

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245636	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/05/2025
NAME OF PROVIDER OR SUPPLIER  MN Veterans Home Fergus Falls		STREET ADDRESS, CITY, STATE, ZIP CODE  1821 North Park Fergus Falls, MN 56537	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45844</p> <p>Based on observation, interview and document review, the facility failed to accurately assess and implement safe smoking interventions for 1 of 1 resident (R17) reviewed for smoking.</p> <p>Findings include:</p> <p>R17's quarterly Minimum Data Set (MDS) dated [DATE], indicated R17 had diagnoses which included chronic obstructive pulmonary disease (COPD) hypertension (elevated blood pressure), and stroke. Identified R17 had severe cognitive impairment and was independent with activities of daily living (ADL's) which included transfers and toileting. Identified R17 used tobacco.</p> <p>R17's annual Care Area Assessment (CAA) dated 5/1//24, identified interventions were in place to address safety needs.</p> <p>R17's care plan revised 4/27/21, identified the facility had determined R17 was a modified independent smoker. Care plan identified facility was to store R17's cigarettes and give R17 one cigarette at a time to smoke independently.</p> <p>R17's smoking assessment dated [DATE], indicated R17 was safe to dispose of ashes and smoking material completely. Assessment indicated R17 did not have any visible burns on clothing or wheelchair cushion. Indicated R17 was safe to smoke independently without supervision and did not require a smoking apron.</p> <p>R17's smoking assessment dated [DATE], indicated R17 was safe to dispose of ashes and smoking material completely. Assessment indicated R17 did not have any visible burns on clothing or wheelchair cushion. Indicated R17 was safe to smoke independently without supervision and did not require a smoking apron.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/4/25 at 9:15 a.m., R17 was standing at the nurses station. R17 received one cigarette from registered nurse (RN)-A. R17 walked into the smoking room which was located about 40 feet from the nurse's station. R17 put the cigarette into the wall lighter. (a small hole within a metal box located on the wall) and lit the cigarette. R17 sat down in the chair and began smoking the cigarette and as R17 was smoking the cigarette ashes began falling on his lap. R17 had not made any effort to remove the cigarette ashes from his pants and continued smoking. R17 placed the cigarette which was still burning in an ashtray and walked back to the nurses station and received another cigarette from RN-A. R17 walked back into the smoking room and picked up his previous cigarette and used it to light the new cigarette then placed the first cigarette still burning into the ashtray. R17 smoked the second cigarette as ashes continued to fall onto his lap. R17 made no effort to remove the cigarette ashes from his lap and continued smoking. R17 then placed the second cigarette which was still burning into the ashtray. R17 made no effort to extinguish either of the two cigarettes. R17 then left the smoking room and went back to his room.</p> <p>During an observation on 2/4/25 at 9:51 a.m., R17 came out of his room and walked to the nurse's station and received one cigarette from RN-A. R17 walked into the smoking room and used the wall lighter to light the cigarette. R17 sat down in the chair and had visible holes in the black sweatpants he was wearing. R17 began smoking the cigarette and ashes began falling onto his lap. R17 made no effort to remove the cigarette ashes from his pants and continued smoking R17 placed the cigarette which was still burning into the ashtray. R17 made no effort to extinguish the cigarette, got up from the chair, several ashes were noted on the floor as R17 left the smoking room and walked back to his room.</p> <p>During an inventory of R17's clothing on 2/4/25 at 9:26 a.m., RN-A identified two pair of blue pants with large burn-holes, one pair of gray pants with burn-holes, and the black sweatpants R17 was wearing had several burn-holes in them.</p> <p>During an interview on 2/4/25 at 10:02 a.m., laundry aide (LA)-A stated she was aware of the burn-holes in R17's pants. LA-A stated she was not sure how long the burn-holes had been on R17's pants.</p> <p>During an interview on 2/4/25 at 11:00 a.m., nursing assistant (NA)-A stated R17 was a smoker and the nurses stored R17's cigarettes for him. NA-A stated R17 was able to smoke in the smoking room without supervision or a smoking apron. NA-A stated she was aware of the burn-holes in R17's pants however, was unsure how long the burn-holes have been there.</p> <p>During an interview on 2/4/25 at 11:10 a.m., NA-B stated R17 was a smoker and the nurses stored R17's cigarettes for him. NA-A stated R17 was able to smoke in the smoking room without supervision or a smoking apron. NA-A stated she was aware of the burn-holes on R17's pants however, was unsure how long the burn-holes have been there.</p> <p>During an interview on 2/4/25 at 11:36 a.m., RN-A stated she had completed smoking assessments on R17 by observing R17 smoke through the window however, had never gone into the smoking room while R17 was smoking. RN-A stated she was aware of the burn-holes on R17's pants however, was not sure how long the holes had been there. RN-A stated she was not sure why the smoking assessments stated there were no visible holes on R17's clothing. RN-A stated for safety reasons her expectation was that staff should have been offering a smoking apron or supervise R17 while smoking.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/4/25 at 12:13 p.m., RN-B stated she had observed R17 smoking through the window however, had never gone into the smoking room while R17 was smoking. RN-B stated she was aware of the burn-holes present on R17's pants and was not sure how long the holes had been there. RN-B stated she had assumed R17 was safe to smoke unsupervised and did not require a smoking apron.</p> <p>During an interview on 2/4/25 at 12:17 p.m., RN-C stated she had not visualized R17 smoking. RN-C stated when the nurses completed a visual smoking assessment on R17, it was usually by visualizing the window. RN-C stated she was aware of the burn-holes present on R17 clothing however, was unsure how long the holes had been there. RN-C stated another assessment was going to be completed to ensure R17's safety while smoking.</p> <p>During an interview on 2/4/25 at 12:42, director of nursing (DON) stated she was aware of the burn-holes present on R17's clothing. DON stated she was unsure how long the holes have been on the clothing or if any of the burn-holes had happened recently. DON stated her expectation was that R17 was safe while smoking and that another smoking assessment was to be completed and that safety interventions would be implemented off of that new smoking assessment to ensure R17 was safe while smoking.</p> <p>Review of a facility policy titled Smoking and Tobacco Policy revised 5/1/19 identified residents ho smoke would have a smoking assessment quarterly and upon change of condition. Identified smoking interventions were based on the individualized smoking assessment. Residents will follow the plan of care. Violations of the rules or agreed to interventions may result in the loss of the smoking privilege or may lead to smoking restrictions.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49620</p> <p>Based on observation, interview and document review, the facility failed to ensure professional standards of practice were followed during medication set-up and administration of insulin with a Novolog insulin pen ( rapid-acting insulin, used to improve blood sugar control in people with diabetes mellitus) for 1 of 2 residents (R15) who received insulin without the pen primed according to manufacturer's recommendations.</p> <p>Findings include:</p> <p>R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 had intact cognition with diagnosis of type two diabetes (DM), and received injections of insulin.</p> <p>R15's care plan revised 5/31/24, identified staff were to administer medications as prescribed.</p> <p>R15's Medication Review Report signed 12/18/24, identified Semglee Pen-100 units/milliliter, inject 12 units Subcutaneously (an injection just under the skin into the fatty tissue) two times daily for DM.</p> <p>During an observation of medication pass on 2/3/25 at 6:10 p.m., registered nurse (RN)-D prepared R15's medication which included her evening, Semglee insulin. RN-D removed the Semglee insulin pen from the medication cart, removed the tip, attached a needle to the end of the pen, dialed the dose to the ordered 12 units, picked up an alcohol wipe, went to R15's room and administered the 12 units of insulin to R15. RN-D then removed the needle from the end of the pen, placed it in the sharps container and sanitized his hands. RN-D did not prime the pen (waste 2 units of insulin to remove the air bubbles) per manufacturer's instructions prior to drawing up the 12 units of insulin.</p> <p>During an interview on 2/5/25 at 9:33 a.m., RN-D verified he had not primed the insulin pen prior to dialing up the 12 units of Semglee for R15 per manufacturer's recommendations. RN-D stated he was aware the insulin pen should have been primed prior to dialing up the insulin to ensure the accurate dosage of insulin was administered.</p> <p>During an interview on 2/5/25 at 9:35 a.m., consultant pharmacist (CP) stated it was important to always prime an insulin pen prior to drawing up the dosage to ensure the residents received the correct dosage of insulin.</p> <p>During an interview on 2/5/25 at 10:27 a.m., director of nursing (DON) stated her expectation was that the insulin pen would have been primed prior to dialing up the insulin dose for R15 to ensure the proper dose of insulin was administered.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Semglee insulin manufacture's package insert dated 2021, identified the need to perform an airshot before each injection to ensure the any air bubbles were removed. The process directed: Attach a new needle, Select a dose of 2 units on the dosage selector, hold the pen with the needle pointing upward, tap the insulin reservoir to move any air bubbles to the top of the reservoir, press the injection button all the way in, and check to see if insulin comes out of the needle tip. Repeat if no insulin comes from the needle, then dial the selector to the ordered insulin dose and administer as ordered.</p> <p>Review of a facility policy titled Medication Administration Standard revised 5/23, identified staff would follow appropriate standards and protocols when administering medications.</p>		