STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emmanuel Nursing Home	1415 Madison Avenue Detroit Lakes, MN 56501

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 - 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** 43367 Based on interview and record review the facility failed to ensure professional standards of care were followed while waiting for emergency medical services for 1 of 3 residents (R1) reviewed for quality of care. This resulted in harm when a trained medication aide (TMA) and a police officer were awaiting EMS arrival when R1's change in condition worsened and the nurse was not notified. Findings include: R1's care plan since admitted d [DATE] to print date [DATE], identified R1's advanced directive: full code and directed staff follow POLST guidelines. R1 had CHF and directed staff to check breath sounds and monitor/document for labored breathing, use of accessory muscles while breathing, and monitor oxygen settings. R1's quarterly Minimum Data Set, dated dated dated [DATE], identified intact cognition and no behaviors. Diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes mellitus (DM), arthritis, upper impairment of bilateral extremities, anxiety, depression, and respiratory failure. Medications included a diuretic (increased urine production used to reduce fluid buildup in the body), insulin, and dependent on continuous oxygen, atrial fibrillation (AFIB), COVID-19, pulmonary hypertension, and acute kidney failure. R1's physician orders identified: -Oxygen 4 liters (L) via nasal cannula (NC) continuous. May titrate 2 to 5 L/minute as needed to maintain Sa02 above 88% and 4 L/minute via BIPAP at night every shift. Order date [DATE]. -Cardiopulmonary resuscitation (CPR) (performed when a person is unresponsive, not breathing, and does not have a pulse), full code/full treatment. Order date [DATE]. -BIPAP per home settings. ,d+[DATE], 35%, back up rate 12. On at night/off in morning (a.m.) two times a day and as needed for naps. Order date [DATE]. -Cardiopulmonary resuscitation (CPR) (full code)/full treatment. Order date [DATE]. Review of R1's Provider Orders for Life-Sustaining Treatment (POLST) form signed on [DATE] at 8:34 a.m. identified R1 was a full code, CPR would be started, and the ambulance would be called for transport to the hospital. (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 - Actual harm Residents Affected - Few	R1's emergency room (ER) visit on [DATE], identified R1 presented with two days of pain 4 out 10 in her bilateral shoulders, arms, knees, and legs, worsening cough with sputum production. R1 complained of SOB, occasional weakness, oxygen normally at 3 L increased to 4 L last night, and denied fever or chills. R1's vital signs were temperature (T) 99.2 Fahrenheit (F), heart rate (HR) 76, respirations (R) 20, blood pressure (BP) , d+[DATE], oxygen saturation level (SaO2) 93% and oxygen on at 4 L. Physical assessment identified mild inspiratory rhonchi and slight expiratory wheezes in the bilateral upper lung field. No significant basilar crackles, no respiratory distress, and speaking full sentences without difficulty. Skin is warm and dry. Troponin blood levels elevated at 25 and positive for COVID. discharged back to facility in stable condition. Focused respiratory assessment related to active illness or exposure. Notify provider if changes in respiratory status are noted for every shift for respiratory status. Check for 8 days start date [DATE] and discontinue [DATE] at 6:10 a.m. R1's treatment assessment record (TAR) identified an order dated [DATE] at 3:57 p.m. focused respiratory assessment related to active illness or exposure every shift. Notify provider if changes in respiratory status are noted. R1's TAR documentation from [DATE] through [DATE] identified: -[DATE] at 2:30 p.m. non-productive cough, diminished lung sounds, O2 on at 4 L, no shortness of breath (SOB), no sputum, T 97.3 F, HR 68, R 18, and SaO2 97%. -[DATE] at 6:30 a.m. non-productive cough, lung sounds diminished, O2 on at 4 L shortness of breath (SOB), no sputum, temperature 96.4 F, HR 70, R 18, and SaO2 97%. -[DATE] at 2:30 p.m. no cough, lung sounds diminished, O2 on at 4 L, no SOB, no sputum, T 97.7 F, HR 89, R 18, and SaO2 94%. -[DATE] at 10:30 p.m. cough, lung sounds diminished, O2 at 4 L, no SOB, no sputum, temperature 96.5 F, HR 68, R 18, and SaO2 93%. -[DATE] at 6:30 a.m. non-productive cough, lung sounds diminished, O2 at 4 L, SOB, no sputum, T 97.2 F, HR 91, SaO2 91 %. -[DATE] at 2:30 p.m. non-productive cough, lung sounds diminished, O2 at 4 L, SOB, no sputum, T 97.6 F, HR 89, R 18, and SaO2 94%. - [DATE] at 10:30 p.m. non-productive cough, lung sounds diminished, O2 at 4 L, SOB, no sputum, temperature 98.2 F, pulse 80, respirations 18, and SaO2 92 %. -[DATE] at 6:30 a.m. no assessment documented on TAR. -[DATE] at 2:30 p.m. productive cough, crackles in the lungs O2 at 4 liters, SOB, yellow sputum, temperature 97.2 F, pulse 64, respirations 20, and SaO2 91 % documented on TAR. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] at 8:07 a.m. R1's progress notes identified R1 was seen by nurse practitioner (NP) following emergency room (ER) visit and COVID positive. She was resting in bed at the time of visit with use of a continuous positive airway pressure (CPAP). R1 was alert and complained of overall pain stating, it hurts from the top of my head to the tips of my toes. Denies nausea/vomiting (N/V). Lung sounds were diminished, SaO2 92% on 4 liters of oxygen per nasal cannula (NC), respirations 18 and unlabored, temperature 97.6 Fahrenheit (F), and non-productive cough. R1 continued isolation due to COVID positive and able to call and make her needs known. R1's call light log dated [DATE] identified call light was activated at 12:39 a.m. and responded to in 1 minute 28 seconds. The 911 call initiated on [DATE] 0059:34 was listened to at the police department with the chief of police (COP) and identified: the facility nurse identified who she was, name of nursing home and a resident needed to go to ER, full code. Please send someone right away. room [ROOM NUMBER] long term care. Police officer (PO)-A report dated [DATE], identified on [DATE] at 12:59 a.m. officers were dispatched to the facility for a patient needing to go to ER and was full code. Officer arrived at facility at approximately 1:02 a. m. and at 1:03 a.m. dialed phone number seeking to be let into building. No answer tried another phone number and was advised staff was on their way to let him in. At 1:05 a.m. PO observed a staff member walking toward the front entrance calm and non-emergent. At approximately 1:07 a.m. was let into the facility building and led to R1's room. R1 laid flat on her bed with trained medical assistant (TMA)-A present. Initial observations of R1 identified labored breathing with an oxygen mask on. TMA-A was unable to find a radial pulse and able to locate one on R1's carotid. PO checked R1's right wrist for a pulse, observed the extremity to be cool to the touch and no pulse. PO completed a sternal rub to attempt to gain her attention and unsuccessful. R1's breathing became further in between breaths as compared to the initial observation and around that time EMS had arrived, determined CPR was appropriate for the circumstances and was initiated. Measures taken by EMS and assisting police were unsuccessful and at 1:42 a.m. R1 was determined to be dead. EMS report dated [DATE] at 2:01 a.m. identified dispatch was notified on [DATE] at 1:02 a.m., in route at 1:02 a.m., arrived at scene at 1:04 a.m., at patient at 1:12 a.m., and depart at 2:38 a.m. EMS waited outside approximately 6 to 8 minutes before being found by aide and taken to patient room. Approximately 10-minute delay of care to patient was noted due to not having someone to guide EMS to patient. Aide informed EMS the patient had COVID, had been complaining of increased pain all over, increasingly got worse by her perspective, and appeared to be declining. No mention of CPR being performed. Upon arrival to patient room, it was noted the patient laid supine flat on bed with a CPAP face mask running, fixed gaze, no pupillary reaction noted, extremities and trunk were cold to the touch, skin pale cyanosis around cheeks and lips. Police officer on scene stated staff member noted a carotid pulse. EMS felt carotid for pulse and noted no pulse and asystole on monitor. R1 was lifted off bed onto the floor and CPR was initiated at 1:12 a.m. EMS was informed by facility staff the patient was just fine prior to their arrival. CPR continued and medications administered, no carotid pulse was noted, and efforts were terminated at 1:43 a.m. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A progress note dated [DATE] at 4:38 a.m. and written after R1's death identified nurse was notified R1 was diaphoretic and in pain. Blood sugars checked 139 and 167. Requested to sit up and wanted to go to the emergency room . Nurse went and called 911 and trained medical assistant (TMA)-A completed vital signs blood pressure ,d+[DATE], heart rate 52, respirations 18 then laid R1 back down. The police officers and emergency medical technician (EMT) arrived, entered R1's room and she had no pulse, they began CPR and administered medications for about half an hour. Family and on call doctor notified and ok was given to stop CPR. Time of death was 1:42 a.m. During an interview on [DATE] at 10:00 PO-A stated the 911 call came into dispatch at 12:59 a.m., EMS was dispatched at 1:00 33 seconds., and PO were dispatched at 1:00 54 seconds. PO-A was in the neighborhood, had taken 45 seconds to drive to facility, and arrived on scene at 1:01 43 seconds. EMS showed up at 1:05 26 seconds. CPR began at 1:13 55 seconds. She was pronounced dead at 1:42 a.m. p. m. When he arrived at the facility, had a hard time with access to the door and staff which delayed his response time, up to seven minutes, before he arrived at R1's room. He entered R1's room and she laid on her back in bed flat with a mask over her face with difficult/labored/anginal (gasping for air usually due to lack of oxygen to the brain and caused by either cardiac arrest or stroke and a sign a person is near death) breathing and unresponsive. TMA-A was in the room alone with R1 and informed him she had been in pain, was sweating with possible blood sugar (BS) concerns (BS was 139 and 167), unable to detect an oxygen level, R1 sat up on side of bed for 5 minutes, then collapsed onto bed, tried sternum rub, and unable to arouse her. TMA-A was calm, relaxed, and seemed to be unaware of how emergent the situation was and/or unaware of what measures to have taken. TMA-A updated him as to medications she had received. He noted right away R1's breathing had changed within seconds, became more difficult, fewer, and spaced out. TMA-A was able to get a carotid pulse but did not indicate what it was. He was unable to get a radial pulse, and her hand/arm skin was cold to the touch. EMS arrived and started CPR manually. Licensed practical nurse (LPN)-A sat at the nurse's station desk approximately 20 feet away from R1's room and from the time he arrived on scene and when EMS arrived, she did not take part in the assessment or any interventions. PO-A stated R1 was full code and it seemed like staff could have taken further measures prior to his arrival. A full code meant CPR was in progress and the facility had taken life saving measures, one he arrived on scene that was not the case, CPR had not been started. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 12:30 a.m. trained medication assistant (TMA)-A stated R1 was COVID-19 positive. On [DATE] at 12:46 a.m. a nursing assistant (NA)-A answered R1's call light, opened the door and told her R1 was hollering out, and NA-A yelled for assistance. TMA-A applied personal protective equipment (PPE) while R1 yelled out and she entered the room. R1 laid on her back in bed with head of bed (HOB) up at 15 degrees with on an oxygen mask over her face, and said she was having a hard time breathing. R1 was soaked in sweat and still talking. She asked NA-B to call LPN-A and tell her to come down to R1's room. R1's blood sugar was 160 and 139, blood pressure ,d+[DATE] and heart rate 54. She was unable find a SaO2 level, fingers and hands were cold. R1 informed her she could not breath and was gasping for air taking deeper breaths. She sat R1 up on the side of the bed with legs hanging down, seemed to have helped, and then LPN-A entered the room. She knew it was an emergency, seemed like LPN-A recognized the same when she arrived, asked R1 if she wanted to go to ER, and left room to call 911. LPN-A did not complete an assessment prior to leaving R1's room, was usually completed mid-shift. There was a crash cart on the floor but was not brought to R1's room. TMA-A assisted R1 back to laying position on her bed, police officer arrived, and she was unable to get an SaO2 reading on R1. R1's fingers were cold and iridescent. She did not contact the nurse, stated she was more concerned about staying with the R1. PO-A made a comment R1 was not responding, had shallow breathing, and then massaged her chest /sternal rub with no response. R1's breathing then stopped, and EMS entered R1's room. R1 was lifted onto the floor and EMS started CPR manually. R1's body and hair were saturated with sweat. During an interview on [DATE] at 1:30 p.m. nursing assistant (NA)-A stated she cared for R1 on [DATE] on the day shift. R1 laid in bed on oxygen, very groggy like when you first wake up from a deep sleep like she was not there with a low energy level and sleepier than she should have been. She attempted to check R1's incontinent brief, R1 refused, said no more, which was not normal for her. She informed the nurse who responded, R1 was sick. During an interview on [DATE] at 3:43 p.m. nursing assistant (NA)-B stated on [DATE] R1 had placed her call light on before 1:00 a.m. and she had answered it. She went into the room and R1 laid on her back with a mask on her face. R1 grabbed onto her arm, pulled her closer, did not want to let go, and tried to speak. R1 pulled the mask off to one side and said come, come, come, and held onto her arm. She could not understand what R1 needed, exited her room, and informed the TMA R1 needed help. TMA-A entered R1's room right away. During an interview [DATE] at 4:00 p.m. licensed practical nurse (LPN)-A stated she was the only nurse working on night shift on [DATE]. The TMA called and informed her R1 was in a lot of pain around 1:00 a.m., she immediately went down to R1's room and noted she was having a hard time breathing and knew she was not doing well. The TMA sat R1 up on side of bed and stayed with her. She asked R1 if she wanted to go to ER, and she said yes. LPN-A left the room and called 911 for a transport and started on the paperwork. The TMA was in the room with R1 and did not feel the need to be in there. She did not complete an assessment or check her vital signs. The TMA did not ask for my help once she left the room, and she stayed at the nurse's station preparing the paperwork to send R1 out to the hospital. R1 was a full code. She went back to R1's room after EMS arrived, R1 was unresponsive, assisted with lowering her to the floor and CPR was started by EMS. CPR was not started prior to EMS arriving and would have been if she had been aware R1 had no heartbeat. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 11:00 a.m. emergency medical technician (EMT) stated EMS was contacted by dispatch to respond to a resident at the nursing home that needed to be transferred to ER and was a full code. She arrived at the facility with the paramedic and PO-B opened the door, no staff was available and walked down the wrong hallway. We stood in the hallway, unfamiliar with the facility for at least 3 to 5 minutes, and no staff were seen anywhere. Finally, we saw a female staff walking towards us slowly, in a calm manner not rushed, and informed us 911 call was made due to R1's increased pain. The CPR equipment was not brought into the facility, unaware it was a code situation. She was informed by the female staff R1 was breathing when she had walked PO-A to her room earlier. We arrived at R1's room [ROOM NUMBER] to 13 minutes after they arrived at the facility and while at R1's bedside noted she was unresponsive, no pulse, diaphoretic, cyanotic around her mouth (usually 8 to 10 minutes for this to occur), and cold without blood flow. R1 was not on oxygen when they arrived. The TMA-A informed her R1 had a pulse when PO-A arrived. We were not made aware of the seriousness of this situation until arrival to the facility and unaware CPR would be needed. She ran outside to the ambulance with PO-A and PO-B and grabbed the equipment for CPR. Communication was very poor with nurse, lacked knowledge, and the TMA was left alone to manage R1's situation alone. LPN-A did not come into R1's room and assist when moved from bed to the floor. After CPR was started LPN-A came to R1's doorway, left right away, and called family, 10 minutes of CPR was completed. LPN-A came back to the doorway and informed us as to what family had said. EMT stated once the pulse was weak enough starting CPR would have been beneficial and the outcome could have been different if the staff would have noticed how critical R1 was. During an interview on [DATE] at 2:45 p.m. registered nurse (RN)-A stated when a resident was in respiratory distress the nurse would be expected to get a crash cart into the room, checked code status, stay with the resident, and carry a facility provided cell phone. When 911 was called a staff nurse would be expected to identify resident room number, location of the room and staff would be expected to wait at the facility doors especially if locked and let them in for easier access. TMA and NA were allowed to gather vitals and should have provided them immediately if abnormal to the nurse by either phone or locating her, due to the possibility to intervene. The nurse would be expected to be the one with the resident during respiratory distress she is trained on how the situation should have been addressed, take whatever measure were needed, and act upon the resident wishes. The nurse would be responsible to have completed an assessment, determined if breathing and/or vitals were abnormal, kept a timeline, and documented as soon as possible. RN-A stated she covered the first part of the evening shift on [DATE] from 2:00 p.m. to 6:00 p.m. and completed R1's respiratory assessment. R1's assessment was abnormal, she had crackles in the lungs, SOB, a productive cough. She passed this information onto the oncoming shift LPN-A, and a provider was not contacted. She should have notified the provider, made her aware R1's condition had changed, may have wanted to do something different. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 2:46 p.m. nurse practitioner (NP) stated she had seen R1 on [DATE] in the morning around 8 a.m. and no SOB noted, vitals stable, and no concerns. R1 had very poor respiratory status to start with, poor lung function, not uncommon to have wheezes or rhonchi that may have cleared with deep breathing, cough, or nebulizer treatments. She would have expected a call from the nurse with a drop in oxygen levels, noted respiratory distress, change in heart rate, respirations, or temperature, not necessarily for only a change in lungs. When respiratory problems are a known problem within a resident's history nursing were expected have tried interventions first. The TMA and NA's would be expected have notified the nurse with a change in condition and should be a standard process for them. We have been taught to use the chain of command and starts with the TMA and NA's, they spend more time with the residents, changes are recognized earlier, and that information should have been given to the nurse. The nurse would be expected to have completed an assessment and notified the provider using their nursing judgement to have kept them updated. During an interview on [DATE] at 3:22 p.m. floor manager, RN-B, stated the nurse would be expected to complete the initial assessment on a resident in respiratory distress, from that point would be acceptable to delegate to TMA or NA. She expected TMA or NA to have communicated with the nurse right away/as soon as possible if any change occurred or noted so that the nurse had all the data, whole picture of the situation, and could have intervened if needed. She stated the PO had a key to enter the facility building, unsure if EMS had one. Staff would be expected to have provided room and lane number to have directed PO and EMS to the right area. She was unsure whether it would have been a courtesy or policy for staff to have been at the door and waited for them, would be possible if staffing allowed but not completely necessary, they were only two units in the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 3:38 p.m. director of nursing (DON) stated R1 had an extensive respiratory/breathing history, and her status would fluctuate and was expected. Staff nurses were expected to follow the policy and orders and indicated a provider should have been contacted. She would have probably called a provider with R1's changed on [DATE] on the evening shift so that the NP would have been made aware there were changes. She was not aware if a provider was contacted. She identified the timeline that occurred on [DATE]: NA-B answered call light, notified TMA-A, and entered room, R1 was cold clammy and unsure if NA-B informed LPN-A about unable to get an oxygen level reading. NA-A called LPN-A and came to R1's room, TMA-A had collected R1's blood sugar (BS) prior to her arrival. LPN-A talked to R1 and asked if she wanted to go to ER, R1 requested ER, LPN-A left room, and called 911. LPN-A gathered R1's paperwork together, should have taken up to 10 minutes to have completed this. She was unsure as to what LPN-A did after that and the resident should have been the number one priority. The nurse would have been expected to make a nursing judgment call on what R1 needed after completion of a respiratory visual and physical assessment that should have included lung sounds, recheck vital signs, and oxygen levels. LPN-A could have delegated the 911 call to another staff, did not have to be a nurse. She would have expected LPN-A to return to R1's room as soon as possible to check on R1 sooner, so that she would have known the situation, and assisted with what was needed. NA-A was not able to leave R1's room but could have called LPN-A if she had a cell phone, was unsure whether she had one with her, placed call light on, or yelled down the hallway from the doorway. She stated there was a lack of communication with staff. There was not a facility policy that identified what the process was when emergency services required access to the facility building when doors were locked so that they are able to respond quickly. There was a key in a locked box located outside the facility door and the PO should have had a key to open it. She did not have a specific procedure/policy staff should have used as a resource when calling 911. There will be changes made to help guide staff such as policies reviewed, what information should be provided to EMS to get the proper assistance, and review change in condition policies so that the nurse would have known the resident's situation and assist with what was needed. TMA job description dated [DATE], identified TMA was responsible for providing direct care and medication administration to residents consistent with the individual plan of care and under the direction of licensed staff. TMA administers medication to residents under the direction of licensed nurse, responds to resident call lights, and requests and notifies nurse of any resident care needs or changes in condition. LPN job description dated [DATE], identified LPN was responsible for providing nursing care to residents including medication and treatment administration, documentation, and other therapeutic interventions under the direction of the DON/clinical director. The position was responsible for providing direction to NA's, resident assistants, TMA's, and other clinical staff on unit/shift. The LPN was responsible to provide nursing care to residents within the scope of practice, assists RN with completion of assessments, documentation, and data collection, acting timely on findings, administers medications, completes treatments as ordered, observes and monitors resident's condition and reports changes as appropriate. Facility policy Transfer or Discharge, Facility-Initiated dated ,d+[DATE], identified for an emergency transfer or discharge to a hospital or other acute care institution, implement the following procedures: a. Call 911 if resident met clinical/behavioral criteria per facility policy or assist in obtaining transportation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	b. Notify the resident's attending physician. c. Orient/prepare the resident for transfer. d. Prepare for medial record transfer. Information conveyed to receiving provider should include: a. Basis for the transfer/discharge. b. Contact information of the practitioner responsible for the care of the resident. c. Resident representative information including contact information. d. Advance directive information. e. All special instructions or precautions for ongoing care, as appropriate such as: treatments and devices (O2, implants, IV's, tubes/catheters), transmission-based precautions. f. Special risks such as falls, elopement, bleeding, or pressure injury, and/or aspiration precautions. g. Comprehensive care plan goals and all other information necessary to meet the resident's needs, including but not limited to: resident status, including baseline and current mental, behavioral and functional status, recent vital signs, diagnoses and allergies, medications (when received last), most recent relevant labs, other diagnostic tests, and recent immunizations, copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. Facility policy Resident Examination and assessment dated ,d+[DATE], identified a physical exam of a resident should have included: 1. Vital signs - blood pressure, pulse (carotid), respirations and temperature 2. Cardiovascular - heart rhythm, peripheral pulses, capillary refill 3. Respiratory - lung sounds (upper and lower lobes) for wheezing, rales, rhonchi, or crackles), irregular or labored respirations, cough (productive or nonproductive) and consistency and color of sputum. (continued on next page)

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	245489	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emmanuel Nursing Home	1415 Madison Avenue Detroit Lakes, MN 56501

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F 0684 Level of Harm - Actual harm Residents Affected - Few	4. Neurological - alertness and orientation, speech clarity, drooping eye lids, facial paralysis, asymmetry, strength and equality of the hand grasp, and numbness or tingling of extremities. 5. Pain - description, location, duration, severity, factors that worsen/relieve pain, how pain affects them, current medication and treatments for pain. The assessment should be recorded in the resident's medical record. Physician would be notified of any abnormalities such as, but not limited to abnormal vital signs, labored breathing, breath sounds that are not clear, or cough, productive or nonproductive, change in cognition, behavioral or neurological status from baseline, and worsening pain. Facility policy requested emergent access to the locked facility and staff process for a 911 call and not received.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on observation, interview, and document review the facility's administrator failed to provide oversight, develop policies and procedures to ensure emergency responders had access to enter the building when called for emergent resident needs for 1 of 1 resident (R1) reviewed. A police officer (PO) and emergency medical services (EMS) arrived at the facility following a 911 call, were not able timely access the resident by entry to the building and the resident room. Findings include: Review of R1's Provider Orders for Life-Sustaining Treatment (POLST) form signed on [DATE] at 8:34 a.m. identified R1 was a full code, CPR would be started, and the ambulance would be called for transport to the hospital. The 911 call from [DATE] was listened to on [DATE] at 11:19 a.m. at the police department with the chief of police (COP) and identified: the facility nurse identified who she was, name of nursing home and a resident needed to go to ER, full code. Please send someone right away. room [ROOM NUMBER] long term care. Police officer (PO)-A report dated [DATE], identified on [DATE] at 12:59 a.m. officers were dispatched to the facility for a patient needing to go to ER and was full code. Officer arrived at facility at approximately 1:02 a. m. and at 1:03 a.m. dialed phone number seeking be let into building. No answer tried another phone number and was advised staff was on their way to let him in. At 1:05 a.m. PO observed a staff member walking toward the front entrance calm and non-emergent. At approximately 1:07 a.m. was let into the facility building and led to R1's room. She laid flat on her bed with trained medical assistant (TMA)-A present. Initial observations of R1 identified labored breathing with an oxygen mask on. TMA-A was unable to find a radial pulse and able to locate one on R1's carotid. PO checked R1's right wrist for a pulse, observed the extremity to be cool to the touch and no pulse. PO completed a sternal rub to attempt to gain her attention and unsuccessful. R1's breathing became further in between breaths as compared to the initial observation and around that time EMS had arrived, determined CPR was appropriate for the circumstances and was initiated. Measures taken by EMS and assisting police were unsuccessful and at 1:42 a.m. R1 was determined to be dead. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EMS report dated [DATE] at 2:01 a.m. identified dispatch was notified on [DATE] at 1:02 a.m., in route at 1:02 a.m., arrived at scene at 1:04 a.m., at patient at 1:12 a.m., and depart at 2:38 a.m. EMS waited outside approximately 6 to 8 minutes before being found by aide and taken to patient room. Approximately 10-minute delay of care to patient was noted due to not having someone to guide EMS to patient. Aide informed EMS the patient had COVID, had been complaining of increased pain all over, increasingly got worse by her perspective and appeared to be declining. No mention of CPR being performed. Upon arrival to patient room, it was noted the patient laid supine flat on bed with a CPAP face mask running, fixed gaze, no pupillary reaction noted, extremities and trunk were cold to the touch, skin pale with cyanosis around cheeks and lips. Police officer on scene stated staff member noted a radial pulse. EMS felt carotid for pulse and noted no pulse and asystole on monitor. R1 was lifted off bed onto the floor and CPR was initiated at 1:12 a.m. EMS was informed by facility staff the patient was just fine prior to their arrival. CPR continued and medications administered, no carotid pulse was noted, and efforts were terminated at 1:43 a.m. During an interview on [DATE] at 10:00 PO-A stated the 911 call came into dispatch at 12:59 a.m., EMS was attached at 1:00 33 seconds., and PO were attached at 1:00 54 seconds. PO-A was in the neighborhood, had taken 45 seconds to drive to facility, and arrived on scene at 1:01 43 seconds. EMS showed up at 1:05 26 seconds. CPR began at 1:13 55 seconds. She was pronounced dead at 1:42 a.m. p.m. When he arrived at the facility, had a hard time with access to the door and staff which delayed his response time, up to seven minutes, before he arrived at R1's room. He entered R1's room and she laid on her back in bed flat with a mask over her face with difficult/labored/anginal (gasping for air usually due to lack of oxygen to the brain and caused by either cardiac arrest or stroke and a sign a person is near death) breathing and unresponsive. During an interview on [DATE] at 11:00 a.m. emergency medical technician (EMT) stated EMS was contacted by dispatch to respond to a resident at the nursing home that needed to be transferred to ER and was a full code. She arrived at the facility with the paramedic and PO-B opened the door, no staff was available and walked down the wrong hallway. We stood in the hallway, unfamiliar with the facility for at least 3 to 5 minutes, and no staff were seen anywhere. Finally, we saw a female staff walking towards us slowly, in a calm manner not rushed, and informed us 911 call was made due to R1's increased pain. The CPR equipment was not brought into the facility, unaware it was a code situation. She was informed by the female staff R1 was breathing when she had walked PO-A to her room earlier. We arrived at R1's room [ROOM NUMBER] to 13 minutes after they arrived at the facility and while at R1's bedside noted she was unresponsive, no pulse, diaphoretic, cyanotic around her mouth (usually 8 to 10 minutes for this to occur), and cold without blood flow. R1 was not on oxygen when we arrived. The TMA-A informed her R1 had a pulse when PO-A arrived. We were not made aware of the seriousness of this situation until arrival to the facility and unaware CPR would be needed. She ran outside to the ambulance with PO-A and PO-B and grabbed the equipment for CPR. Communication was very poor with nurse, lacked knowledge, and the TMA was left alone to manage R1's situation alone. The LPN-A did not come into R1's room and assist when moved from bed to the floor. After CPR was started LPN-A came to R1's doorway, left right away, and called family 10 minutes of CPR was completed LPN-A came back to the doorway and informed us as to what family had said. EMT stated once the pulse was weak enough starting CPR would have been beneficial and the outcome could have been different if the staff would have noticed how critical R1 was. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:45 p.m. registered nurse (RN)-A stated when a resident was in respiratory distress the nurse would be expected to get a crash cart into the room, checked code status, stay with the resident, and carry a facility provided cell phone. When 911 was called a staff nurse would be expected to identify resident room number, location of the room and staff would be expected to wait at the facility doors especially if locked and let them in for easier access. Observation of the police officer's body camera (cam) on [DATE] at 10:30 a.m. at the police department along with chief of police (COP) identified on [DATE] body cam was engaged when police officer (PO)-B received a call and was dispatched at 1:01 a.m. and in route drove to nursing home. Observation of the [DATE] body cam from 1:01 a.m. to 1:48 a.m. identified: -At 1:04 a.m. arrived at nursing home. First police officer on scene (PO)-A stood in facility front entrance area was observed and heard on a cell phone calling facility to access to building. -At 1:04 46 seconds a nursing assistant (NA)-C calmly and slowly walked towards the front door of the facility and let PO-A into the building. PO-B remained at the front door and waited for EMS to arrive to let them in. PO-A followed NA-C down the hallway. -At 1:06 a.m. EMS arrived, and paramedic (P)-A and emergency medical technician (EMT) entered the front door pushed a stretcher and PO-B walked down the hallway to the transitional care unit (TCU). No staff could be seen in the hallways. -At 1:07 a.m. P-A, EMT, and PO-B stood in hallway looking around for staff and P-A stated no room number was given. No staff was seen in the hallway. -At 1:09 a.m. NA-C walked calmly down the hallway and led P-A, EMT, and PO-B to room R1's room while she conversed with them. -At 1:12 a.m. (6 minutes since entry to building) P-A and EMT entered R1's room. PO-B remained outside the room in the hallway. P-A was in R1's room and said loudly can you hear me to R1. -At 1:14 a.m. PO-A and PO-B were directed to go back to ambulance and get equipment for CPR. They ran together down facility hallways back to the front door and grabbed equipment out of ambulance and ran back through facility to R1's room. -At 1:15 a.m. 4 seconds both PO-A and PO-B entered R1's room and she was positioned on the floor while P-A and EMT administered CPR manually. TMA-A was seen standing at the R1's feet in the room. No other staff was seen in R1's room. -At 1:25 a.m. P-A stated R1 had been asystole (when the heart electrical system fails causing it to stop pumping also known as flat line) since we got here and no circulatory blood flow for a while now. -At 1:26 a.m. TMA stood in R1's doorway answering questions being asked by the POs. TMA stated R1's call light was on, was answered, she came in R1's room, got the nurse, vitals taken, sat R1 up on side of bed, and complained she needed more oxygen. R1 requested to go to hospital and nurse called 911. P-A stated R1 was cold when we arrived and most likely down at least 5 to 10 minutes before we got here. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 1:30 a.m. Conversations could be heard among POs and P-A in R1's room. PO stated no CPR was started when we arrived, and EMS had a hard time finding the room took an extra 3 to 4 minutes longer to get here. -At 1:33 a.m. EMT stated we did not come here for a full code; staff told us when we arrived and while we walked down the hallways R1 had increased pain. -At 1:48 a.m. PO-A, PO-B and sergeant (S) conversing, dispatch placed full code, and that meant CPR had been started. Why did the NH tell them full code, seemed to be a communication issue here. S asked PO-B who was in the room when he arrived, and he stated TMA. -At 1:56 a.m. PO-B along with PO-A went to nurse's station. LPN-A stated R1 was alert and orientated, could tell something was wrong, came out and called 911. TMA stated R1 was having a hard time breathing, after she had placed her back to bed she went down. PO-B asked TMA what R1's breathing was like from the time he showed up and TMA stated she was so sweaty took blood sugar then she collapsed and became unresponsive and then you arrived. LPN-A stated she had told dispatch ambulance requested to go to ER and a full code, wanted everything done. PO-B stated seemed like there was a lack of communication. During an interview on [DATE] at 3:10 p.m. COP stated facility had a [NAME] box (a small box outside the facility with a key to the front door in it). The PO and firefighter had a key to this box and was a requirement for all establishments in this town to have. One key opens all the [NAME] boxes. Unsure if the PO's had the key on the night of [DATE] when the 911 call came into dispatch or if that would have made a difference, since it was only a couple of minutes before staff came and opened the door and PO-A entered the facility. Would have been helpful to have facility staff at door so that PO's and EMS could have accessed R1's room quicker. During an interview on [DATE] at 3:22 p.m. floor manager RN-B stated the PO had a key to enter the facility building, unsure if EMS had one. Staff would be expected to have provided room and lane number to have directed PO and EMS to the right area. She was unsure whether it would have been a courtesy or policy for staff to have been at the door and waited for them, would be possible if staffing allowed but not completely necessary, they were only two units in the facility. During an interview on [DATE] at 3:38 p.m. director of nursing (DON) stated there was a lack of communication with staff. There was not a facility policy that identified what the process was when emergency services required access to the facility building when doors were locked so that they are able to respond quickly. There was a key in a locked box located outside the facility door and the PO should have had a key to open it. She did not have a specific procedure/policy staff should have used as a resource when calling 911. There will be changes made to help guide staff such as policies reviewed, what information should be provided to EMS to get the proper assistance, and review change in condition policies so that the nurse would have known the resident's situation and assist with what was needed. Facility policy Transfer or Discharge, Facility-Initiated dated ,d+[DATE], identified for an emergency transfer or discharge to a hospital or other acute care institution, implement the following procedures: (continued on next page)

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