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	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN Veterans Home Fergus Falls	1821 North Park Fergus Falls, MN 56537

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and document review the facility failed to provide adequate supervision and monitoring to prevent resident to resident physical abuse for 1 of 1 resident (R1) reviewed for abuse when R2, who had a history of verbal and physical aggression towards staff and residents went into R1's room, allegedly grabbed him by the neck and threw him to the floor before leaving the room with R1's cane. Following the incident, the facility failed to provide adequate supervision and monitoring to ensure residents were protected from physical abuse putting them at the likelihood for serious harm, impairment or death when R2 continued to exhibit behaviors such as wandering into other resident rooms unsupervised. The IJ began on 4/10/26 at 1:50 p.m., when R2 entered R1's room and was seen exiting the room with R1's cane. R1 reported to facility staff, R2 entered his room and touched his belongings, R1 reported he got up from his chair, told R2 to stop, R2 placed his hand around R1's neck and threw him down to the floor. The administrator and director of nursing (DON) were notified of the IJ on 4/27/26 at 5:00 p.m. The facility implemented corrective action by 4/24/26 and therefore is issued as past non-compliance. R1 R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was admitted to the facility on [DATE], from home/community. R1 had moderately impaired cognition and moderate difficulty with hearing. R1 had verbal behavioral symptoms directed toward others (threatening others, screaming, cursing at others) and wandered one to three days out of seven. R1 was independent with toileting, transfers, and ambulation with a cane. R1's diagnoses included non-traumatic brain dysfunction, arthritis, Alzheimer's disease, Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia, mixed dementia, frontotemporal dementia, and dementia related to stroke), and depression. R1's height was 5 feet 5 inches and weighed 234 pounds. He was taking antipsychotic, antidepressant, and antiplatelet mediations. R1's St. Louis University Mental Status (SLUMS) (a tool for detecting cognitive impairment in older adults) dated 3/24/26, identified a total score of 13 out of 30, to indicate cognitive impairment or possible dementia. A lower score in this range indicated more pronounced cognitive deficits that could be indicative of dementia. R1's progress notes from 3/25/26 through 4/26/26, identified: On 3/25/26 at 3:22 a.m., During rounds [R1] tried to barricade his door shut. Quiet and stayed in his room tonight. 3/26/26 at 9:09 p.m., [R1] received first scheduled dose of Seroquel 50 mg, not effective. Was one of the more agitated/restless shifts that he has had in the evening in the past week. 3/2026 at 12:23 p.m., [R1] sundown's hard after lunch and can become verbally aggressive with family and others as well fixated and upset about not being able to go home. 4/1/26 at 3:45 p.m., [R1] grew frustrated when he tried to ask peer what he was doing and did not respond. [R1] stated to peer what are you stupid, you never answer me? Peer grew agitated at name calling and put up fist and drew near [R1]. He raised cane and threatened to strike peer. Recreation staff placed self in between residents and deescalated the two. 4/5/26 at 8:42 p.m., [R1] was out of his room on the south unit and a resident walked near, reached out and grasped his cane. [R1] yelled at the other resident in a threatening tone and raised his cane at the resident. Staff remained 1:1 with resident due to both residents not wanting to be in their rooms. Anger lasted approximately 20 minutes. 4/7/26 at 3:03 p.m., physical therapy (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(PT) was asked to see if [R1] was appropriate to use front wheeled walker (FWW) as resident raised hisˆcane toward another resident. [R1] demonstrated walking with his cane, which was appropriate and stable. [R1] had diagnoses of polyarthritis and lumbar spinal stenosis which could affect his balance so it would be best to stay with some assistive device but did not need a FWW. [R1] showed the cane to PT and described how he made it by using the natural curves in the diamond willow. He was very proud of the cane he had made. 4/9/26 at 9:38 p.m., [R1] looked for his jacket, was in the laundry cart to be washed. NA located it and told him about it being in the wash cart. He became upset and ripped the jacket from NA's hands. He was upset and angry and later apologized to NA. 4/10/26 at 1:55 p.m., [R1] was noted to be yelling out from his room. [R1] sat up against the wall on the floor inside room doorway and left elbow was bruised and slightly swollen. Lifted [R1] off the floor with Hoyer and placed in recliner. [R1] stated that guy came into my room, started moving some of my stuff, I got up out of my recliner, and went over to him to tell him to stop. Then that guy grabbed my neck to choke me, threw me on the ground and took my cane. 4/10/26 at 6:20 p.m., [R1] complained of right elbow tenderness. Purple bruising present, swelling estimated the size of a golf ball. Offer to send to ER for x-ray and stated he would go in morning if it was still bothering him. Ice applied. 4/11/26 at 1:15 p.m., [R1] was quiet this shift. Out for meals then returned to his room. Right arm elbow is tender. Did not allow staff to assist with cares this a.m. pleasant with all interactions. 4/11/26 at 4:39 p.m., 24 follow-up: complained of elbow pain. Applied ice two times a day shift. ˆBruise on buttock was larger. 4/12/26 at 11:35 a.m., Right elbow had bruising all the way around joint, light purple in color with one darker circular area noted on the posterior and one darker bruise on the anterior side. Range of motion (ROM) within normal limits. 4/14/26 at 12:50 p.m., [R1] had been pleasant this shift. Pain in lower back, right elbow and arm. 4/13/26 at 12:20 p.m,. Fall related to 4/10/26, incident involved another resident who initiated physical aggression towards [R1]. Contusion to right elbow has absorbed and now had bruising around right elbow. Bruising also noted to left elbow and left buttock due to resident landing /falling on floor because of incident. No new fall interventions put into place due to nature of incident. Other interventions put into place to keep both residents involved separated. 4/19/26 at 8:58 a.m., [R1] had a memory this a.m. of a traumatic event that occurred in the past week. The memory felt very real to [R1], which can be typical for post traumatic stress disorder (PTSD) diagnosis. Emotional support provided by staff. Details of memory are inconsistent. To assure this was a memory and not a new incident DON reviewed camera footage from the a.m. Other resident [R2] involved in past incident did not appear to have entered [R1's] room this a.m. 4/19/26 at 10:49 a.m., [R1] came to day room and started talking about other peer. Stated if he saw him, he was going to hurt him and lay him out, threatened that he would hit this peer with his cane if he saw him. The other resident [R2] was 1:1 with staff for safety and had been kept out of sight of [R1]. Staff attempted to redirect him which seemed to escalate his agitation even more. He started to accuse stuff you got someone to take other peer away when I am the one that he hurt. [R1] seemed to be remembering the incident and insistent that it happened today at 6:00 a.m. DON reviewed camera footage which revealed no accident had occurred this morning. 4/20/26 at 12:22 p.m [R1] was pleasant and at times walked around peer he had incident with on 4/10/26 without being fearful of him. R1's nursing assistant (NA) behavioral documentation from 3/29/26 through 4/26/26, (29 days) indicated R1's behavioral symptoms included: 3/29/26 at 1:32 a.m., through 4/2/26 at 11:52 p.m., 16 entries, no behaviors. 4/3/26 at 1:58 p.m., wandering 4/3/26 at 8:28 p.m., through 4/5/26 at 1:07 p.m., 6 entries, no behaviors. 4/5/26 at 10:06 p.m., and 10:07 p.m. yelling/screaming. 4/6/26 at 12:31 a.m., through 4/9/26 at 2:06 p.m., 9 entries, no behaviors. 4/9/26 at 10:04 p.m., yelling/screaming. 4/10/26 at 5:20 a.m., through 4/19/26 at 1:59 a.m., 26 entries, no behaviors. 4/19/26 at 1:50 p.m., yelling/screaming, abusive language, and threatening behavior (see progress notes on this date). 4/19/26 at 9:06 p.m., through 4/26/26 at 11:55 p.m., 21 entries, no behaviors. There was a total of 83 entries, 78 entries with no behaviors, and 5 entries with behaviors.ˆ R1's Psychiatric visit progress note dated 3/26/26, identified [R1] had a history of (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	progressive dementia and Alzheimer's. [R1] seemed to be doing well during the day but clearly had some sundowning that started early afternoon and can become problematic at night. [R1] has not been combative, worked as a police officer and laid carpet. He was calm and thought process was clearly confused and slightly repetitive. During an interview on 4/22/26 at 2:50 p.m., FM stated [R1] had gotten confused and forgetful, leading to his admission to the facility. At one point, [R1] had a cloth barrier placed across his doorway to discourage residents from coming into his room. Prior to the incident with [R2], R1 kept his door open. Since the incident with [R2], R1 kept his door closed to prevent [R2] from coming into his room. Even though R1 had poor recall, he was able to tell FM the details of the encounter with [R2]. R1 told FM he stood up and told [R2], you cannot take things. R1 stated he [R2] started to choke [R1] and threw him down onto the floor. R1 told FM, he ended up on the floor with a sore elbow that turned black and blue. FM did not recall noticing marks on R1's neck. FM stated R1's explanation of the incident was accurate. FM felt R1 would most likely remember a good part of what happened especially when [R2], laid his hands on him. She had seen [R2] wandering around the unit and was surprised it happened. FM felt the staff were good at keeping the two of them (R1 and R2) apart and placed at different spots in dining room when eating meals. FM stated [R1] has had no issues with any other residents that she was aware of since admission.ˆ During a follow up interview on 4/27/26 at 3:35 p.m., FM stated in the past, prior to R1's decline in cognition, if an intruder came into their home he would have gotten angry, would not attack but would asked them why they were there and told them, This is my place get out. R1 was a retired police officer and was careful, making sure the doors were closed, locked, and secure at nighttime. R1 was protective but never violent. FM was not aware of R1 making false allegations of violence against him, he was very social and never seemed to get angry.ˆ During an observation and interview on 4/23/27 at 9:37 a.m., R1's room door was closed with a cloth barrier draped across the doorway. R1 sat in his recliner, fully dressed, and well groomed. R1 stated FM visited last week and was not able to recall FM's visit the day before. R1 identified he had five children, their names, and where they lived. R1 stated he had not fallen until about two weeks ago, had a sore elbow and right side since then. R1 stated he left the door to his room open and a gentleman who lived there entered his room, while he [R1] sat in his recliner. This man [R2] went through my stuff across my room, by my door and started taking things. I told him, 'get out of here!' R1 stated he stood up and walked over to him. R2 then placed his hands on R1's neck and choked him. He was a big man and strong. He slammed me down on the floor onto my right side. R1 stated he bruised his right elbow. The nurses offered to send him to the emergency room but he did not go. R1 stated his right hand and thumb still hurt/throbbed and he felt is was slightly puffy. R1 stated, That man was not in my room long, only five minutes or less, taking things and putting them in his arms. R1 stated, If that man came into my room again, he will not get another chance to hurt me again. Geez, being a cop for all those years and I could not even defend myself. R1 stated he yelled for help and staff came.ˆ R2 R2 quarterly MDS dated [DATE], identified R2 was admitted to the facility on [DATE], from home/community. R2 had minimal difficulty hearing, sometimes understood others, responded adequately to simple, direct communication only. R2 had severely impaired cognition with disorganized thinking or incoherence that fluctuated (comes and goes, changes in severity), and delusions (misconceptions or beliefs that are firmly held, contrary to reality). R2 wandered one to three days out of seven. He was independent with ambulation. R2's diagnoses included: non-traumatic brain dysfunction, Alzheimer's disease, non-Alzheimer's dementia, and depression. R2 was five feet, eight inches tall and weighed 216 pounds. R2 took antipsychotics and antidepressant medications. R2's SLUMS examination dated 5/5/25, identified a total score of 10 out of 30. A score range of 1 to 20 points indicated cognitive impairment or possible dementia. R2's physician and nursing orders identified: Escitalopram Oxalate (antidepressant) give 20 mg tablet by mouth in the evening related to Alzheimer's disease. Start date: 9/15/25 at 2:45 p.m. Mirtazapine (antidepressant) oral tablet give 30 mg by mouth one time a day to help with sleep and irritation. Start date: 3/12/26 at 5:00 p.m. Olanzapine (antipsychotic) oral tablet (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	give 10 mg by mouth one time a day for agitation related to Alzheimer's Disease. Start date: 3/12/26 at 4:00 p.m. End date: 4/16/26 at 11:30 a.m. Olanzapine oral tablet give 10 mg by mouth two times a day for agitation related to Alzheimer's Disease. Start date: 4/16/26 at 5:00 p.m. Quetiapine Fumarate (antipsychotic) oral tablet give 25 mg by mouth every morning and at bedtime for mood. Start date: 4/11/26 at 6:00 a.m. End date: 4/16/26 at 11:21 a.m. Quetiapine Fumarate oral tablet give 50 mg by mouth as needed two times a day (bid) as needed (PRN) for agitation/restlessness. Start date: 4/10/26 at 4:30 p.m. End date: 4/16/26 at 11:21 a.m. N.O. Document behaviors every shift, document non-pharm and pharm interventions used for behavioral management. Document facial expressions, tone of voice, body language/gestures. Document activity/whereabouts. Every shift for behavior charting. Start date: 4/14/26 at 2:45 p.m. R2's Electronic Medication Administration Record (EMAR) and Treatment Administration Record (TAR) for April 2026, identified: Audible Door Sensor Alarm. Please monitor functioning and document amount of times triggered by resident each shift. Start date 4/24/26 at 10:45 p.m. Triggered on 4/24/26, three times on night shift.^ Triggered on 4/25/26 and 4/26/26/26 p.m., ten times on p.m. shift. Silent Alarm (bed). Please monitor functioning and document amount of times triggered by resident each shift. Started date: 4/24/26 at 10:45 p.m. Triggered 4/24/26 four times night shift, 4/25/26 a.m. one time day shift, ten times p.m. shift, and zero times night shift. Triggered on 4/26/26, three times on day shift, five times on p.m. shift and zero times on night shift. Silent Alarm (recliner). Please monitor functioning and document amount of times triggered by resident each shift. Start date: 4/24/26 at 10:45 p.m. Triggered: 4/24/26, through 4/26/26, zero times on all three shifts. R2's care plan dated 4/13/26, identified: Behavior/Mood. He may exhibit behaviors related to Alzheimer's /dementia and depression. Staff were directed to: effective 9/18/25- keep R2 occupied during times of restlessness/sundowning as those seemed to be times he wandered into other resident rooms; effective 9/18/25- engage him in meaningful cleaning or tinkering tasks; effective 9/18/25- anticipate his needs, be creative to keep him busy and out of situations that have the potential to cause another resident to yell at him as that can be a trigger for him to act-out physically; effective 1/12/26- if difficult to redirect or resistive to cares, reapproach task with male caregiver assist as resident at times is more receptive to males; effective 1/30/26- monitor whereabouts frequently due to him wandering into private spaces and his actions of touching and taking other residents' belongings as this is not always welcome by others; effective- 4/13/26- often on the move, entered rooms and others' spaces and unaware of others' personal space. Does not respect DO NOT ENTER signs. When approached by other residents, he can be unpredictable in his response; effective 4/22/25- when having behaviors, if not bothering others or super disruptive, do not redirect; effective Allow him to tinker. Non-pharm interventions liked to garden, work for a paycheck. Redirect, remove from environment if appropriate, provide activity, likes ice cream, look for unmet need and assist, redirect to toilet and assist if resident appears that he is about to void in inappropriate places, ask him to babysit baby doll, organize items, and fix things. R2 was at risk for elopement related to impaired safety awareness and history of elopement when at home. Staff were directed to monitor his whereabouts frequently due to him wandering into private spaces as this placed him at risk of his peers becoming aggressive with him and he may return aggression. Psychosocial wellbeing. R2 wandered about his environment and had dementia like behaviors related to the early onset of Alzheimer's disease. He went into other resident rooms and may take their things without realizing it was not his. Staff were directed to anticipate needs and redirect as able when needed. Therapeutic Recreation. Will need invitations, reminders and escorts to small and large groups and nearly constant redirection due to his impaired cognition and impulsiveness. Staff were directed to encourage independent leisure pursuits of cleaning, straightening, sweeping, folding towels, wiping tables.^ Please give him tasks around the unit to help him feel purposeful. He enjoyed being outdoors but needed constant redirection as he had little safety awareness and was impulsive. He liked to rake and water the grass but needed supervision. R2's progress behavior notes from 1/12/26, through 4/26/26, identified: On 1/12/26 at 8:52 p.m., 1/13/26 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at 8:52 p.m., 1/15/26 at 9:44 p.m. [R2] walked in and out of other resident rooms. He had another resident's clothes on, taking things from one room to another, turning chairs over, rearranging furniture, and pulled fire alarm. Unable to redirect at times. On 1/15/26 at 8:31 p.m., [R2] was difficult to redirect this afternoon. He approached a table with two peers seated for supper, took papers and clothing protectors off table. Another resident told [R2] to leave in an angry voice, staff stood between residents and tried to de-escalate the situation. [R2] wanted to go outside, and fight. [R2] then turned and swung the clothing protector at staff and knocked over the other resident's milk. Staff stood between residents and [R2] held up his arm as to hit staff but was only verbally aggressive. On 1/21/26 at 8:12 p.m., [R2] became agitated, irritable around 3:00 p.m. and made several angry comments stated, I'm not going to let these punks boss me around. He took other resident's belongings (walkers) and became agitated when staff attempted to remove item to prevent altercations with other residents. [R2] stated I am not going to give it back, this is mine. Staff allowed him space due to increased agitation. On 1/21/26 at 10:09 a.m., [R2] continued to wander in and out of private areas, taking others personal belongings. He does have aggressive tendency mostly in the evening hours and had the potential to hit or become physically aggressive almost daily. On 1/23/26 at 10:13 p.m., noted in [other] resident's room twice, redirectable. On 1/26/26 at 8:49 p.m., [R2] walked by a table in dining room with two male peers sitting at it and touched peer's walker. [Peer] stated that is not yours several times. Nurse immediately intervened between the two residents. She cupped [peer's] elbow as he attempted to hit [R2]. Then [R2] threw approximately three or four closed fist punches towards [peer's] face: hitting him twice in the forehead. Staff placed her arms around [peer], attempted to block [R2's] punches and was hit a couple of times in the arm by [R2]. Door between north and south dining area was now locked until manager's team meeting to review incident. On 1/27/26 at 9:22 p.m., Wandering unit and went into two other resident rooms on south side, redirectable. Tried to exit out of the courtyard south side door, redirected by staff multiple times. On 1/29/26 at 9:07 p.m., Took nap and woke up angry very busy went into the three different resident rooms on the north unit side. On 2/10/26 at 9:06 p.m., Resistive to cares. [R2] removed garbage can from medication cart. After supper he went into a peer's room and was going to pick up an item and peer said, that's mine. Re-directed out of the peer's room. On 2/17/26 at 1:44 p.m., [R2] incontinent of BM. Staff assisted him and became upset, resisting and hitting out. Additional staff assisted and distracted him. On 2/19/26 at 9:21 p.m.,. [R2] urinated in dayroom and in the sunporch. Very busy wandered around unit and went into peers' room and redirected. On 2/21/26 at 6:12 a.m., [R2] very active beginning of shift, going into other resident room. Not agitated and easily re-directed. Very busy pacing around. Stayed up until 3:00 a.m. On 2/21/26 at 10:27 p.m., [R2] was served supper and received [peer's] utensils. [Peer] stated give it back to me! [R2] was mad and agitated, moved to another [peer's] table. [Peer] protected his utensils and stated, don't get mestaffs [sic]. [R2] held up the fork towards [peer]. Writer tried to redirect, de-escalate, and tried to move [R2] from the area. He was mad and stated to writer I can hurt anyone. [R2] Calmed down more than one hour later. On 2/24/26 at 9:24 p.m., [R2] incontinent of bowel refused to go to bathroom, withdrawn and irritable. Ambulated about the south and north village, tried to open doors and went into other peers' rooms. On 2/28/26 at 8:38 p.m., Around supper time [R2] agitated/restless more than usual. He started to upset some of the other residents at his table. One of the other residents raised his hands up and in a joking manner as if in a boxing motion. [R2] became very agitated, had to be separated from the other resident, and placed at another table. [R2] stated to the nurse do you want me to beat that guy up for you? [R2] was kept away from other residents until they went to bed. On 3/4/26 at 8:45 a.m., Staff reported this a.m. notice [R2's] increased agitation/behaviors with cares since discontinuation of olanzapine. Fax sent to provider. No new orders. On 3/7/26 at 1:53 p.m., per kitchen staff report, [R2] upset a peer when he attempted to take his walker out of the dining room. Peer intervened and said, [NAME] leave that alone it's mine. Peer repeatedly replied, who said it's yours? [R2] stepped away from peer and walker and went in a (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	different director. Monitor. On 3/10/26 at 9:23 p.m., After supper [R2] wandered around the unit and went into a north side peers' room. Staff attempted to get him to come out of the room, sat on peer's bed and laid down. Peer upset and asked him to exit the room. [R2] left the room. On 3/11/26 at 8:43 p.m., R2] very agitated this evening after supper. Wandered around quite a bit into resident rooms (with some of them getting upset), removed items out of other resident rooms and hard to redirect out of the rooms. [R2] attempted to push another resident in a wheelchair, upset the other resident (was getting angry/upset). Several staff approached [R2] multiple times to get him away from the resident in the wheelchair. On 3/12/26 at 8:40 a.m., increase in two psych medications today. Wandered around unit off and on, less agitated/aggressive and more directable. On 3/13/26 at 9:29 p.m., [R2] wandered about unit, seemed on edge and short with staff, and redirectable at times. On 3/16/26 at 5:15 a.m., [R2] wandered all shift on both north and south units. Finally asleep by 4:45 a.m. On 3/18/26 at 11:13 a.m., [R2] was on antipsychotics for wandering, aggression, and multiple behaviors. His mood was worse in the p.m. hours, medications do seem to help some. On 3/24/26 at 9:48 a.m., Behavior rounds: [R2] seemed to sundown shortly after lunch. Keep resident on south side of village if able due to history of physical aggression towards residents that live on the north side. If difficult to redirect or resistive to cares, reapproach task with male caregiver. On 3/27/26 at 9:21 p.m., [R2] sleepy, wandered into a peer's room and laid down on his bed. Staff brought him to his room to lay down. Urinated in front of the curtain by entrance On 3/28/26 at 4:55 p.m., prior to supper [R2] was agitated, wandering between north and south side. At one point on the north side came up with two residents, appeared to possibly touch one of the residents' drink/sodas. The resident sitting at the table became visibly upset at [R2] had somewhat of verbal altercation of which [R2] raised his arm and stood somewhat over the sitting resident, looked down at him, made a comment about beating him up. The writer stepped in between the residents, took [R2's] hand and walked away from the table. No physical interaction occurred, however, there was a possibility it could have escalated. [R2] was monitored to attempt to prevent him from coming over to the north side again. On 3/28/26 at 8:46 p.m., [R2] was agitated once daughter left. Wandering unit, hard to redirect. On 3/30/26 at 8:23 p.m., While attempting to administer medications in the afternoon, [R2] grabbed this writer's arm forcefully and stated, I'm not gonna do that. Writer removed hand, disengaged him and gave him space. Irritable throughout the afternoon and early evening. On 4/8/26 at 8:30 p.m., Wandering, pushing furniture, going into other resident rooms and often will take their food or candy if not noticed right away. Continued behaviors but redirectable. On 4/10/26 at 2:00 p.m., [R2] was noted to be coming out of another resident room with a cane. This was an ongoing behavior of this resident to wander throughout the unit, entering other resident rooms and moving things around. The resident of who [R2] entered stated the resident came into my room and moved things around, then choked me and threw me to the ground. Removed cane from [R2], monitor, currently not agitated currently oriented to self only. On 4/10/26 at 4:00 p.m., and 4:48 p.m., Called mental health provider unable to reach, left message. Called primary provider updated regarding [R2's] behavior and received PRN for agitation. On 4/10/26 at 6:00 p.m., transferred to medical facility ED in van with facility staff. On 4/10/26 at 6:07 p.m., In lieu of another incident of aggression by [R2] towards another resident who did not appreciate him wandering into his room, touching their belongings, writer had a long conversation with his [R2] wife about next steps, sent to ED for evaluation of psychiatric inpatient to evaluate his continued aggression. Discussion also had that they may not admit him as he is usually calm natured, but a quick anger and become physical or verbal when he is confronted by peers and told to not do or touch something. That was not something easily treated without the potential of over sedation. Family aware that made it hard for the facility to manage as he is almost constantly wandering about the village unit, in and out of resident rooms commons areas, fidgeting and touching everything without constant supervision. It was hard to predict when a behavior may occur from any resident on the Village. They [family] are aware they [facility] may need to start discharge planning to a different facility to ensure everyone's safety. Family voiced understanding. If not admitted to the (continued on next page)

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	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN Veterans Home Fergus Falls	1821 North Park Fergus Falls, MN 56537

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medical center family will help over the weekend to increase our ability to monitor [R2's] whereabouts on the unit more closely. On 4/10/26 at 6:28 p.m., provided [R2] with 1:1 supervision by recreation staff immediately after incident until he was transported to the ER. He was calm, cooperative, and did not recall an incident occurring. On 4/10/26 at 8:55 p.m., ED provider had talked to psych medical doctor (MD), administered 50 mg of Seroquel (Quetiapine Fumarate). Will be sending [R2] back to facility with written orders: Seroquel scheduled twice a day (b.i.d.) and PRN. On 4/10/26 at 10:22 p.m., [R2] returned to facility with his wife. A new psych visit will be requested for next week. If conditions worsen return to ED. Discussed with wife if family would be available during specific times on Saturday and Sunday. Maybe difficult due to grandchild sporting event. On 4/11/26 at 5:45 a.m., [R2] slept all shift after he arrived back to facility at 10:22 p.m. Every 15-minute checks completed for his shift. On 4/11/26 at10:51 a.m., Woke up at 9:00 a.m., ate breakfast and was calm. Staff continued every 15-minute checks. Spoke with wife, she will be coming in at 2:00 p.m. to sit with resident as he becomes more agitated and busier in the afternoons. On 4/11/26 at 1:35 p.m., Staff provided very 15-minute checks, gets busy, wandering, busy easily redirected. On 4/11/26 at 2:21 p.m., Wife here sitting in [R2's] room with him. Continuing to monitor. On 4/11/26 at 10:27 p.m., Wife here from 2:00 p.m. to 4:00 p.m. [R2] has been pleasant currently sitting with staff. On 4/13/26 at 12:06 p.m., scheduled an appointment for 4/16/26 with psych. On 4/13/26 at 10:03 p.m., [R2's] Behaviors heightened before supper time. He was hard to redirect and refused cares multiple encouragements. When given PRN Seroquel noted to be calmer. On 4/14/26 at 1:18 p.m., remained 1:1 for this shift. On 4/14/26 at 10:18 p.m., [R2] busy this shift wandering, moving furniture. Had 1:1 starting at 4:00 p.m. to 10:00 p.m. On 4/15/26 at 4:14 a.m., slept almost entire shift, no behaviors. Continue frequent checks. On 4/15/26 at 1:45 p.m., [R2] walked around courtyard, attempting to break off branches and flowers. Recreation staff attempted to distract and remove from [NAME] and tried to sneak a peak down back of pants as there was a foul odor [R2] grabbed staff's fingers and said, If you touch me again, I'll break every finger on your hand. Proceeded to squeeze hand and lead recreation staff with him for approximately 15 seconds then let go. On 4/16/26 at 12:05 p.m., [R2] seen by psychiatric provider. New orders received: discontinue scheduled Seroquel (no need for two antipsychotics), change Zyprexa to 10 mg po every a.m. and 10 mg po every 5:00 p.m. (when available), add Zyprexa 5 mg po every six hours PRN for agitation or aggression. On 4/16/26 at 9:21 p.m., No behaviors this shift. Wife here for activity and had 1:1 from 4:00 p.m. to 9:00 p.m. On 4/16/26 at 5:37p.m., Late entry 4/14/26. Wife returned writer's call. Discussed possible discharge planning maybe needed for resident related to recent behaviors or an inpatient behavioral hospital stay. Writer asked if family would be able to come and be with resident. Wife does not live locally and indicated family would not be able to come. On 4/17/26 at 22:19 p.m., No noted aggressive behaviors. He did have some unrecognizable type of conversation, wandering, but no noted issues. On 4/18/26 and 4/19/29, no behaviors noted. On 4/19/26 at 1:28 p.m., Walking around, wandering around unit today. Typical baseline. Has walked around peer he had incident on 4/10/26. [R2] did not appear fearful when he has walked by peer or when peer walked by him. Did not appear to remember incident or other resident involved. On 4/20/26 at 9:39 p.m., Beginning of shift [R2] had increased agitation and not able to redirect. He received Zyprexa 5 mg which was effective. On 4/23/26 at 9:25 p.m., [R2] wandering in south and north units and into other resident rooms, rearranging furniture. Used redirection, positive reinforcement and distractions. Confused and not aggressive responses. On 4/24/26 at 10:16 p.m., [R2] was very agitated, took food from another resident's plate, walked around with the dinner plate and silverware, very hard to redirect. Currently 1:1 with staff person. On 4/26/26 at 12:46 p.m., Required more supervision as he wandered, unable to stay on task, easily redirectable but required frequent redirection. R2's psychiatric visit progress note dated 1/22/26, identified [R2] as having a lot of behaviors, not sleeping well, seemed to have his days and night