STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265672	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dutchtown Care Center	3421 Gasconade Saint Louis, MO 63118

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 - Immediate jeopardy to resident health or safety 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** 46104 Based on interview and record review, the facility failed to provide acceptable nursing services by not directly and continuously monitoring and intervening for one resident who was in respiratory distress (Resident #1). Two therapy staff found the resident difficult to wake, breathing heavily, and would groan and open and then close his/her eyes when his/her name was called. The resident was identified not connected to the oxygen concentrator and the resident did not have his/her BiPap on. The concentrator was broken. When staff attempted to use the emergency oxygen tank (e-tank) on the back of the resident's wheelchair, it was found empty, further delaying treatment while staff went to retrieve a full e-tank. Staff applied the nasal cannula with oxygen at 4 liters from the e-tank. The resident had an order for a BiPap which was not applied when the resident was noted to be in distress. The resident's oxygen saturation level was 68%. When Emergency Medical Services (EMS) arrived at the resident's bedside, the resident was unattended, prone (chest down) on a flat bed, with his/her head to the side. The resident had audible rales (crackling noises), thick white sputum, peripheral cyanosis (bluish-purple color) of the fingers and lips, an oxygen saturation level of 57%, and was hot and diaphoretic (sweating). EMS placed the resident on a nonrebreather mask (fits over mouth and nose) at 15 liters. His/Her breathing rate was 40 and shallow. The resident was transferred to the hospital, where he/she expired a short time later. The census was 71. The Administrator was notified on [DATE] at 4:58 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. Review of the facility's Abuse and Neglect - Clinical Protocol Policy, revised ,d+[DATE], showed: -Neglect, as defined at S483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.; -Assessment and Recognition: -l. The nurse will assess the individual and document related findings. Assessment data will include: -e. All current medications; -g. Vital signs; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Dutchtown Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3421 Gasconade Saint Louis, MO 63118	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-j. All active diagnoses; -k. Any recent labs; -2. The nurse will report findings to the physician. As needed, the physician will assess the resident/patient to verify or clarify such findings, especially if the cause or source of the problem is unclear; -4. The physician and staff will help identify risk factors for abuse within the facility; for example, significant numbers of residents/patients with unmanaged problematic behavior, significant injuries in physically dependent individuals; problematic family issues; deficiencies in the physical environment; problems related to adequate staffing, staff burnout, poor preparation, and training; and lack of knowledge, skills, or performance that might affect how the residents/patients are being cared for; -Treatment/Management: -1. The facility management and staff will institute measures to address the needs of residents/patients and minimize the possibility of abuse and neglect. -Monitoring and Follow-Up: -2. The medical director will advise facility management and staff about systems to ensure that basic medical, functional, and psychosocial needs are being met and that potentially preventable or treatable conditions affecting function and quality of life are addressed appropriately; -3. The medical director will advise the facility and help review and address abuse and neglect issues as part of the quality assurance process. Review of the facility's Pulse Oximetry (Assessing Oxygen Saturation) Policy, revised ,d+[DATE], showed: -Purpose: The purpose of this procedure is to monitor arterial blood oxygen saturation (SaO2) without the use of invasive devices; -Preparation: -1. Review the physician's orders or facility protocol for pulse oximetry; -2. Review the resident's care plan to assess for any special needs of the resident; -General Guidelines: -1. The pulse oximeter is a probe with light emitting diodes (LEDs) connected to an oximeter. The LED emits light waves that are absorbed by oxygenated and deoxygenated hemoglobin molecules. The oximeter measures the light reflected by these molecules and calculates the pulse oxygen saturation (SpO2) which is a reliable measure of SaO2; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration; -2. Review the resident's care plan to assess for any special needs of the resident; -General Guidelines: -1. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter; -a. The oxygen mask is a device that fits over the resident's nose and mouth. It is held in place by an elastic band placed around the resident's head; -b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head; -Assessment: -Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: -1. Signs or symptoms of cyanosis (blue tone to the skin and mucous membranes); -2. Signs or symptoms of hypoxia (rapid breathing, rapid pulse rate, restlessness, confusion); -3. Signs or symptoms of oxygen toxicity (tracheal irritation, difficulty breathing, or slow, shallow rate of breathing); -4. Vital signs; -5. Lung sounds; -Steps in the procedure: -13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated (see Assessment); -Documentation: -After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: -1. The date and time that the procedure was performed; -2. The name and title of the individual who performed the procedure; -3. The rate of oxygen flow, route, and rationale; -4. The frequency and duration of the treatment: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-6. Before contacting a physician about someone with an acute change of condition, the nursing staff will make detailed observations and collect pertinent information to report to the Physician; for example, history of present illness and previous and recent test results for comparison; -a. Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident's current symptoms and status; -b. Nurses are encouraged to use the situation, background, assessment, and recommendation (SBAR) communication form and progress note as a tool to help gather and organize information before notifying the Physician; -7. The nursing staff will contact the Physician based on the urgency of the situation. For emergencies, they will call or page the Physician and request a prompt response (within approximately one-half hour or less); -8. The Attending Physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status; -a. The staff will notify the Medical Director for additional guidance and consultation if they do not receive a timely or appropriate response. The Physician should ask questions to clarify the situation; for example, vital signs, physical findings, and description of symptoms; -9. The Nurse and Physician will discuss and evaluate the situation; -a. The Physician should ask questions to clarify the situation; for example, vital signs, physical findings, and description of symptoms; -Treatment/Management: -2. If it is decided, after sufficient review, that care or observation cannot reasonably be provided in the facility, the Attending Physician will authorize transfer to an acute hospital, emergency room , or another appropriate setting; -Monitoring and Follow-Up: -1. The staff will monitor and document the resident's progress and responses to treatment, and the Physician will adjust treatment accordingly; -2. The Physician will help the staff monitor a resident with a recent acute change of condition until the problem or condition has resolved or stabilized. -The facility policy did not address emergency situations such as when a resident is in acute distress (such as respiratory distress), if the staff should call for assistance, and how the staff should care for the resident. Review of the facility's Change in a Resident's Condition or Status, revised ,d+[DATE], showed: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Policy Statement: -Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status; -Policy Interpretation and Implementation: -1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): -d. Significant change in the resident's physical/emotional/mental condition; -g. Need to transfer the resident to a hospital/treatment center; -i. Specific instruction to notify the Physician of changes in the resident's condition; -2. A significant change of condition is a major decline or improvement in the resident's status that: -a. Will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting); -3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the Interact SBAR Communication Form. -The facility policy did not address emergency situations such as when a resident is in acute distress (such as respiratory distress). If the staff should call for assistance and how the staff should care for the resident. Review of the facility's Emergency Procedure for Critically Low Oxygen Level, dated [DATE], showed: -In the event that a resident has critically low oxygen level and you are unable to immediately reach the resident's PCP the following procedures should be followed: -Start the resident on oxygen at 2L (liters) per nasal cannula or mask and titrate up to 10L until SpO2's reach 90%; -Continue to attempt to reach PCP and call EMS to transport the resident to the ER for emergency care. Review of Resident #1's hospital discharge orders, dated [DATE], showed, bilevel positive airway pressure (BiPap, machine that helps with breathing when the patient is unable to get enough oxygen or unable to get rid of carbon dioxide) to be used with sleep and as needed during the daytime, use nightly. Review of Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated [DATE], showed: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-admitted [DATE]; -Cognitively intact; -Rejection of care not exhibited; -Independent with eating, oral hygiene, upper body dressing, and putting on or taking off footwear; -Required supervision or touching assistance with toileting, bathing, sit to stand, transfers, and walking 10 feet, and walking 10 feet on uneven surface; -Required set up or clean up assistance with lower body dressing, roll left and right, sit to lying, lying to sitting; -Shortness of breath with exertion walking, bathing, transferring, none; -Shortness of breath or trouble breathing when sitting at rest, none; -Shortness of breath or trouble breathing when lying flat, none; -Received continuous oxygen therapy on admission and while a resident; -Used noninvasive positive pressure ventilation (NPPV, ventilatory assistance without an invasive artificial airway. It is delivered to a spontaneously breathing patient via a tight-fitting mask that covers the nose or both the nose and mouth), BiPap; -Diagnoses included chronic obstructive pulmonary disease (COPD, lung disease), obstructive sleep apnea (intermittent airflow blockage during sleep), narcolepsy, congestive heart failure (CHF, a weakened heart condition that causes fluid buildup), Covid 19, respiratory failure, and obesity. Review of the resident's care plan, in use during the survey, showed: -Problem: Resident has COPD; -Goals: Resident will display optimal breathing patterns and will be free of signs and symptoms of respiratory infections through the review date; -Interventions: -Give aerosol (fine mist inhaler, used to treat breathing disorders) or bronchodilators (inhaler used to treat breathing disorders) as ordered. Monitor and document any side effects and effectiveness; -Head of bed (HOB) elevated to 45 degrees if tolerated or out of bed upright in a chair during episodes of difficulty breathing; -Monitor for difficulty breathing on exertion. Remind resident not to push beyond endurance; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Monitor for signs and symptoms of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath (SOB) at rest, cyanosis, somnolence (lethargy); -Monitor, document, report PRN any signs and symptoms of respiratory infection: fever, chills, increase in sputum (document amount, color, and consistency), chest pain, increased difficulty breathing, increased coughing and wheezing; -Problem: Resident has oxygen therapy related to CHF, ineffective gas exchange at 3L/NC and use BiPap with the following settings: NPPV settings: titrate to keep SpO2 greater than or equal to 90%, FiO2 (fraction of inspired oxygen, an estimation of the oxygen content a person inhales) 40%, set respiratory rate to 20; -Goals: Resident will have no signs or symptoms of poor oxygen absorption through the review date; -Interventions: -Monitor for signs and symptoms of respiratory distress and report to physician PRN: respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis (partial or complete collapse of the lung), hemoptysis (coughing up blood), cough, pleuritic pain (inflammation of the lining of the lungs that causes sharp chest pains), accessory (muscles of the shoulder and chest wall that are utilized during respiratory distress to help the flow of air in and out of the lungs) muscle usage, skin color; -Oxygen settings: oxygen via nasal cannula at 3L and BiPap: NPPV settings: titrate to keep oxygen greater than or equal to 90%, Fio2: 40%, set respiratory rate to 20; -Promote lung expansion and improve air exchange by positioning with proper body alignment. If tolerated, HOB elevated to 45 degrees. Review of the resident's electronic physician order summary (ePOS), showed: -Order date, [DATE], Full code (when vital signs are not present, basic cardiopulmonary resuscitation (CPR) will be initiated and 911 will be called); -Order date, [DATE], listed under other (orders listed under other do not show up on the electronic medication administration (eMAR) or electronic treatment administration (eTAR)), oxygen 3 L per minute continuous via nasal cannula (NC); -Order date, [DATE], listed under other, NPPV Settings: titrate (adjust) to keep oxygen saturations greater than or equal to 90%, FiO2 40%, set respiratory rate 20; -Order does not specify when to use BiPap. Review of the resident's vital signs summary, dated [DATE] through [DATE], showed: -[DATE] at 6:25 P.M.: -SpO2, 92% via 3L/NC (normal range 95% - 100%); (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Respiratory rate (RR, breaths per minute, normal range is ,d+[DATE]) 18; -Pulse rate, (PR, heart beats per minute (BPM), normal range 60 - 100) 98; -Blood pressure, (BP, normal ,d+[DATE]) ,d+[DATE]; -Temperature, (T, normal 98.6 degrees Fahrenheit (F)) 98.3 F; -[DATE] at 12:51 A.M.: -SpO2, 98% via 4L/NC; -RR, 18; -PR, 70; -BP, ,d+[DATE]; -T, 98.6 F; -[DATE] at 12:56 A.M.: -SpO2, no value recorded; -RR, 18; -PR, 72; -BP, ,d+[DATE]; -T, 98.2 F; -[DATE] at 12:42 P.M.: -SpO2, 98% via 4L/NC; -RR, 16; -PR, 120; -BP, ,d+[DATE]; -T, 96.6 F. Review of the resident's progress notes, dated [DATE], showed: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 7:39 A.M., resident was up in wheelchair watching TV. Resident slept well through the night. Resident denied pain until he/she went to the bathroom with staff assistance. PRN pain medication was administered as ordered and pain medication was effective; -At 12:31 P.M., nurse was called to resident's room to check oxygen concentrator. Resident's oxygen concentrator was found to be broken and portable e-tank was obtained, and oxygen was administered at 4L per nasal cannula. Resident's SpO2 started out at 61% when oxygen was first applied. Resident's SpO2 increased to 76% on 4L, resident is lethargic, and only answered to name. Primary Care Physician (PCP) called and orders given to send to ER. Report called to ER, ambulance arrived and transported resident to ER. Review of the Emergency Medical Services (EMS) Care Report, dated [DATE], showed: -Nature of call: Breathing problem; -Response mode to scene: Emergent; -Timeline of EMS services: -Public-safety answering point (PSAP, call center) call at 12:46 P.M.; -Unit arrived on scene at 12:56 P.M.; -Arrived at patient at 1:02 P.M.; -Unit left scene at 1:56 P.M.; -Destination patient transfer of care 2:16 P.M.; -Primary impression: Respiratory failure; -Initial patient acuity: critical; -Assessment summary: -Skin: diaphoretic, hot, cyanotic; -Mental status: somnolent; -Eyes: left reactive, right reactive; -Findings: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-BP, ,d+[DATE]; -At 1:13 P.M.: -SpO2, 89%; -RR, 40, normal; -PR, 127; -BP, ,d+[DATE]; -At 1:18 P.M.: -SpO2, 92%; -RR, 40, shallow; -PR, 128; -BP, ,d+[DATE]; -At 1:28 P.M.: -SpO2, 95%; -RR, no value recorded; -PR, 48; -BP, ,d+[DATE]; -At 1:38 P.M.: -SpO2, 48%; -RR, 21, mechanically assisted with BVM; -PR, 107; -BP, ,d+[DATE]; -At 1:43 P.M.: -SpO2, 94%; -RR, 12, mechanically assisted with BVM; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Dutchtown Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3421 Gasconade Saint Louis, MO 63118	

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-PR, 118; -BP, ,d+[DATE]; -At 1:48 P.M.: -SpO2, 90%; -RR, 10, mechanically assisted with BVM; -PR, 116; -BP, ,d+[DATE]; Review of the resident's Emergency Department (ED) record, dated [DATE], showed: -At 1:54 P.M. resident arrived in ED, resident was in respiratory distress and unresponsive; -At 2:01 P.M. vital signs: -SpO2, 100%; -RR, 16; -PR, 115; -BP, ,d+[DATE]; -At 2:13 P.M., CPR started; -At 2:33 P.M., time of death was called. During an interview on [DATE] at 8:55 A.M., Certified Medication Technician (CMT) D said the last time he/she worked with the resident was on Thursday [DATE]. CMT D said the resident wore his/her oxygen and thought he/she was on 3L via nasal cannula. CMT D said the resident did not refuse to wear his/her oxygen. CMT D said the resident did not voice any complaints of not feeling well on Thursday. He/She monitors if a resident is wearing oxygen when he/she passes medication to the resident. CMT D said he/she does not document the monitoring that the nurse is responsible for that documentation. CMT D said if a resident had a change in condition, he/she would take the resident's vitals and ask the resident how they are feeling and then report the information to the nurse. Vitals would be documented in the electronic medical record (EMR) in the vitals section. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dutchtown Care Center	3421 Gasconade Saint Louis, MO 63118

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:05 A.M., Licensed Practical Nurse (LPN) E said the last time he/she worked with the resident was on Thursday [DATE]. LPN E said the resident wore oxygen and did not refuse care. LPN E said the resident would use his/her call light to request assistance as needed. LPN E said he/she would know a resident receives oxygen by looking at the orders in the EMR. LPN E said if a resident wore oxygen, it would be monitored on rounds and when medication is administered. Certified Nurse Aides (CNAs) check to make sure residents are wearing the oxygen and the head of the bed is elevated. LPN E said the oxygen monitoring would be documented in the progress note if the resident wore the oxygen as ordered or if the resident refused. If a resident had a change in condition, he/she would assess the resident including taking vitals and call the PCP with the assessment and follow the PCP orders. If a resident was in respiratory distress, 911 would be called. The change of condition would be documented in PCC under progress notes along with any other interventions completed for the resident including notifications to PCP and responsible party. During an interview on [DATE] at 12:45 P.M., LPN F said he/she worked with the resident on the night shift Thursday [DATE]. LPN F said the resident wore his/her BiPap during the night shift and only removed it when she got up that morning to go to the bathroom. The resident wore his/her oxygen after removing the BiPap. The resident required assistance with transfers. The resident never had any respiratory distress while LPN F was caring for the resident. LPN F said the resident did not have any respiratory problems when he/she assisted the resident with transfers. The resident did not breath heavily on his/her shift, did not have cold skin and was not sweating. LPN F said that would not be normal for the resident. The resident wheeled himself/herself outside and back inside on Thursday and the resident did not sweat then. The resident did not report any concerns of not feeling well to LPN F on Thursday or Friday morning [DATE]. There were no problems with the oxygen concentrator during LPN F's shift. When LPN F left Friday morning, the resident was sitting up in his/her wheelchair and was A&O X 4. During an interview on [DATE] at 9:49 A.M., CNA G said he/she was familiar with the resident. CNA G said the resident always wore his/her oxygen. The resident was independent except he/she required assistance with transfers. CNA G said the resident wore oxygen on Friday [DATE]. CNA G did not notice any problems with the resident on Friday. He/She delivered the breakfast tray to the resident in his/her room. When CNA G delivered the breakfast tray, the resident had his/her eyes closed and he/she opened and then closed them CNA G said he/she would know a resident uses oxygen by the nurse informing him/her in report. CNA G said he/she would ask the nurse to find out how many liters the resident is supposed to be receiving. CNA G said residents who wear oxygen are monitored when they complete rounds, they visually check to see if the residents are wearing oxygen. Monitoring the oxygen is not documented by the CNA. If a resident was noticed not wearing oxygen and they were supposed to, CNA G would report it to the nurse. If a resident had a change in condition, CNA G would take the resident's vitals and report the change and vitals to the nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Dutchtown Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3421 Gasconade Saint Louis, MO 63118	

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:41 A.M., CNA B said he/she worked with the resident on Friday [DATE]. CNA B said when he/she came in and was making rounds, the resident was up in his/her wheelchair and he/she wore oxygen. CNA B said the resident requested assistance with getting into bed and CNA B assisted the resident from his/her wheelchair into bed. CNA B said he/she asked the resident if he/she was going to eat breakfast and the resident said no. CNA B said he/she went to check on the resident after breakfast between 9:00 A.M. and 10:00 A.M. CNA B said the resident had his/her oxygen on at that time. CNA B said he/she went into the resident's room around 11:00 A.M. to take this/her vitals because LPN A asked him/her to. CNA B said when he/she went into the resident's room, he/she lay on his/her side on the bed. CNA B said it looked like the resident was breathing harder than he/she was earlier. The resident did not open his/her eyes or respond to CNA B when he/she spoke to him/her when CNA B went to get the resident's vitals. CNA B said the resident's fingers were purple, the resident was cold to touch and his/her head was sweaty. CNA B took the resident's vitals and wrote them down on a piece of paper and gave them to the nurse. CNA B did not document the vitals in the EMR. CNA B said He/She did not recall what the vitals were or if they were abnormal. CNA B told LPN A he/she did not think the resident was alright because the resident was breathing harder and not responding when CNA B spoke to him/her or when CNA B took the resident's vitals. CNA B also reported the resident was cold to touch, his/her head was sweaty and his/her three fingers (index, middle, and ring finger) on his/her the right hand were purple. LPN A said the resident is always like that, cold and sweaty. CNA B did not remember what LPN A did after reporting the change in condition. CNA B did not go back into the resident's room, because it was lunch time and he/she started assisting other residents into the dining room. CNA B said EMS arrived approximately 10 minutes later. During an interview on [DATE] at 7:09 A.M., CMT C said Friday [DATE] was the first time he/she had worked with the resident. CMT C went in to administer medications to the resident between 10:20 A.M. and 11:00 A. M. CMT C said the first time he/she saw the resident, the resident breathed funny. The resident would take deep breaths, like he/she was breathing heavy. CMT C asked the resident about his/her breathing and the resident told CMT C he/she had COPD and said he/she was fine, that was just how he/she breathes. CMT C said the resident laid in bed on his/her right side. The resident propped himself/herself up a little on his/her right elbow so CMT C could give the resident's medication. CMT C also administered inhalers to the resident. The resident took his/her medication and inhaler fine and then laid back down in bed. CMT C asked the resident if he/she wanted a BiPap treatment because the machine was right there. The resident told CMT C he/she just had a BiPap treatment. CMT C said he/she was unsure who administered the treatment, maybe the night nurse, but the resident did not want a BiPap treatment whi