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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PHU7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00531

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245636**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **MN VETERANS HOME FERGUS FALLS**
(L4) **1821 NORTH PARK**
(L5) **FERGUS FALLS, MN** (L6) **56537**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/17/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **106** (L18)
13.Total Certified Beds **106** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	106			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, Unit Supervisor 01/06/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/06/2022 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/06/2018
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/08/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: PHU7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00531

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245636**
2.STATE VENDOR OR MEDICAID NO.
(L2)

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(L3) **MN VETERANS HOME FERGUS FALLS**
(L4) **1821 NORTH PARK**
(L5) **FERGUS FALLS, MN** (L6) **56537**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/07/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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06/30

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To (b) :

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	106			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Dani Yuretich, HFE - NE II 11/30/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/03/2021 (L20)

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

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X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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07/06/2018
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23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245636	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	**1821 NORTH PARK FERGUS FALLS, MN 56537**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/4/21 through 10/7/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/4/21 through 10/7/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED H5636015C (MN76001); however no deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5636016C (MN68786) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/05/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245636	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	**1821 NORTH PARK FERGUS FALLS, MN 56537**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676		11/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245636	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 676	Continued From page 2 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were assisted with eating for 1 of 1 residents (R2) reviewed who needed staff assistance to eat. Findings include: R2's annual Minimum Data Set (MDS) dated 9/1/21, identified R2 had severe cognitive impairment and required supervision and physical assist of one with eating. Diagnoses included Alzheimer's disease and aphasia (loss of ability to understand or express speech). R2's nutritional status Care Area Assessment (CAA) dated 9/1/21, identified R2 had a moderately high body mass index (BMI) of 26.5 and needed mechanically altered textures due to a diagnosis of dementia and missing or broken teeth. R2's diet order was minced and moist. Further, R2 had a potential for chewing difficulty, choking and/or aspiration. R2's current care plan reviewed 9/1/21, identified an intervention initiated on 9/6/19, identified R2 had a potential for nutritional decline (weight loss/dehydration, chewing/swallowing impairments) with progression of dementia. R2 needed texture modifications related to his dementia and age. Staff were directed to deliver, set up and assist during meals, observe for choking, swallowing problems or dehydration and	F 676	1. On 10/8, the IDT met in consultation with SLP, all resident care plans with an eating dependency, need for supervision/assistance, altered diet or dysphagia diagnosis were reviewed and necessary changes were made. Changes included removal of canned care plan language used by CDM to reflect all residents needing set up and supervision. Nursing added feeding dependencies and level of assistance to the ADL care plan and CDM updated nutrition and hydration care plans to reflect the current diet and any modalities or modifications while in the dining room. R2 was assessed by the speech language pathologist on 10-28-21. Changes to the care plan include a change in assistance/supervision. R2 is care planned to be at a supervised table with cueing. New resident kardex's were printed and are available to all staff. 2. Any resident that has dysphagia, a difficulty swallowing, or is care planned to have 1 on 1 supervision for eating. 3. The IDT team reviewed all care plans for residents that have dysphagia, difficulty swallowing, and 1 on 1 supervision to ensure accuracy. Education was provided to all nurses on 10-18-21 and HSTs (CNAs) on 10-21-21 regarding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MN VETERANS HOME FERGUS FALLS	**1821 NORTH PARK FERGUS FALLS, MN 56537**

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F 676	Continued From page 3 report as needed. During continuous observation on 10/5/21, at 8:58 a.m. R2 was served his breakfast in the dining room. All other residents had finished their breakfast and R2 was the last resident trying to eat his meal in the dining room. Staff did not attempt to provide R2 with assistance with eating; however, R2 was spilling food onto himself and the floor. - At 9:16 a.m. R2 continued to attempt to eat his meal. R2 used a large bowl and a regular spoon to scrape hot cereal towards himself. While R2 was able to spoon some hot cereal into his mouth, more hot cereal went over the edge of the bowl and landed on the table edge, floor or onto R2's clothing protector. - At 09:17 a.m. licensed practical nurse (LPN)-A applied gloves and approached R2. LPN-A repositioned R2's food for R2 to be able to spoon into his mouth, but did not offer to assist R2 with eating. R2 continued to attempt to eat his meal by himself. - At 9:23 a.m. R2 ate food that had fallen onto his clothing protector by picking it up with his hands, then picked up his fork and attempted to fork hot cereal into his mouth. - At 9:26 a.m. R2 continued to eat his hot cereal with his fork while hot cereal dripped onto the table, the floor and onto R2's clothing protector. No staff attempted redirection for R2 nor had offered assistance. During interview on 10/5/21, at 9:31 a.m. LPN-A stated that day was not a normal day for R2. R2	F 676	assistance during meals. Swallow screening form was updated by DON, CDM and ST to reflect current MDS language for level of assistance needed with meals. This will provided consistent language throughout the facility and resident care plan to lessen any confusion by staff. 4. The director of nursing, or her designee, will conduct audits on care plan accuracy for assistance with feeding on R2 and 5 random residents. The audits will be conducted weekly for four weeks then monthly for two months. The results of the audits will be sent to the QAPI committee for further recommendation.	

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normally rose every day at 7:30 a.m. and ate breakfast with the other residents. R2 needed fasting lab work that morning which delayed his breakfast. LPN-A stated R2 was fairly independent and only needed assistance when food was falling off his plate. The care plan probably was not updated from when R2 was previously sick and R2 no longer required assistance.

During an interview on 10/7/21, at 2:19 p.m. registered nurse (RN)-A stated R2 should have been assisted while eating whether that meant sitting with, watching or cueing.

During an interview on 10/7/21, at 3:36 p.m. the director of nursing (DON) stated the residents in the memory care unit were difficult as their abilities changed daily and the care plan provided varying levels of "assistance" and "supervision". R2 required supervision with eating, but would rely on RN-A because she knew the residents best. The staff were expected to follow the care plan to provide the assistance each resident required.

The facility policy Activities of Daily Living (ADLs) dated 12/9/19, indicated ADL care and assistance would be provided and managed by the nursing department to ensure that the resident was provided the assistance needed to complete ADL needs while encouraging the resident to exercise highest level of independence. The policy defined the level of assistance as follows:
1. Independent - performed self-care in a specific area without assistance or help from staff, nor need for any staff oversight, with/without assistance devices and within a reasonable time. No set up or physical help from staff.

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F 676	Continued From page 5 2. Supervision - staff were to provide cues and/or reminding. 3. Limited assistance - Needed set up/placement of items needed to perform cares. May need minimal physical assistance. Staff provided guided maneuvering of limbs or other non-weight bearing assistance. 4. Extensive assistance - Needed physical assistance in performing a portion of cares. Resident involved in activity. Staff provided weight bearing support. 5. Total dependence - Needed full staff assistance with all tasks.	F 676		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning services for 3 of 3 residents (R21, R67, R2) reviewed who were at risk for pressure ulcer development and dependent upon staff for repositioning.	F 686	1. The care plans for R21, R67, and R2 were reviewed by 11/4/2021 and deemed appropriate. No changes were made to their care plans. 2. Any resident that is unable to reposition	12/10/21

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F 686	Continued From page 6 Findings include: R21's quarterly Minimum Data Set (MDS) dated 6/25/21, identified R21 had moderate cognitive impairment and required extensive to total assistance with all activities of daily living. The MDS further identified R21 was at risk of developing pressure ulcers. Diagnoses included diabetes mellitus, hemiplegia (mild or partial weakness or loss of strength on one side of the body) or hemiparesis (severe or complete loss of strength or paralysis on one side of the body), generalized muscle weakness, and multiple sclerosis (MS). R21's current care plan dated 2/26/20, identified R21 had skin breakdown 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 11/22/20, identified R21 was unable to reposition himself and utilized boots, pillows and pressure relieving mattress while in bed. R21 was repositioned every two hours according to his care plan. He presently had breakdown on his coccyx area and Aquafor was used when incontinent. R21's Braden Scale (for predicting pressure ulcer risk) dated 9/18/21, identified R21 was moderate risk for developing pressure ulcers. R21's Quarterly Skin Risk Factors dated 9/24/21,	F 686	on their own or is care planned to be repositioned has the potential to be affected by this deficient practice. 3. The director of nursing educated nurses on 10-18-21 and 11-22-21 with more specifics to plan of correction and HSTs (CNAs) on 10-21-21 and will with more specifics on 11-18-21 regarding the importance of repositioning residents per the care plan in accordance with evidence based practice and facility policy. All residents that are unable to reposition or are care planned to be repositioned had their care plans reviewed and revised if appropriate on 11/9/2021. All HST's were made aware of the residents that need assistance with repositioning through changes in the Kardex. MNVH-FF will implement a task through PCC for all residents with an identified toileting and/or repositioning care planned need 12/10/2021. This will task will trigger the CNA's to chart q shift in POC that the resident received these cares per the care plan. The facility will also implement a 24 hour toileting and repositioning form that will be started daily by the night nurse. This form will include a synopsis of each residents care plan for toileting and repositioning and a space for the C N A's to document when this occurred last on their shift. This form will be reviewed at the weekly focus meeting on each resident unit. This form will be maintained and updated by medical records as needed or requested. 4. The director of nursing, or her	

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F 686	Continued From page 7 identified R21 had chronic skin break down to his bottom as R21 was not able to reposition himself in wheelchair or bed due to his MS. R21 was able to alert to staff when he wanted to lay down and be repositioned. He had no open areas and Aquafor was applied to his bottom for prevention. R21 had a Foley catheter in place. He had times of refusing to be repositioned either in bed or his wheelchair. 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. -At 7:16 a.m. licensed practical nurse (LPN)-B provided R21 his morning medications. -At 7:24 a.m. LPN-B brought R21 to a conference room behind the nurses' station, administered his insulin and then returned him to the common sitting area. -At 8:40 a.m. LPN-B wheeled R21 to the dining room and sat him at a table. -At 9:11 a.m. registered nurse (RN)-B obtained R21's breakfast order, brought the completed meal slip to the dietary aid and returned to the table with beverages for R21. -At 9:17 a.m. R21 received his meal and RN-B provided total feeding assistance to R21. -At 9:47 a.m. R21 completed eating his meal and RN-B wheeled him from the dining room to his	F 686	designee, will conduct audits on reposition on R21, R67, R2, and 5 random residents. The audits will be conducted twice a week for four weeks and monthly for two months or until 100% compliance is achieved with 1:1 education provided to staff with non-compliance. The results of the audits will be sent to the QAPI committee for further recommendations.	

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room and positioned his wheelchair next to the bed. RN-B did not offer repositioning to R21.

On 10/6/21, at 9:58 a.m. NA-E stated R21 got up a little after 7:00 a.m. (2 hours and 49 minutes prior) and he required repositioning every two to three hours. She was just going to his room now. NA-E entered R21's room and transferred him to the bed utilizing a ceiling lift. R21 stated he felt a little bit of pain on his bottom from sitting. NA-E stated R21 currently had three open areas; one on the right buttock crease and two on the coccyx. They applied Aquafor (moisturizing skin protestant) and Calmoseptine (moisture barrier ointment) on the areas for protection and encouraged R21 to lay down every day to get off his bottom. When asked to clarify R21's repositioning schedule, NA-E displayed a care plan posted on the inside of R21's closet door and identified it directed R21 required repositioning every two hours. She stated breakfast was really hard for staff as they had a lot of people to get up and a lot who liked to sleep in. Due to this, it was usually three hours in the morning before they could reposition R21 and then every two hours after that.

During interview on 10/6/21, at 10:20 a.m. RN-B stated R21 was to be repositioned every two hours. His skin was compromised in the past and they used Aquafor as a barrier cream. R21's last bath note indicated the areas on his bottom were continuing to heal. RN-B and LPN-B both stated they were not aware of any open areas to R21's bottom.

On 10/6/21, at 10:49 a.m. RN-B entered R21's room and asked R21 to rate the pain in his bottom. R21 stated the pain was a five on a 1/10

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scale. RN-B stated the issues to R21's bottom developed and resolved quickly and were areas of excoriation (an abrasive or tearing injury to the surface of the body) from shearing (force generated when the skin is moved against a fixed surface such as a bony skeleton moving in an opposite direction to the surface skin). She measured and described the areas as follows:
Area 1 (right of coccyx): 2.0 x 1.0 centimeters (cm). The area was blanchable.
Area 2 (right of Area 1): 0.2 x 0.4 cm. The area was blanchable.
Area 3 (coccyx) 2.2 x 0.4 cm The area was blanchable.
Area 4 (right gluteal crease) 3.1 x 0.4 cm. The area was blanchable with blood.

During interview on 10/7/21, at 3:44 p.m. RN-C stated R21 had an ongoing chronic issue with the skin integrity on his bottom. The areas opened and closed repeatedly. He should be repositioned every two hours and three hours was too long for him to sit.

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.

R67's significant change MDS dated 8/5/21, identified R67 had severe cognitive impairment and required assistance with for all transfers. R67 was at risk for pressure ulcers; however, did not have any current pressure ulcers. The MDS included a diagnosis of dementia with behavioral disturbance.

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R67's current care plan dated 7/30/21, identified R67 was at risk for skin breakdown related to dementia, a possibility of non-adequate meal intake and age. R67 used a rock-king chair and staff were directed to assist R67 with all transfers with a ceiling lift; and take R67 to the nearest toilet on a routine basis as R67 was unable to get there by himself. However, the care plan did not identify frequency of R3's repositioning needs.

R67's Skin Risk Factors -MVH dated 8/2/21, identified R67 was at high risk for skin injury. R67 had limited ability to communicate his needs with staff and R67 relied on staff to anticipate needs and complete cares.

R67's Tissue Tolerance Assessment -MVH dated 8/21/21, identified R67 had a recent change in condition and was no longer able to reposition himself in bed or in his chair. Staff needed to anticipate R67 needs and reposition every two hours.

During a continuous observation on 10/6/21, at 7:02 a.m. R67 was observed to sit in his rock-king chair in the dining room.

- At 8:28 a.m. R67 continued to sit in the dining room in his rock-king chair. R67 was not repositioned during this time nor did R67 reposition himself. At this time, R67 was served his breakfast.

- At 8:57 a.m. R67 had finished his breakfast but continued to sit in his rock-king chair in the dining room.

- At 9:30 a.m. NA-A approached R67 and removed R67's clothing protector. NA-A did not

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attempt to reposition R67 . NA-A assisted R67 from the dining room and wheeled R67 in front of the TV in the common area.

- At 10:00 a.m. NA-A stated he was assigned to the southside and was basically assigned to every resident on that side. Repositioning of residents was not tracked in any form for any resident because they were repositioned every 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-A assisted R67 with repositioning.

During interview on 10/6/21, at 10:09 a.m. LPN-A stated every resident was to be repositioned every two hours. It should be every two hours. "Sometimes, time just goes against us."

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 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.

R2's current care plan reviewed 3/8/21, identified an intervention initiated on 9/20/21, that R2 had impaired mobility related to dementia and directed staff to aid with transfers and mobility. Interventions included R2 needed one to two staff along with a mechanical standing lift to transfer R2. The care plan additionally direct staff to

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F 686	Continued From page 12 reposition R2 every two hours and/or as needed. During observation on 10/6/21, at 8:27 a.m. R2 was assisted to the dining room for his breakfast meal. R2 was sitting in his wheelchair with a pressure reducing cushion. - At 9:24 a.m. R2 wheeled himself away from the dining room table. NA-A did not offer to reposition R2. - At 10:40 a.m. the surveyor intervened and NA-A and NA-B repositioned R2. NA-A was unable to confirm the last time 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.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		11/5/21

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F 689	Continued From page 13 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide supervision while eating, for 1 of 1 residents (R2) reviewed for nutrition and who were at risk for choking and aspiration. Findings include: R2's annual Minimum Data Set (MDS) dated 6/2/21, identified R2 had severe cognitive impairment and required supervision (oversight, encouragement and cueing) with eating. Diagnoses included Alzheimer's disease and aphasia (loss of ability to understand or express speech). 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. R2's current care plan reviewed 9/1//21, identified an intervention initiated on 9/6/19 which identified	F 689	1. R2's care plan was reviewed by the IDT team on 10/08/2021. It was determined that R2 should be observed at meals for signs of choking or swallowing problems. Nutrition Follow-up: SLP evaluation done 10/28/21.Review of the following: Diet appropriateness, strategies, assistance/supervision needed, medication administration. Recommendations: No changes in diet (remain on Minced & Moist), thin liquids, No straws, supervised table/with cueing, small bites/Sips, meds crushed in puree consistency. Plan of care reviewed and updated. 2. Any resident that has dysphagia, a difficulty swallowing, or is care planned to have 1 on 1 supervision for eating. 3. The IDT team reviewed all care plans for residents that have dysphagia, difficulty swallowing, and 1 on 1 supervision to ensure accuracy. Education was provided to all nurses on 10-18-21 and 11-22-21 with more specifics to plan of correction and HST's (CNAs) on 10-21-21 and will with more specifics on 11-18-21 regarding level of	

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F 689	Continued From page 14 R2 needed texture modifications related to dementia and age. Interventions included were directed to deliver, set up and assist during meals; observe for choking; swallowing problems; dehydration and to report as needed and staff were to monitor R2 for chewing/swallowing difficulties related to his memory issues and his age. R2's physician orders dated 10/1/19, identified R2 was to receive a regular diet with a minced and moist texture and thin liquids. During a continuous observation on 10/5/21, at 8:58 a.m. R2 was served his breakfast meal in the dining room. All other residents had finished their breakfast and R2 was the last resident eating in the dining room. R2's meal was set up and R2 began eating independently. - At 9:05 a.m. licensed practical nurse (LPN)-A left the dining room to assist other residents. At this time, R2 was not in sight of any staff and continued to eat independently. R2 does not have signs/symptoms of choking or aspiration. - At 9:17 a.m. LPN-A returned to the medication cart parked at the edge of dining room. R2 continued to eat independently. - At 9:16 a.m. R2 continued to attempt to eat his meal by himself. - At 9:17 a.m. LPN-A applied gloves and approached R2. LPN-A repositioned R2's food for R2 to be able to spoon into his mouth, but did not offer to assist R2 with eating. R2 continued to eat his meal independently.	F 689	supervision during meals. 4. The director of nursing, or her designee, will conduct audits on care plan accuracy for level of supervision with residents eating on R2 and 5 random residents. The audits will be conducted weekly for four weeks then monthly for two months. The results of the audits will be sent to the QAPI committee for further recommendation.	

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	245636	A. BUILDING _____ B. WING _____	C 10/07/2021

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F 689	Continued From page 15	F 689		

- At 9:20 a.m. LPN-A left the dining room. No staff were in sight of R2 who continued to attempt to eat his meal while he continued to spill hot cereal onto his clothing protector, but was without signs/symptoms of choking or aspiration.

- At 9:22 a.m. LPN-A returned to the dining room, but did not attempt to assist R2 with his meal. R2 continued to attempt to spoon hot cereal into his mouth, but dripped hot cereal from his spoon onto his clothing protector before reaching his mouth.

- At 9:28 a.m. dietary Aide (DA)-A returned to R2's side of the kitchenette. LPN-A had again left the dining room. DA-A stated she was not a nursing assistant, but was trained in CPR and the Heimlich maneuver. DA-A tried to watch the residents especially when the nursing staff were busy, because it was like a community. However, she would expect them to tell her when she needed to watch residents.

During interview on 10/5/21, at 9:31 a.m. LPN-A stated that day was not a normal day for R2. R2 normally rose every day at 7:30 a.m. and ate breakfast with the other residents. R2 needed fasting lab work that morning which delayed his breakfast. R2 was fairly independent and only needed assistance when food was falling off his plate. Additionally, the care plan probably was not updated from when R2 was previously sick and R2 no longer required assistance. LPN-A she was watching R2 and always had him out of the corner of her eye; however, LPN-A did leave the dining room because she had tasks for other residents. R2 did not have any trouble and LPN-A was sure R2 was identified as a choking risk because he was on a mechanically altered diet

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F 689	Continued From page 16	F 689		

but did really well.

During interview on 10/5/21, at 10:09 a.m. nursing assistant (NA)-C stated staff should stay in the dining room until at least most of the residents were done eating; however, if there was one resident left eating there must always be someone in the dining room to watch. Staff would know who was at risk for choking or aspiration risk due to the diet type, but was unable to say if R2 was at risk. NA-C stated she was unsure why R2 was not supervised while eating.

During an interview on 10/7/21, at 2:19 p.m. registered nurse (RN)-A stated R2 should not have been left alone in the dining room and should have been assisted with his meal. Whether that meant sitting, watching or cueing. RN-A would have to find the policy that addressed supervision or assistance in the dining room to determine exactly what R2's needs were.

During interview on 10/7/21, at 3:36 p.m. the director of nursing (DON) stated the residents in the memory care unit were difficult as their condition and abilities changed daily. This was why the care plan provided varying levels of "assistance" and "supervision". R2 required supervision with eating, but would rely on RN-A because she knew the residents best. The staff were expected to follow the care plan to provide the assistance each resident required.

The facility policy Activities of Daily Living (ADLs) dated 12/9/19, indicated ADL care and assistance would be provided and managed by the nursing department to ensure that the resident was provided the assistance needed to complete ADL needs while encouraging the resident to exercise

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F 689	Continued From page 17 highest level of independence. The policy defined the level of assistance as follows: 1. Independent - performed self-care in a specific area without assistance or help from staff, nor need for any staff oversight, with/without assistance devices and within a reasonable time. No set up or physical help from staff. 2. Supervision - staff were to provide cues and/or reminding. 3. Limited assistance - Needed set up/placement of items needed to perform cares. May need minimal physical assistance. Staff provided guided maneuvering of limbs or other non-weight bearing assistance. 4. Extensive assistance - Needed physical assistance in performing a portion of cares. Resident involved in activity. Staff provided weight bearing support. 5. Total dependence - Needed full staff assistance with all tasks. A facility policy regarding supervision dining practices was requested, but not received.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	C 10/07/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/4/21 through 10/7/21, a licensing and abbreviated survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H5636015C (MN76001); however, no licensing orders were issued. The following complaints were found to be UNSUBSTANTIATED: H5636016C (MN68786) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000		

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide supervision while eating, for 1 of 1 residents (R2) reviewed for nutrition and who were at risk for choking and aspiration. Findings include:	2 830	Corrected	11/5/21

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2 830	Continued From page 3 R2's annual Minimum Data Set (MDS) dated 6/2/21, identified R2 had severe cognitive impairment and required supervision (oversight, encouragement and cueing) with eating. Diagnoses included Alzheimer's disease and aphasia (loss of ability to understand or express speech). 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. R2's current care plan reviewed 9/1//21, identified an intervention initiated on 9/6/19 which identified R2 needed texture modifications related to dementia and age. Interventions included were directed to deliver, set up and assist during meals; observe for choking; swallowing problems; dehydration and to report as needed and staff were to monitor R2 for chewing/swallowing difficulties related to his memory issues and his age. R2's physician orders dated 10/1/19, identified R2 was to receive a regular diet with a minced and moist texture and thin liquids. During a continuous observation on 10/5/21, at 8:58 a.m. R2 was served his breakfast meal in the dining room. All other residents had finished their breakfast and R2 was the last resident	2 830		

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2 830	Continued From page 4	2 830		

eating in the dining room. R2's meal was set up and R2 began eating independently.

- At 9:05 a.m. licensed practical nurse (LPN)-A left the dining room to assist other residents. At this time, R2 was not in sight of any staff and continued to eat independently. R2 does not have signs/symptoms of choking or aspiration.

- At 9:17 a.m. LPN-A returned to the medication cart parked at the edge of dining room. R2 continued to eat independently.

- At 9:16 a.m. R2 continued to attempt to eat his meal by himself.

- At 9:17 a.m. LPN-A applied gloves and approached R2. LPN-A repositioned R2's food for R2 to be able to spoon into his mouth, but did not offer to assist R2 with eating. R2 continued to eat his meal independently.

- At 9:20 a.m. LPN-A left the dining room. No staff were in sight of R2 who continued to attempt to eat his meal while he continued to spill hot cereal onto his clothing protector, but was without signs/symptoms of choking or aspiration.

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2 830	Continued From page 5	2 830		

residents especially when the nursing staff were busy, because it was like a community. However, she would expect them to tell her when she needed to watch residents.

During interview on 10/5/21, at 9:31 a.m. LPN-A stated that day was not a normal day for R2. R2 normally rose every day at 7:30 a.m. and ate breakfast with the other residents. R2 needed fasting lab work that morning which delayed his breakfast. R2 was fairly independent and only needed assistance when food was falling off his plate. Additionally, the care plan probably was not updated from when R2 was previously sick and R2 no longer required assistance. LPN-A she was watching R2 and always had him out of the corner of her eye; however, LPN-A did leave the dining room because she had tasks for other residents. R2 did not have any trouble and LPN-A was sure R2 was identified as a choking risk because he was on a mechanically altered diet but did really well.

During interview on 10/5/21, at 10:09 a.m. nursing assistant (NA)-C stated staff should stay in the dining room until at least most of the residents were done eating; however, if there was one resident left eating there must always be someone in the dining room to watch. Staff would know who was at risk for choking or aspiration risk due to the diet type, but was unable to say if R2 was at risk. NA-C stated she was unsure why R2 was not supervised while eating.

During an interview on 10/7/21, at 2:19 p.m. registered nurse (RN)-A stated R2 should not have been left alone in the dining room and should have been assisted with his meal. Whether that meant sitting, watching or cueing. RN-A would have to find the policy that addressed

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2 830	Continued From page 6 supervision or assistance in the dining room to determine exactly what R2's needs were. During interview on 10/7/21, at 3:36 p.m. the director of nursing (DON) stated the residents in the memory care unit were difficult as their condition and abilities changed daily. This was why the care plan provided varying levels of "assistance" and "supervision". R2 required supervision with eating, but would rely on RN-A because she knew the residents best. The staff were expected to follow the care plan to provide the assistance each resident required. The facility policy Activities of Daily Living (ADLs) dated 12/9/19, indicated ADL care and assistance would be provided and managed by the nursing department to ensure that the resident was provided the assistance needed to complete ADL needs while encouraging the resident to exercise highest level of independence. The policy defined the level of assistance as follows: 1. Independent - performed self-care in a specific area without assistance or help from staff, nor need for any staff oversight, with/without assistance devices and within a reasonable time. No set up or physical help from staff. 2. Supervision - staff were to provide cues and/or reminding. 3. Limited assistance - Needed set up/placement of items needed to perform cares. May need minimal physical assistance. Staff provided guided maneuvering of limbs or other non-weight bearing assistance. 4. Extensive assistance - Needed physical assistance in performing a portion of cares. Resident involved in activity. Staff provided weight bearing support. 5. Total dependence - Needed full staff assistance with all tasks.	2 830		

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2 830	Continued From page 7 A facility policy regarding supervision dining practices was requested, but not received. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to providing supervision during meals for residents according to assessed need. The DON or designee could educate staff and conduct audits to ensure compliance and report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning services for 3 of 3 residents (R21, R67, R2) reviewed who were at risk for pressure ulcer development and dependent upon staff for repositioning. Findings include:	2 905	Corrected	11/5/21

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	00531	A. BUILDING: _____ B. WING _____	C 10/07/2021

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

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2 905	Continued From page 8 R21's quarterly Minimum Data Set (MDS) dated 6/25/21, identified R21 had moderate cognitive impairment and required extensive to total assistance with all activities of daily living. The MDS further identified R21 was at risk of developing pressure ulcers. Diagnoses included diabetes mellitus, hemiplegia (mild or partial weakness or loss of strength on one side of the body) or hemiparesis (severe or complete loss of strength or paralysis on one side of the body), generalized muscle weakness, and multiple sclerosis (MS). R21's current care plan dated 2/26/20, identified R21 had skin breakdown 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 11/22/20, identified R21 was unable to reposition himself and utilized boots, pillows and pressure relieving mattress while in bed. R21 was repositioned every two hours according to his care plan. He presently had breakdown on his coccyx area and Aquafor was used when incontinent. R21's Braden Scale (for predicting pressure ulcer risk) dated 9/18/21, identified R21 was moderate risk for developing pressure ulcers. R21's Quarterly Skin Risk Factors dated 9/24/21, identified R21 had chronic skin break down to his bottom as R21 was not able to reposition himself in wheelchair or bed due to his MS. R21 was able	2 905		

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2 905	Continued From page 9	2 905		

to alert to staff when he wanted to lay down and be repositioned. He had no open areas and Aquafor was applied to his bottom for prevention. R21 had a Foley catheter in place. He had times of refusing to be repositioned either in bed or his wheelchair.

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.

-At 7:16 a.m. licensed practical nurse (LPN)-B provided R21 his morning medications.

-At 7:24 a.m. LPN-B brought R21 to a conference room behind the nurses' station, administered his insulin
and then returned him to the common sitting area.

-At 8:40 a.m. LPN-B wheeled R21 to the dining room and sat him at a table.

-At 9:11 a.m. registered nurse (RN)-B obtained R21's breakfast order, brought the completed meal slip to the dietary aid and returned to the table with beverages for R21.

-At 9:17 a.m. R21 received his meal and RN-B provided total feeding assistance to R21.

-At 9:47 a.m. R21 completed eating his meal and RN-B wheeled him from the dining room to his room and positioned his wheelchair next to the bed. RN-B did not offer repositioning to R21.

On 10/6/21, at 9:58 a.m. NA-E stated R21 got up

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2 905	Continued From page 10	2 905		

a little after 7:00 a.m. (2 hours and 49 minutes prior) and he required repositioning every two to three hours. She was just going to his room now. NA-E entered R21's room and transferred him to the bed utilizing a ceiling lift. R21 stated he felt a little bit of pain on his bottom from sitting. NA-E stated R21 currently had three open areas; one on the right buttock crease and two on the coccyx. They applied Aquafor (moisturizing skin protestant) and Calmoseptine (moisture barrier ointment) on the areas for protection and encouraged R21 to lay down every day to get off his bottom. When asked to clarify R21's repositioning schedule, NA-E displayed a care plan posted on the inside of R21's closet door and identified it directed R21 required repositioning every two hours. She stated breakfast was really hard for staff as they had a lot of people to get up and a lot who liked to sleep in. Due to this, it was usually three hours in the morning before they could reposition R21 and then every two hours after that.

During interview on 10/6/21, at 10:20 a.m. RN-B stated R21 was to be repositioned every two hours. His skin was compromised in the past and they used Aquafor as a barrier cream. R21's last bath note indicated the areas on his bottom were continuing to heal. RN-B and LPN-B both stated they were not aware of any open areas to R21's bottom.

On 10/6/21, at 10:49 a.m. RN-B entered R21's room and asked R21 to rate the pain in his bottom. R21 stated the pain was a five on a 1/10 scale. RN-B stated the issues to R21's bottom developed and resolved quickly and were areas of excoriation (an abrasive or tearing injury to the surface of the body) from shearing (force generated when the skin is moved against a fixed

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2 905	Continued From page 11	2 905		

surface such as a bony skeleton moving in an opposite direction to the surface skin). She measured and described the areas as follows:
Area 1 (right of coccyx): 2.0 x 1.0 centimeters (cm). The area was blanchable.
Area 2 (right of Area 1): 0.2 x 0.4 cm. The area was blanchable.
Area 3 (coccyx) 2.2 x 0.4 cm The area was blanchable.
Area 4 (right gluteal crease) 3.1 x 0.4 cm. The area was blanchable with blood.

During interview on 10/7/21, at 3:44 p.m. RN-C stated R21 had an ongoing chronic issue with the skin integrity on his bottom. The areas opened and closed repeatedly. He should be repositioned every two hours and three hours was too long for him to sit.

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.

R67's significant change MDS dated 8/5/21, identified R67 had severe cognitive impairment and required assistance with for all transfers. R67 was at risk for pressure ulcers; however, did not have any current pressure ulcers. The MDS included a diagnosis of dementia with behavioral disturbance.

R67's current care plan dated 7/30/21, identified R67 was at risk for skin breakdown related to dementia, a possibility of non-adequate meal intake and age. R67 used a rock-king chair and staff were directed to assist R67 with all transfers with a ceiling lift; and take R67 to the nearest toilet on a routine basis as R67 was unable to get there by himself. However, the care plan did not

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2 905	Continued From page 12	2 905		

identify frequency of R3's repositioning needs.

R67's Skin Risk Factors -MVH dated 8/2/21, identified R67 was at high risk for skin injury. R67 had limited ability to communicate his needs with staff and R67 relied on staff to anticipate needs and complete cares.

R67's Tissue Tolerance Assessment -MVH dated 8/21/21, identified R67 had a recent change in condition and was no longer able to reposition himself in bed or in his chair. Staff needed to anticipate R67 needs and reposition every two hours.

During a continuous observation on 10/6/21, at 7:02 a.m. R67 was observed to sit in his rock-king chair in the dining room.

- At 8:28 a.m. R67 continued to sit in the dining room in his rock-king chair. R67 was not repositioned during this time nor did R67 reposition himself. At this time, R67 was served his breakfast.

- At 8:57 a.m. R67 had finished his breakfast but continued to sit in his rock-king chair in the dining room.

- At 9:30 a.m. NA-A approached R67 and removed R67's clothing protector. NA-A did not attempt to reposition R67 . NA-A assisted R67 from the dining room and wheeled R67 in front of the TV in the common area.

- At 10:00 a.m. NA-A stated he was assigned to the southside and was basically assigned to every resident on that side. Repositioning of residents was not tracked in any form for any resident because they were repositioned every

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2 905	Continued From page 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-A assisted R67 with repositioning.

During interview on 10/6/21, at 10:09 a.m. LPN-A stated every resident was to be repositioned every two hours. It should be every two hours. "Sometimes, time just goes against us."

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 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.

R2's current care plan reviewed 3/8/21, identified an intervention initiated on 9/20/21, that R2 had impaired mobility related to dementia and directed staff to aid with transfers and mobility. Interventions included R2 needed one to two staff along with a mechanical standing lift to transfer R2. The care plan additionally direct staff to reposition R2 every two hours and/or as needed.

During observation on 10/6/21, at 8:27 a.m. R2 was assisted to the dining room for his breakfast meal. R2 was sitting in his wheelchair with a pressure reducing cushion.

- At 9:24 a.m. R2 wheeled himself away from the dining room table. NA-A did not offer to reposition R2.

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2 905	Continued From page 14 - At 10:40 a.m. the surveyor intervened and NA-A and NA-B repositioned R2. NA-A was unable to confirm the last time 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. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure residents receive the repositioning assistance according the assessed need. The DON or designee could develop an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs	2 915		11/5/21

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2 915	Continued From page 15 Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were assisted with eating for 1 of 1 residents (R2) reviewed who needed staff assistance to eat. Findings include: R2's annual Minimum Data Set (MDS) dated 9/1/21, identified R2 had severe cognitive impairment and required supervision and physical assist of one with eating. Diagnoses included Alzheimer's disease and aphasia (loss of ability to understand or express speech). R2's nutritional status Care Area Assessment (CAA) dated 9/1/21, identified R2 had a moderately high body mass index (BMI) of 26.5	2 915	Corrected	

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2 915	Continued From page 16	2 915		

and needed mechanically altered textures due to a diagnosis of dementia and missing or broken teeth. R2's diet order was minced and moist. Further, R2 had a potential for chewing difficulty, choking and/or aspiration.

R2's current care plan reviewed 9/1/21, identified an intervention initiated on 9/6/19, identified R2 had a potential for nutritional decline (weight loss/dehydration, chewing/swallowing impairments) with progression of dementia. R2 needed texture modifications related to his dementia and age. Staff were directed to deliver, set up and assist during meals, observe for choking, swallowing problems or dehydration and report as needed.

During continuous observation on 10/5/21, at 8:58 a.m. R2 was served his breakfast in the dining room. All other residents had finished their breakfast and R2 was the last resident trying to eat his meal in the dining room. Staff did not attempt to provide R2 with assistance with eating; however, R2 was spilling food onto himself and the floor.

- At 9:16 a.m. R2 continued to attempt to eat his meal. R2 used a large bowl and a regular spoon to scrape hot cereal towards himself. While R2 was able to spoon some hot cereal into his mouth, more hot cereal went over the edge of the bowl and landed on the table edge, floor or onto R2's clothing protector.

- At 09:17 a.m. licensed practical nurse (LPN)-A applied gloves and approached R2. LPN-A repositioned R2's food for R2 to be able to spoon into his mouth, but did not offer to assist R2 with eating. R2 continued to attempt to eat his meal by himself.

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2 915	Continued From page 17 - At 9:23 a.m. R2 ate food that had fallen onto his clothing protector by picking it up with his hands, then picked up his fork and attempted to fork hot cereal into his mouth. - At 9:26 a.m. R2 continued to eat his hot cereal with his fork while hot cereal dripped onto the table, the floor and onto R2's clothing protector. No staff attempted redirection for R2 nor had offered assistance. During interview on 10/5/21, at 9:31 a.m. LPN-A stated that day was not a normal day for R2. R2 normally rose every day at 7:30 a.m. and ate breakfast with the other residents. R2 needed fasting lab work that morning which delayed his breakfast. LPN-A stated R2 was fairly independent and only needed assistance when food was falling off his plate. The care plan probably was not updated from when R2 was previously sick and R2 no longer required assistance. During an interview on 10/7/21, at 2:19 p.m. registered nurse (RN)-A stated R2 should have been assisted while eating whether that meant sitting with, watching or cueing. During an interview on 10/7/21, at 3:36 p.m. the director of nursing (DON) stated the residents in the memory care unit were difficult as their abilities changed daily and the care plan provided varying levels of "assistance" and "supervision". R2 required supervision with eating, but would rely on RN-A because she knew the residents best. The staff were expected to follow the care plan to provide the assistance each resident required.	2 915		

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2 915	Continued From page 18 The facility policy Activities of Daily Living (ADLs) dated 12/9/19, indicated ADL care and assistance would be provided and managed by the nursing department to ensure that the resident was provided the assistance needed to complete ADL needs while encouraging the resident to exercise highest level of independence. The policy defined the level of assistance as follows: 1. Independent - performed self-care in a specific area without assistance or help from staff, nor need for any staff oversight, with/without assistance devices and within a reasonable time. No set up or physical help from staff. 2. Supervision - staff were to provide cues and/or reminding. 3. Limited assistance - Needed set up/placement of items needed to perform cares. May need minimal physical assistance. Staff provided guided maneuvering of limbs or other non-weight bearing assistance. 4. Extensive assistance - Needed physical assistance in performing a portion of cares. Resident involved in activity. Staff provided weight bearing support. 5. Total dependence - Needed full staff assistance with all tasks. SUGGESTED METHOD OF CORRECTION: The DON, or designee, could inservice staff regarding how to assist residents to eat by providing supervision, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		

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	245636	A. BUILDING **01 - MN VETS HOME FERGUS FALLS** B. WING _____	**10/06/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, MN Veterans Home Fergus Falls was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care, and the 2012 edition of the Healthcare Facilities Code (NFPA 99) THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

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

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	245636	A. BUILDING **01 - MN VETS HOME FERGUS FALLS** B. WING _____	**10/06/2021**

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

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K 000	Continued From page 1	K 000		

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

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

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

MN Veterans Home Fergus Falls was constructed in 1997, with an addition constructed on the west end in 2011. The construction type is II (111). The building is fully sprinkled and has a fire alarm system per NFPA 72. There is smoke detection in the corridors, spaces open to the corridor, and in resident rooms.
There are five 2 hour fire barriers separating the building into 5 smoke compartments and one 2

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K 000	Continued From page 2 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 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance 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 and staff interview, the facility failed to test and maintain the fire alarm in accordance with NFPA 101 "Life Safety Code" 2012 edition, section 9.6.1.3, and NFPA 72 "National Fire Alarm and Signaling Code" 2010 edition, sections 14.5.3. and 14.6.2.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/06/2021, at 10:55 AM, during a review of all available fire alarm test and inspection documentation and an interview with a Maintenance staff member (TK), it was revealed that the facility could not provide any current	K 345	1. The building maintenance foreman scheduled a semiannual inspection of the initiating devices for December 2021. 2. All residents have the potential to be affected by this deficient practice. 3. The building maintenance foreman schedule semiannual inspections of the initiating devices for December 2021 and June 2022. 4. The building maintenance foreman, or his designee, will conduct audits on inspections of the initiating devices. The audits will be conducted twice in the next year in order to ensure compliance is	11/5/21

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K 345	Continued From page 3 documentation verifying that a semiannual inspection of all initiating devices had been completed. This deficient condition was verified by Maintenance staff member (TK).	K 345	reached. The results of the audit will be reported to the QAPI committee.	
K 353 SS=D	Sprinkler System - Maintenance and Testing 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 by: Based on observations, documentation review, and staff interview, the automatic sprinkler system is not maintained in accordance with NFPA 101 "The Life Safety Code" 2012 edition, section 9.7.1.1, and NFPA 25 "Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems" 2011 edition,	K 353	1. The three defective sprinkler heads were replaced on 11/10/2021. 2. All residents have the potential to be affected by this deficient practice. 3. The building maintenance foreman	11/10/21

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K 353	Continued From page 4 sections 5.2.1.1.4 and 5.3.2.1 . This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 10/06/2021, at 12:35 PM, observations revealed that there were 3 corroded fire sprinkler heads located in the dish washing room within the kitchen. This deficient condition was verified by Maintenance staff member (TK).	K 353	ensured the three sprinkler heads were replaced on 11/10/2021. 4. The building maintenance foreman, or his designee, will inspect all sprinkler heads for corrosion by 11/15/2021. Results of the inspection will be reported to the QAPI committee.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. This deficient condition could have a widespread impact on the residents within the facility.	K 712	1. The maintenance department was educated on 11/5/2021 on proper fire drill scheduling. All future fire drills will be held during different hours for each shift. 2. All residents have the potential to be	11/5/21

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K 712	Continued From page 5 Findings include: 1. On 10/06/2021, at 10:50 AM, during the review of all available fire drill documentation and an interview with Maintenance Staff member (TK), it was revealed that the facility did not vary the times of the 2nd shift fire drill by conducting 3 of 4 drills in the 4 PM hour. 2. On 10/06/2021, at 10:50 AM, during the review of all available fire drill documentation and an interview with Maintenance Staff member (TK), it was revealed that the facility did not vary the times of the 3rd shift fire drill by conducting 4 of 4 drills in the 5 AM hour. These deficient conditions were verified by Maintenance staff member (TK).	K 712	affected by this deficient practice. 3. The maintenance department was provided education on 11/5/2021 on the proper scheduling of fire drills. All fire drills will be held during different hours on each shift. 4. The building maintenance foreman, or his designee, will conduct audits on the scheduling of fire drills. The audits will be conducted quarterly for two quarters. Results of the audits will be sent to the QAPI committee for further review and recommendation.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of all	K 901	1. The building maintenance foreman	11/5/21

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K 901	Continued From page 6 available documentation, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/06/2021, at 11:30 AM, during the documentation review and an interview with Maintenance staff member (TK), it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not cover patient care equipment as detailed in NFPA 99 "Health Care Facilities Code" 2012 edition Chapter 10 - Electrical Equipment, and Chapter 11 - Gas Equipment. This deficient condition was verified by Maintenance staff member (TK).	K 901	updated the Utility Risk Assessment to reflect the addition of chapters 10 and 11 on 11/05/2021. 2. All residents have the potential to be affected by this deficient practice. 3. The building maintenance foreman provided education review for all departments during there next departmental meetings reflecting the additions of chapters 10 and 11 in the Utility Risk Assessment. 4. The building maintenance foreman checked every Utility Risk Assessment in the building to ensure they were updated with chapters 10 and 11. The report was sent to the QAPI committee.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or	K 923		11/5/21

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K 923	Continued From page 7 gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the oxygen storage room was not identified in accordance with NFPA 101 "Life Safety Code" 2012 edition, sections 8.7.1.3, 19.3.2.1.3, and NFPA 99 (2012 Edition), Health Care Facilities Code, section 11.3.4.2 These deficient conditions could have a patterned impact on the residents within the facility.	K 923	1. The general repair worker fixed the door (D112), ensuring that it latched properly. The general repair worker also separated empty oxygen cylinders from full cylinders. 2. All residents have the potential to be affected by this deficient practice. 3. The director of nursing, or her	

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K 923	Continued From page 8 Findings include: 1. On 10/06/2021, at 12:40 PM, during the facility tour, observation revealed that the door to the D112 oxygen storage room did not fully close and positively latch into the door frame. 2. On 10/06/2021, at 12:45 PM, during the facility tour, observations revealed in the west wing 134 oxygen storage room, there are oxygen cylinders that were not separated by full and empty status at the time of the inspection. These deficient conditions were verified by Maintenance staff member (TK).	K 923	designee, educated the nurses on proper storage of oxygen tanks on 10/18/202. The general repair worker checked oxygen storage room doors to ensure proper latching on 10/8/2021. 4. The building maintenance foreman, or designee, will conduct audits on the proper storage of oxygen tanks. Audits will be conducted weekly for 4 weeks then monthly for two months. The results of audits will be reported to the QAPI committee for further recommendation. The building maintenance foreman, or his designee, will conduct audits on proper door latching for oxygen storage rooms. Audits will be conducted weekly for 4 weeks then monthly for two months. The results of audits will be reported to the QAPI committee for further recommendation	