DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

DETAKTMENTO	MI			O CERTIFIC	CATION A	AND TRANSM	ITTAL		D: PHU7	EG
						E SURVEY A		F	acility ID: 00531	
1. MEDICARE/MEDICA (L1) 245636 2.STATE VENDOR OR M		(L3 (L4	3. NAME AND ADDRESS OF FACILITY (L3) MN VETERANS HOME FERGUS F (L4) 1821 NORTH PARK (L5) FERGUS FALLS, MN			ALLS (L6) 5	6537	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	on
5. EFFECTIVE DATE C (L9) 6. DATE OF SURVEY 8. ACCREDITATION ST 0 Unaccredited 2 AOA	12/17/2021 (L34) 01 02 L10) 03	PROVIDER/SU Hospital SNF/NF/Dual SNF/NF/Distinct SNF	PPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 14 CORF 15 ASC 16 HOSPICE	22 CLIA	7. On-Site Visit 8. Full Survey After FISCAL YEAR ENDIN 06/30		55)
11. LTC PERIOD OF CE From (a): To (b):	RTIFICATION		THE FACILITY A. In Complian Program Re Compliance	nce With equirements	AS:	2. Techr	nical Personnel	E Following Requireme 6. Scope of Set 7. Medical Dir 8. Patient Roon	vices Limit	
12.Total Facility Beds 13.Total Certified Beds	106 (I	L18)	B. Not in Com	pliance with Prog	_	5. Life S	safety Code	9. Beds/Room	i size	
14. LTC CERTIFIED BEI 18 SNF		9 SNF	ICF	IID		15. FACILITY M 1861 (e) (1) or		(L15)		
(L37) 16. STATE SURVEY AC		(L39) .PPLICABLE	(L42) SHOW LTC CA	(L43)	DATE):					
17. SURVEYOR SIGNA	TURE		Date :			18. STATE SURV	VEY AGENCY AP	PPROVAL	Date:	
Jennifer Bah	r, Unit Superviso	r		1/06/2022	(L19)	Joanne Sim	on, Enforceme	nt Specialist	01/06/202	22 (L2
	PART II - T	O BE CO	MPLETED B	BY HCFA RE	EGIONAL	OFFICE OR	SINGLE STA	TE AGENCY		
_	is Eligible to Participate	(L21)		PLIANCE WITE	H CIVIL	2. Ov		al Solvency (HCFA-2572 atterest Disclosure Stmt (
22. ORIGINAL DATE	23. LTC A	AGREEMEN'	Т 24	LTC AGREEN	MENT	26. TERMINAT	ION ACTION:	(1	L30)	

	(L21)			
22. ORIGINAL DATE OF PARTICIPATION	23. LTC AGREEMENT BEGINNING DATE	24. LTC AGREEMENT ENDING DATE	26. TERMINATION ACTION: VOLUNTARY 00	(L30) <u>INVOLUNTARY</u>
07/06/2018 (L24)	(L41)	(L25)	01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: (L27)	ALTERNATIVE SANCTIO A. Suspension of Admissions B. Rescind Suspension Date	s: (L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
	B. Resenia Suspension Bate	(L45)		
28. TERMINATION DATE:	29. INTERMED	DIARY/CARRIER NO.	30. REMARKS	
	06201			
	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMIN. 12/08/2021	ATION OF APPROVAL DATE (L33)	DETERMINATION APPROVAL	



Electronically delivered January 6, 2022

CMS Certification Number (CCN): 245636

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 10, 2021 the above facility is certified for:

106 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 106 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us



Electronically delivered January 6, 2022

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

RE: CCN: 245636

Cycle Start Date: October 7, 2021

Dear Administrator:

On December 16, 2021, we notified you a remedy was imposed. On December 17, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 10, 2021.

As authorized by CMS the remedy of:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective January 7, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 27, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 7, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 10, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us



Electronically delivered

January 6, 2022

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

Re: Reinspection Results

Event ID: PHU712

Dear Administrator:

On December 17, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 17, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Statement of Financial Solvency (HCFA-2572)
 Ownership/Control Interest Disclosure Stmt (HCFA-1513)
 Both of the Above :

DEFARTMENT OF HI	LALIH AND HUM	AN SERVICES			CENTERS FO	OK MEDICA	ARE & MEDIC	AID SERVICES	3
	MEDI	CARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMIT	TAL		ID: PHU7	
	PART	I - TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGE	ENCY		Facility ID: 00531	
. MEDICARE/MEDICAID PI (L1) 245636 2.STATE VENDOR OR MEDI (L2)		3. NAME AND AI (L3) MN VETER (L4) 1821 NORT (L5) FERGUS FA	RANS HOME I H PARK		ALLS (L6) 5653		4. TYPE OF ACTIO 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	i
5. EFFECTIVE DATE CHANG (L9)	GE OF OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22	CLIA	7. On-Site Visit 8. Full Survey Afte	9. Other or Complaint	
	10/07/2021 (L34) S: (L10) TJC Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FI	SCAL YEAR ENDI 06/30	ING DATE: (L35))
11LTC PERIOD OF CERTIFI	CATION	10.THE FACILITY	IS CERTIFIED	AS:		<u> </u>			
From (a): To (b):			equirements e Based On:		And/Or Approved V 2. Technical 3. 24 Hour F	l Personnel	Following Requirem 6. Scope of So 7. Medical Di	ervices Limit	
12. Total Facility Beds	106 (L18)	1. A	cceptable POC		4. 7-Day RN		8. Patient Roo		
13.Total Certified Beds	106 (L17)	X B. Not in Cor Requirements	mpliance with Prog and/or Applied V	_	5. Life Safet * Code: B *	ty Code (L1	9. Beds/Room 2)	ı	
14. LTC CERTIFIED BED BRI	EAKDOWN				15. FACILITY MEET	TS			
	9 SNF 19 SN 06	F ICF	IID		1861 (e) (1) or 1861	1 (j) (1):	(L15)		
(L37) (L	38) (L39)	(L42)	(L43)						
16. STATE SURVEY AGENC	Y REMARKS (IF APPLI	CABLE SHOW LTC CA	ANCELLATION I	DATE):					
17. SURVEYOR SIGNATURE	3	Date :			18. STATE SURVEY	AGENCY APP	ROVAL	Date:	
Dani Yuretich, HFE - NE II		1	1/30/2021	(L19)	Joanne Simon, Enforce	ement Specialist		12/03/2021	(L20

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

	(L21)			
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING DATE	ENDING DATE	VOLUNTARY 00	INVOLUNTARY
07/06/2018			01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTION	NS	03-Risk of Involuntary Termination	OTHER
	A. Suspension of Admissions:	:	04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind Suspension Date:	(L44)		00-Active
	b. Reschid Suspension Date:			
		(L45)		
28. TERMINATION DATE:	29. INTERMED	IARY/CARRIER NO.	30. REMARKS	
	06201			
	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINA	ATION OF APPROVAL DATE		
	(I 32)	(1 33)	DETERMINIATION APPROVAL	

19. DETERMINATION OF ELIGIBILITY

X 1. Facility is Eligible to Participate ____ 2. Facility is not Eligible



Electronically delivered October 27, 2021

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

RE: CCN: 245636

Cycle Start Date: October 27, 2021

Dear Administrator:

On October 7, 2021, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Unit Supervisor Bemidji District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, MN 56601-2933

Email: Jennifer.bahr@state.mn.us

Office: (218) 308-2104 Mobile: (218) 368-3683

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 January 7, 2022 (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 April 7, 2022 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

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.

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:

> William Abderhalden, Fire Safety Supervisor **Deputy State Fire Marshal** Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145

Cell: (507) 361-6204

Email: william.abderhalden@state.mn.us

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

PRINTED: 11/24/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245636	B. WING				C 07/2021	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	107	0172021	
MN VETE	ERANS HOME FERG	US FALLS			821 NORTH PARK ERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 000	Initial Comments		ΕO	000				
F 000	compliance with Appreparedness Req conducted during a survey. The facility The facility is enroll signature is not reconducted to the CMS-2 correction is require acknowledge receil INITIAL COMMENT On 10/4/21 throug recertification survey facility. A complaint	h 10/7/21, a survey for opendix Z, Emergency uirements, §483.73(b)(6) was a standard recertification was in compliance. led in ePOC and therefore a puired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility pt of the electronic documents. TS h 10/7/21, a standard ey was conducted at your trinvestigation was also cility was found to be in	FΟ	000				
	compliance with the Subpart B, Require Facilities. The following comp SUBSTANTIATED however no deficie	e requirements of 42 CFR 483, ements for Long Term Care plaints were found to be H5636015C (MN76001); ncies were cited due to actions a facility prior to survey:						
		plaints were found to be ED: H5636016C (MN68786)						
	as your allegation of Departments acception enrolled in ePOC, yat the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.						
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE	

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

Electronically Signed 11/05/2021

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245636	B. WING				C 07/2021
	PROVIDER OR SUPPLIER	JS FALLS		182	REET ADDRESS, CITY, STATE, ZIP CODE 1 NORTH PARK RGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	onsite revisit of you	ge 1 acceptable electronic POC, an r facility may be conducted to ntial compliance with the	F 0	00			
	regulations has bee	en attained. ng (ADLs)/Mntn Abilities	F 6	76			11/5/21
	assessment of a re- resident's needs an provide the necessary ensure that a reside daily living do not di of the individual's cl	on the comprehensive sident and consistent with the ad choices, the facility must ary care and services to ent's abilities in activities of iminish unless circumstances inical condition demonstrate in was unavoidable. This ensuring that:					
	treatment and servi or her ability to carr	ident is given the appropriate ces to maintain or improve his y out the activities of daily se specified in paragraph (b)					
		ovide care and services in ragraph (a) for the following					
	§483.24(b)(1) Hygic grooming, and oral	ene -bathing, dressing, care,					
	§483.24(b)(2) Mobil including walking,	lity-transfer and ambulation,					
	§483.24(b)(3) Elimi	nation-toileting,					
	§483.24(b)(4) Dinin snacks,	g-eating, including meals and					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	COMI	SURVEY PLETED
		245636	B. WING			C 07/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (1821 NORTH PARK FERGUS FALLS, MN 56537	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 676	Continued From p	page 2	F6	76		
	(i) Speech, (ii) Language, (iii) Other function This REQUIREME by: Based on observereview, the facility assisted with eatir reviewed who need Findings include: R2's annual Minim 9/1/21, identified Fi impairment and re assist of one with Alzheimer's disea understand or exp R2's nutritional sta (CAA) dated 9/1/2 moderately high be and needed mecha a diagnosis of der teeth. R2's diet or Further, R2 had a choking and/or as R2's current care an intervention inithad a potential for loss/dehydration, impairments) with needed texture medementia and age set up and assist	atus Care Area Assessment 11, identified R2 had a ody mass index (BMI) of 26.5 nanically altered textures due to mentia and missing or broken der was minced and moist. potential for chewing difficulty,		1. On 10/8, the IDT met in with SLP, all resident care eating dependency, need for supervision/assistance, alter dysphagia diagnosis were necessary changes were necessary changes were nincluded removal of cannel language used by CDM to residents needing set up at Nursing added feeding deplevel of assistance to the A and CDM updated nutrition care plans to reflect the cuany modalities or modificate the dining room. R2 was a speech language pathologic Changes to the care plan in change in assistance/supecare planned to be at a supwith cueing. New resident printed and are available to 2. Any resident that has dy difficulty swallowing, or is contained to the contained to the supervision for the supervision to ensure accurate provided to all nurses and HSTs (CNAs) on 10-27	plans with an or ered diet or reviewed and nade. Changes d care plan reflect all nd supervision. Dendencies and nad hydration rrent diet and tions while in assessed by the ist on 10-28-21. Include a revision. R2 is pervised table kardex's were of all staff. Tesphagia, a care planned to reating. all care plans phagia, on 1 uracy. Education on 10-18-21	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED		
		245636	B. WING _			10/0	C 07/2021
	PROVIDER OR SUPPLIER	JS FALLS		18	TREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTH PARK ERGUS FALLS, MN 56537	1 10/0	7172021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676	report as needed. During continuous 8:58 a.m. R2 was sidining room. All off breakfast and R2 weat his meal in the attempt to provide I however, R2 was sithe floor. - At 9:16 a.m. R2 comeal. R2 used a lart to scrape hot cereal was able to spoon smouth, more hot commouth, but eating. R2 continue himself. - At 9:23 a.m. R2 and clothing protector but the picked up his correct into his mouth. - At 9:26 a.m. R2 commouth himself. - At 9:26 a.m. R2 commouth himself.	observation on 10/5/21, at erved his breakfast in the her residents had finished their was the last resident trying to dining room. Staff did not R2 with assistance with eating; pilling food onto himself and ontinued to attempt to eat his rege bowl and a regular spoon. It towards himself. While R2 some hot cereal into his ereal went over the edge of the atthe table edge, floor or onto etor. Insed practical nurse (LPN)-A approached R2. LPN-A approached R2. LPN-A approached R2 to be able to spoon did not offer to assist R2 with the dot attempt to eat his meal by the food that had fallen onto his y picking it up with his hands, fork and attempted to fork hot	F 6	76	assistance during meals. Swallow screening form was updated by DC CDM and ST to reflect current MDS language for level of assistance ne with meals. This will provided cons language throughout the facility and resident care plan to lessen any coby staff. 4. The director of nursing, or her designee, will conduct audits on ca accuracy for assistance with feedin R2 and 5 random residents. The awill be conducted weekly for four withen monthly for two months. The rof the audits will be sent to the QAF committee for further recommendations.	eded istent d infusion re plan g on udits eeks esults	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED C				
		245636	B. WING _		10	/07/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 1821 NORTH PARK FERGUS FALLS, MN 56537				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 676	normally rose ever breakfast with the fasting lab work the breakfast. LPN-A sindependent and of food was falling of probably was not up reviously sick and assistance. During an interview registered nurse (Ibbeen assisted whill sitting with, watchi During an interview director of nursing the memory care up abilities changed of varying levels of "a R2 required super rely on RN-A becabest. The staff wei	other residents. R2 needed at morning which delayed his stated R2 was fairly only needed assistance when f his plate. The care plan updated from when R2 was d R2 no longer required w on 10/7/21, at 2:19 p.m. RN)-A stated R2 should have e eating whether that meant	F 67	6			
	dated 12/9/19, indiwould be provided department to ens provided the assis needs while encounighest level of indithe level of assistance devices need for any staff assistance devices	Activities of Daily Living (ADLs) icated ADL care and assistance and managed by the nursing ure that the resident was tance needed to complete ADL traging the resident to exercise dependence. The policy defined unce as follows: erformed self-care in a specific tance or help from staff, nor oversight, with/without is and within a reasonable time. cal help from staff.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245636	B. WING			C 07/2021	
	PROVIDER OR SUPPLIER	JS FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1821 NORTH PARK FERGUS FALLS, MN 56537		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
	reminding. 3. Limited assistance of items needed to minimal physical as guided maneuvering bearing assistance. 4. Extensive assistance in perform Resident involved in bearing support. 5. Total dependence assistance with all the Treatment/Svcs to CFR(s): 483.25(b)(1) Present Based on the compresident, the facility (i) A resident receive professional standard pressure ulcers and ulcers unless the indemonstrates that (ii) A resident with professional standard pressure ulcers and ulcers unless the indemonstrates that (iii) A resident with professional standard pressure ulcers and ulcers unless the indemonstrates that (iii) A resident with professional standard pressure ulcers and ulcers unless the indemonstrates that (iii) A resident with professional standard pressure ulcers and ulcers from deling, promote healing, promote healing, promote from deling, promo	off were to provide cues and/or ce - Needed set up/placement perform cares. May need esistance. Staff provided g of limbs or other non-weight cance - Needed physical rming a portion of cares. In activity. Staff provided weight e - Needed full staff easks. Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. The provided weight estate and services, to prevent does not develop pressure dividual's clinical condition they were unavoidable; and pressure ulcers receives and and services, consistent andards of practice, to revent infection and prevent	F6	576		12/10/21	
	by: Based on observareview, the facility frepositioning service R67, R2) reviewed	tion, interview and document ailed to provide timely ses for 3 of 3 residents (R21, who were at risk for pressure and dependent upon staff for		 The care plans for R21, R67 were reviewed by 11/4/2021 an appropriate. No changes were their care plans. Any resident that is unable to 	d deemed made to		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	COMI	E SURVEY PLETED
		245636	B. WING			C 0 7/2021
NAME OF F	PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP	•	
				1821 NORTH PARK		
MN VETE	ERANS HOME FERG	SUS FALLS		FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 686	μ	age 6	F 6	on their own or is care plar		
		nimum Data Set (MDS) dated R21 had moderate cognitive		repositioned has the poten affected by this deficient pr 3. The director of nursing e	ractice.	
	impairment and re assistance with all MDS further identi	equired extensive to total activities of daily living. The ified R21 was at risk of		nurses on 10-18-21 and 11 more specifics to plan of co HSTs (CNAs) on 10-21-21	I-22-21 with orrection and and will with	
	diabetes mellitus, weakness or loss	re ulcers. Diagnoses included hemiplegia (mild or partial of strength on one side of the esis (severe or complete loss of		more specifics on 11-18-21 importance of repositioning the care plan in accordanc based practice and facility	21 regarding the ng residents per ce with evidence	
		sis on one side of the body), le weakness, and multiple		residents that are unable to are care planned to be reptheir care plans reviewed appropriate on 11/9/2021.	ositioned had and revised if	
	R21 had skin brea buttock crease an ulcer on his left ou directed staff to as two hours when si encourage R21 to	e plan dated 2/26/20, identified akdown to his coccyx and dhad a history of pressure after ankle. The care plan esist with repositioning every ting and when laying down and lay down between meals and esals were to be documented.		made aware of the residen assistance with repositionin changes in the Kardex. MI implement a task through I residents with an identified repositioning care planned 12/10/2021. This will task CNA's to chart q shift in PC resident received these care	ats that need ang through NVH-FF will PCC for all toileting and/or need will trigger the DC that the	
	11/22/20, identified himself and utilize relieving mattress repositioned every care plan. He pre	rance Assessment dated d R21 was unable to reposition d boots, pillows and pressure while in bed. R21 was two hours according to his sently had breakdown on his equafor was used when		plan. The facility will also in hour toileting and reposition will be started daily by the interest to document when this occurrence to document when this occurrence to their shift. This form will be the weekly focus meeting of	mplement a 24 ning form that night nurse. nopsis of each eting and for the C N A's curred last on e reviewed at	
	risk) dated 9/18/2 ² risk for developing	•		resident unit. This form wi and updated by medical re needed or requested.	cords as	
	RZTS Quarterly SI	kin Risk Factors dated 9/24/21,		4. The director of nursing,	or ner	

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
			A. DOILD					
		245636	B. WING				7/2021	
	PROVIDER OR SUPPLIER ERANS HOME FERGU	JS FALLS		18	TREET ADDRESS, CITY, STATE, ZIP CODE 321 NORTH PARK ERGUS FALLS, MN 56537			
(X4) ID PREFIX TAG					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	identified R21 had bottom as R21 was in wheelchair or be to alert to staff whe be repositioned. He Aquafor was applie R21 had a Foley ca of refusing to be rewheelchair. During continuous 7:09 a.m. nursing a from his room in a lan attached headrenear the nursing stathe wheelchair was -At 7:16 a.m. licens provided R21 his mand then returned harea. -At 8:40 a.m. LPN-lroom behind the nuinsulin and then returned harea. -At 9:11 a.m. regist R21's breakfast ord meal slip to the diestable with beverage -At 9:17 a.m. R21 reprovided total feediling -At 9:47 a.m.	chronic skin break down to his a not able to reposition himself d due to his MS. R21 was able in he wanted to lay down and a had no open areas and id to his bottom for prevention. Atheter in place. He had times positioned either in bed or his cobservation on 10/6/21, at assistant (NA)-D pushed R21 high-backed wheelchair with est, to the television sitting area action. R21 was dressed and reclined slightly. Bed practical nurse (LPN)-B arorning medications. B brought R21 to a conference arses' station, administered his him to the common sitting B wheeled R21 to the dining at a table. B wheeled R21 to the dining at a table. B wheeled R21 to the dining at a table.	F	686	designee, will conduct audits on repon R21, R67, R2, and 5 random residents. The audits will be conduct wice a week for four weeks and m for two months or until 100% comp is achieved with 1:1 education provistaff with non-compliance. The residue audits will be sent to the QAPI committee for further recommendate.	cted onthly liance ided to ults of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245636	B. WING _		10	C / 07/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 1821 NORTH PARK FERGUS FALLS, MN 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 686	room and positioned bed. RN-B did not On 10/6/21, at 9:58 a little after 7:00 a. prior) and he requithree hours. She was NA-E entered R21 the bed utilizing a clittle bit of pain on I stated R21 current on the right buttook coccyx. They apply protestant) and Ca ointment) on the all encouraged R21 to his bottom. When repositioning scheeplan posted on the and identified it directly breakfast was real lot of people to get in. Due to this, it was morning before the then every two hours. His skin was they used Aquafor bath note indicated continuing to heal, they were not award bottom. On 10/6/21, at 10:4 room and asked R2	ed his wheelchair next to the offer repositioning to R21. B a.m. NA-E stated R21 got up m. (2 hours and 49 minutes red repositioning every two to was just going to his room now. Is room and transferred him to ceiling lift. R21 stated he felt a his bottom from sitting. NA-E ly had three open areas; one corease and two on the ied Aquafor (moisturizing skin Imoseptine (moisture barrier reas for protection and to lay down every day to get off asked to clarify R21's dule, NA-E displayed a care inside of R21's closet door ected R21 required two hours. She stated by hard for staff as they had a up and a lot who liked to sleep was usually three hours in the ey could reposition R21 and	F 68	36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION) ´COM	(X3) DATE SURVEY COMPLETED	
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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	(EACH CORRECTIVE ACTION	DER'S PLAN OF CORRECTION PRECTIVE ACTION SHOULD BE PERENCED TO THE APPROPRIATE DEFICIENCY)		
F 686	scale. RN-B stated developed and rescord excoriation (an a surface of the body generated when the surface such as a lopposite direction to measured and des Area 1 (right of coc (cm). The area was blanchable. Area 3 (coccyx) 2. blanchable. Area 4 (right glutea area was blanchable. During interview or stated R21 had an skin integrity on his and closed repeater repositioned every too long for him to During interview or director of nursing expected R21 be reconstructed.	d the issues to R21's bottom olved quickly and were areas abrasive or tearing injury to the v) from shearing (force e skin is moved against a fixed bony skeleton moving in an to the surface skin). She cribed the areas as follows: ccyx): 2.0 x 1.0 centimeters is blanchable. In a 1): 0.2 x 0.4 cm. The area are 2 x 0.4 cm. The area was all crease) 3.1 x 0.4 cm. The alle with blood. In 10/7/21, at 3:44 p.m. RN-C ongoing chronic issue with the shottom. The areas opened edly. He should be two hours and three hours was	F 68	36			
	identified R67 had and required assist was at risk for pres have any current p	nange MDS dated 8/5/21, severe cognitive impairment tance with for all transfers. R67 sure ulcers; however, did not ressure ulcers. The MDS is of dementia with behavioral					

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	PROVIDER OR SUPPLIER	JS FALLS		182	REET ADDRESS, CITY, STATE, ZIP CODE 21 NORTH PARK RGUS FALLS, MN 56537	1 107	0112021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	R67's current care R67 was at risk for dementia, a possibintake and age. R6 staff were directed with a ceiling lift; ar toilet on a routine bethere by himself. Hidentify frequency of R67's Skin Risk Faidentified R67 was R67 had limited ab with staff and R67 needs and completed R67's Tissue Tolera 8/21/21, identified I condition and was himself in bed or in anticipate R67 nee hours. During a continuou 7:02 a.m. R67 was rock-king chair in the At 8:28 a.m. R67 room in his rock-king repositioned during repositioned during repositioned during repositioned to sit in homom. - At 9:30 a.m. NA-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-	plan dated 7/30/21, identified skin breakdown related to ility of non-adequate meal 7 used a rock-king chair and to assist R67 with all transfers and take R67 to the nearest wasis as R67 was unable to get owever, the care plan did not of R3's repositioning needs. ctors -MVH dated 8/2/21, at high risk for skin injury. ility to communicate his needs relied on staff to anticipate be cares. ance Assessment -MVH dated R67 had a recent change in no longer able to reposition his chair. Staff needed to ds and reposition every two	F6	86			

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F 686	attempt to reposit from the dining ro the TV in the com - At 10:00 a.m. Nother southside and every resident on residents was not resident because two hours. At that repositioned before been close to seven the composition of the composition	ion R67 . NA-A assisted R67 om and wheeled R67 in front of mon area. A-A stated he was assigned to that side. Repositioning of tracked in any form for any they were repositioned every time, NA-A stated R67 was last re 7:00 a.m., but it "must have en". A-A assisted R67 with on 10/6/21, at 10:09 a.m. LPN-A lent was to be repositioned the should be every two hours. Figure goes against us." on 10/7/21, at 3:42 p.m. the ministrator stated staff were with care plan for repositioning. dated 9/1/21, identified R2 had meaniment and required epositioning. R2 was at risk for nowever, did not have any ulcers. Diagnoses that included	F	686					

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F 686	During observation was assisted to the meal. R2 was sitting pressure reducing of a six of the meal. R2 was sitting pressure reducing of a six of the meal. R2 was also and the six of the meal of the	on 10/6/21, at 8:27 a.m. R2 dining room for his breakfast g in his wheelchair with a cushion. Theeled himself away from the NA-A did not offer to reposition surveyor intervened and NA-A ned R2. NA-A was unable to e R2 was repositioned. 10/6/21, at 10:48 a.m. NA-B e to keep track of each in time because they needed to hours. "That way, you know on't guess." 10/7/21, at 3:42 p.m. the histrator stated staff were the care plan for toileting and Assessment and Management 8, directed the facility would give measures for skin de an individualized turning chedule for residents with the policy also directed the on changes would be titrated	F6	86		
F 689 SS=D	Free of Accident Ha CFR(s): 483.25(d)(§483.25(d) Acciden		F 6	89		11/5/21

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F 689	The facility must er §483.25(d)(1) The as free of accident \$483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on observareview, the facility for the facil	resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview and document failed to provide supervision of 1 residents (R2) reviewed for were at risk for choking and um Data Set (MDS) dated 2 had severe cognitive quired supervision (oversight, d cueing) with eating. If Alzheimer's disease and illity to understand or express attus Care Area Assesmment I, identified R2 needed textures related to a intia and broken or missing ceive a Minced & Moist diet.	F 6	1. R2's care plan was review IDT team on 10/08/2021. It was determined that R2 should be meals for signs of choking or problems. Nutrition Follow-upevaluation done 10/28/21.Resuluation done 10/28/21.R	vas e observed at e swallowing p: SLP view of the ss, vision ration. ges in diet thin liquids, with cueing, ed in puree iewed and sphagia, a e planned to ating. all care plans agia, n 1		
	discomfort or pain altered diet. R2's current care p	and required a mechanically alan reviewed 9/1//21, identified ated on 9/6/19 which identified		supervision to ensure accura Education was provided to all 10-18-21 and 11-22-21 with r specifics to plan of correction (CNAs) on 10-21-21 and will specifics on 11-18-21 regardi	I nurses on more and HST's with more		

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 689	R2 needed texture dementia and age. directed to deliver, meals; observe for dehydration and to were to monitor R2 difficulties related to age. R2's physician order was to receive a remoist texture and the During a continuou 8:58 a.m. R2 was some the dining room. A their breakfast and eating in the dining and R2 began eating and R2 began eating left the dining room this time, R2 was not continued to eat incompany to eat incompa	modifications related to Interventions included were set up and assist during choking; swallowing problems; report as needed and staff for chewing/swallowing his memory issues and his ers dated 10/1/19, identified R2 gular diet with a minced and hin liquids. Is observation on 10/5/21, at served his breakfast meal in III other residents had finished R2 was the last resident room. R2's meal was set up in gindependently. Is ed practical nurse (LPN)-A to assist other residents. At oot in sight of any staff and dependently. R2 does not have choking or aspiration. A returned to the medication edge of dining room. R2 dependently. Characteristic in the medication of the dependently of the medication of the me	F 689	supervision during meals. 4. The director of nursing, or he designee, will conduct audits on accuracy for level of supervision residents eating on R2 and 5 ran residents. The audits will be conweekly for four weeks then mont two months. The results of the abesent to the QAPI committee for recommendation.	care plan with dom ducted hly for udits will	

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 689	- At 9:20 a.m. LPN-were in sight of R2 eat his meal while honto his clothing prosigns/symptoms of - At 9:22 a.m. LPN-but did not attempt continued to attempt mouth, but dripped onto his clothing promouth. - At 9:28 a.m. dieta R2's side of the kito the dining room. DA nursing assistant, but the dining room assistant, but dining room assistant	A left the dining room. No staff who continued to attempt to the continued to spill hot cereal otector, but was without choking or aspiration. A returned to the dining room, to assist R2 with his meal. R2 of to spoon hot cereal into his hot cereal from his spoon otector before reaching his ery Aide (DA)-A returned to chenette. LPN-A had again left A-A stated she was not a few was trained in CPR and the control of the cont	F 6	889		
	stated that day was normally rose every breakfast with the clasting lab work that breakfast. R2 was needed assistance plate. Additionally, tupdated from when R2 no longer requir watching R2 and all corner of her eye; hing room because residents. R2 did nowas sure R2 was in	10/5/21, at 9:31 a.m. LPN-A not a normal day for R2. R2 day at 7:30 a.m. and ate other residents. R2 needed at morning which delayed his fairly independent and only when food was falling off his the care plan probably was not R2 was previously sick and red assistance. LPN-A she was ways had him out of the nowever, LPN-A did leave the se she had tasks for other of have any trouble and LPN-A lentified as a choking risk a mechanically altered diet				

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F 689	but did really well. During interview on nursing assistant (Nin the dining room or residents were donone resident left easomeone in the dinknow who was at ririsk due to the diet. R2 was at risk. NA-R2 was not supervious During an interview registered nurse (Rhave been left along should have been a Whether that mean RN-A would have to supervision or assist determine exactly whether that mean RN-A would have to supervision or assist determine exactly whether that mean RN-A would have to supervision or assist determine exactly whether that mean RN-A would have to supervision or assist determine exactly whether that mean RN-A would have to supervision or assist determine exactly whether that mean RN-A would have to supervision with easistance and "supervision with eabecause she knew were expected to for the assistance each The facility policy A dated 12/9/19, indicated the assistance resident to ensuprovided the assistance provided the assistance resident in the facility policy A dated 12/9/19, indicated the assistance resident in the facility policy A dated the assistance resident in the facility policy A dated the assistance resident in the facility policy A dated the assistance resident in the facility policy A dated the assistance resident in the facility policy A dated the assistance resident in the facility policy A dated the assistance resident in the facility policy A dated the assistance resident in the facility policy A dated the assistance resident in the facility policy A dated the assistance resident resident in the facility policy A dated the assistance resident resid	10/5/21, at 10:09 a.m. NA)-C stated staff should stay until at least most of the e eating; however, if there was ting there must always be ing room to watch. Staff would sk for choking or aspiration type, but was unable to say if C stated she was unsure why sed while eating. on 10/7/21, at 2:19 p.m. N)-A stated R2 should not e in the dining room and assisted with his meal. It sitting, watching or cueing. In of the policy that addressed stance in the dining room to what R2's needs were. 10/7/21, at 3:36 p.m. the EDON) stated the residents in the were difficult as their es changed daily. This was rovided varying levels of upervision". R2 required ting, but would rely on RN-A the residents best. The staff ollow the care plan to provide	F 6	89			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		245636	B. WING		C 10/07/2021		
	PROVIDER OR SUPPLIER	JS FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1821 NORTH PARK FERGUS FALLS, MN 56537		10112021	
(X4) ID PREFIX TAG				X (EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 689	highest level of indethe level of assistant 1. Independent - pearea without assistanced for any staff cassistance devices No set up or physic 2. Supervision - stareminding. 3. Limited assistance fitems needed to minimal physical as guided maneuvering bearing assistance 4. Extensive assistance in perform Resident involved in bearing support. 5. Total dependence assistance with all A facility policy regar	ependence. The policy defined nce as follows: erformed self-care in a specific ance or help from staff, nor oversight, with/without and within a reasonable time. cal help from staff. If were to provide cues and/or oce - Needed set up/placement perform cares. May need esistance. Staff provided ag of limbs or other non-weight ance - Needed physical rming a portion of cares. In activity. Staff provided weight on the ended full staff	F6	689			



Electronically delivered October 27, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: PHU711

Dear Administrator:

The above facility was surveyed on October 4, 2021 through October 7, 2021 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 <u>only a suggestion</u> 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:

Jen Bahr, RN, Unit Supervisor Bemidji District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, MN 56601-2933

Email: Jennifer.bahr@state.mn.us

Office: (218) 308-2104 Mobile: (218) 368-3683

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPFIDENTIFICATION		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BOILDING.			C
		00531		B. WING		l l	7/2021
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
MN VETI	ERANS HOME FERGU	JS FALLS	-	RTH PARK FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION O	RDER				
		ction order has be by. If, upon reinspe- iency or deficienci ected, a fine for ea be assessed in ac fines promulgated artment of Health. hether a violation he compliance with all	en issued ection, it is es cited ch violation cordance by rule of nas been Il he tag				
	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 that may result from orders provided that the Department wit notice of assessme	n non-compliance at a written request hin 15 days of rece	with these t is made to eipt of a				
	INITIAL COMMENTON 10/4/21 through abbreviated survey by surveyors from the Health (MDH). Your compliance with the following correction indicate in your elections.	n 10/7/21, a licensing was conducted at the Minnesota Deput facility was found the MN State Licens orders are issued	your facility partment of I NOT in ure and the I. Please				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 11/05/21

STATE FORM 6899 If continuation sheet 1 of 19 PHU711

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDING.			
		00531	B. WING			7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
MN VETI	ERANS HOME FERGI	JS FALLS	RTH PARK FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
	when they will be control of the following compounds of the following compo	se orders and identify the date ompleted. plaints were found to be H5636015C (MN76001); ing orders were issued. plaints were found to be ED: H5636016C (MN68786) ment of Health is documenting a Correction Orders using ag numbers have been sota state statutes/rules for the assigned tag number eft column entitled "ID Prefix atute/rule out of compliance is the "To Comply" portion of r. This column also includes are in violation of the state attement, "This Rule is not met				
	as evidence by." For are the Suggested Time period for Con You have agreed to receipt of State lice the Minnesota Dep Informational Bullet https://www.health.n/infobulletins/ib14 orders are delineated Department of Heat you electronically. is necessary for State the word "context. You must them State licensure pro-	ollowing the surveyors findings Method of Correction and rection. o participate in the electronic ensure orders consistent with artment of Health				

Minnesota Department of Health

STATE FORM PHU711 If continuation sheet 2 of 19

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED			
	00524		B. WING			C 10/07/2021		
		00531	B. WC		10/0	17/2021		
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MN VETI	ERANS HOME FERGL	IS FALLS	TH PARK FALLS, MN	56537				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
2 000	corrected prior to el Minnesota Departm PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEAL IS NO REQUIREMI CORRECTION FOR	ectronically submitting to the eent of Health. RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES.	2 000					
2 830	Proper Nursing Car Subpart 1. Care in receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830			11/5/21		
	by: Based on observati review, the facility fa while eating, for 1 o	ent is not met as evidenced on, interview and document ailed to provide supervision f 1 residents (R2) reviewed for ere at risk for choking and		Corrected				

Minnesota Department of Health

STATE FORM PHU711 If continuation sheet 3 of 19

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				С		
00531			B. WING		10/0	7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VETI	ERANS HOME FERG	JS FALLS	RTH PARK FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 3	2 830			
	6/2/21, identified R impairment and recencouragement an Diagnoses included	um Data Set (MDS) dated 2 had severe cognitive quired supervision (oversight, d cueing) with eating. d Alzheimer's disease and ility to understand or express				
	R2's Nutritional Status Care Area Assesmment (CAA) dated 9/3/21, identified R2 needed mechanically altered textures related to a diagnosis of dementia and broken or missing teeth. R2 was to receive a Minced & Moist diet. R2's Nutrition Assessment - V2 dated 9/1/21, identified R2 had poor dentition and required close monitoring for chewing difficulties, discomfort or pain and required a mechanically altered diet.					
	an intervention initi R2 needed texture dementia and age. directed to deliver, meals; observe for dehydration and to were to monitor R2	lan reviewed 9/1//21, identified ated on 9/6/19 which identified modifications related to Interventions included were set up and assist during choking; swallowing problems; report as needed and staff for chewing/swallowing o his memory issues and his				
		ers dated 10/1/19, identified R2 gular diet with a minced and hin liquids.				
	8:58 a.m. R2 was s the dining room. A	s observation on 10/5/21, at served his breakfast meal in Il other residents had finished R2 was the last resident				

Minnesota Department of Health

STATE FORM PHU711 If continuation sheet 4 of 19

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		A. BOILDING.		C			
00531		B. WING		10/07/2021			
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VETI	ERANS HOME FERGI	JS FALLS		RTH PARK 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	eating in the dining and R2 began eating. At 9:05 a.m. licens left the dining room this time, R2 was not continued to eat individual signs/symptoms of the signs and the signs are signs are signs and the signs are signs and the signs are signs and the signs are	room. R2's many independently sed practical nutro assist other ot in sight of and dependently. R2 choking or asport. A returned to the dependently. The dependently set on tinued to attend to the dependently. The dependently set on tinued to attend to a the dependently. The dependently set on the dependently set on the dependently. The dependently set on tinued to a the dependent of the dependen	ly. Jurse (LPN)-A residents. At r	2 830	DEFICIENCY)		
	the dining room. Donursing assistant, be Heimlich maneuver	out was trained	in CPR and the				

Minnesota Department of Health

STATE FORM PHU711 If continuation sheet 5 of 19

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BOILDING.		С		
00531			B. WING	B. WING 10/07/2		
NAME OF PRO	VIDER OR SUPPLIER			STATE, ZIP CODE		
MN VETERA	ANS HOME FERGU	IS FALLS	RTH PARK FALLS, MN	56537		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Dest not be standard for the standard fo	uring interview on eated that day was breakfast with the oresting lab work that eakfast. R2 was eeded assistance ate. Additionally, to dated from when 2 no longer requiratching R2 and altorner of her eye; honing room because sidents. R2 did not as sure R2 was independent of the dining room to be decause he was on the dining room to be decause he was on the dining room to be decause he was on the dining room to be decause he was on the dining room to be decause he was on the dining room to be decause he was on the dining room to be decause he was on the dining room to be decaused here. We was at risk due to the diet of the dining an interview of the dining an interview of the diet of the dining an interview of the dining an interview of the diet of the dining an interview of the dining and the dining an	when the nursing staff were as like a community. However, nem to tell her when she sidents. 10/5/21, at 9:31 a.m. LPN-A not a normal day for R2. R2 day at 7:30 a.m. and ate other residents. R2 needed to morning which delayed his fairly independent and only when food was falling off his he care plan probably was not R2 was previously sick and ed assistance. LPN-A she was ways had him out of the owever, LPN-A did leave the se she had tasks for other of thave any trouble and LPN-A lentified as a choking risk a mechanically altered diet 10/5/21, at 10:09 a.m. IA)-C stated staff should stay until at least most of the e eating; however, if there was ting there must always be ing room to watch. Staff would sk for choking or aspiration type, but was unable to say if C stated she was unsure why	2 830			

Minnesota Department of Health

STATE FORM PHU711 If continuation sheet 6 of 19

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		A. BUILDING:			_		
00531		B. WING		C 10/07/2021			
NAME OF PRO	VIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VETER/	ANS HOME FERGU	IS FALLS		TH PARK FALLS, MN	56537		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Didith cowline subsequent the cowline subsequ	ontinued From parapervision or assistermine exactly warring interview on rector of nursing (exactly in a memory care urondition and abilition	stance in the or what R2's need and warping the resident requirements of Data and managed are that the resident the resident resident repeated ADL care and managed are that the resident repeated aging the residence or help for the resident requirements of Data and managed are that the residence or help for the residence or help	ds were. :36 p.m. the the residents in ult as their laily. This was ng levels of R2 required d rely on RN-A best. The staff plan to provide uired. illy Living (ADLs) e and assistance by the nursing sident was to complete ADL ident to exercise he policy defined care in a specific rom staff, nor /without reasonable time. Staff. vide cues and/or set up/placement s. May need ff provided other non-weight d physical on of cares. If provided weight	2 830			

Minnesota Department of Health

STATE FORM PHU711 If continuation sheet 7 of 19

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00524	B. WING		40/0	
NAME OF I		00531			10/0	7/2021
	PROVIDER OR SUPPLIER	1821 NOR		STATE, ZIP CODE		
MN VETI	ERANS HOME FERGU	JS FALLS FERGUS	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 7	2 830			
		arding supervision dining ested, but not received.				
	DON or designee c and procedures rela during meals for re- need. The DON or and conduct audits	THOD OF CORRECTION: The ould review and revise policies ated to providing supervision sidents according to assessed designee could educate staff to ensure compliance and e quality assurance committee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
2 905	MN Rule 4658.0525	5 Subp. 4 Rehab - Positioning	2 905			11/5/21
	positioned in good of residents unable must be changed a including periods of been put to bed for has documented the hours during this tire.	g. Residents must be body alignment. The position to change their own position t least every two hours, fitime after the resident has the night, unless the physician at repositioning every two me period is unnecessary or rdered a different interval.				
	by: Based on observati review, the facility for repositioning service R67, R2) reviewed ulcer development repositioning.	ent is not met as evidenced on, interview and document ailed to provide timely ses for 3 of 3 residents (R21, who were at risk for pressure and dependent upon staff for		Corrected		
	Findings include:					

6899

Minnesota Department of Health STATE FORM

PHU711 If continuation sheet 8 of 19

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			,
		00531	B. WING			7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VETI	ERANS HOME FERGI	JS FALLS	RTH PARK FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	Continued From page 8		2 905			
	6/25/21, identified I impairment and recassistance with all MDS further identification developing pressur diabetes mellitus, hweakness or loss obody) or hemipares strength or paralysigeneralized musclesclerosis (MS). R21's current care R21 had skin break	nimum Data Set (MDS) dated R21 had moderate cognitive quired extensive to total activities of daily living. The ied R21 was at risk of re ulcers. Diagnoses included remiplegia (mild or partial of strength on one side of the sis (severe or complete loss of is on one side of the body), we weakness, and multiple plan dated 2/26/20, identified adown to his coccyx and				
	buttock crease and had a history of pressure ulcer on his left outer ankle. The care plan directed staff to assist with repositioning every two hours when sitting and when laying down and encourage R21 to lay down between meals and activities. Any refusals were to be documented. R21's Tissue Tolerance Assessment dated					
	himself and utilized relieving mattress v repositioned every care plan. He pres	R21 was unable to reposition boots, pillows and pressure while in bed. R21 was two hours according to his ently had breakdown on his quafor was used when				
		e (for predicting pressure ulcer , identified R21 was moderate pressure ulcers.				
	identified R21 had bottom as R21 was	in Risk Factors dated 9/24/21, chronic skin break down to his not able to reposition himself d due to his MS. R21 was able				

Minnesota Department of Health

STATE FORM PHU711 If continuation sheet 9 of 19

Minnesota Department of Health

winnesc	ta Department of He	aim				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
					l c	:
		00531	B. WING			7/2021
NAME OF I		CTDEET AD		STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MN VET	ERANS HOME FERGU	IS FALLS	RTH PARK FALLS, MN	56537		
	OLIMANA DV OTA				N	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINED TO THE	D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 9	2 905			
	be repositioned. He Aquafor was applied R21 had a Foley ca	n he wanted to lay down and had no open areas and d to his bottom for prevention. theter in place. He had times positioned either in bed or his				
	During continuous observation on 10/6/21, at 7:09 a.m. nursing assistant (NA)-D pushed R21 from his room in a high-backed wheelchair with an attached headrest, to the television sitting area near the nursing station. R21 was dressed and the wheelchair was reclined slightly.					
		ed practical nurse (LPN)-B orning medications.				
	room behind the nu insulin	B brought R21 to a conference rses' station, administered his him to the common sitting				
	-At 8:40 a.m. LPN-E	3 wheeled R21 to the dining t a table.				
	R21's breakfast ord	ered nurse (RN)-B obtained ler, brought the completed ary aid and returned to the s for R21.				
		eceived his meal and RN-B ng assistance to R21.				
	RN-B wheeled him room and positione	completed eating his meal and from the dining room to his d his wheelchair next to the offer repositioning to R21.				
	On 10/6/21, at 9:58	a.m. NA-E stated R21 got up				

Minnesota Department of Health

STATE FORM PHU711 If continuation sheet 10 of 19

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					c	
		00531	B. WING		10/0	7/2021
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
MN VETI	ERANS HOME FERGU	JS FALLS 1821 NOR	TH PARK FALLS, MN	56537		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)NI	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 905	Continued From pa	ge 10	2 905			
	prior) and he requir three hours. She w NA-E entered R21's the bed utilizing a c little bit of pain on h stated R21 currently on the right buttock coccyx. They appli protestant) and Cal ointment) on the are encouraged R21 to his bottom. When a repositioning sched plan posted on the and identified it dire repositioning every breakfast was really lot of people to get in. Due to this, it was really the same posted on the and identified it directly breakfast was really lot of people to get in. Due to this, it was really the same posted on the same posted on the and identified it directly breakfast was really lot of people to get in. Due to this, it was really the same posted on the same poste	two hours. She stated / hard for staff as they had a up and a lot who liked to sleep as usually three hours in the / could reposition R21 and				
	stated R21 was to be hours. His skin was they used Aquafor a bath note indicated continuing to heal. they were not award bottom. On 10/6/21, at 10:4 room and asked R2 bottom. R21 stated scale. RN-B stated developed and resconf excoriation (an a surface of the body	10/6/21, at 10:20 a.m. RN-B be repositioned every two is compromised in the past and as a barrier cream. R21's last the areas on his bottom were RN-B and LPN-B both stated is of any open areas to R21's end to rate the pain in his at the pain was a five on a 1/10 the issues to R21's bottom blved quickly and were areas brasive or tearing injury to the promise of the pain (force is skin is moved against a fixed).				

Minnesota Department of Health

STATE FORM PHU711 If continuation sheet 11 of 19

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONTROL OF THE CON	IDENTIFICATION NOMBER.	A. BUILDING:			
		00531	B. WING		10/0°	; 7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MN VFTI	ERANS HOME FERGU	IS FALLS 1821 NOR	TH PARK			
	I	FERGUS	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 11	2 905			
	opposite direction to measured and description (cm). The area was Area 2 (right of Area was blanchable. Area 3 (coccyx) 2.2 blanchable. Area 4 (right glutea area was blanchabl During interview on stated R21 had an eskin integrity on his and closed repeater	a 1): 0.2 x 0.4 cm. The area 2 x 0.4 cm The area was 1 crease) 3.1 x 0.4 cm. The e with blood. 10/7/21, at 3:44 p.m. RN-C ongoing chronic issue with the bottom. The areas opened dly. He should be two hours and three hours was				
	During interview on 10/7/21, at 4:51 p.m. the director of nursing (DON) stated she would have expected R21 be repositioned or offered repositioning as directed by his care plan.					
	identified R67 had s and required assista was at risk for press have any current pr	ange MDS dated 8/5/21, severe cognitive impairment ance with for all transfers. R67 sure ulcers; however, did not essure ulcers. The MDS s of dementia with behavioral				
	R67 was at risk for dementia, a possibi intake and age. R67 staff were directed with a ceiling lift; an	plan dated 7/30/21, identified skin breakdown related to lity of non-adequate meal 7 used a rock-king chair and to assist R67 with all transfers d take R67 to the nearest				

Minnesota Department of Health

there by himself. However, the care plan did not

STATE FORM PHU711 If continuation sheet 12 of 19

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00531	B. WING		10/0	; 7/2021
NAME OF	PROVIDER OR SUPPLIER		I.	STATE, ZIP CODE	1 10/0	172021
MN VET	ERANS HOME FERGU	IS FALLS	TH PARK FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	identify frequency of R67's Skin Risk Falidentified R67 was R67 had limited about with staff and R67 in needs and completed R67's Tissue Tolera 8/21/21, identified Foondition and was in himself in bed or in anticipate R67 need hours. During a continuour 7:02 a.m. R67 was rock-king chair in the - At 8:28 a.m. R67 room in his rock-king repositioned during repositioned during reposition himself. At 8:57 a.m. R67 continued to sit in his breakfast. - At 8:57 a.m. R67 continued to sit in his preakfast. - At 9:30 a.m. NA-Aremoved R67's clot attempt to reposition from the dining root the TV in the community in the community residents was not the residents w	of R3's repositioning needs. ctors -MVH dated 8/2/21, at high risk for skin injury. lity to communicate his needs relied on staff to anticipate e cares. ance Assessment -MVH dated R67 had a recent change in no longer able to reposition his chair. Staff needed to ds and reposition every two s observation on 10/6/21, at observed to sit in his ne dining room. continued to sit in the dining ng chair. R67 was not this time nor did R67 At this time, R67 was served had finished his breakfast but his rock-king chair in the dining approached R67 and ching protector. NA-A did not n R67. NA-A assisted R67 m and wheeled R67 in front of	2 905	DEFICIENCY)		

Minnesota Department of Health

STATE FORM PHU711 If continuation sheet 13 of 19

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					(
		00531	b. WING		10/0	7/2021
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
MN VETI	ERANS HOME FERGU	JS FALLS 1821 NOR	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 13	2 905			
	two hours. At that time, NA-A stated R67 was last repositioned before 7:00 a.m., but it "must have been close to seven".					
	- At 10:05 a.m. NA-repositioning.	A assisted R67 with				
	stated every reside every two hours. It	10/6/21, at 10:09 a.m. LPN-A nt was to be repositioned should be every two hours. ust goes against us."				
	DON and the admir	10/7/21, at 3:42 p.m. the nistrator stated staff were he care plan for repositioning.				
	R2's annual MDS dated 9/1/21, identified R2 had severe cognitive impairment and required assistance with repositioning. R2 was at risk for pressure ulcers; however, did not have any current pressure ulcers. Diagnoses that included Alzheimer's disease and diabetes.					
	an intervention initial impaired mobility redirected staff to aid Interventions includations with a mechan R2. The care plan a	lan reviewed 3/8/21, identified ated on 9/20/21, that R2 had elated to dementia and with transfers and mobility. led R2 needed one to two staff unical standing lift to transfer additionally direct staff to two hours and/or as needed.				
	was assisted to the	on 10/6/21, at 8:27 a.m. R2 dining room for his breakfast g in his wheelchair with a cushion.				
		heeled himself away from the NA-A did not offer to reposition				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 50.25 (6.			2
		00531	B. WING		10/0	7/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MN VETI	ERANS HOME FERGU	IS FALLS	RTH PARK FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 14	2 905			
	and NA-B reposition confirm the last time	surveyor intervened and NA-A ned R2. NA-A was unable to e R2 was repositioned.				
	During interview on 10/6/21, at 10:48 a.m. NA-B stated the staff were to keep track of each resident's reposition time because they needed assistance every two hours. "That way, you know the time and you don't guess."					
	During interview on 10/7/21, at 3:42 p.m. the DON and the administrator stated staff were expected to follow the care plan for toileting and repositioning.					
	The Skin Integrity: Assessment and Management policy revised 5/2/18, directed the facility would implement preventive measures for skin breakdown to include an individualized turning and repositioning schedule for residents with decreased mobility. The policy also directed the frequency of position changes would be titrated for the individual resident.					
	DON or designee c revise policies and residents receive th according the asses	THOD OF CORRECTION: The ould develop, review, and/or procedures to ensure the repositioning assistance assed need. The DON or relop an auditing system to impliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 915	MN Rule 4658.0525	5 Subp. 6 A Rehab - ADLs	2 915			11/5/21

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00531	B. WING		10/0	7/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MN VET	ERANS HOME FERG	JS FALLS	RTH PARK FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Subp. 6. Activities comprehensive reshome must ensure A. a resident is treatments and ser abilities in activities deterioration is a nother esident's condition part, activities of daresident's ability to: (1) bathe, dres (2) transfer and (3) use the toi (4) eat; and (5) use speece	of daily living. Based on the ident assessment, a nursing that: a given the appropriate vices to maintain or improve of daily living unless formal or characteristic part of ition. For purposes of this faily living includes the ass, and groom; and ambulate;	2 915			
	by: Based on observat review, the facility f assisted with eating reviewed who need Findings include: R2's annual Minimu 9/1/21, identified R impairment and red assist of one with e Alzheimer's diseas understand or expr	ent is not met as evidenced ion, interview and document ailed to ensure residents were g for 1 of 1 residents (R2) led staff assistance to eat. The provided staff assistance to eat. The provided supervision and physical eating. Diagnoses included eand aphasia (loss of ability to ess speech). The provided supervision and physical eating. Diagnoses included eand aphasia (loss of ability to ess speech). The provided supervision and physical eating. Diagnoses included eand aphasia (loss of ability to ess speech).		Corrected		

Minnesota Department of Health

STATE FORM PHU711 If continuation sheet 16 of 19

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION		/SUPPLIER/CLIA TION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00531		B. WING		10/0	7/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	-
MN VET	ERANS HOME FERGU	JS FALLS		RTH PARK FALLS, MN	56537		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 915	Continued From parand needed mecha a diagnosis of demeteeth. R2's diet order Further, R2 had a prochoking and/or asport R2's current care proceeding and potential for reloss/dehydration, claimpairments) with proceeded texture more dementia and age. Set up and assist dechoking, swallowing report as needed. During continuous 8:58 a.m. R2 was seed dining room. All off breakfast and R2 weat his meal in the lattempt to provide I however, R2 was seed the floor. - At 9:16 a.m. R2 comeal. R2 used a latto scrape hot cereat was able to spoon smouth, more hot cereat was able to spoon smouth.	nically altered entia and miser was minced otential for chiration. Ian reviewed stated on 9/6/19 nutritional dechewing/swallo progression of diffications relasted were directly as the last residents l	sing or broken d and moist. newing difficulty, 19/1/21, identified 20, identified R2 line (weight wing a dementia. R2 ated to his ected to deliver, observe for dehydration and 10/5/21, at akfast in the had finished their sident trying to Staff did not ance with eating; to himself and tempt to eat his a regular spoon self. While R2 eal into his er the edge of the ge, floor or onto a nurse (LPN)-A be able to spoon assist R2 with	2 915			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00531	B. WING		10/0	7/2021
	PROVIDER OR SUPPLIER	1821 NOF	DRESS, CITY, S	STATE, ZIP CODE	·	
MN VET	ERANS HOME FERGU	IS FALLS	FALLS, MN	56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 17	2 915			
	clothing protector be then picked up his formal into his mout a series of the picked up his formal into his mout a series of the picked up his formal into his fork while he table, the floor and No staff attempted offered assistance. During interview on stated that day was normally rose every breakfast with the contact of the picked up his fasting lab work that breakfast. LPN-A strindependent and or food was falling off probably was not up	ontinued to eat his hot cereal of cereal dripped onto the onto R2's clothing protector. redirection for R2 nor had 10/5/21, at 9:31 a.m. LPN-A not a normal day for R2. R2 or day at 7:30 a.m. and ate other residents. R2 needed t morning which delayed his				
	registered nurse (R	on 10/7/21, at 2:19 p.m. N)-A stated R2 should have eating whether that meant g or cueing.				
	director of nursing (the memory care un abilities changed da varying levels of "as R2 required superv rely on RN-A becausest. The staff were	on 10/7/21, at 3:36 p.m. the DON) stated the residents in nit were difficult as their aily and the care plan provided esistance" and "supervision". ision with eating, but would se she knew the residents expected to follow the care assistance each resident				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00531	B. WING		10/0	7/2021
	PROVIDER OR SUPPLIER ERANS HOME FERGU	IS FALLS 1821 NOR	, ,	STATE, ZIP CODE 56537		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 915	The facility policy Adated 12/9/19, indice would be provided a department to ensure provided the assistanceds while encour highest level of indet the level of assistant 1. Independent - pearea without assistanced for any staff of assistance devices. No set up or physic 2. Supervision - stareminding. 3. Limited assistance of items needed to minimal physical as guided maneuvering bearing assistance. 4. Extensive assistance. 4. Extensive assistance. 5. Total dependence assistance with all the SUGGESTED MET The DON, or design regarding how to as providing supervision compliance.	ctivities of Daily Living (ADLs) cated ADL care and assistance and managed by the nursing are that the resident was ance needed to complete ADL aging the resident to exercise ependence. The policy defined are as follows: afformed self-care in a specific ance or help from staff, nor versight, with/without and within a reasonable time. all help from staff. If were to provide cues and/or see - Needed set up/placement perform cares. May need as isstance. Staff provided g of limbs or other non-weight ance - Needed physical ming a portion of cares. In activity. Staff provided weight the - Needed full staff	2 915			

6899

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MN VETS HOME FERGUS FALLS			(X3) DATE SURVEY COMPLETED	
		245636	B. WING			10/	06/2021
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME FERGUS FALLS				STREET ADDRESS, CITY, STATE, ZIP CODE 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	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMEN	ΓS	K 0	00			
	FIRE SAFETY						
	Minnesota Departmentime of this survey, Falls was found not requirements for particular Medicare/Medicaid 483.70(a), Life Safe National Fire Protection Standard 101, Life 19 Existing Health	Survey was conducted by the nent of Public Safety. At the MN Veterans Home Fergus in compliance with the articipation in at 42 CFR, Subpart ety from Fire, 2012 edition of ction Association (NFPA) Safety Code (LSC), Chapter Care, and the 2012 edition of illities Code (NFPA 99)					
	ALLEGATION OF (DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ONSITE REVISIT (CONDUCTED TO ' SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
		E AN EPOC, A PAPER COPY CORRECTION IS NOT					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY					
ABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

11/05/2021

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.

PRINTED: 11/30/2021 FORM APPROVED OMB NO. 0938-0391

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MN VETS HOME FERGUS FALLS			(X3) DATE SURVEY COMPLETED	
	245636	B. WING			10/	06/2021
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME FERGUS FA	ALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 NORTH PARK FERGUS FALLS, MN 56537				
PREFIX (EACH DEFICIENCY MUS	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		D BE COMPLÉTION	
2. Address the measure to ensure the deficiency 3. Indicate how the faci performance to ensure at the deficiency of the remains and monitoring of the remedy. MN Veterans Home Fer in 1997, with an addition end in 2011. The construction building is fully sprinkled system per NFPA 72. The corridors, spaces op resident rooms.	ASPECTIONS L DIVISION EET, SUITE 145 145, or ate.mn.us CTION FOR EACH CLUDE ALL OF THE ATION: In of the corrective action rect the deficiency. es that will be put in place of does not reoccur. Ility plans to monitor future solutions are sustained. Insible for the corrective of compliance. Is ed date for completion of In constructed on the west suction type is II (111). The d and has a fire alarm here is smoke detection in the barriers separating the	KC	000			

PRINTED: 11/30/2021 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MN VETS HOME FERGUS FALLS 245636 B. WING 10/06/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1821 NORTH PARK** MN VETERANS HOME FERGUS FALLS FERGUS FALLS, MN 56537 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) K 000 | Continued From page 2 K 000 hour fire barrier separating a clinic. The facility has a capacity of 106 beds and had a census of 93 at the time of the survey. The requirements at 42 CFR. Subpart 483.70(a) are NOT MET as evidenced by: K 345 Fire Alarm System - Testing and Maintenance K 345 11/5/21 SS=F CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation 1. The building maintenance foreman scheduled a semiannual inspection of the and staff interview, the facility failed to test and maintain the fire alarm in accordance with NFPA initiating devices for December 2021. 101 "Life Safety Code" 2012 edition, section 9.6.1.3, and NFPA 72 "National Fire Alarm and 2. All residents have the potential to be Signaling Code" 2010 edition, sections 14.5.3. affected by this deficient practice. and 14.6.2.4. This deficient condition could have a widespread impact on the residents within the 3. The building maintenance foreman schedule semiannual inspections of the facility. initiating devices for December 2021 and June 2022. Findings include: On 10/06/2021, at 10:55 AM, during a review of 4. The building maintenance foreman, or all available fire alarm test and inspection his designee, will conduct audits on documentation and an interview with a inspections of the initiating devices. The Maintenance staff member (TK), it was revealed audits will be conducted twice in the next that the facility could not provide any current year in order to ensure compliance is

PRINTED: 11/30/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MN VETS HOME FERGUS FALLS 245636 B. WING 10/06/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1821 NORTH PARK** MN VETERANS HOME FERGUS FALLS FERGUS FALLS, MN 56537 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 345 | Continued From page 3 K 345 documentation verifying that a semiannual reached. The results of the audit will be inspection of all initiating devices had been reported to the QAPI committee. completed. This deficient condition was verified by Maintenance staff member (TK). K 353 Sprinkler System - Maintenance and Testing K 353 11/10/21 SS=D CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5. 9.7.7. 9.7.8. and NFPA 25 This REQUIREMENT is not met as evidenced Based on observations, documentation review, 1. The three defective sprinkler heads and staff interview, the automatic sprinkler were replaced on 11/10/2021. system is not maintained in accordance with NFPA 101 "The Life Safety Code" 2012 edition, 2. All residents have the potential to be section 9.7.1.1, and NFPA 25 "Standard for the affected by this deficient practice. Inspection, Testing, and Maintenance of Water Based Fire Protection Systems" 2011 edition, 3. The building maintenance foreman

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The director of nursing, or her

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