Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Minnesota Veterans Home - Fergus Falls

Location: 1821 North Park Street, Fergus Falls, Minnesota 56537

Onsite / Virtual: Virtual

Dates of Survey: 11/7/22-11/10/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 106

Census on First Day of Survey: 81

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from November 7, 2022 through November 10, 2022 at the Minnesota Veterans Home - Fergus Falls. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.120 (a) (3) Reporting of Sentinel Events The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1-22) and Office of Geriatrics and Extended Care in VA Central Office within 24 hours of notification. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on record reviews, interviews, and review of the facility's policy, the facility failed to report sentinel events to the director of the VA medical center within 24 hours of identification of the event for two (2) out of four (4) incidents reviewed. The findings include: A review of the facility's records revealed Resident #10 had an unwitnessed fall on [DATE], in their room as they were self-transferring. The resident was sent to the local hospital and diagnosed with a right femoral head fracture and surgical intervention was declined. The date the SVH contacted the [LOCATION] to report the fall was [DATE]. The Resident returned very weak, with low hemoglobin, and not wanting to eat. The family chose to keep Resident #10 comfortable, and they passed away on [DATE]. During an interview, on 11/10/22, at 11:00 a.m., EST Administrative Staff A confirmed the reports were not submitted within the 24-hour time frame.

§ 51.120 (a) (4) Reporting of Sentinel Events The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on record reviews and interviews, the facility failed to establish a mechanism to review and analyze a sentinel event, resulting in a written report no later than 10 working days following the event for one (1) resident. The findings include: A review of the facility's records revealed Resident #11 fell from a lift recliner on [DATE]. The resident was sent to the local emergency room and was admitted. Resident #11 was diagnosed with a urinary tract infection with sepsis, acute renal failure, and acute L5 compression fracture. The resident returned to the [LOCATION] on [DATE], and elected to have hospice care. The facility did not create a written report within 10 working days. During an interview, on 11/10/22, at 11:00 a.m., EST Administrative Staff A confirmed the reports were not reviewed, analyzed, and written within the 10-day time frame. Administrative Staff A stated they were not aware that they needed to write a report within 10 days.