STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245631	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN Veterans Home-Luverne	1300 North Kniss Avenue Luverne, MN 56156

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	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a change of condition was identified and assessed by a nurse to determine what, if any, additional intervention maybe needed for 1 of 2 residents (R1) reviewed. R1 developed audible gurgling and potential respiratory impairment on [DATE] in the mid-afternoon which was not comprehensively assessed by a nurse until several hours later. Findings include: On [DATE] at 11:46 a.m., an interview was held with emergency medical technician (EMT)-E who stated they were on a crew that responded to the care center for R1 on [DATE], with reported respiratory distress. They arrived and found R1 lying in bed and very clearly in respiratory distress. The staff members present reported R1's condition onset about 2:00 p.m., which EMT-E then questioned aloud, Why did it take eight hours [to call]!? R1 had just had oxygen placed via cannula at 2 liters per minute (LPM) as EMT arrived and R1's oxygen saturations were poor when they checked them. EMT-E stated R1 was then transported to the hospital where she was found to have a very intense pneumonia in her lungs. R1's Physician Orders for Life Sustaining Treatment (POLST), dated 1/2024, identified R1 had wishes for selective treatment marked but was agreeable to limited interventions such as IV/IM antibiotics or a defined trial of artificial nutrition. R1's quarterly Minimum Data Set (MDS), dated [DATE], identified R1 had both long and short-term memory impairment and a history of previous stroke. R1 did not have a history of respiratory failure recorded. R1's care plan, last reviewed [DATE], identified R1 had an activity of daily living (ADL) self-care deficit and was dependent on staff for most care. The care plan lacked evidence R1 had any current respiratory issues or concerns such as wet-sounding voice or ?gurgling' with spoken wordR1's Respiration / Pulse / O2 Sat Summaries, printed [DATE], identified the recorded vital signs for R1 over the previous 90-day period. These vitals were recorded: [DATE] - 18 respirations per minute (RPM), 53 beats per minute (BPM), and 92% on room air (RA). [DATE] - 18 RPM, 62 BPM, and 93% on RA. R1's progress note, dated [DATE] at 10:19 a.m., identified R1 was seen by medical doctor (MD)-D and no new orders were written. R1's corresponding Family Medicine Progress Note, dated [DATE], identified R1 was seen for a routine 60-day examination. MD-D recorded himself as having a hard time understanding R1's speech but R1 had been eating okay. The note identified R1 had a previous choking episode but the congestion . seems to be better at this time. The note recorded R1 had no cardiopulmonary symptoms present and a physical exam was done which recorded R1's vital signs as 110/62 (BP), 62 BPM, and 16 breaths per minute. R1's lung sounds were listed as clear and R1 was in no acute distress. However, R1's subsequent progress note, dated [DATE] at 9:45 p.m., identified the staff had noticed R1 sounded gurgle [sic] when getting her up for the supper meal. R1 was alert and ate 25% of her supper meal. The note then recorded, By the time she was assisted to bed. She started to cough more and sounded even more gurgle [sic]. She looked pale and was difficult to arouse. She said she was tired . was afebrile with 96.5 [F], P 67 and went up to 161, R 35 and irregular. O2Sat ranged from 75 to 80% [on] RA. After administering O2 [oxygen] per [cannula] it increased to 85% at 2 L [liters per min] . Family called to communicate resident's change of condition. EMS was then called and R1 was transported to the hospital at 10:18 p.m. Registered nurse (RN)-B authored the note, however, the note lacked what, if any, assessment had been completed of R1's respiratory (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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