



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 21, 2026

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

RE: CCN: 245636

Cycle Start Date: April 27, 2026

Dear Administrator:

On April 27, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J).

The Statement of Deficiencies (CMS-2567) is being electronically delivered.

Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On April 24, 2026, the situation of immediate jeopardy to potential health and safety cited at F600 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- **Civil money penalty, (42 CFR 488.430 through 488.444).**

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 27, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS location may notify you of their determination regarding any imposed remedies.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, MN VETERANS HOME FERGUS FALLS is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 27, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon St.
Marshall, MN 56258
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH

Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

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



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May 21, 2026

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

Re: Event ID: 22F49B-H1

Dear Administrator:

The above facility survey was completed on April 27, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245636		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/27/2026	
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME FERGUS FALLS				STREET ADDRESS, CITY, STATE, ZIP CODE 1821 NORTH PARK , FERGUS FALLS, Minnesota, 56537			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 4/22/26, 4/23/26, and 4/27/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H56361243C (2981086) with a deficiency issued at F600 PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.			F0000			
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation and document review the facility failed to provide adequate supervision and monitoring to prevent resident to			F0600	"Past Noncompliance - no plan of correction required"		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0600 SS = SQC-J	Continued from page 1 resident physical abuse for 1 of 1 resident (R1) reviewed for abuse when R2, who had a history of verbal and physical aggression towards staff and residents went into R1's room, allegedly grabbed him by the neck and threw him to the floor before leaving the room with R1's cane. Following the incident, the facility failed to provide adequate supervision and monitoring to ensure residents were protected from physical abuse putting them at the likelihood for serious harm, impairment or death when R2 continued to exhibit behaviors such as wandering into other resident rooms unsupervised. The IJ began on 4/10/26 at 1:50 p.m., when R2 entered R1's room and was seen exiting the room with R1's cane. R1 reported to facility staff, R2 entered his room and touched his belongings, R1 reported he got up from his chair, told R2 to stop, R2 placed his hand around R1's neck and threw him down to the floor. The administrator and director of nursing (DON) were notified of the IJ on 4/27/26 at 5:00 p.m. The facility implemented corrective action by 4/24/26 and therefore is issued as past non-compliance. R1 R1's admission Minimum Data Set (MDS) dated 3/25/26, identified R1 was admitted to the facility on 3/12/26, from home/community. R1 had moderately impaired cognition and moderate difficulty with hearing. R1 had verbal behavioral symptoms directed toward others (threatening others, screaming, cursing at others) and wandered one to three days out of seven. R1 was independent with toileting, transfers, and ambulation with a cane. R1's diagnoses included non-traumatic brain dysfunction, arthritis, Alzheimer's disease, Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia, mixed dementia, frontotemporal dementia, and dementia related to stroke), and depression. R1's height was 5 feet 5 inches and weighed 234 pounds. He was taking antipsychotic, antidepressant, and antiplatelet mediations. R1's Saint Louis University Mental Status (SLUMS) (a tool for detecting cognitive impairment in older adults) dated 3/24/26, identified a total score of 13 out of 30, to indicate cognitive impairment or possible dementia. A lower score in this range indicated more pronounced cognitive deficits that could be indicative of dementia. R1's progress notes from 3/25/26 through 4/26/26, identified:			F0600			

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F0600 SS = SQC-J	Continued from page 2 On 3/25/26 at 3:22 a.m., During rounds [R1] tried to barricade his door shut. Quiet and stayed in his room tonight. 3/26/26 at 9:09 p.m., [R1] received first scheduled dose of Seroquel 50 mg, not effective. Was one of the more agitated/restless shifts that he has had in the evening in the past week. 3/2026 at 12:23 p.m., [R1] sundown's hard after lunch and can become verbally aggressive with family and others as well fixated and upset about not being able to go home. 4/1/26 at 3:45 p.m., [R1] grew frustrated when he tried to ask peer what he was doing and did not respond. [R1] stated to peer "what are you stupid, you never answer me?" Peer grew agitated at name calling and put up fist and drew near [R1]. He raised cane and threatened to strike peer. Recreation staff placed self in between residents and deescalated the two. 4/5/26 at 8:42 p.m., [R1] was out of his room on the south unit and a resident walked near, reached out and grasped his cane. [R1] yelled at the other resident in a threatening tone and raised his cane at the resident. Staff remained 1:1 with resident due to both residents not wanting to be in their rooms. Anger lasted approximately 20 minutes. 4/7/26 at 3:03 p.m., physical therapy (PT) was asked to see if [R1] was appropriate to use front wheeled walker (FWW) as resident raised his cane toward another resident. [R1] demonstrated walking with his cane, which was appropriate and stable. [R1] had diagnoses of polyarthritis and lumbar spinal stenosis which could affect his balance so it would be best to stay with some assistive device but did not need a FWW. [R1] showed the cane to PT and described how he made it by using the natural curves in the diamond willow. He was very proud of the cane he had made. 4/9/26 at 9:38 p.m., [R1] looked for his jacket, was in the laundry cart to be washed. NA located it and told him about it being in the wash cart. He became			F0600			

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F0600 SS = SQC-J	Continued from page 3 upset and ripped the jacket from NA's hands. He was upset and angry and later apologized to NA. 4/10/26 at 1:55 p.m., [R1] was noted to be yelling out from his room. [R1] sat up against the wall on the floor inside room doorway and left elbow was bruised and slightly swollen. Lifted [R1] off the floor with Hoyer and placed in recliner. [R1] stated “that guy came into my room, started moving some of my stuff, I got up out of my recliner, and went over to him to tell him to stop. Then that guy grabbed my neck to choke me, threw me on the ground and took my cane.” 4/10/26 at 6:20 p.m., [R1] complained of right elbow tenderness. Purple bruising present, swelling estimated the size of a golf ball. Offer to send to ER for x-ray and stated he would go in morning if it was still bothering him. Ice applied. 4/11/26 at 1:15 p.m., [R1] was quiet this shift. Out for meals then returned to his room. Right arm elbow is tender. Did not allow staff to assist with cares this a.m. pleasant with all interactions. 4/11/26 at 4:39 p.m., 24 follow-up: complained of elbow pain. Applied ice two times a day shift. Bruise on buttock was larger. 4/12/26 at 11:35 a.m., Right elbow had bruising all the way around joint, light purple in color with one darker circular area noted on the posterior and one darker bruise on the anterior side. Range of motion (ROM) within normal limits. 4/14/26 at 12:50 p.m., [R1] had been pleasant this shift. Pain in lower back, right elbow and arm. 4/13/26 at 12:20 p.m., Fall related to 4/10/26, incident involved another resident who initiated physical aggression towards [R1]. Contusion to right elbow has absorbed and now had bruising around right elbow. Bruising also noted to left elbow and left buttock due to resident landing /falling on floor because of incident. No new fall interventions put into place due to nature of incident. Other interventions put into place to keep both residents involved separated.			F0600			

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F0600 SS = SQC-J	Continued from page 4 4/19/26 at 8:58 a.m., [R1] had a memory this a.m. of a traumatic event that occurred in the past week. The memory felt very real to [R1], which can be typical for post traumatic stress disorder (PTSD) diagnosis. Emotional support provided by staff. Details of memory are inconsistent. To assure this was a memory and not a new incident DON reviewed camera footage from the a.m. Other resident [R2] involved in past incident did not appear to have entered [R1's] room this a.m. 4/19/26 at 10:49 a.m., [R1] came to day room and started talking about "other peer." Stated if he saw him, he was going to hurt him and lay him out, threatened that he would hit this peer with his cane if he saw him. The other resident [R2] was 1:1 with staff for safety and had been kept out of sight of [R1]. Staff attempted to redirect him which seemed to escalate his agitation even more. He started to accuse stuff "you got someone to take other peer away when I am the one that he hurt." [R1] seemed to be remembering the incident and insistent that it happened today at 6:00 a.m. DON reviewed camera footage which revealed no accident had occurred this morning. 4/20/26 at 12:22 p.m.. [R1] was pleasant and at times walked around peer he had incident with on 4/10/26 without being fearful of him. R1's nursing assistant (NA) behavioral documentation from 3/29/26 through 4/26/26, (29 days) indicated R1's behavioral symptoms included: 3/29/26 at 1:32 a.m., through 4/2/26 at 11:52 p.m., 16 entries, no behaviors. 4/3/26 at 1:58 p.m., wandering 4/3/26 at 8:28 p.m., through 4/5/26 at 1:07 p.m., 6 entries, no behaviors. 4/5/26 at 10:06 p.m., and 10:07 p.m. yelling/screaming. 4/6/26 at 12:31 a.m., through 4/9/26 at 2:06 p.m., 9 entries, no behaviors.			F0600			

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F0600 SS = SQC-J	Continued from page 5 4/9/26 at 10:04 p.m., yelling/screaming. 4/10/26 at 5:20 a.m., through 4/19/26 at 1:59 a.m., 26 entries, no behaviors. 4/19/26 at 1:50 p.m., yelling/screaming, abusive language, and threatening behavior (see progress notes on this date). 4/19/26 at 9:06 p.m., through 4/26/26 at 11:55 p.m., 21 entries, no behaviors. There was a total of 83 entries, 78 entries with no behaviors, and 5 entries with behaviors. R1's Psychiatric visit progress note dated 3/26/26, identified [R1] had a history of progressive dementia and Alzheimer's. [R1] seemed to be doing well during the day but clearly had some sundowning that started early afternoon and can become problematic at night. [R1] has not been combative, worked as a police officer and laid carpet. He was calm and thought process was clearly confused and slightly repetitive. During an interview on 4/22/26 at 2:50 p.m., FM stated [R1] had gotten confused and forgetful, leading to his admission to the facility. At one point, [R1] had a cloth barrier placed across his doorway to discourage residents from coming into his room. Prior to the incident with [R2], R1 kept his door open. Since the incident with [R2], R1 kept his door closed to prevent [R2] from coming into his room. Even though R1 had poor recall, he was able to tell FM the details of the encounter with [R2]. R1 told FM he stood up and told [R2], "you cannot take things." R1 stated he [R2] started to choke [R1] and threw him down onto the floor. R1 told FM, he ended up on the floor with a sore elbow that turned black and blue. FM did not recall noticing marks on R1's neck. FM stated R1's explanation of the incident was accurate. FM felt R1 would most likely remember a good part of what happened especially when [R2], "laid his hands on him." She had seen [R2] wandering around the unit and was surprised it happened. FM felt the staff were good at keeping the two of them (R1 and R2) apart and placed at different spots in dining room when eating meals. FM stated [R1] has had no issues with any other residents that she was aware of since admission.			F0600			

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F0600 SS = SQC-J	Continued from page 6 During a follow up interview on 4/27/26 at 3:35 p.m., FM stated in the past, prior to R1's decline in cognition, if an intruder came into their home he would have gotten angry, would not attack but would asked them why they were there and told them, "This is my place get out." R1 was a retired police officer and was careful, making sure the doors were closed, locked, and secure at nighttime. R1 was protective but never violent. FM was not aware of R1 making false allegations of violence against him, he was very social and never seemed to get angry. During an observation and interview on 4/23/27 at 9:37 a.m., R1's room door was closed with a cloth barrier draped across the doorway. R1 sat in his recliner, fully dressed, and well groomed. R1 stated FM visited last week and was not able to recall FM's visit the day before. R1 identified he had five children, their names, and where they lived. R1 stated he had not fallen until about two weeks ago, had a sore elbow and right side since then. R1 stated he left the door to his room open and a gentleman who lived there entered his room, while he [R1] sat in his recliner. "This man [R2] went through my stuff across my room, by my door and started taking things. I told him, 'get out of here!'" R1 stated he stood up and walked over to him. R2 then placed his hands on R1's neck and choked him. "He was a big man and strong. He slammed me down on the floor onto my right side." R1 stated he bruised his right elbow. The nurses offered to send him to the emergency room but he did not go. R1 stated his right hand and thumb still hurt/throbbbed and he felt is was slightly puffy. R1 stated, "That man was not in my room long, only five minutes or less, taking things and putting them in his arms." R1 stated, "If that man came into my room again, he will not get another chance to hurt me again. Geez, being a cop for all those years and I could not even defend myself." R1 stated he yelled for help and staff came. R2 R2 quarterly MDS dated 2/5/26, identified R2 was admitted to the facility on 4/16/25, from home/community. R2 had minimal difficulty hearing, sometimes understood others, responded adequately to simple, direct communication only. R2 had severely impaired cognition with disorganized thinking or incoherence that fluctuated (comes and goes, changes in severity), and delusions (misconceptions or beliefs that are firmly held, contrary to reality). R2 wandered one to three days out of seven. He was independent with ambulation.			F0600			

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F0600 SS = SQC-J	Continued from page 7 R2's diagnoses included: non-traumatic brain dysfunction, Alzheimer's disease, non-Alzheimer's dementia, and depression. R2 was five feet, eight inches tall and weighed 216 pounds. R2 took antipsychotics and antidepressant medications. R2's SLUMS examination dated 5/5/25, identified a total score of 10 out of 30. A score range of 1 to 20 points indicated cognitive impairment or possible dementia. R2's physician and nursing orders identified: Escitalopram Oxalate (antidepressant) give 20 mg tablet by mouth in the evening related to Alzheimer's disease. Start date: 9/15/25 at 2:45 p.m. Mirtazapine (antidepressant) oral tablet give 30 mg by mouth one time a day to help with sleep and irritation. Start date: 3/12/26 at 5:00 p.m. Olanzapine (antipsychotic) oral tablet give 10 mg by mouth one time a day for agitation related to Alzheimer's Disease. Start date: 3/12/26 at 4:00 p.m. End date: 4/16/26 at 11:30 a.m. Olanzapine oral tablet give 10 mg by mouth two times a day for agitation related to Alzheimer's Disease. Start date: 4/16/26 at 5:00 p.m. Quetiapine Fumarate (antipsychotic) oral tablet give 25 mg by mouth every morning and at bedtime for mood. Start date: 4/11/26 at 6:00 a.m. End date: 4/16/26 at 11:21 a.m. Quetiapine Fumarate oral tablet give 50 mg by mouth as needed two times a day (bid) as needed (PRN) for agitation/restlessness. Start date: 4/10/26 at 4:30 p.m. End date: 4/16/26 at 11:21 a.m. N.O. Document behaviors every shift, document non-pharm and pharm interventions used for behavioral management. Document facial expressions, tone of voice, body language/gestures. Document activity/whereabouts. Every shift for behavior charting. Start date: 4/14/26 at 2:45 p.m.			F0600			

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F0600 SS = SQC-J	Continued from page 8 R2's Electronic Medication Administration Record (EMAR) and Treatment Administration Record (TAR) for April 2026, identified: Audible Door Sensor Alarm. Please monitor functioning and document amount of times triggered by resident each shift. Start date 4/24/26 at 10:45 p.m. Triggered on 4/24/26, three times on night shift. Triggered on 4/25/26 and 4/26/26/26 p.m., ten times on p.m. shift. Silent Alarm (bed). Please monitor functioning and document amount of times triggered by resident each shift. Started date: 4/24/26 at 10:45 p.m. Triggered 4/24/26 four times night shift, 4/25/26 a.m. one time day shift, ten times p.m. shift, and zero times night shift. Triggered on 4/26/26, three times on day shift, five times on p.m. shift and zero times on night shift. Silent Alarm (recliner). Please monitor functioning and document amount of times triggered by resident each shift. Start date: 4/24/26 at 10:45 p.m. Triggered: 4/24/26, through 4/26/26, zero times on all three shifts. R2's care plan dated 4/13/26, identified: Behavior/Mood. He may exhibit behaviors related to Alzheimer's /dementia and depression. Staff were directed to: effective 9/18/25- keep R2 occupied during times of restlessness/sundowning as those seemed to be times he wandered into other resident rooms; effective 9/18/25- engage him in meaningful cleaning or tinkering tasks; effective 9/18/25- anticipate his needs, be creative to keep him busy and out of situations that have the potential to cause another resident to yell at him as that can be a trigger for him to act-out physically; effective 1/12/26- if difficult to redirect or resistive to cares, reapproach task with male caregiver assist as resident at times is more receptive to males; effective 1/30/26- monitor whereabouts frequently due to him wandering into private spaces and his actions of touching and taking other residents' belongings as this is not always welcome by others; effective- 4/13/26- often on the move, entered rooms and others' spaces and unaware of others' personal space. Does not respect DO NOT ENTER signs. When approached by other residents, he can be			F0600			

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F0600 SS = SQC-J	Continued from page 9 unpredictable in his response; effective 4/22/25-when having behaviors, if not bothering others or super disruptive, do not redirect; effective Allow him to tinker. Non-pharm interventions liked to garden, work for a paycheck. Redirect, remove from environment if appropriate, provide activity, likes ice cream, look for unmet need and assist, redirect to toilet and assist if resident appears that he is about to void in inappropriate places, ask him to babysit baby doll, organize items, and fix things. R2 was at risk for elopement related to impaired safety awareness and history of elopement when at home. Staff were directed to monitor his whereabouts frequently due to him wandering into private spaces as this placed him at risk of his peers becoming aggressive with him and he may return aggression. Psychosocial wellbeing. R2 wandered about his environment and had dementia like behaviors related to the early onset of Alzheimer's disease. He went into other resident rooms and may take their things without realizing it was not his. Staff were directed to anticipate needs and redirect as able when needed. Therapeutic Recreation. Will need invitations, reminders and escorts to small and large groups and nearly constant redirection due to his impaired cognition and impulsiveness. Staff were directed to encourage independent leisure pursuits of cleaning, straightening, sweeping, folding towels, wiping tables. Please give him tasks around the unit to help him feel purposeful. He enjoyed being outdoors but needed constant redirection as he had little safety awareness and was impulsive. He liked to rake and water the grass but needed supervision. R2's progress behavior notes from 1/12/26, through 4/26/26, identified: On 1/12/26 at 8:52 p.m., 1/13/26 at 8:52 p.m., 1/15/26 at 9:44 p.m. [R2] walked in and out of other resident rooms. He had another resident's clothes on, taking things from one room to another, turning chairs over, rearranging furniture, and pulled fire alarm. Unable to redirect at times. On 1/15/26 at 8:31 p.m., [R2] was difficult to redirect this afternoon. He approached a table with			F0600			

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F0600 SS = SQC-J	Continued from page 10 two peers seated for supper, took papers and clothing protectors off table. Another resident told [R2] to leave in an angry voice, staff stood between residents and tried to de-escalate the situation. [R2] wanted to go outside, and fight. [R2] then turned and swung the clothing protector at staff and knocked over the other resident's milk. Staff stood between residents and [R2] held up his arm as to hit staff but was only verbally aggressive. On 1/21/26 at 8:12 p.m., [R2] became agitated, irritable around 3:00 p.m. and made several angry comments stated, "I'm not going to let these punks boss me around." He took other resident's belongings (walkers) and became agitated when staff attempted to remove item to prevent altercations with other residents. [R2] stated "I am not going to give it back, this is mine." Staff allowed him space due to increased agitation. On 1/21/26 at 10:09 a.m., [R2] continued to wander in and out of private areas, taking others personal belongings. He does have aggressive tendency mostly in the evening hours and had the potential to hit or become physically aggressive almost daily. On 1/23/26 at 10:13 p.m., noted in [other] resident's room twice, redirectable. On 1/26/26 at 8:49 p.m., [R2] walked by a table in dining room with two male peers sitting at it and touched peer's walker. [Peer] stated "that is not yours" several times. Nurse immediately intervened between the two residents. She cupped [peer's] elbow as he attempted to hit [R2]. Then [R2] threw approximately three or four closed fist punches towards [peer's] face: hitting him twice in the forehead. Staff placed her arms around [peer], attempted to block [R2's] punches and was hit a couple of times in the arm by [R2]. Door between north and south dining area was now locked until manager's team meeting to review incident. On 1/27/26 at 9:22 p.m., Wandering unit and went into two other resident rooms on south side, redirectable. Tried to exit out of the courtyard south side door, redirected by staff multiple times. On 1/29/26 at 9:07 p.m., Took nap and woke up			F0600			

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F0600 SS = SQC-J	Continued from page 11 angry very busy went into the three different resident rooms on the north unit side. On 2/10/26 at 9:06 p.m., Resistive to cares. [R2] removed garbage can from medication cart. After supper he went into a peer's room and was going to pick up an item and peer said, "that's mine." Re-directed out of the peer's room. On 2/17/26 at 1:44 p.m., [R2] incontinent of BM. Staff assisted him and became upset, resisting and hitting out. Additional staff assisted and distracted him. On 2/19/26 at 9:21 p.m.,. [R2] urinated in dayroom and in the sunporch. Very busy wandered around unit and went into peers' room and redirected. On 2/21/26 at 6:12 a.m., [R2] very active beginning of shift, going into other resident room. Not agitated and easily re-directed. Very busy pacing around. Stayed up until 3:00 a.m. On 2/21/26 at 10:27 p.m., [R2] was served supper and received [peer's] utensils. [Peer] stated "give it back to me!" [R2] was mad and agitated, moved to another [peer's] table. [Peer] protected his utensils and stated, "don't get mestaffs [sic]". [R2] held up the fork towards [peer]. Writer tried to redirect, de-escalate, and tried to move [R2] from the area. He was mad and stated to writer "I can hurt anyone." [R2] Calmed down more than one hour later. On 2/24/26 at 9:24 p.m., [R2] incontinent of bowel refused to go to bathroom, withdrawn and irritable. Ambulated about the south and north village, tried to open doors and went into other peers' rooms. On 2/28/26 at 8:38 p.m., Around supper time [R2] agitated/restless more than usual. He started to upset some of the other residents at his table. One of the other residents raised his hands up and in a joking manner as if in a "boxing motion." [R2] became very agitated, had to be separated from the other resident, and placed at another table. [R2] stated to the nurse "do you want me to beat that guy up for you?" [R2] was kept away from other residents until they went to bed.			F0600			

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F0600 SS = SQC-J	Continued from page 12 On 3/4/26 at 8:45 a.m., Staff reported this a.m. notice [R2's] increased agitation/behaviors with cares since discontinuation of olanzapine. Fax sent to provider. No new orders. On 3/7/26 at 1:53 p.m., per kitchen staff report, [R2] upset a peer when he attempted to take his walker out of the dining room. Peer intervened and said, "heh leave that alone it's mine." Peer repeatedly replied, "who said it's yours?" [R2] stepped away from peer and walker and went in a different director. Monitor. On 3/10/26 at 9:23 p.m., After supper [R2] wandered around the unit and went into a north side peers' room. Staff attempted to get him to come out of the room, sat on peer's bed and laid down. Peer upset and asked him to "exit the room." [R2] left the room. On 3/11/26 at 8:43 p.m., R2] very agitated this evening after supper. Wandered around quite a bit into resident rooms (with some of them getting upset), removed items out of other resident rooms and hard to redirect out of the rooms. [R2] attempted to push another resident in a wheelchair, upset the other resident (was getting angry/upset). Several staff approached [R2] multiple times to get him away from the resident in the wheelchair. On 3/12/26 at 8:40 a.m., increase in two psych medications today. Wandered around unit off and on, less agitated/aggressive and more directable. On 3/13/26 at 9:29 p.m., [R2] wandered about unit, seemed on edge and short with staff, and redirectable at times. On 3/16/26 at 5:15 a.m., [R2] wandered all shift on both north and south units. Finally asleep by 4:45 a.m. On 3/18/26 at 11:13 a.m., [R2] was on antipsychotics for wandering, aggression, and multiple behaviors. His mood was worse in the p.m. hours, medications do seem to help some.			F0600			

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F0600 SS = SQC-J	Continued from page 13 On 3/24/26 at 9:48 a.m., Behavior rounds: [R2] seemed to sundown shortly after lunch. Keep resident on south side of village if able due to history of physical aggression towards residents that live on the north side. If difficult to redirect or resistive to cares, reapproach task with male caregiver. On 3/27/26 at 9:21 p.m., [R2] sleepy, wandered into a peer’s room and laid down on his bed. Staff brought him to his room to lay down. Urinated in front of the curtain by entrance On 3/28/26 at 4:55 p.m., prior to supper [R2] was agitated, wandering between north and south side. At one point on the north side came up with two residents, appeared to possibly touch one of the residents’ drink/sodas. The resident sitting at the table became visibly upset at [R2] had somewhat of verbal altercation of which [R2] raised his arm and stood somewhat over the sitting resident, looked down at him, made a comment about beating him up. The writer stepped in between the residents, took [R2's] hand and walked away from the table. No physical interaction occurred, however, there was a possibility it could have escalated. [R2] was monitored to attempt to prevent him from coming over to the north side again. On 3/28/26 at 8:46 p.m., [R2] was agitated once daughter left. Wandering unit, hard to redirect. On 3/30/26 at 8:23 p.m., While attempting to administer medications in the afternoon, [R2] grabbed this writer’s arm forcefully and stated, “I’m not gonna do that.” Writer removed hand, disengaged him and gave him space. Irritable throughout the afternoon and early evening. On 4/8/26 at 8:30 p.m., Wandering, pushing furniture, going into other resident rooms and often will take their food or candy if not noticed right away. Continued behaviors but redirectable. On 4/10/26 at 2:00 p.m., [R2] was noted to be coming out of another resident room with a cane. This was an ongoing behavior of this resident to wander throughout the unit, entering other resident rooms and moving things around. The resident of who [R2] entered stated “the resident came into my			F0600			

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F0600 SS = SQC-J	Continued from page 14 room and moved things around, then choked me and threw me to the ground.” Removed cane from [R2], monitor, currently not agitated currently oriented to self only. On 4/10/26 at 4:00 p.m., and 4:48 p.m., Called mental health provider unable to reach, left message. Called primary provider updated regarding [R2's] behavior and received PRN for agitation. On 4/10/26 at 6:00 p.m., transferred to medical facility ED in van with facility staff. On 4/10/26 at 6:07 p.m., In lieu of another incident of aggression by [R2] towards another resident who did not appreciate him wandering into his room, touching their belongings, writer had a long conversation with his [R2] wife about next steps, sent to ED for evaluation of psychiatric inpatient to evaluate his continued aggression. Discussion also had that they may not admit him as he is usually calm natured, but a quick anger and become physical or verbal when he is confronted by peers and told to not do or touch something. That was not something easily treated without the potential of over sedation. Family aware that made it hard for the facility to manage as he is almost constantly wandering about the village unit, in and out of resident rooms commons areas, fidgeting and touching everything without constant supervision. It was hard to predict when a behavior may occur from any resident on the Village. They [family] are aware they [facility] may need to start discharge planning to a different facility to ensure everyone’s safety. Family voiced understanding. If not admitted to the medical center family will help over the weekend to increase our ability to monitor [R2’s] whereabouts on the unit more closely. On 4/10/26 at 6:28 p.m., provided [R2] with 1:1 supervision by recreation staff immediately after incident until he was transported to the ER. He was calm, cooperative, and did not recall an incident occurring. On 4/10/26 at 8:55 p.m., ED provider had talked to psych medical doctor (MD), administered 50 mg of Seroquel (Quetiapine Fumarate). Will be sending [R2] back to facility with written orders: Seroquel scheduled twice a day (b.i.d.) and PRN.			F0600			

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F0600 SS = SQC-J	Continued from page 15 On 4/10/26 at 10:22 p.m., [R2] returned to facility with his wife. A new psych visit will be requested for next week. If conditions worsen return to ED. Discussed with wife if family would be available during specific times on Saturday and Sunday. Maybe difficult due to grandchild sporting event. On 4/11/26 at 5:45 a.m., [R2] slept all shift after he arrived back to facility at 10:22 p.m. Every 15-minute checks completed for his shift. On 4/11/26 at10:51 a.m., Woke up at 9:00 a.m., ate breakfast and was calm. Staff continued every 15-minute checks. Spoke with wife, she will be coming in at 2:00 p.m. to sit with resident as he becomes more agitated and busier in the afternoons. On 4/11/26 at 1:35 p.m., Staff provided very 15-minute checks, gets busy, wandering, busy easily redirected. On 4/11/26 at 2:21 p.m., Wife here sitting in [R2's] room with him. Continuing to monitor. On 4/11/26 at 10:27 p.m., Wife here from 2:00 p.m. to 4:00 p.m. [R2] has been pleasant currently sitting with staff. On 4/13/26 at 12:06 p.m., scheduled an appointment for 4/16/26 with psych. On 4/13/26 at 10:03 p.m., [R2's] Behaviors heightened before supper time. He was hard to redirect and refused cares multiple encouragements. When given PRN Seroquel noted to be calmer. On 4/14/26 at 1:18 p.m., remained 1:1 for this shift. On 4/14/26 at 10:18 p.m., [R2] busy this shift wandering, moving furniture. Had 1:1 starting at 4:00 p.m. to 10:00 p.m. On 4/15/26 at 4:14 a.m., slept almost entire shift, no behaviors. Continue frequent checks.			F0600			

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F0600 SS = SQC-J	Continued from page 16 On 4/15/26 at 1:45 p.m., [R2] walked around courtyard, attempting to break off branches and flowers. Recreation staff attempted to distract and remove from roses and tried to sneak a peak down back of pants as there was a foul odor [R2] grabbed staff's fingers and said, "If you touch me again, I'll break every finger on your hand." Proceeded to squeeze hand and lead recreation staff with him for approximately 15 seconds then let go. On 4/16/26 at 12:05 p.m., [R2] seen by psychiatric provider. New orders received: discontinue scheduled Seroquel (no need for two antipsychotics), change Zyprexa to 10 mg po every a.m. and 10 mg po every 5:00 p.m. (when available), add Zyprexa 5 mg po every six hours PRN for agitation or aggression. On 4/16/26 at 9:21 p.m., No behaviors this shift. Wife here for activity and had 1:1 from 4:00 p.m. to 9:00 p.m. On 4/16/26 at 5:37p.m., Late entry 4/14/26. Wife returned writer's call. Discussed possible discharge planning maybe needed for resident related to recent behaviors or an inpatient behavioral hospital stay. Writer asked if family would be able to come and be with resident. Wife does not live locally and indicated family would not be able to come. On 4/17/26 at 22:19 p.m., No noted aggressive behaviors. He did have some unrecognizable type of conversation, wandering, but no noted issues. On 4/18/26 and 4/19/29, no behaviors noted. On 4/19/26 at 1:28 p.m., Walking around, wandering around unit today. Typical baseline. Has walked around peer he had incident on 4/10/26. [R2] did not appear fearful when he has walked by peer or when peer walked by him. Did not appear to remember incident or other resident involved. On 4/20/26 at 9:39 p.m., Beginning of shift [R2] had increased agitation and not able to redirect. He received Zyprexa 5 mg which was effective.			F0600			

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F0600 SS = SQC-J	Continued from page 17 On 4/23/26 at 9:25 p.m., [R2] wandering in south and north units and into other resident rooms, rearranging furniture. Used redirection, positive reinforcement and distractions. Confused and not aggressive responses. On 4/24/26 at 10:16 p.m., [R2] was very agitated, took food from another resident's plate, walked around with the dinner plate and silverware, very hard to redirect. Currently 1:1 with staff person. On 4/26/26 at 12:46 p.m., Required more supervision as he wandered, unable to stay on task, easily redirectable but required frequent redirection. R2's psychiatric visit progress note dated 1/22/26, identified [R2] as having a lot of behaviors, not sleeping well, seemed to have his days and night mixed up. Staff indicated he was having sundowning, getting a little bit scary, and worried he might hurt somebody. [R2] wandered frequently into other resident rooms to use their bathroom or sleep in their bed and very hard to redirect. Sometimes [R2] was verbally aggressive but luckily, he was not significantly physically aggressive and irritates a lot of the other residents who potentially might hurt him because of his behaviors. Unfortunately, we will not be able to stop [R2's] wandering but could add a medication, Mirtazapine (Remeron) to solidify his sleep and decrease irritability. [R2's] diagnoses included: senile dementia, Alzheimer's type with history of aggression and behavioral issues, insomnia, and sundowning. He was sleeping in a room that was not his own, woke up quite easily, and confused. R2's psychiatric visit progress note dated 2/26/26, identified [R2] was started on Mirtazapine last month and does not seem to be doing much will leave him on it for now. He was occasionally agitated with his peers when confused. He was not typically physically aggressive with staff and peers if people approach him the right way. R2's psychiatric visit progress note dated 3/26/26, identified recently more agitated and pushed some other residents around in their wheelchairs. [R2] can be occasionally, a little bit irritable, continued to go into other resident rooms,			F0600			

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F0600 SS = SQC-J	Continued from page 18 and staff have tried to redirect him. Medications are appropriate and no changes will be made. R2's psychiatric visit progress note dated 4/16/26, identified [R2's] record review and a conversation with nursing staff identified an incident a week ago that led him to being placed in the emergency room for potential psychiatric admission. [R2] had once again gone into somebody's room and removed an item. The individual in that room accused him of aggression. After the incident [R2] seemed oblivious to these accusations, seemed calm and pleasant in ER and at the facility. [R2] frequently wandered into other people's rooms and took belongings or food or drink when people were eating. This was a chronic dementia behavior that he has had since admission. He sleeps well, although sometimes in people's rooms, and not angry or aggressive unless other residents confront him. Occasionally he refused medications but with redirection, took them. He was never spontaneously aggressive or violent and for the most part calm but very confused. [R2] had no recollection of any sort of negative interaction with any other residents. [R2] was napping when approached, sat up on edge of bed and pleasantly confused, and a bit tangential (having only a slight or indirect connection with something). He was unable to finish sentences, clearly had some word finding difficulties, calm and a little bit blunted (showed very little emotion). [R2] was unable to identify, his age, where he was, what town he was in, and thought he was still working. [R2] had some typical dementia related behaviors of taking other people's belongings and was typically not spontaneously aggressive or agitated with anyone, usually in good spirits, no symptoms of depression or anxiety, does not seem psychotic or mantic, and would be very difficult to try to calm the situation down. Psychiatric hospitalization would not be beneficial. Medication changes: discontinuation of quetiapine and increase olanzapine (Zyprexa) (antipsychotic) to 10 mg in the morning and evening at 5:00 p.m., and 5 mg available every six hours PRN for agitation or aggressive behaviors. [R2] does not exhibit a lot of anger unless provoked. Hopefully his wandering and sticky finger behavior will settle down as his dementia progressed. Evaluation planned for next month. R2's NA target behavior monitoring: Which listed behavior(s) did the resident display? Review of behaviors identified from 1/1/26, through 4/26/26, identified: Interventions: Target behaviors choices: 1) exit seeking 2) wandering 3) verbal aggression towards others 4) unaware of personal space 5) physical aggression 6) voiding in inappropriate			F0600			

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F0600 SS = SQC-J	Continued from page 19 places 7) intrusiveness 8) taking others' belongings 9) entering others' rooms. Triggers 1) yelling at [R2] 2) entering R2's personal space 3) certain tones of ones' voice 4) when approached aggressively or loudly (Trigger responses were not identified in documentation received): NA target behavior monitoring from 1/1/26, through 1/31/26, identified out of 93 entries documented: -Wandering 24 times (occurred typically from 1:15 p.m. to 5:33 a.m.). -Rejection of cares three times. -Kicking /hitting one time. NA target behavior monitoring from 2/1/26 through 2/28/26, identified out of 74 entries documented: -Wandering nine times (occurred typically from 1:32 p.m. to 6:10 a.m.). -Repeat movements one time. -Pushing one time. -Rejection of care one time. NA target behavior monitoring from 3/1/26 through 3/31/26, identified out of 92 entries documented: -Wandering 11 times (occurred typically from 1:26 p.m. to 5:15 a.m.). -Repeats movements three times. -Grabbing one time. -Rejection of cares two times. NA target behavior monitoring from 4/1/26 through 4/26/26, identified out of 73 entries documented: -Wandering 12 times (occurred from 1:48 p.m. through 5:15 p.m.). R2's ER visit dated 4/10/26 at 7:35 p.m., arrived at emergency department (ED) for reported aggressive behavior. [R2] was confused, unable to identify why he was there or the events leading up to his ER (emergency room) visit today. He is unable to			F0600			

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F0600 SS = SQC-J	Continued from page 20 follow commands but is calm and somewhat cooperative. Behavior notes from MVH (Minnesota Veteran's home) on 4/10/26 at 2:00 p.m. This was an ongoing behavior of [R2] to wander throughout the unit, sometimes entering other resident rooms, may move things around. The resident whose room [R2] wandered into stated that he came into my room and was moving things and then choked me and threw me to the ground. Unable to assess violence risk due to confusion. There are many other behavior notes indicating [R2] has been wandering and became irritable when staff attempt to redirect. He started some new medications for these behaviors on 3/12/26. Spoke with VA staff and relayed this was a challenging situation of need to keep other residents safe but knowing this patient had advanced Alzheimer's dementia and often was calm but wandered and got into other patient rooms and they get angry and confront him, which made him get angry and he had assaulted other residents then is easy to calm and redirect, hard to predict when it will happen. Spoke to on call psych provider and reviewed [R2] case and agreed if VA home was willing to take him back with med changes this was the best thing for him. [R2] was given quetiapine 50 mg in the ER and added an extra dose, start first dose of this medication 25 mg tomorrow with morning medications. A consultation was placed asking if tele psych for medication management with more continuity and availability could be available for this patient given the complexity of his situation and the risk to other veterans with his violent outbursts. Please discuss this more with his regular care provider. The facility implemented and documented 15-minute safety checks beginning 4/10/26 and discontinued them on 4/16/26 at 5:45 a.m. Email dated 4/16/26, at 9:51 a.m. sent to DON and Assistant director of nursing (ADON) by staffing registered nurse (RN)-B identified: Do we need to continue 1:1's in the village over the weekend? Email response dated 4/16/26, at 10:50 a.m. to DON and RN-B identified: Yes. Please do. I am unaware of any other interventions to prevent recurrence or options for alternative placement. Staffing is something we can do for now. During an interview on 4/27/26 at 10:19 a.m., staffing RN-B reviewed nursing schedules 4/10/26, through 4/27/26, and identified when extra			F0600			

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F0600 SS = SQC-J	Continued from page 21 staff were available,1:1's were completed with R2: 4/11/26 and 4/13/26- one extra staff in the village on the day shift, no extra staff on evening or night shift in the village. 4/14/26- one extra staff in village on day shift, one extra staff in village 4:00 p.m. to 9:00 p.m., in the village. No extra staff on night shift in the village. 4/15/26, 4/16/26 and 4/17/26- one extra staff in the village 4 p.m. to 9 p.m. 4/18/26- one extra staff in the village on day shift and evening shift, 6:45 a.m. to 9:00 p.m. 4/19/26- one extra in the village on day shift and evening shift, 6:15 a.m. to 9:00 p.m. 4/20/26- on extra in the village on day shift 9:00 a.m. to 2:45 p.m., and one extra in the village 4:00 p.m. to 9:00 p.m. 4/23/26, at this point RN-B had not been instructed to keep extra staff on the day shift. Two staff were extra on day shift, one had taken vacation and the other one completed education on computer. No p.m. or night shift 1:1 was provided for R2 on 4/23/26. 4/24/26- one extra on the village for evening and night shift. 4/25/26- on extra on the village for day shift, evening shift and night shift starting at 10:00 a.m. 4/26/27 and 4/27/26- one extra staff on the village for day shift, evening shift and night shift. During observations of R2 on 4/22/26: At 12:35 p.m., R2 walked over to a small table where another resident had eaten their lunch and located a plate, bowl, silverware, and leftovers. He grabbed a spoon and a small bowel of sliced			F0600			

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F0600 SS = SQC-J	Continued from page 22 pears, R2 ate the pears as he walked away. There were no staff in this area during this observation. He continued to walk down the hall and came upon a staff, and they stated, “make sure you put that bowl and spoon in the kitchen.” During an observation on 4/27/26 at 8:15 a.m., located outside R2’s door to his room was a Curebell cordless monitor sensor located on the upper right width of the door frame. During an observation on 4/27/26 at 9:27 a.m., R2 entered his room and NA-D walked behind him. The alarm to his door sensor went off as he walked through the doorway and sounded like a call light. NA-D reached up and turned off the alarm and followed R2 into his room. R2 sat down on his bed. NA-D talked with R2. During an observation on 4/27/26 at 4:03 p.m., R2 lay in his bed covered with blankets, lights off, and shades closed. NA-C was in the room providing 1:1 monitoring. R3 R3’s quarterly MDS dated 3/16/26, identified R3 had intact cognition. R3 ambulated with a walker. Diagnoses included: post-traumatic stress disorder (PTSD). R3’s Care plan dated 4/9/26, identified: Behavior/Mood: he may exhibit behaviors related to PTSD, depression, and anxiety. Staff were directed to knock on door prior to entering room including at night, covering his head with a blanket when sleeping due to PTSD. R3 had nightmares and yelled out/thrash out in sleep. He does not like people to sneak into his room at night, knock and announce when entering his room at night as well as during the day. Do not approach R3 from behind, gets startled easily. Triggers for behaviors: people entering his room and missing items due to being taken. During an interview on 4/22/26 at 3:51 p.m., R3 stated there were residents who came into his room at night when he was sleeping, almost every night. They tap on his head or shoulder or kick the bed. There was one resident [R2] who entered his room many times uninvited and still does. [R2] had taken his personal belongs and R3 told staff. One			F0600			

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F0600 SS = SQC-J	Continued from page 23 night R3 lay in bed sleeping between 1:00 a.m. and 2:00 a.m., woke up, heard someone in his room, looked up and saw [R2] standing next to his bed. [R2] had removed his resident handbook off a high shelf-located on the wall, opened it up, laid it across R3's legs while he slept, flipping through the pages. Early one morning [R2] came into R3's room and took his laptop computer. R3 asked him to bring it back, but [R2] continued to walk out of the room with it. R3 stated he had to rearrange things in his room and lock things up. [R2] was the only resident who visited his room frequently. [R2] had not been aggressive yet. R3 stated [R2] seemed to be a very nice man if you showed him attention, asked him how he's doing, and looked for someone to share love with. R3 stated he can see why other residents had gotten upset with [R2], things could get nasty, a resident could get hurt if they reacted in a way to upset [R2] with his behaviors. R3 had seen [R2] get physical one day when another resident with a walker sat in dining room. [R2] grabbed the walker, both residents pulled on it hard, arguing, staff had to intervene. [R2] was attracted to almost anything, loved to touch and take things. [R2] did not sit for more than two minutes, he was constantly on the move, always into everything, and he may cause someone to get hurt. [R2] needed 1:1 staff care but there was not enough staff to cover that. R3 stated he felt safe living at this facility, just must cope with it and live his life, however, it was unsettling and bothered R3 waking up during the night with [R2] standing next to his bed. R3 stated the uncertainly bothered him, he never knew what [R2] was doing or how [R2] would react if R3 said something. R3 was concerned that one night [R2] may react aggressively, but it was hard to predict. R3 had talked to staff about his concerns, [R2] continued to visit his room. R3 created a plan so that he was ready when [R2] entered his room while he was sleeping. Lately, before R3 turned in for the night, around midnight, R3 turned the volume up loud on his television then turned it off, placed the remote control under his pillow, and went to sleep. When he heard [R2] in his room or felt the bed being kicked or pushed with [R2's] knees (usually what happened), R3 turned the television on, once [R2] heard it, he would leave the room. Observation on 4/23/26 at 10:22 a.m., The Village Unit had five resident rooms from 130's through 140's had cloth material barriers draped across the doorways. Random rooms had signs located by or			F0600			

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F0600 SS = SQC-J	Continued from page 24 on the resident door: “No Trespassing!!! Private Property!!!! and “STOP” as well as “DO NOT ENTER!!!! During an interview on 4/23/26 at 10:26 a.m., nursing assistant (NA)-B stated R1’s cognition and memory seemed with it most of the time but does not remember when his wife visited and was worse on p.m. shift due to sundowning. R1 had no mobility issues when he ambulated with his cane and no falls. NA-B stated she had not seen R1 being aggressive with other residents or staff. When R2 walked/paced around the unit, R1 seemed a bit concerned but not anxious, upset, or fearful, and asked her, “what is he going to do?” R2 was confused, unable to sit for very long, and liked to stay busy. R2 wandered around the Village unit and into other residents’ rooms. NA-B stated a couple of weeks ago they had taken R2 off some of his medications, his behavior was worse. R2 was more agitated with everyone, resistive and not easily re-directed. NA-B heard about a spat that happened between R1 and R2. Types of things that would increase R2’s agitation were being told what to do, demanding, and getting in his face. Staff provided 1:1 with R1 after the incident for about one week. “We do not have enough staff for that, now staff tried to keep an eye on him and keep him [R2] out of [R1’s] room as discussed in staff report.” NA-B stated it was important to protect the residents when R2 was around and if staff noticed R2 became agitated and/or went into resident rooms, staff were directed to talked to him, distracted him with things such as play basketball or take him with them. During an interview on 4/23/26 at 11:15 a.m., recreation therapy staff (RTS) stated she provided recreation activities for the residents that lived on the Village unit. RTS stated she witnessed R2 being aggressive last week when they were outside. R2 stated to RTS, “if you touch me again,” and made a fist in front of her. RTS may have touched him and agitated him. When that happened, space was provided while RTS made sure R2 was safe. RTS had concerns about R1 a couple of weeks ago when RTS was outside with him and another resident while they sat on the bench. R1 stated he was not going to take crap from anyone, raised his cane, and shock it at the other resident. She placed herself in between the two residents and everything was ok. During an interview on 4/23/26 at 12:30 p.m., nurse manager registered nurse (RN)-A stated R1 was admitted to the facility on 3/12/26, family reported			F0600			

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F0600 SS = SQC-J	Continued from page 25 he did not allow assistance he needed at home. He had no previous falls within the last year. He was a retired police officer, liked people, and was not mean to others. His primary provider documented R1 was nervous, confused, anxious, and sometimes agitated at night. When he was admitted we identified verbal aggression to others and threatening self-harm. R1 had placed up his fists, raised a cane and threatened to strike a peer/another resident. Staff intervened; no physical contact occurred. RN-A stated she arrived in R1's room right after the incident on 4/10/26, between R1 and R2, and assessed R1. R1 had a swollen right elbow, bruising to both the right and left elbows, and a bruise on his left buttock. R1 did not have any marks around his neck. RN-A stated we had to believe what R1 had told us about the incident. R2 was a gentle giant, cognition level was not the best, struggled with memory, confused, and had a hard time focusing. R2 had behaviors and became startled when other residents had behaviors. R2 was unable to understand his boundaries, moved into other resident spaces, depending on how they reacted, would get up upset and his behaviors increased. Regarding the incident on 4/10/26, when R1 had gotten out of his chair, R2 may have seen it as R1 challenging him. Staff were expected to intervene when R2 seemed agitated. Staff should take his hand, turn him away from the situation and re-direct. Staff were instructed to not tell R2, "stop that", "don't do that", do not scold him, instead provide him with something to do. R2 had not always recognized or understood the signs on the residents' doors to stay out. Staff did their best to monitor R2's whereabouts, redirect him quietly out of another resident's room, and keep R1 and R2 separated to keep them safe. RN-A was unsure if R1 and R2 would recognize each other. After the incident, staff provided frequent checks on R2 and 1:1 when staff could spend individualized time with him. Extra staff worked on the unit (days/evenings) and helped monitor R2. RN-A stated there were no extra staff scheduled during night shift while the residents slept. There were times during the night R2 was up quite a bit and wandered out into the commons area. RN-A verified R2 had a history of incidents which included: 1/26/26, punched another resident three or four times, 2/21/26, held up a fork and threatened another resident, and 3/30/26, grabbed a nurse forcefully, RN-A did not believe the nurse was hurt. During an interview on 4/23/26 at 1:48 p.m., NA-A stated he worked mostly night shift and			F0600			

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F0600 SS = SQC-J	Continued from page 26 picked up day shifts when needed. During the night, R2 went into other resident rooms, picked up things such as clothing or anything he wanted, and carried them out of the rooms. On 4/10/26 around 2:00 p.m., NA-A noticed R2 was by the dining room table with a cane. NA-A recognized the cane belonged to R1. NA-A stated he heard R1 call out, "help, help me," and went to his room. R1 was on the floor on his right side/stomach area, inside the door with door open. R1 told NA-A, "[R2] had taken his cane away, grabbed him by the neck, and put him on the floor." NA-A stated he notified the nurse. R1 was lifted off floor with a Hoyer lift and placed on the bed. The nurse assessed R1, and NA-A left the room. Staff were expected to monitor R2's whereabouts more often, re-direct him, keep him away from R1, since that incident. R1 was believable and sometimes he was not, due to confusion. NA-A was not aware of R1 making this type of accusation against other residents. R2 could get aggressive if you tried to re-direct him, R2 physically pushed NA-A away during cares, and was more confused than anything. NA-A handled the situation, provided R2 space and reapproached when R2 became physical aggressive. NA-A stated he noticed R2's wandering behavior had increased over the months. During an interview on 4/23/26 at 2:40 p.m., director of nursing (DON) was unsure how to accommodate R2's wandering while ensuring he stayed out of other residents' rooms. DON stated concern if finding alternate placement was necessary for R2, related to his behavior. DON stated she called a local geriatric psychiatric unit, talked to the administrator but the unit was full. Additionally, she had checked a local hospital with behavioral health outreach but was unsure if it would be appropriate for R2. R2 had typical dementia behaviors, was agile, strong and reacted when confronted. R1 was very confused, and no one saw him pushed down. R2 was not typically aggressive. Those residents who would not talk back to him or were unable to, while he was in their rooms, would not be approached by R2, their things would not be taken, and he would have walked out of the room, but DON was unable to guarantee that. R2 usually touched other resident's belongings, not other residents. Residents with dementia would have screamed and not remembered five minutes later. Most of the time when a resident formulates anger they remember. During a follow-up interview on 4/27/26 at 12:24			F0600			

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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME FERGUS FALLS				STREET ADDRESS, CITY, STATE, ZIP CODE 1821 NORTH PARK , FERGUS FALLS, Minnesota, 56537			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = SQC-J	Continued from page 27 p.m., DON stated every 15-minute checks were started on R2 after the incident on 4/10/26 at 2:00 p.m. through 4/16/26 at 5:45 a.m., every 15-minute checks were completed and documented by staff. Every 15-minute checks were discontinued on 4/16/26 at 11:00 a.m., by the administrator. The frequent checks were not sustainable moving forward or for a nursing home setting. R2 had medication changes (discontinued Seroquel and increased Zyprexa), was sleeping ok, and appeared calmer. No time frame was set on how often staff were expected to monitor R2. Staff should have been aware of his whereabouts frequently. DON referred to R2’s care plan which indicated “frequently”. DON stated, frequently, meant at least every 15 minutes on days, and evening shifts. Night shift would essentially be a little different, residents would be sleeping, and staff would frequently patrol the area. At times R2, got up during the night, found staff, and got his needs met. DON stated she had not been informed that R2 had been in resident rooms during night shift, if he had been it would have been reported. During an interview on 4/27/26 at 3:12 p.m., occupational therapist (OT) stated all residents in the facility were considered vulnerable. OT had observed R1 walking and his balance was, “not tip top.” R1 used a cane for upper body support to aid in balance. He would have been more likely to have fallen or easier for someone to have pushed him down without a cane for support. R2 was physically able to ambulate independently, bend over and picked things up. R2’s cognition was not intact and was unable to follow directions. R2 was strong, had strength to pull a resident out of a chair but may have lost his balance. R2 could have physically shoved a person but there would have been factors to consider with the other resident and how the other resident’s gait was. During an interview on 4/27/26 at 4:05 p.m., NA-C stated she was assigned 1:1 with R2 tonight and that was her only assignment. NA-C stated R2’s cognition was not completely there; he was forgetful and confused. NA-C had witnessed R2 wandering into other resident rooms and was aware of a couple incidents when R2 was physical with other residents. R2 would get upset, mostly angry but also sometimes aggressive when confronted negatively or aggressively (verbally) by other residents or staff. Interventions she had used when R2 wandered into other resident rooms included: tried to keep him out of the rooms with redirection, if that did not			F0600			

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F0600 SS = SQC-J	Continued from page 28 work, followed him into the room and if unable to get him out, called for help to protect the other resident. Usually, R2 was easily redirected. During an interview on 4/27/26 at 4:15 p.m., RN-B stated she had completed 1:1 with R2 on an evening shift. R2 went into other resident rooms often. Residents on the Village were confused, did not understand and got upset when R2 entered their room. Staff were expected to monitor R2's whereabouts, redirect him as needed, avoid being too pushy, which seemed to trigger R2's aggression. She had not seen R2 get physical with another resident or staff but was aware of the incident between R1 and R2. Village focus Meeting document dated 4/15/26, identified [R1] and [R2] 4/10, incident: closely monitor both residents' whereabouts/activity. Try to keep separate. Document all behaviors. Give as needed (PRNs) as appropriate, both have PRN quetiapine (Seroquel) (antipsychotic) orders. See care plans (CPs). Facility policy Vulnerable Ault Resident Protection Plan dated 4/8/26, identified abuse as the intentional infliction of injury, unreasonable confinement, intimidation, or punishment that causes physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause bodily harm, or mental anguish. Physical abuse was defined as the use of force that may result in bodily injury, physical pain, or impairment. Population: The MHVs population presents the following factors which could result in maltreatment of residents: The assessment, planning of care, and services, and monitoring of residents may identify residents with needs and behaviors which may lead to conflict or neglect, such as residents with a history of cognitive deficits, sensory deficits, aggressive behaviors, behaviors such as entering other residents' room, wandering, self-injurious behaviors, socially inappropriate behaviors verbal outbursts, communication deficits, and those who require heavy care and/or are totally dependent on staff. It is the policy of MVH that all resident(s) will be protected from the alleged offender(s) or alleged Perpetrator(s). Facility policy Resident Danger to Self and/or Others, dated 12/4/24, identified definition of danger to self or others when a person may have demonstrated or are demonstrating danger or substantial and imminent harm to oneself and/or other through some recent or present act, attempt, or threat of the same. Others include all individuals			F0600			

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F0600 SS = SQC-J	Continued from page 29 surrounding the resident. A person may be considered dangerous to self and/or others when a guideline for assessment and interventions in instances of physical harm to others as appropriate: Any facility staff member directing observing or learning of a resident's behavior that is harmful to others will act immediately to ensure the safety of the resident and others. The IJ began on 4/10/26 and was removed on 4/24/26 after the facility implemented: Provide 1:1 supervision for R2 especially on the night shift through the weekend. There will no longer be a 4:00 p.m. to 9:00 p.m. staff person scheduled in the Village and instead three instead of two staff scheduled for the full 8-hour shifts. The third staff will be assigned to monitor R2. An extra staff will be added to the night shift Friday through Sunday and re-evaluated on Monday. Document patterns when staff are with him 1:1 to determine a better plan to know his patterns A silent bed and recliner alarm were placed on his bed. Motion sensor alarm was placed on the door to his room. Education posted on village unit for staff on instructions on how to use alarm. Review of R2's recent MD and psychiatry visits to ensure that any recommendations made had been explored and followed through to the care plan. Interviews completed with all residents in the Village and documented. Completed behavioral analysis of residents who have been impacted any time by R2 and noted if there had been any increased behaviors noted in those residents. No increased behaviors noted. All staff on Village will be educated at change of shift report on changes to care plans, staffing changes, new alarms, why they are being used and interventions on how to prevent further risk of injury to residents.			F0600			

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F0600 SS = SQC-J	Continued from page 30 Education regarding triggering events and high-risk residents and residents' danger to self and others policy was placed out on all three nursing units on 4/24/26.			F0600			

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/22/26, 4/23/26, and 4/27/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaints were reviewed during the survey. H56361243C (2981086) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.			20000			

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			