DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 21, 2025

Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

RE: CCN: 245489
Cycle Start Date: December 18, 2024

Dear Administrator:

On February 18, 2025, we notified you a remedy was imposed. On March 18, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 12, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 18, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 18, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 18, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 12, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 21, 2025

Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

Re: Reinspection Results
Event ID: XNQO12

Dear Administrator:

On March 18, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 20, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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Electronically delivered

March 5, 2025

Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

RE: CCN: 245489
Cycle Start Date: December 18, 2024

Dear Administrator:

On February 18, 2025, we informed you of imposed enforcement remedies.

On February 20, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 18, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 18, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 18, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 18, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Emmanuel Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 18, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E"tag), i.e., the plan of correction should be directed to:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 18, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate

formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

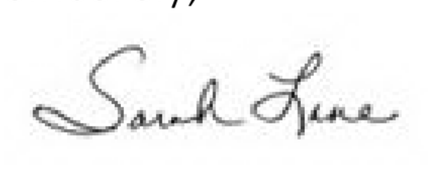
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 5, 2025

Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

Re: State Nursing Home Licensing Orders
Event ID: XNQO11

Dear Administrator:

The above facility was surveyed on February 18, 2025 through February 20, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

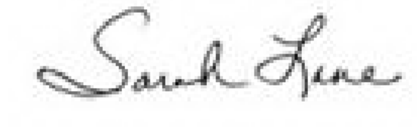
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



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Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/18/25 through 2/20/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H54897768C (MN00110768) with eficiencies at F684 and F835. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	F 684	Tag: F 684 Quality of care	3/12/25

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

Electronically Signed | 03/06/2025

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.

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 _____	C 02/20/2025

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EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

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F 684	Continued From page 1 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 admission dated 4/02/24 to print date 2/20/25, 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 12/2/24, 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 11/26/24.	F 684	Corrective action to resident found to be affected: TMA notified nurse on R1; Education given to TMA on notifying nurse immediately when change in condition is noticed. How the facility identified other residents' potential to be affected: Audit done on current residents and if changes in conditions assured nurse and provider has been notified. Measures put in place to ensure it will not recur: Education to all nursing personnel on notifying a nurse immediately if noted change in condition. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits, it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: Nurses/RN Managers/Director of Nursing/Designee Date of completion: 3/12/25	

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 _____	C 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 684	Continued From page 2 -Cardiopulmonary resuscitation (CPR) (performed when a person is unresponsive, not breathing, and does not have a pulse), full code/full treatment. Order date 11/26/24. -BIPAP per home settings. 10/5, 35%, back up rate 12. On at night/off in morning (a.m.) two times a day and as needed for naps. Order date 11/26/24. -Cardiopulmonary resuscitation (CPR) (full code)/full treatment. Order date 11/27/24. Review of R1's Provider Orders for Life-Sustaining Treatment (POLST) form signed on 11/27/24 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. R1's emergency room (ER) visit on 1/31/25, 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) 122/45, 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	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

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F 684	Continued From page 3 respiratory status are noted for every shift for respiratory status. Check for 8 days start date 1/31/25 and discontinue 2/4/25 at 6:10 a.m. R1's treatment assessment record (TAR) identified an order dated 1/31/25 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 1/31/25 through 2/3/25 identified: -1/31/25 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%. -2/1/25 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%. -2/1/25 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%. -2/1/25 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%. -2/2/25 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 %. -2/2/25 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%. - 2/2/25 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 %. -2/3/25 at 6:30 a.m. no assessment documented on TAR. -2/3/25 at 2:30 p.m. productive cough, crackles in	F 684		

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 _____	C 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 684	Continued From page 4 the lungs O2 at 4 liters, SOB, yellow sputum, temperature 97.2 F, pulse 64, respirations 20, and SaO2 91 % documented on TAR. 2/3/25 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 2/4/25 identified call light was activated at 12:39 a.m. and responded to in 1 minute 28 seconds. The 911 call initiated on 2/4/25 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 126 long term care. Police officer (PO)-A report dated 2/4/25, identified on 2/4/25 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	F 684		

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F 684	Continued From page 5 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 2/4/25 at 2:01 a.m. identified dispatch was notified on 2/4/25 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,	F 684		

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F 684	Continued From page 6 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. A progress note dated 2/4/25 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 142/109, 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 2/18/25 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	F 684		

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F 684	Continued From page 7 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. During an interview on 2/18/25 at 12:30 a.m. trained medication assistant (TMA)-A stated R1	F 684		

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F 684	Continued From page 8 was COVID-19 positive. On 2/4/25 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 140/109 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.	F 684		

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F 684	Continued From page 9 During an interview on 2/18/25 at 1:30 p.m. nursing assistant (NA)-A stated she cared for R1 on 2/3/25 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 2/18/25 at 3:43 p.m. nursing assistant (NA)-B stated on 2/4/25 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 2/18/25 at 4:00 p.m. licensed practical nurse (LPN)-A stated she was the only nurse working on night shift on 2/3/25. 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	F 684		

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F 684	Continued From page 10 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. During an interview on 2/19/25 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 9 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	F 684		

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F 684	Continued From page 11 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 2/19/25 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 2/3/25 from 2:00 p.m. to 6:00 p.m. and completed R1's	F 684		

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F 684	Continued From page 12 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. During an interview on 2/20/25 at 2:46 p.m. nurse practitioner (NP) stated she had seen R1 on 2/3/25 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 2/20/25 at 3:22 p.m. floor manager, RN-B, stated the nurse would be expected to complete the initial assessment on a	F 684		

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F 684	Continued From page 13 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. During an interview on 2/20/25 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 2/3/35 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 2/4/25: 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	F 684		

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F 684	Continued From page 14 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 January 2025, 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.	F 684		

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F 684	Continued From page 15 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 January 2025, 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 10/2022, 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. 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.	F 684		

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F 684	Continued From page 16 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 2/2014, 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. 4. Neurological - alertness and orientation,	F 684		

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	245489	A. BUILDING _____ B. WING _____	C 02/20/2025

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F 684	Continued From page 17 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.	F 684		
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: 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.	F 835	Tag: F 835 Administration Corrective action to resident found to be affected: Emergency access was obtained by EMS/PO. How the facility identified other residents' potential to be affected: Assured each	3/12/25

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F 835	Continued From page 18 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 11/27/24 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 2/4/25 was listened to on 2/20/25 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 126 long term care. Police officer (PO)-A report dated 2/4/25, identified on 2/4/25 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	F 835	entrance has emergency access and communication with the local Chief of police; to assure they are aware of the process to enter buildings. Measures put in place to ensure it will not recur: Education to Nursing team on 911 procedure. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits, it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: Nurses/RN Managers/Director of Nursing/Designee Date of completion 3/12/25	

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F 835	Continued From page 19 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 2/4/25 at 2:01 a.m. identified dispatch was notified on 2/4/25 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.	F 835		

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F 835	Continued From page 20 During an interview on 2/18/25 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 2/19/25 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 9 to 13 minutes after they arrived at the facility and while	F 835		

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F 835	Continued From page 21 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. During an interview on 2/19/25 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 2/20/25 at 10:30 a.m. at the police department along with chief of police (COP)	F 835		

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F 835	Continued From page 22 identified on 2/4/25 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 2/4/25 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	F 835		

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F 835	Continued From page 23 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. -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	F 835		

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F 835	Continued From page 24 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 2/20/25 at 3:10 p.m. COP stated facility had a Knox 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 Knox boxes. Unsure if the PO's had the key on the night of 2/4/25 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 2/20/25 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 2/20/25 at 3:38 p.m. director of nursing (DON) stated there was a lack of communication with staff. There was not a	F 835		

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F 835	Continued From page 25 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 10/2022, 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. 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	F 835		

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F 835	Continued From page 26 precautions. Facility policy requested emergent access to the locked facility and staff process for a 911 call and not received.	F 835		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/18/25 through 2/20/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed: H54897768C (MN00110768) with a licensing order issued at 0190. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 190	MN Rule 4658.0060 B. Responsibilities of Administrator; policies The administrator is responsible for the: B. formulation of written policies, procedures, and programs for operation, management, and maintenance of the nursing home; This MN Requirement is not met as evidenced by: 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 11/27/24 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.	2 190	Tag: F 835 Administration Corrective action to resident found to be affected: Emergency access was obtained by EMS/PO. How the facility identified other residents' potential to be affected: Assured each entrance has emergency access and communication with the local Chief of police; to assure they are aware of the process to enter buildings. Measures put in place to ensure it will not recur: Education to Nursing team on 911 procedure. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits, it will be reviewed at the QAPI meeting and determined if	3/12/25

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2 190	Continued From page 3 The 911 call from 2/4/25 was listened to on 2/20/25 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 126 long term care. Police officer (PO)-A report dated 2/4/25, identified on 2/4/25 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. EMS report dated 2/4/25 at 2:01 a.m. identified dispatch was notified on 2/4/25 at 1:02 a.m., in route at 1:02 a.m., arrived at scene at 1:04 a.m.,	2 190	additional audits are necessary based on findings. Responsible Persons: Nurses/RN Managers/Director of Nursing/Designee Date of completion 3/12/25	

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2 190	Continued From page 4 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 2/18/25 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	2 190		

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2 190	Continued From page 5 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 2/19/25 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 9 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	2 190		

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2 190	Continued From page 6 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 2/19/25 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 2/20/25 at 10:30 a.m. at the police department along with chief of police (COP) identified on 2/4/25 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 2/4/25 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)	2 190		

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2 190	Continued From page 7 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	2 190		

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2 190	Continued From page 8 least 5 to 10 minutes before we got here. -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 2/20/25 at 3:10 p.m. COP stated facility had a Knox 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 Knox boxes. Unsure if the PO's had the key on the night of 2/4/25 when the 911 call came into dispatch or if that would have made a difference,	2 190		

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2 190	Continued From page 9 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 2/20/25 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 2/20/25 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 10/2022, identified for an emergency transfer or discharge to a hospital or other acute care institution, implement the	2 190		

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2 190	Continued From page 10 following procedures: a. Call 911 if resident met clinical/behavioral criteria per facility policy or assist in obtaining transportation. 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. Facility policy requested emergent access to the locked facility and staff process for a 911 call and not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on administration responsibility. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all staff are appropraiatly trained and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 190		