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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	01/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49620 Based on observation, interview, and document review, the facility failed to ensure proper infection control practices were followed for 1 of 1 residents (R82) when exiting the residents room with a COVID-19 positive diagnosis during medication observation. This deficient practice had the potential to affect all 84 residents who were currently residing in the facility, staff and visitors. Per the Center for Disease Control (CDC), Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. This would include Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. The CDC further identified contact precaution use for a COVID-19 infection included use of designated or disposable patient care equipment. Findings include: R82's admission Minimum Data Set (MDS) identified R82 had intact cognition with diagnoses of bladder mass, weakness, rheumatoid arthritis, urinary tract infection and receiving palliative care. The MDS further identified R82 required extensive to total dependence of staff for activities of daily living (ADL's) which included bathing, toileting, dressing and wheelchair mobility. On 12/30/24, R82 tested positive for COVID-19. R82's care plan revised 1/7/25, lacked documentation of R82's COVID-19 diagnosis and contact precautions. R82's physician order report signed 1/8/25, identified R82 was to receive the following medications. Calcium 600 mg with Vitamin D3 by mouth twice daily, Nicotine patch 14 mg/24 hours once daily and remove old patch before applying new patch, Senna-S 8.6 mg by mouth daily, Tylenol 325mg two tablets by mouth four times a day, Nitrofurantoin 100 mg by mouth twice daily, Oxycodone 2.5 mg/0.125 ml by mouth every twelve hours. (continued on next page)

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/8/25 at 7:02 a.m., licensed practical nurse (LPN)-A prepared the following medications for R82 at the medication cart stationed in the hallway near the dining room. Calcium 600 milligrams (mg) with Vitamin D, Nicotine patch 14 mg, Senna-S 1 tablet, Tylenol 325mg two tablets, Nitrofurantoin 100 mg, Oxycodone 100 mg/5 milliliters (ml). LPN-A opened the locked drawer in the medication cart and removed a box with an oral syringe inside the box. LPN-A drew up 0.125 ml equal to 2.5 mg and set the syringe in a plastic cup. LPN-A put the box and medication back into the locked drawer, locked medication cart and brought prepared medications towards R82's room. LPN-A put on (PPE)in the hallway outside of R82's room; gown, gloves, N95 mask and goggles and entered R82's room. LPN-A put the syringe of Oxycodone into R82's mouth and handed R82 a plastic glass of water. LPN-A gave R82 the other medications on a spoon into R82's mouth, R82 drank the water and handed the glass back to LPN-A who set the syringe into the empty glass. LPN-A proceeded to remove an old nicotine patch off R82's back and placed a new nicotine patch to R82's left back/shoulder area. LPN-A left R82's room and placed the empty plastic glass with the syringe in it on the (PPE) bin outside of R82's room in the hallway. LPN-A removed his gown and gloves and discarded them, sanitized his hands, removed goggles and N95 mask and discarded them, sanitized hands, put a surgical mask on and used sanitizing wipes to clean goggles and placed back in the (PPE) bin. LPN-A picked up the plastic glass and brought back to the medication cart and placed on top of the cart. LPN-A opened the medication cart and the locked drawer, placed the syringe back into the box of Oxycodone, locked the drawer and the medication cart, threw the cup away and sanitized his hands. During an interview on 1/8/25 at 11:30 a.m., LPN-A stated the facility policy was to sanitize any item that was put back into the medication cart if it was in a residents room. LPN-A further stated if a resident had COVID-19 that nothing would be returned to the cart but should be left in the residents room. LPN-A confirmed R82 was positive for COVID-19 and supplies brought into the room that R82 touched were returned to the medication cart and not sanitized. LPN-A verified it was important to clean any items returning to the cart to get rid of germs and prevent the spread of germs to other residents or staff. During an interview on 1/8/25 at 11:37 a.m., registered nurse (RN)-A confirmed R82 was positive with COVID-19 and that supplies should not be leaving the residents room when in isolation. RN-A stated the (PPE) cart in the hallway was a clean area and supplies from a residents room should not be placed on the cart to prevent contamination. RN-A verified the plastic glass and syringe used for R82 should have been thrown away in the residents room to prevent the spread of germs or COVID-19 to others. During an interview on 1/8/25 at 11:52 a.m., clinical support interim director of nursing (DON) confirmed any disposable items should be discarded in a positive COVID-19 resident room. DON stated items used in a residents room would not be placed on the (PPE) bin in the hallway as that was considered a clean space. DON verified this was important to reduce the risk of Covid-19 exposure and cross contamination from clean to dirty items. A facility policy titled Infection Prevention and Control Program revised 8/12/22, identified transmission based precautions and enhanced barrier precautions would be provided for residents requiring additional precautions if the facility was able to meet the resident's needs and infection control recommendations. Multiple use equipment would be sanitized per manufacturer's instructions and per procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy for use of transmission based precautions was requested from the facility and not received.