Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 13, 2025

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

RE: CCN: 245636
Cycle Start Date: February 5, 2024

Dear Administrator:

On February 5, 2025, 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 May 5, 2025 (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 August 5, 2025 (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

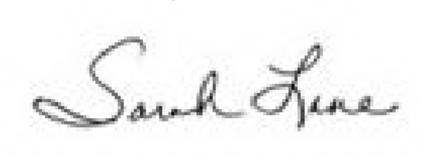
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process 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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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February 13, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 2U9Y11

Dear Administrator:

The above facility was surveyed on February 3, 2025 through February 5, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245636	A. BUILDING _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 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
E 000	Initial Comments On 2/3/25 to 2/5/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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.	E 000		
F 000	INITIAL COMMENTS On 2/3/25 to 2/5/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		3/18/25

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

Electronically Signed | 02/20/2025

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.

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F 689	Continued From page 1 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess and implement safe smoking interventions for 1 of 1 resident (R17) reviewed for smoking. Findings include: R17's quarterly Minimum Data Set (MDS) dated 1/17/25, indicated R17 had diagnoses which included chronic obstructive pulmonary disease (COPD) hypertension (elevated blood pressure), and stroke. Identified R17 had severe cognitive impairment and was independent with activities of daily living (ADL's) which included transfers and toileting. Identified R17 used tobacco. R17's annual Care Area Assessment (CAA) dated 5/1//24, identified interventions were in place to address safety needs. R17's care plan revised 4/27/21, identified the facility had determined R17 was a modified independent smoker. Care plan identified facility was to store R17's cigarettes and give R17 one cigarette at a time to smoke independently. R17's smoking assessment dated 4/14/24, indicated R17 was safe to dispose of ashes and smoking material completely. Assessment indicated R17 did not have any visible burns on	F 689	Plan of Correction (POC) for F689 1. On 3/12/25 R17 was diagnosed with Covid 19. Due to acute illness and increased fatigue on 3/13/25 R17 has been told by nursing and administrative staff that at this time he is not safe to smoke and will not be allowed to smoke, due to holes being noted in a new pair of pants. A conversation was held with the resident and/or resident representative and discussed smoking activity and recognized assessment results. Family is aware of the closing of the smoking room as well as resident will not be allowed to smoke while at the facility, as well as encouraging family not to purchase any smoking paraphernalia for the resident. Fire retardant pants did not arrive until after he was deemed unsafe to smoke. He refuses to appropriately wear the smoking apron as offered by nursing staff when cigarettes are given to the resident. A TAR was set up to check pants for holes if he refused to wear the smoking apron. Skin immediately assessed and no alteration noted. His cigarettes have been locked up, and the smoking room is also locked. He has been instructed to stay in his room due to Covid diagnosis. He has	

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F 689	Continued From page 2 clothing or wheelchair cushion. Indicated R17 was safe to smoke independently without supervision and did not require a smoking apron. R17's smoking assessment dated 1/11/25, indicated R17 was safe to dispose of ashes and smoking material completely. Assessment indicated R17 did not have any visible burns on clothing or wheelchair cushion. Indicated R17 was safe to smoke independently without supervision and did not require a smoking apron. During an observation on 2/4/25 at 9:15 a.m., R17 was standing at the nurses station. R17 received one cigarette from registered nurse (RN)-A. R17 walked into the smoking room which was located about 40 feet from the nurse's station. R17 put the cigarette into the wall lighter. (a small hole within a metal box located on the wall) and lit the cigarette. R17 sat down in the chair and began smoking the cigarette and as R17 was smoking the cigarette ashes began falling on his lap. R17 had not made any effort to remove the cigarette ashes from his pants and continued smoking. R17 placed the cigarette which was still burning in an ashtray and walked back to the nurses station and received another cigarette from RN-A. R17 walked back into the smoking room and picked up his previous cigarette and used it to light the new cigarette then placed the first cigarette still burning into the ashtray. R17 smoked the second cigarette as ashes continued to fall onto his lap. R17 made no effort to remove the cigarette ashes from his lap and continued smoking. R17 then placed the second cigarette which was still burning into the ashtray. R17 made no effort to extinguish either of the two cigarettes. R17 then left the smoking room and went back to his room.	F 689	been offered the nicotine patch and has refused it at this time. R17 stopped smoking on 3/18/2025 after he was assessed not to be safe during a 25 minute visual smoking assessment. He demonstrated unsafe smoking due to not disposing of his cigarette ash timely into the ashtray, holding cigarette to close to his body and not appropriately replacing the smoking apron back over his lap after using the wall lighter. His safety awareness was altered due CV19 diagnosis at that time. Staff did not witness him not extinguishing his cigarettes full when put in ashtray. The smoking room is surrounded by glass windows so that staff can see into the smoking room at all times. He has not suffered from any withdrawal symptoms and has not had any behaviors/adverse reactions related to not smoking. He was offered smoking cessation treatment in the form of the patch or lozenges and her refused. Currently there are no residents actively smoking at our facility as R17 was the last smoking resident. The smoking room was closed on 3/18/2025 at our facility. Per our policy our facility does not admit new residents who smoke. The nursing staff will monitor for smoking cessation withdrawals for such things as urges or cravings to smoke, increase in irritability, restlessness, difficulty in sleeping, anxiousness, depression or sadness. 2. All residents have the potential to be affected, however R17 was the only remaining resident in the building with	

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F 689	Continued From page 3 During an observation on 2/4/25 at 9:51 a.m., R17 came out of his room and walked to the nurse's station and received one cigarette from RN-A. R17 walked into the smoking room and used the wall lighter to light the cigarette. R17 sat down in the chair and had visible holes in the black sweatpants he was wearing. R17 began smoking the cigarette and ashes began falling onto his lap. R17 made no effort to remove the cigarette ashes from his pants and continued smoking.. R17 placed the cigarette which was still burning into the ashtray. R17 made no effort to extinguish the cigarette, got up from the chair, several ashes were noted on the floor as R17 left the smoking room and walked back to his room. During an inventory of R17's clothing on 2/4/25 at 9:26 a.m., RN-A identified two pair of blue pants with large burn-holes, one pair of gray pants with burn-holes, and the black sweatpants R17 was wearing had several burn-holes in them. During an interview on 2/4/25 at 10:02 a.m., laundry aide (LA)-A stated she was aware of the burn-holes in R17's pants. LA-A stated she was not sure how long the burn-holes had been on R17's pants. During an interview on 2/4/25 at 11:00 a.m., nursing assistant (NA)-A stated R17 was a smoker and the nurses stored R17's cigarettes for him. NA-A stated R17 was able to smoke in the smoking room without supervision or a smoking apron. NA-A stated she was aware of the burn-holes in R17's pants however, was unsure how long the burn-holes have been there. During an interview on 2/4/25 at 11:10 a.m., NA-B	F 689	smoking privileges. At this time there are no residents actively smoking at our facility. The smoking room was closed on 3/18/2025 at our facility. Per our policy our facility does not admit new residents who smoke. 3. At this time there are no residents actively smoking at our facility. The smoking room was closed on 3/18/2025 at our facility and will not be reopened. Policy titled Smoking and Tobacco Policy was reviewed and revised to reflect the new practice at MN Veterans Home-Fergus Falls of no admission of new residents who are active smokers, and no current residents will be assessed to smoke at the facility. 4. R17s room will be checked for smoking paraphernalia q shift x 30 days, then daily x 30 days and then results will be brought to QAPI for reevaluation and determination for continued auditing. The smoking room has been shut down and locked and signs placed on door to alert staff and resident that we no longer have an open smoking room. If R17 were to request to smoke again the facility would review with him and his resident representative the previous smoking violations that led to him being deemed unsafe to smoking at MVH-FF. His smoking privileges were revoked per the policy, his care plan was updated to reflect his nonsmoking status. MVH's policy now goes into effect for R17 that we are a nonsmoking facility, and he is no longer grandfathered into smoke again.	

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F 689	Continued From page 4 stated R17 was a smoker and the nurses stored R17's cigarettes for him. NA-A stated R17 was able to smoke in the smoking room without supervision or a smoking apron. NA-A stated she was aware of the burn-holes on R17's pants however, was unsure how long the burn-holes have been there. During an interview on 2/4/25 at 11:36 a.m., RN-A stated she had completed smoking assessments on R17 by observing R17 smoke through the window however, had never gone into the smoking room while R17 was smoking. RN-A stated she was aware of the burn-holes on R17's pants however, was not sure how long the holes had been there. RN-A stated she was not sure why the smoking assessments stated there were no visible holes on R17's clothing. RN-A stated for safety reasons her expectation was that staff should have been offering a smoking apron or supervise R17 while smoking. During an interview on 2/4/25 at 12:13 p.m., RN-B stated she had observed R17 smoking through the window however, had never gone into the smoking room while R17 was smoking. RN-B stated she was aware of the burn-holes present on R17's pants and was not sure how long the holes had been there. RN-B stated she had assumed R17 was safe to smoke unsupervised and did not require a smoking apron. During an interview on 2/4/25 at 12:17 p.m., RN-C stated she had not visualized R17 smoking. RN-C stated when the nurses completed a visual smoking assessment on R17, it was usually by visualizing the window. RN-C stated she was aware of the burn-holes present on R17 clothing however, was unsure how long the holes had	F 689	We do not have any designated smoking areas inside or outside of the building. If a current resident of MVH was found smoking in the facility or on the grounds, staff would intervene, extinguish the flame and ask for the smoking paraphernalia so that it could be locked up and sent home with family. We would assess the resident for injury immediately. Staff would then meet with the resident and their representative and go through the non-smoking policy. A smoking assessment would not be completed because we do not allow residents to smoke on our campus. Care plan would be updated to state that the resident has a history of smoking or brining smoking items to the facility so monitoring can be done. 5. 3/18/2025	

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F 689	Continued From page 5 been there. RN-C stated another assessment was going to be completed to ensure R17's safety while smoking. During an interview on 2/4/25 at 12:42, director of nursing (DON) stated she was aware of the burn-holes present on R17's clothing. DON stated she was unsure how long the holes have been on the clothing or if any of the burn-holes had happened recently. DON stated her expectation was that R17 was safe while smoking and that another smoking assessment was to be completed and that safety interventions would be implemented off of that new smoking assessment to ensure R17 was safe while smoking. Review of a facility policy titled Smoking and Tobacco Policy revised 5/1/19 identified residents ho smoke would have a smoking assessment quarterly and upon change of condition. Identified smoking interventions were based on the individualized smoking assessment. Residents will follow the plan of care. Violations of the rules or agreed to interventions may result in the loss of the smoking privilege or may lead to smoking restrictions.	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure professional standards of practice were followed during medication set-up and administration of insulin	F 760	1. Immediate Assessment: Resident R15□s blood sugars were reviewed by DON at time she was notified that insulin pen was not primed in an isolated incident	3/3/25

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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
F 760	Continued From page 6 with a Novolog insulin pen (rapid-acting insulin, used to improve blood sugar control in people with diabetes mellitus) for 1 of 2 residents (R15) who received insulin without the pen primed according to manufacturer's recommendations. Findings include: R15's quarterly Minimum Data Set (MDS) dated 11/28/24, identified R15 had intact cognition with diagnosis of type two diabetes (DM), and received injections of insulin. R15's care plan revised 5/31/24, identified staff were to administer medications as prescribed. R15's Medication Review Report signed 12/18/24, identified Semglee Pen-100 units/milliliter, inject 12 units Subcutaneously (an injection just under the skin into the fatty tissue) two times daily for DM. During an observation of medication pass on 2/3/25 at 6:10 p.m., registered nurse (RN)-D prepared R15's medication which included her evening, Semglee insulin. RN-D removed the Semglee insulin pen from the medication cart, removed the tip, attached a needle to the end of the pen, dialed the dose to the ordered 12 units, picked up an alcohol wipe, went to R15's room and administered the 12 units of insulin to R15. RN-D then removed the needle from the end of the pen, placed it in the sharps container and sanitized his hands. RN-D did not prime the pen (waste 2 units of insulin to remove the air bubbles) per manufacturer's instructions prior to drawing up the 12 units of insulin. During an interview on 2/5/25 at 9:33 a.m., RN-D	F 760	as observed by MDH surveyor. No significant change noted between 2/1-2/5/25. The error of not priming the insulin pen was isolated and no specifics were given by surveyor to DON. The DON was notified via email that we would need to await 2567 for specifics. GNP will be notified of error on rounds on 2/20/25 and asked to review blood sugars at that time. No medical follow up was need at the time of the isolated incident. 2. There are twelve residents that are on medication injector pens and have the potential to be affected by this practice. 3. The facility□s medication administration policies were reviewed and updated to reinforce error prevention strategies. RN-D was re-educated immediately verbally and visually with package insert for semglee insulin pen by DON on 2/5/25. He verbalized understanding. At nurses meeting on 2/10/25 all nurses in attendance were also re-educated on appropriate priming of insulin pens. All nurses received electronic copies of minutes which included the medication policy. All licensed nurses will receive re-education on proper medication administration practices regarding medication pens, including priming all medication pens and the "Five Rights" (Right Resident, Right Medication, Right Dose, Right Route, Right Time). Formal education will be put out for all licensed nursing staff by 2/24/25. Education understanding will be signed off and returned by all nurses by 3/3/25. Intermittent nurses will sign off before next scheduled shift. Training	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245636	A. BUILDING _____ B. WING _____	02/05/2025

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F 760	Continued From page 7 verified he had not primed the insulin pen prior to dialing up the 12 units of Semglee for R15 per manufacturer's recommendations. RN-D stated he was aware the insulin pen should have been primed prior to dialing up the insulin to ensure the accurate dosage of insulin was administered. During an interview on 2/5/25 at 9:35 a.m., consultant pharmacist (CP) stated it was important to always prime an insulin pen prior to drawing up the dosage to ensure the residents received the correct dosage of insulin. During an interview on 2/5/25 at 10:27 a.m., director of nursing (DON) stated her expectation was that the insulin pen would have been primed prior to dialing up the insulin dose for R15 to ensure the proper dose of insulin was administered. Review of the Semglee insulin manufacture's package insert dated 2021, identified the need to perform an airshot before each injection to ensure the any air bubbles were removed. The process directed: Attach a new needle, Select a dose of 2 units on the dosage selector, hold the pen with the needle pointing upward, tap the insulin reservoir to move any air bubbles to the top of the reservoir, press the injection button all the way in, and check to see if insulin comes out of the needle tip. Repeat if no insulin comes from the needle, then dial the selector to the ordered insulin dose and administer as ordered. Review of a facility policy titled Medication Administration Standard revised 5/23, identified staff would follow appropriate standards and protocols when administering medications.	F 760	emphasized the importance of priming the medication injector pen to assure the full dose of medication is received and the air bubbles are removed. 4. The Director of Nursing (DON) or designee will conduct random medication pass observations weekly for four weeks, then monthly for two months to ensure compliance. QA Audits: All medication errors are reviewed M-F by the DON and administrator. Findings will be discussed in the facility□s Quality Assurance and Performance Improvement (QAPI) meetings to track improvements and implement further preventive strategies if needed.	

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	245636	A. BUILDING **01 - MN VETS HOME FERGUS FALLS** B. WING _____	**02/04/2025**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety on 02/04/2025. At the time of this survey, MN 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, 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care, and the 2012 edition of the Healthcare Facilities Code (NFPA 99) 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/20/2025

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.

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K 000	Continued From page 1	K 000		

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail to:
FM.HC.Inspections@state.mn.us

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 has 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

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K 000	Continued From page 2 building into 5 smoke compartments and one 2 hour fire barrier separating a clinic. The facility has a capacity of 106 beds and had a census of 72 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 761 SS=F	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. 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 REQUIREMENT 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 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 761	1. The Building Utilities Maintenance Worker completed a fire door inpection on 2/5/2025. 2. All residents have the potential to be affected by this deficient practice. 3. The building maintenance foreman scheduled annual fire door inspections for February 2026 in Archibus (Our automated scheduling program). 4. The Building Maintenance Supervisor	2/20/25

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K 761	Continued From page 3 On 02/04/2025 between 9:00 and 11:30 AM, it was revealed by a review of available documentation that the last fire door inspection that took place in the facility took place on December 15, 2023. A fire door inspection has not been conducted within the last 12 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	or his designee and QAPI committee will continue to monitor until 2/28/2026 to ensure practice is remedied.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/3/25 to 2/5/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess and implement safe smoking interventions for 1 of 1 resident (R17) reviewed for smoking. Findings include: R17's quarterly Minimum Data Set (MDS) dated 1/17/25, indicated R17 had diagnoses which included chronic obstructive pulmonary disease (COPD) hypertension (elevated blood pressure), and stroke. Identified R17 had severe cognitive impairment and was independent with activities of daily living (ADL's) which included transfers and toileting. Identified R17 used tobacco.	2 830	Corrected	3/3/25

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2 830	Continued From page 3 R17's annual Care Area Assessment (CAA) dated 5/1//24, identified interventions were in place to address safety needs. R17's care plan revised 4/27/21, identified the facility had determined R17 was a modified independent smoker. Care plan identified facility was to store R17's cigarettes and give R17 one cigarette at a time to smoke independently. R17's smoking assessment dated 4/14/24, indicated R17 was safe to dispose of ashes and smoking material completely. Assessment indicated R17 did not have any visible burns on clothing or wheelchair cushion. Indicated R17 was safe to smoke independently without supervision and did not require a smoking apron. R17's smoking assessment dated 1/11/25, indicated R17 was safe to dispose of ashes and smoking material completely. Assessment indicated R17 did not have any visible burns on clothing or wheelchair cushion. Indicated R17 was safe to smoke independently without supervision and did not require a smoking apron. During an observation on 2/4/25 at 9:15 a.m., R17 was standing at the nurses station. R17 received one cigarette from registered nurse (RN)-A. R17 walked into the smoking room which was located about 40 feet from the nurse's station. R17 put the cigarette into the wall lighter. (a small hole within a metal box located on the wall) and lit the cigarette. R17 sat down in the chair and began smoking the cigarette and as R17 was smoking the cigarette ashes began falling on his lap. R17 had not made any effort to remove the cigarette ashes from his pants and continued smoking. R17 placed the cigarette	2 830		

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2 830	Continued From page 4 which was still burning in an ashtray and walked back to the nurses station and received another cigarette from RN-A. R17 walked back into the smoking room and picked up his previous cigarette and used it to light the new cigarette then placed the first cigarette still burning into the ashtray. R17 smoked the second cigarette as ashes continued to fall onto his lap. R17 made no effort to remove the cigarette ashes from his lap and continued smoking. R17 then placed the second cigarette which was still burning into the ashtray. R17 made no effort to extinguish either of the two cigarettes. R17 then left the smoking room and went back to his room. During an observation on 2/4/25 at 9:51 a.m., R17 came out of his room and walked to the nurse's station and received one cigarette from RN-A. R17 walked into the smoking room and used the wall lighter to light the cigarette. R17 sat down in the chair and had visible holes in the black sweatpants he was wearing. R17 began smoking the cigarette and ashes began falling onto his lap. R17 made no effort to remove the cigarette ashes from his pants and continued smoking.. R17 placed the cigarette which was still burning into the ashtray. R17 made no effort to extinguish the cigarette, got up from the chair, several ashes were noted on the floor as R17 left the smoking room and walked back to his room. During an inventory of R17's clothing on 2/4/25 at 9:26 a.m., RN-A identified two pair of blue pants with large burn-holes, one pair of gray pants with burn-holes, and the black sweatpants R17 was wearing had several burn-holes in them. During an interview on 2/4/25 at 10:02 a.m., laundry aide (LA)-A stated she was aware of the burn-holes in R17's pants. LA-A stated she was	2 830		

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2 830	Continued From page 5 not sure how long the burn-holes had been on R17's pants. During an interview on 2/4/25 at 11:00 a.m., nursing assistant (NA)-A stated R17 was a smoker and the nurses stored R17's cigarettes for him. NA-A stated R17 was able to smoke in the smoking room without supervision or a smoking apron. NA-A stated she was aware of the burn-holes in R17's pants however, was unsure how long the burn-holes have been there. During an interview on 2/4/25 at 11:10 a.m., NA-B stated R17 was a smoker and the nurses stored R17's cigarettes for him. NA-A stated R17 was able to smoke in the smoking room without supervision or a smoking apron. NA-A stated she was aware of the burn-holes on R17's pants however, was unsure how long the burn-holes have been there. During an interview on 2/4/25 at 11:36 a.m., RN-A stated she had completed smoking assessments on R17 by observing R17 smoke through the window however, had never gone into the smoking room while R17 was smoking. RN-A stated she was aware of the burn-holes on R17's pants however, was not sure how long the holes had been there. RN-A stated she was not sure why the smoking assessments stated there were no visible holes on R17's clothing. RN-A stated for safety reasons her expectation was that staff should have been offering a smoking apron or supervise R17 while smoking. During an interview on 2/4/25 at 12:13 p.m., RN-B stated she had observed R17 smoking through the window however, had never gone into the smoking room while R17 was smoking. RN-B stated she was aware of the burn-holes present	2 830		

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2 830	Continued From page 6 on R17's pants and was not sure how long the holes had been there. RN-B stated she had assumed R17 was safe to smoke unsupervised and did not require a smoking apron. During an interview on 2/4/25 at 12:17 p.m., RN-C stated she had not visualized R17 smoking. RN-C stated when the nurses completed a visual smoking assessment on R17, it was usually by visualizing the window. RN-C stated she was aware of the burn-holes present on R17 clothing however, was unsure how long the holes had been there. RN-C stated another assessment was going to be completed to ensure R17's safety while smoking. During an interview on 2/4/25 at 12:42, director of nursing (DON) stated she was aware of the burn-holes present on R17's clothing. DON stated she was unsure how long the holes have been on the clothing or if any of the burn-holes had happened recently. DON stated her expectation was that R17 was safe while smoking and that another smoking assessment was to be completed and that safety interventions would be implemented off of that new smoking assessment to ensure R17 was safe while smoking. Review of a facility policy titled Smoking and Tobacco Policy revised 5/1/19 identified residents ho smoke would have a smoking assessment quarterly and upon change of condition. Identified smoking interventions were based on the individualized smoking assessment. Residents will follow the plan of care. Violations of the rules or agreed to interventions may result in the loss of the smoking privilege or may lead to smoking restrictions. SUGGESTED METHOD OF CORRECTION:	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	02/05/2025

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2 830	Continued From page 7 The director of nursing or designee, could review/revise policies and procedures related to smoking and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and	21545		3/3/25

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21545	Continued From page 8 precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure professional standards of practice were followed during medication set-up and administration of insulin with a Novolog insulin pen (rapid-acting insulin, used to improve blood sugar control in people with diabetes mellitus) for 1 of 2 residents (R15) who received insulin without the pen primed according to manufacturer's recommendations. Findings include: R15's quarterly Minimum Data Set (MDS) dated 11/28/24, identified R15 had intact cognition with diagnosis of type two diabetes (DM), and received injections of insulin.	21545	Corrected	

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21545	Continued From page 9 R15's care plan revised 5/31/24, identified staff were to administer medications as prescribed. R15's Medication Review Report signed 12/18/24, identified Semglee Pen-100 units/milliliter, inject 12 units Subcutaneously (an injection just under the skin into the fatty tissue) two times daily for DM. During an observation of medication pass on 2/3/25 at 6:10 p.m., registered nurse (RN)-D prepared R15's medication which included her evening, Semglee insulin. RN-D removed the Semglee insulin pen from the medication cart, removed the tip, attached a needle to the end of the pen, dialed the dose to the ordered 12 units, picked up an alcohol wipe, went to R15's room and administered the 12 units of insulin to R15. RN-D then removed the needle from the end of the pen, placed it in the sharps container and sanitized his hands. RN-D did not prime the pen (waste 2 units of insulin to remove the air bubbles) per manufacturer's instructions prior to drawing up the 12 units of insulin. During an interview on 2/5/25 at 9:33 a.m., RN-D verified he had not primed the insulin pen prior to dialing up the 12 units of Semglee for R15 per manufacturer's recommendations. RN-D stated he was aware the insulin pen should have been primed prior to dialing up the insulin to ensure the accurate dosage of insulin was administered. During an interview on 2/5/25 at 9:35 a.m., consultant pharmacist (CP) stated it was important to always prime an insulin pen prior to drawing up the dosage to ensure the residents received the correct dosage of insulin.	21545		

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21545	Continued From page 10 During an interview on 2/5/25 at 10:27 a.m., director of nursing (DON) stated her expectation was that the insulin pen would have been primed prior to dialing up the insulin dose for R15 to ensure the proper dose of insulin was administered. Review of the Semglee insulin manufacture's package insert dated 2021, identified the need to perform an airshot before each injection to ensure the any air bubbles were removed. The process directed: Attach a new needle, Select a dose of 2 units on the dosage selector, hold the pen with the needle pointing upward, tap the insulin reservoir to move any air bubbles to the top of the reservoir, press the injection button all the way in, and check to see if insulin comes out of the needle tip. Repeat if no insulin comes from the needle, then dial the selector to the ordered insulin dose and administer as ordered. Review of a facility policy titled Medication Administration Standard revised 5/23, identified staff would follow appropriate standards and protocols when administering medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on ensuring insulin pens and needles are used in accordance with standards of practice; then provide education to all nursing staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21545		