STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245474	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Care Center	200 Park Lane Buffalo, MN 55313

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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48040 Based on interview and document review, the facility failed to monitor and provide treatment for a resident following a fall with a head strike, hyperglycemia and changes in respiratory status for 1 of 3 residents (R1) reviewed for change of condition. Findings include: R1's Admission Record dated 8/2/22, indicated R1's diagnoses included diabetes mellitus type 1, chronic kidney disease, polyneuropathy (damage to the nerves in the hands and feet/legs), atherosclerotic heart disease and chronic pain syndrome. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had history of falls, required extensive assist of two persons for transfers, limited assistance with activities of daily living (ADLs) and had intact cognition. R1's care plan initiated 8/2/22, indicated R1 had type one diabetes mellitus and was at risk for decline in medical condition. Staff intervention included monitor for change of condition and notify provider and resident representative as indicated and administer medications and treatments per provider order. R1 had history of falls and scored 16 on the John Hopkins fall risk assessment tool indicating R1 was at high risk for falls. R1 required extensive assist of two persons for transfers using standing lift. R1 vital signs were stable and she was on room air. R1's Provider Orders for Life-Sustaining Treatment (POLST) dated 8/11/22 indicated R1 was a Do Not Resuscitate (DNR) resuscitation status, with comfort-focused treatment which directed nurses to transfer R1 if comfort needs could not be met in current location. R1's oxygen saturation levels never got above 88% (normal is 90% or above) on 4 Liters of oxygen from 6:00 a.m. to 9:30 a.m. R1's medical record lacked evidence of other interventions implemented to alleviate her respiratory distress. On 3/15/24 at 7:12 a.m., a progress note indicated R1 had unwitnessed fall with 0.5 centimeter (cm) x 0.4 cm bruise at right side of her forehead in her room at 4:59 a.m. She was disoriented, alert and had mild lack of energy. R1's vital signs and blood glucose (BG) levels dated 3/15/24 revealed the following: (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-5:00 a.m.: blood pressure (BP) 95/59; temperature (temp) 97.1; pulse 126; respirations (RR) 28 -5:15 a.m.: BP 103/61; temp 97.2; pulse 113; RR 25 -5:30 a.m.: BP 110/70; temp 97.2; pulse 109; RR 25 -5:45 a.m.: BP 101/63; temp 97.2; pulse 101; RR 27 -6:00 a.m.: BG 521 mg/dl -6:15 a.m.: BP 101/65; temp 97.2; pulse 101; RR 23 -6:45 a.m.: BP 108/63; temp 97.3; pulse 120; RR 21 -6:56 a.m.: BG 489 mg/dl -7:37 a.m.: BG 479 mg/dl -7:45 a.m.: BP 113/71; temp 97.4; pulse 119; RR 22, oxygen saturation (O2 sats) 84% -9:30 a.m.: BG 544; BP 82/54; temp 97.7; pulse 117; RR 16; O2 sats 74% On 3/15/24 at 8:25 a.m., a progress note indicated R1 had at 6:00 a.m. blood glucose reading of 512 mg/dl, O2 sats of 80-81%, oxygen 4-5 L was applied via nasal canula, but her O2 sats remained at 83-85%. The note also indicated the on-call provider (MD)-A was notified, and ordered to give scheduled 10 units insulin, continue monitoring the resident's condition, and update the nurse practitioner (NP)-A for any sudden changes on R1's status. The note indicated family member (FM)-A was updated and aware of the resident's condition, and agreed to send R1 to the hospital for evaluation if needed. On 3/15/24 at 9:30 a.m., a progress note indicated R1 had crackles to her lungs upon auscultation. R1 was lethargic, in respiratory distress with O2 sat at 69 to 74% on 4L of O2. The note also indicated NP-A was notified, and ordered R1 to be sent to the hospital per family request. On 3/15/24 at 11:30 a.m., a progress note indicated R1 had passed away at the hospital with the family at the bedside. R1's hospital Patient Discharge Note dated 3/15/24 at 12:11 p.m. indicated R1 had coarse breath sounds bilaterally right worse than left, gasping for air, was unresponsive and was requiring bag-valve-mask (BVM), a handheld tool to deliver possitive pressure ventilation support to maintain O2 sats upon arrival at the hospital. It was suspected R1's hyperglycemia (high blood glucose level) was from severe sepsis/septic shock from pneumonia. The note also indicated R1 passed away at 11:38 a.m. on 3/15/24. MD-A's progress note dated 3/15/24 at 6:33 a.m. indicated R1 was found down on the floor with a BG of 552, systolic BP of 95, pulse 104, and O2 sats of 80-84% on 4 L of O2. R1 had a few basilar crackles, an abnormal breath sounds at the bases of the lungs with no apparent injuries. The note also indicated to update primary team in two hours depending upon BP, and anything further regarding BG and O2 sats. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	NP-A's note dated 3/15/24 at 1:06 p.m. indicated R1 had unwitnessed fall in her room at 5:00 a.m., received a head strike and had an acute change in condition. Family did not want to send R1 to the hospital at that time. NP-A observed R1 sitting slumped over in bed, with the head of the bed (HOB) elevated because of labored/congested breathing. R1 was unresponsive and appeared at the end of life. On 4/8/24 at 12:42 p.m. family member (FM)-A stated she got a call from the facility around 7:00 a.m. on 3/15/24 regarding R1's fall. She told the facility to send R1 to the hospital for further evaluation. At around 10:00 a.m. she got another call again from NP-A who told her R1 was at the end of life. She requested R1 to be sent to the hospital for further care. On 4/9/24 at 8:14 a.m. registered nurse (RN)-A stated nurses were responsible for monitoring residents. RN-A stated R1 was found on the floor in her room at 5:00 a.m. and sustained an injury on her forehead. R1's BP was 90/69, her O2 sats were below 90%, O2 was applied at 4L and her O2 sats increased to 86%, but remained below 90%. She acknowledged she did not document the O2 sats. She called MD-A at 6:00 a.m. and was directed to hold R1's BP medications, continue supplemental oxygen, encourage R1 to do deep breathing, and to continue monitor R1's respiratory status. She was to update the primary team in two hours. On 4/9/24 at 11:51 a.m. RN-C stated if a resident had a change of condition, she would assess the resident. Based on the findings, she would notify the provider and the family, and would continue to monitor the resident every 15 minutes. If the resident's condition had not improved, she would call the provider to request sending the resident to the hospital for further care, and document everything. On 4/9/24 at 1:33 p.m. NP-A stated RN-B updated her about R1's deteriorating condition. She arrived at the facility at about 8:30 a.m. Upon assessment, R1 appeared at the end of life, she was unresponsive, pale, diaphoretic, hypotensive and had agonal breathing with 4 L of O2 on. She directed RN-B to update the family as R1's condition looked poor. She ordered to send R1 to the hospital per family request. On 4/9/24 at 3:05 p.m. MD-A stated he did not recall the nurse informing him of any injury to R1. He gave orders to manage R1 comfort based on the information provided by the nurse. The plan was to manage R1's BG, to continue with supplemental O2, and update the primary care team in two hours. The plan was to focus on comfort care according to R1's advance directives. On 4/10/24 at 9:59 a.m. RN-B stated the last respiratory assessment she did on R1 was around 7:45 a.m. with O2 sats of 84% on 4L of O2. She called the unit manager around 8:15-8:30 a.m. to come and assess R1. R1 was lethargic with O2 sats of 74% to 69% around 9:00 a.m. and she immediately notified NP-A who was on site. On 4/10/24 at 10:51 a.m. RN-D (the unit manager) stated when RN-B told him about R1's change in condition, he went to see R1 in her room but did not do a full assessment. RN-D stated he just wanted to check R1's cognition, and she was able to tell him his name, but was still having hard time breathing. He did not know what R1's O2 sats were when he got to her room, nor did he check. He left R1, and went to his office to be prepare for his daily meeting. Around 9:15 a.m. he saw NP-A who told him R1 was actively dying, and he was surprised. R1 was unresponsive when emergency medical service (EMS) arrived, and EMS put R1 on high flow O2 with BVM support. After a fall with a head strike, nurses should to initiate neuro check and vital signs (VS) which would include O2 sats every 15 minutes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 4/10/24 at 12:22 a.m. the director of nursing (DON) stated she got a report from RN-B between 8:00 a.m. and 9:30 a.m. regarding R1's fall, and was not told of any respiratory distress. After a fall with a head strike, nurses should initiate neuro checks and full VS every 15 minutes, assess the resident frequently, and report to the provider and the family. The facility Fall Assessment and Managing Fall Risk policy revised 11/6/23 directed nurses to assess the resident VS and to complete the neuro checks form every 15 minutes (min) times (x) one hour, every 30 min x one hour, every one hour x one hour, and then every 4 hours until 24 hours post fall. Notify the provider and resident representative of the fall for residents with unwitnessed fall. The facility Notification to Physician/Family/Resident Representative of Change in Resident Health Status policy reviewed 4/14/23 defined a significant change of condition as a major decline or improvement in the resident's status which will not normally resolve itself without intervention by staff or by implementing standard disease related clinical intervention. The policy directed nurses to make detailed observations and gather relevant and pertinent information for the provider.