Potentially Affected Areas: All annual fire door inspection records were reviewed to verify compliance with NFPA 80 inspection requirements and documentation standards. Systemic Changes: The facility educated maintenance personnel regarding required annual fire door inspection criteria and documentation requirements, including unobstructed inspection of door surfaces and components. Monitoring: The Maintenance Director or designee will complete the Fire Door Inspection Documentation Audit annually semi-annually thereafter to ensure required documentation is maintained and deficiencies corrected timely. Responsible Person: Maintenance Director	06/06/2026
K0162 SS = A Bldg. 01	Roofing Systems Involving Combustibles CFR(s): NFPA 101 Roofing Systems Involving Combustibles 2012 EXISTING Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing	K0162		05/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MN VETS HO... B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK , 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
K0162 SS = A Bldg. 01	Continued from page 6 combustible roofing supports, decking or roofing meet the following: 1. Roof covering meets Class C requirements. 2. Roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2 1/2 inches concrete or gypsum fill. 3. Attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 19.1.6.2*, ASTM E108, ANSI/UL 790 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain non-combustible ceiling in accordance with the NFPA Life Safety Code 101 2012 edition section 19.1.6.3 subsection 1 and 3. This deficient practice could have an isolated impact on the residents within the facility. Findings include: On 5/5/2026 at following times, it was revealed by observation that exit corridor ceiling was missing ceiling a tile. Missing tile was located in exit corridor, lower level by the elevator room (village wing) * Ceiling tiles were replaced at time of survey. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0162		05/06/2026
K0363 SS = A Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor	K0363		05/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245636**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MN VETS HO...** B. WING	(X3) DATE SURVEY COMPLETED **05/05/2026**
NAME OF PROVIDER OR SUPPLIER **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE **1821 NORTH PARK , 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
K0363 SS = A Bldg. 01	Continued from page 7 covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/05/2026 at 11:50am, it was revealed by observation that the Soiled Utility (door E112) did not close or latch and time of inspection. * door E112 was repaired at time of survey. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0363		05/06/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245636**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/06/2026**
NAME OF PROVIDER OR SUPPLIER **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE **1821 NORTH PARK , 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
E0000	Initial Comments On 5/4/26 through 5/7/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a 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 that the facility acknowledge receipt of the electronic documents.	E0000		05/11/2026
F0000	INITIAL COMMENTS On 5/4/26 through 5/6/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was in substantial compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed, and no deficiencies were cited as a result of the investigations: H56361717C (2605872) and H56361718C (2605888). The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F0000		05/11/2026
F0641 SS = A	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F0641		05/11/2026

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: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026
NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE: **1821 NORTH PARK , 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
F0641 SS = A	Continued from page 1 §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure Minimum Data Set (MDS) section N was accurately coded for the medications received for 2 of 5 residents (R10, R3) who's medication management was reviewed. Findings include: R10 R10's quarterly Minimum Data Set dated 3/13/26, identified R10 had severe cognitive impairment and was independent with eating. R10's diagnoses included Alzheimer's disease and severe morbid obesity. R10 received insulin injections one time during the assessment period. The assessment did not identify R10 had a diagnosis of diabetes mellitus (DM). R10's provider orders dated 12/29/26, identified an order for Tirzepitide GLP-1 (a glucagon-like peptide-1, a hormone that regulates blood sugar and appetite) 2.5 mg/0.5 ml injection – inject 2.5 mg subcutaneously in the morning every Wed for morbid obesity/obstructive sleep apnea for 4 weeks.	F0641		05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245636**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/06/2026**
NAME OF PROVIDER OR SUPPLIER **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE **1821 NORTH PARK , 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
F0641 SS = A	Continued from page 2 During interview on 5/6/26 at 10:10 a.m., registered nurse (RN)-A stated R10 had morbid obesity because of excessive caloric intake and was pre-diabetic and did not have a diagnosis of DM. R10 was prescribed Tirzepitide to help with weight loss. RN-A stated according to the facilities electronic medical record, GLP-1 medications were considered anti-diabetic medication and for that reason had coded it as a hypoglycemic During interview on 5/6/26 at 11:12 a.m., the director of nursing (DON) stated R10’s Tirzepitide was coded as insulin on the most recent MDS. Tirzepitide was classified as a GLP-1 medication and not insulin and should not have been coded as insulin on the MDS. R3 R3's quarterly MDS dated 3/11/26, identified R3 did not have any cognitive impairment. R3 received one insulin injection during the assessment period. R3's diagnosis included diabetes mellitus-type 2 (a chronic metabolic condition where the body develops insulin resistance or fails to produce enough insulin). R3's provider orders dated 4/14/26, identified R3 was receiving semaglutide (a GLP-1 receptor agonist to improve blood sugar control, reduce appetite) subcutaneous solution pen injector 2 mg/3 milliliters (ml) (semaglutide) Inject 2 mg subcutaneously in the morning every Wed related to type 2 diabetes mellitus. The provider's orders dated 4/14/26, and the medication administration record (MAR) from March 2026, did not identify R3 received any insulin injections. During an interview on 5/6/26 at 10:08 a.m. RN-B stated she did identify R3 received insulin on the MDS because R3 received an injectable hypoglycemic medication and thought it was in the same category as insulin. During interview on 5/6/26 at 11:12 a.m., DON stated R3’s semaglutide was coded as insulin on the most recent MDS. Semaglutide was classified as a GLP-1 medication and not insulin and should not have been coded as insulin on the MDS.	F0641		05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245636	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026
NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME FERGUS FALLS**		STREET ADDRESS, CITY, STATE, ZIP CODE: **1821 NORTH PARK , 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
F0641 SS = A	Continued from page 3 The facilities Resident Assessment – Care Plan policy dated 4/8/26, identified the MDS as a core set of screening, clinical and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The purpose was to establish a process for ensuring all residents received a comprehensive assessment, which was used to develop a comprehensive, culturally competent, trauma-informed, person-centered care plan with written interventions designed to accommodate the resident's individualized needs and preferences and support the resident's choices.	F0641		05/11/2026