

Electronically delivered October 12, 2020

Administrator Guardian Angels Care Center 400 Evans Avenue Elk River, MN 55330

RE: CCN: 245012 Cycle Start Date: June 29, 2020

Dear Administrator:

On July 21, 2020, we notified you a remedy was imposed. On September 9, 2020 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 September 9, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective August 20, 2020 be discontinued as of September 9, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 21, 2020, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 30, 2020. This does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us



Electronically delivered

October 12, 2020

Administrator Guardian Angels Care Center 400 Evans Avenue Elk River, MN 55330

Re: Reinspection Results Event ID: 9E4B12

Dear Administrator:

On September 9, 2020 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 September 9, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us



Electronically delivered August 14, 2020

Administrator Guardian Angels Care Center 400 Evans Avenue Elk River, MN 55330

RE: CCN: 245012 Cycle Start Date: June 29, 2020

Dear Administrator:

On July 21, 2020, we informed you of imposed enforcement remedies.

On July 30, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

### **REMOVAL OF IMMEDIATE JEOPARDY**

On July 30, 2020, the situation of immediate jeopardy to potential health and safety cited at F0760 was removed. However, continued non-compliance remains at the lower scope and severity of G.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 20, 2020, will remain in effect.
- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 20, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 20, 2020.

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.

As we notified you in our letter of July 21, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 20, 2020. However, due to the extended survey the new NATCEP loss date is July 30, 2020.

# SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Guardian Angels Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 30, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

# ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Civil money penalty (42 CFR 488.430 through 488.444).

### DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor St. Cloud A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 3333 West Division Street, Suite 212 St. Cloud, Minnesota 56301 Email: susie.haben@state.mn.us Phone: 320-223-7356

## 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 December 29, 2020 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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:

## Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

### INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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.

Feel free to contact me if you have questions.

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us

		AND HUMAN SERVICES					APPROVED
	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION		0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	l` í				IPLETED
							С
		245012	B. WING	Ì		07/:	30/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	ENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	CARE CENTER400 EVANS AVENUE ELK RIVER, MN 55330IMARY STATEMENT OF DEFICIENCIES IMARY STATEMENT OF DEFICIENCIES TORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCDMMENTSF 000F 0000 to 7/30/20, an abbreviated survey eted at your facility by surveyors from tota Department of Health (MDH) to omplaint investigation(s). Guardian re Center was found not to be in e with 42 CFR Part 483, Requirements erm Care Facilities.F 000, a COVID-19 Focused Infection rvey was conducted at the facility by termine compliance with §483.80 ontrol. Guardian Angels Care Center not to be in compliance with the nt.Immediate jeopardy (IJ) ten a resident's ordered aspirin was not ed in accordance with physician orders					
	was completed at y the Minnesota Depa conduct complaint i Angels Care Center compliance with 42 for Long Term Care In addition, a COVII Control survey was MDH to determine Infection Control. G was found not to be requirement. The survey resulted at F760 when a res administered in acc resulting in a signifi resident subsequen stroke and was hos completed an inves identified potential of error; however, no se educate staff on the potential electronic human error, result additional medicatio and director of nurs IJ for R1 on 7/29/20 removed on 7/30/20 non-compliance rer with actual harm wh (Level G).	our facility by surveyors from artment of Health (MDH) to investigation(s). Guardian r was found not to be in CFR Part 483, Requirements e Facilities. D-19 Focused Infection conducted at the facility by compliance with §483.80 suardian Angels Care Center e in compliance with the d in an immediate jeopardy (IJ) ident's ordered aspirin was not					
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 08/21/2020
	ically Signed						00/21/2020

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/24/2020

		AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245012	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI/	AN ANGELS CARE CI	ENTER			00 EVANS AVENUE LK RIVER, MN 55330		
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F 000	• • • • • • • • • • • • • • • • • • •	ige 1 plaint(s) were found to be	F 0	000			
		deficiency issued at F760.					
	H5012038C; with a	deficiency issued at F760.					
	H5012039C; with a	deficiency issued at F760.					
	The following comp unsubstantiated:	laint(s) were found					
	H5012036C						
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 730 SS=C	on-site revisit of you validate substantial regulations has bee your verification. Nurse Aide Peform	acceptable electronic POC, an ur facility may be conducted to compliance with the en attained in accordance with Review-12 hr/yr In-Service 7)	F 7	'30			8/21/20
	The facility must co of every nurse aide months, and must p education based on reviews. In-service requirements of §48	ular in-service education. Implete a performance review at least once every 12 provide regular in-service the outcome of these training must comply with the 83.95(g). NT is not met as evidenced					

Facility ID: 00611

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STATEMENT	F OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	of contraction	IDENTIFICATION NOMBER.	A. BUILD	ING	C
		245012	B. WING		07/30/2020
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GUARDI	AN ANGELS CARE C	ENTER		400 EVANS AVENUE ELK RIVER, MN 55330	
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F 730	Continued From pa	age 2	F 7	30	
		v and document review, the sure an annual performance		F730	
	assistants (NA-C) of This had potential to residing in the facil survey. Findings include: During the abbrevia 7/30/20, evidence of the last completed several NA(s), inclu A provided Annual Review was review signed as completed prior). No other per provided during the On 7/30/20, at 2:35 (DON) and register -A and RN-B were process for NA per completion. When message is receive "PayCor" system w review (i.e. 30-Day NA-C had been em for "a few years," a recent completed r 11/21/17). RN-A ar	ated for 1 of 3 nursing whose files were reviewed. to affect all 103 residents ity during the abbreviated ated survey, from 7/27/20 to was requested demonstrating performance evaluation for uding NA-C. Employee Performance ved for NA-C. The review was ed on 11/21/17 (over two years or formance reviews were a abbreviated survey period. 5 p.m. the director of nursing red nurse unit managers (RN) interviewed and explained the formance evaluation an evaluation is due, a ed from human resources via a which outlines whom and what , 60-Day, Annual) is needed. aployed by the nursing home nd HR had provided the most eview they had (dated and RN-B expressed they were 's annual performance reviews		Guardian Angels Care Cer adhere to Nurse Assistant, performance reviews and I education requirements. Recent performance review been completed. Performance reviews will for all Nursing Assistant, R are employed greater than will be completed by 8/26/2 Training/inservice needs w based on performance rev employee feedback to dete necessary changes or add education programs. The Administrator will be p pending NAR performance Human Resources) and wi the Director of Nursing and Managers for ongoing com QAA Committee (subset) H discussed RCA factors imp performance reviews inclu- commitments necessitated The QAA Committee unde significance of performance the need to develop a stron balance system for comple overdue NAR performance WEEKS OVERDUE) will b the Administrator at QAA Cometings.	Registered In-service w for NA-C has be completed tegistered that 90 days. PA's 2020. vill be compiled iew as well ermine any itions in annual provided list of e reviews (by ill follow up with d the Nurse Unit hpletion. has met and bacting ding recent time d by Covid-19. prstands the re reviews and nger check and petion. Any e reviews (> 2 e reported by
	continued to work f Further, RN-A voic	ince then, and added NA-C full-time at the nursing home. ed it was important to ensure eviews were completed timely		Correction date: 8/26/2020	)

Facility ID: 00611

If continuation sheet Page 3 of 25

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF		(X3) DATE S	1938-039 SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	S	COMPL	ETED
		245012	B. WING		С	
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				400 EVANS AVENUE		
GUARDI	AN ANGELS CARE C	ENTER		ELK RIVER, MN 55330		
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F 730	Continued From pa	age 3	F 730	)		
	to "make sure they	re [NA] competent" and ons" in their job duties.				
	5/2017, identified re summarize an emp work-related factors "Reviews will be do near the employee' date," and, " will employee's direct s head."	nance Reviews policy, dated eviews were done to ployee's performance and other s. The policy directed, one on an annual basis on or s employment anniversary be completed by an supervisor and/or department				/0.1/00
F 760 SS=J		of Significant Med Errors 2)	F 760	)	8	/21/20
	medication errors. This REQUIREMEN by: Based on interview facility failed to ens blood clotting was a with physician orde reviewed who suffe ordered aspirin was significant medicati resulted in an imme for R1 when the fac systemic action(s) f factors which contr potential for similar subsequent medication The IJ began on 5/ for a daily dosing of anti-inflammatory n	Antiparties are free of any significant NT is not met as evidenced wand document review, the ure medication to prevent administered in accordance rs for 1 of 1 residents (R1) ered a stroke after their is not provided resulting in a ion error. These findings ediate jeopardy (IJ) situation cility failed to take adequate, to educate staff to potential ibuted to the error causing the reoccurrences and further		F760 Guardian Angels Care Center strive adhere to practices that ensure resid are free of significant medication err Resident (R1) was discharged from hospital back to the nursing home w principle diagnosis of right frontal ste with residual facial droop and dysart R1 was provided rehabilitation servit and made improvements and was discharged home on 7/24/2020. Review of medication/allergy orders changes did not yield any other resid were impacted by errors. Staff training has been conducted for licensed nurses to ensure that order written clearly. Licensed nurses and	dents rors. the vith a oke thria. ces dents or all rs are	

Facility ID: 00611

If continuation sheet Page 4 of 25

		& MEDICAID SERVICES	r		OMB NO.		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION	COMF	SURVEY PLETED	
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IAME OF F	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP COL		0/2020	
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SUARDI	AN ANGELS CARE C	ENTER		ELK RIVER, MN 55330			
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F 760	Continued From no	ao 4	F 7/	20			
1 700	Continued From pa	-	F 76		d to		
		ntinued resulting in R1 not ed medication from 5/7/20 to		station secretaries were traine question any ambiguous order			
		), R1 developed facial droop		processing.			
		iness; was transferred to the		Medical providers will receive			
		ment (ED) and subsequently		communication regarding the			
		oke. The facility investigated		provide clarity in all written, ve	rbal and		
		vered factor(s) which		telephone orders.			
		rror, including potential		Retraining will be done with th			
		record (EMR) issues, and e factors with a systemic fix		nurses to review all orders pro preceding day. Processing wi			
		staff whom process orders to		reviewing:			
		rs did not reoccur and placed		A) Copies of orders from tele	phone		
		harm or injury. The facility		orders	•		
		lirector of nursing (DON) were		<ul> <li>B) Order listing report</li> </ul>			
		R1 on 7/29/20, at 2:16 p.m.		C) Allergy report (new addition	on to review		
		d on 7/30/20, when the facility		process).			
		ioval plan; however, mained at an isolated scope of		The order transcription proces updated to include the require			
		not immediate jeopardy (Level		person check at the time of pr			
	G).			(station secretary and nurse o			
	- /			nurses). This process will be f			
	Findings include:			through the EMR. The QAA Committee (subset)			
	On 7/28/20, at 1:30	p.m. R1's family member		and discussed RCA factors in			
		wed. FM-A explained R1 had		transcription errors. The QAA			
		tion error while residing at the		identified the reason for the er			
		her physician ordered aspirin		isolated, however the electron			
		her and she subsequently M-A explained the nursing		and human error have the pot make an error. Additional che			
		up with him about the error;		beneficial. Chart audits will be			
		's ordered aspirin had been		for accuracy in order transcrip			
		tinued instead of just R1's		audit will be conducted weekly			
		y, which is what had been		weeks. If no issues are identif			
		nis caused R1 to miss several		audits will be reduced to 5% for	or the		
		sing. FM-A voiced he believed		remainder of the year.	ad by Numer		
		d to R1 suffering the stroke; e, R1 is no longer able to live		Weekly audits will be conducte Unit Manager or Director of N			
		eds more help to complete		Audit results will be reported a			
		r, FM-A expressed frustration		Committee meeting by the Dir			

Facility ID: 00611

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TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
	CONTECTION					C
		245012	B. WING			/30/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
GUARDI	AN ANGELS CARE C	ENTER		100 EVANS AVENUE ELK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 760	Continued From pa	nge 5	F 760			
		and voiced the error made him		Nursing.		
		viously a problem" at the their order processing.		Correction date: 8/26/2020		
	required extensive daily living (ADLs). neurological diagno aphasia, hemiplegi	dication(s) only on one (1) day				
	dated 4/22/20, iden discharged to the n hospitalized due to hematoma. R1's ho being complicated dictation directed to (an anticoagulant n The report identifier regarding continuat risk." R1's discharg home were listed w [milligrams] 1 tat meal," along with a	zation After Discharge Orders, tified R1 was being pursing home after being a fall and fracture with a ospitalization was listed as due to atrial fibrillation, and b hold R1's warfarin sodium medication) for a set period. d, "May need discussion tion of [warfarin] given high fall ge medications to the nursing hich included, "aspirin 81 mg blet by mouth once daily with a listed allergy to aspirin with *patient tolerating daily 14/16."				
	identified an order aspirin 325 mg EC mouth everyday] or Afib [atrial fibrillatio	phone Orders, dated 5/4/20, for R1 which read, "Start [enteric coated] PO QD [by n 5/6/2020. Dx: [diagnosis] n; an abnormal heath rhythm l, irregular beating]."				

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		I AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245012	B. WING				C 30/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS CARE CI	ENTER			00 EVANS AVENUE ELK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	to DC [discontinue] order was provided The order was sign including station see However, a Discont 5/6/20, identified lic discontinued R1's of with dictation prese R1's Medication Ad dated 5/1/20 to 5/37 medications while a provided aspirin 81 5/4/20 and 5/5/20. If started 5/6/20, was provide aspirin 325 for atrial fibrillation. on 5/6/20; however discontinue date of aspirin were provide MAR. R1's progress note, a.m. which recorder orientated and need with her walker. A progress note on SBAR (Situation, B Recommendations) recorded as having weakness and left-s the restroom. The r set of vital signs on saying, "I don't know physician (MD)-A w	aspirin alergy [sic]." The by the nurse practitioner (NP). ed by various staff members,	F 7	760			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245012	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				40	00 EVANS AVENUE		
GUARDI	AN ANGELS CARE C	ENTER		Е	LK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	Physical, dated 5/2 <sup>4</sup> with a chief compla- recorded as being a presentation to the her condition," with of ability to understa- left-sided weakness The report identified warfarin due to hav 4/18/20, and she wa therapy to dissolve section labeled, "Pr listed all of R1's me administered by the list lacked any phys report continued an allergy to aspirin wi myalgia; however, or read, "*patient toler 12/14/16." Further, problems with subs- each one. This inclu- was listed as being (inadequate blood s weakness and left f was admitted to the R1's Hospital Disch- identified R1 was di back to the nursing diagnosis of right fr droop and dysarthri listed as having atri read, " [warfarin] because of fall with and feels she shoul time and to use AS.	ED Admission History & E/20, identified R1 presented int of weakness. R1 was a poor historian upon ED, " due to the acuity of slurred speech, aphasia (loss and or express speech) and s being recorded as present. d R1 had been taken off her ing sustained multiple falls on as given TPA (thrombolytic blood clots) in the ED. A eadmission Medications," dications which were being a nursing home; however, the ician orders for aspirin. The d listed R1 as having an th a reaction of rash and dictation was present which ating daily doses of aspirin the report listed R1's medical equent plan(s) to address uded, "Acute stroke," which caused by ischemia supply) and left-sided acial droop were present. R1		760			

Facility ID: 00611

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CENTERS	FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			OI	FORM MB NO.	08/24/2020 APPROVED 0938-0391
STATEMENT O AND PLAN OF (	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	СОМ	E SURVEY PLETED C
		245012	B. WING	;			30/2020
NAME OF PRO	OVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDIAN	I ANGELS CARE CE	ENTER			400 EVANS AVENUE ELK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
ir TF cpd Orch rie Fa Air carch boaowd tott ton throttir 05 fi	Take 1 tablet by mo further, the outlined continued to list asp present which read, loses of aspirin 12/ On 6/1/20, a progre e-admitted to the n tospital. The note of eadmission due to eff sided facial droc R1 was now listed a all transfers using a A completed State a novestigation, dated completed investigation, dated completed investigation, dated sompleted investigation didentified R1 towever, the provid profers were receive to the station secret he listed allergy and to confirm. However he confirm. However he listed allergy and to confirm. However he dical system (Po he nurse to confirm esulting in the nurs he aspirin dose ord eport outlined R1 the f condition and sub f/29/20, and listed, unctional decline di	s for, "aspirin 325 mg tablet buth once daily with a meal." d allergies on the report birin with the same dictation "*patient tolerating daily 14/16." ss note identified R1 was ursing home from the butlined, "Resident is a a recent stroke. Resident has oping and weakness." Further, as needing assist of two with	F7	760			

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DA	D. 0938-039		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CO	MPLETED		
		245012	B. WING		07	7/30/2020		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE	DE		
GUARDI	AN ANGELS CARE C	ENTER		400 EVANS AVENUE ELK RIVER, MN 55330				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE		
F 760	to prevent reoccurr and other residents education was pro- committed the error what actions had b reoccurrence to ott "N/a [not applicable actions or evidence the facility to help a identified findings of not allowing nurses removed; nor was completed education the incident regard clarified if they are During interview or registered nurse (F able to view reside system; however, v adjust allergy order significant medication included the incorror of insulin, warfarin RN-C stated she w process for reportine medication errors a provided any recent transcription and p When interviewed explained the facilii processing. The Se electronic health sy completes a second order is then listed	rence to the subjected resident s. The facility identified vided to the nurse, LPN-A, who or; however, the field to write een taken to prevent hers was completed with only, e]." The report lacked any e of a systemic response by alert or educate staff to their of the electronic health system is to confirm allergies are there evidence of any on to other staff not involved in ing ensuring orders are unclear. n 7/28/20, at 7:57 a.m. RN)-C stated the nurses were nt allergies in the computer voiced she did not know how to rs. RN-C explained a ion error would be one which ect administration or omission or other "high risk meds." vas not sure on the facility' ng or investigating significant and added she had not been at training or education on order	F 7	60				

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		AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245012	B. WING	i			C 30/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	ENTER			00 EVANS AVENUE ELK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 760	would act on the or they're not a physic would then follow-u order. Further, RN- provided any re-edu order processing w When interviewed of expressed they (SS change allergies wi system; however, S uncomfortable doin she would ask a nu instead of her doing interview, on 7/29/2 she could not recall or re-education on a within the past seve During interview on voiced she was una involving the electro allergies are modifie she was not aware medication error (do originally processed discontinue the asp had not been given guidance on order p or medication order On 7/29/20, at 9:57 (MD)-A was intervie R1's primary care p the nursing home. I to the nursing home. I to the nursing home. I	der and not question it, as sian; however, afterwards up with the provider about the E stated she had not been ucation or new guidance on ithin the past several weeks. on 7/28/20, at 9:20 a.m. SS-A S) had rights and access to ithin the electronic health SS-A voiced she was og so. As a result, SS-A stated urse to change the order g it. During subsequent 20 at 9:10 a.m., SS-A stated I receiving any new guidance allergy or order processing	F 7	760			

STATEMEN	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	ONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COI	MPLETED	
		245012	B. WING			07	C	
	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	07	/30/2020	
					EVANS AVENUE			
GUARDI	AN ANGELS CARE (	CENTER			RIVER, MN 55330			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 760	Continued From p	age 11	F 7	60				
1 700	• • • • • • • • • • • • • • • • • • •	-	F /	00				
		zed. R1 had several "heart atrial fibrillation, carotid artery						
		nary artery disease (CAD), all of						
		1's risk of stroke; so R1 had						
		a daily dosing of aspirin 81						
		ID-A stated she had numerous						
		1 and her responsible party as						
		bout R1's anticoagulation "in						
		r frequent falls. As a result, a						
		e to start R1 on a full-strength er was provided on 5/4/20 to						
		irin dosing from 81 mg to 325						
		daily basis. MD-A explained a						
		e where they identified R1's						
		d a listed allergy to aspirin;						
		etermined to not be accurate						
	•	der was written on 5/6/20 to						
		allergy. MD-A verified the order						
		vas meant to remove the						
		vever, not meant to remove the						
		stration order. MD-A explained error then occurred where the						
		long with the identified allergy						
		nued, which resulted in R1						
		dosing of the ordered aspirin						
		ID-A expressed on 5/29/20,						
		or a visit earlier in the day and						
		signs of distress outside of						
		e pain; however, afterwards R1						
		ficulty speaking and left-sided subsequently sent to the ED						
		h a stroke. MD-A stated when						
		d been hospitalized for a						
		ed her medication list and						
		pirin was not being given. MD-A						
	then e-mailed the	nursing home and expressed						
	concern about the	error which MD-A voiced was						
		the nursing home had been ad happened. MD-A explained						

Facility ID: 00611

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(V2) DA	TE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:		NG	· · ·	MPLETED	
						С	
		245012	B. WING		07	//30/2020	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
GUARDI	AN ANGELS CARE C	ENTER		400 EVANS AVENUE ELK RIVER, MN 55330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 760	if R1 had been provided against stroke add risk of stroke to have provided against stroke add risk of stroke to have provided against stroke add risk of stroke to have reviewed R1's risk omitted aspirin wood "significant" medicated expressed regret ave were multiple opport herself, to notice the provided and corregit." Further, MD-A se there being "any di staff to modify any prevent future error surrounding R1's in she was not sure we policies the nursing on since the incided On 7/29/20, at 10:4 and verified he pro- which called to disc LPN-A expressed is specifics of the evel entry and subseque acknowledged he we explained the educed merely a telephoned directed him to "do if unsure of them. I no education or fur ensure allergy order	vided the ordered aspirin rder on 5/4/20 called for, it ed R1 "some protection" ing, "I do think it increased her ve nothing [medication]." MD-A factors and stated she felt the uld be considered a ation error for R1. MD-A bout the error and voiced there ortunities for staff, including ne aspirin was not being ct it adding, "None of us saw stated she was not aware of rect request" of the physician of their procedures to help rs with circumstances noident; however, MD-A stated what new procedures or g staff may have been directed int to help avoid further errors. A1 a.m. LPN-A was interviewed cessed R1's order from 5/6/20, continue R1's aspirin allergy. he was unable to recall ents surrounding the order					

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		E & MEDICAID SERVICES				). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		245012	B. WING		07	С
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07	/30/2020
	AN ANGELS CARE C			400 EVANS AVENUE ELK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	JLD BE	(X5) COMPLETIO DATE
F 760	•	ch happened with the order	F 76	60		
	director of nursing explained R1's unit vacation currently a received notificatio error involving R1's vulnerable adult (V error was reviewed corresponding staft the process used f multiple "chart che orders are entered secretary staff. The R1 as being "isolat widespread concer system; however, t "process failed" reg aspirin error. The in explained the facilii investigation pertai and discovered an record system (Poi readily display whe so they notified the "trying to get that fi "bottom line" of the R1's physician orded discontinue the asp questioned it" inste medication versus At 11:15 a.m. the o the interview and v R1's medication er an accident." R1 has	07 a.m. the administrator and (DON) were interviewed. They it manager, whom was on and not available for interview, n on 5/29/20 of a medication is aspirin. As a result, a (A) report was made and the d with the physician and f involved. The DON explained or order processing included cks" by the nurses after the into the system by the station ey expressed the incident with red" and didn't feel there was a m with their order check the DON acknowledged the garding the incident with R1's interview continued and they ty had completed an ning to R1's medication error issue with their electronic intClickCare) where it did not en allergies were discontinued, e software developer and were xed." The DON added the e error was the nurse mis-read er on 5/6/20 (directing to opinin allergy) and "should have ead of discontinuing the the allergy.				

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		I AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245012	B. WING				C 30/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GUARDI	AN ANGELS CARE C	ENTER			00 EVANS AVENUE ELK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 760	however, there was R1's record so the r written an order to d written order was a secretary whom dis system and the nur behind later on to c transcription." Howe system does not log discontinued; so thi order and, in error, meant to discontinu allergy was no long not provided any as on 5/29/20, which c contact the unit ma investigation was st revealed those deta the best of all world re-worded the order regret as everyone thought was the right The interview contin error, DOQ express re-education with the involved with the er LPN-A; however, the require whole-hous stated she felt the fit the incident was rev overall system for c adequate; however system had "failed or reiterated had the er	a listed allergy to aspirin on nurse practitioner (NP) had discontinue the allergy. The cted on by the station continued the allergy in the se, LPN-A, then followed omplete the process and "final ever, the electronic record g or record when an allergy is is caused the nurse to read the the nurse thought the order ue the medication itself as the er listed. R1 subsequently was spirin and sustained a stroke caused R1's physician to nager about the error and an tarted into the incident which ails. DOQ expressed that "in ls" the NP could have r to be clearer, and expressed involved was "doing what they	F7	760			

		HAND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245012	B. WING				C 30/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
				40	00 EVANS AVENUE		
GUARDI	AN ANGELS CARE C	ENTER		Е	LK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	error likely would not voiced they had real company regarding not received a resp proceed or amend a questioned on any splace to help ensur- occur until the softw feedback, they expl- were asked to "kee The DOQ voiced sh order transcription p and balance" to ensi investigation identif overall process. Fut to the medical direct neither him or the fa with the physician g questions on the cla the facility "authored provider. When interviewed w 4:35 p.m. the facility expressed she had medication errors, i started in April 2020 only CP the facility been involved with nurses or SS staff r issues with transcri reviewed R1's med she had noticed R1 discontinued, it wou would have questio history. Further, CP comment on how R	ot have ever happened. DOQ ached out to the software g their findings; however, had oonse from them on how to the identified issue. When stop-gap measures put into e other similar errors did not ware company provided ressed the unit manager staff op an eye on it going forward." he felt the facility had a solid process in place for "check sure order accuracy and their fied there "wasn't a flaw" in the urther, the facility did reach out ctor of the campus; however, acility had done any follow-up group(s), despite some arity of the provider order, as d" the order and not the via telephone on 7/29/20, at y' consulting pharmacist (CP) not been updated on any including R1's error, since she 0, and verified she was the used. CP stated she had not any education processes for regarding medication orders or ption/order processing. CP ical record and expressed if I's aspirin had been uld have been something she oned given R1's medical P voiced she was unable to R1's aspirin omission could o her subsequent stroke;	F 7	760			

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		I AND HUMAN SERVICES					FORM	08/24/2020 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		СОМ	E SURVEY PLETED C
		245012	B. WING					30/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP (	CODE		
GUARDI	AN ANGELS CARE C	ENTER			00 EVANS AVENUE LK RIVER, MN 55330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 760	regarding allergy or processing. A provided Medicat 6/15, identified the assure medication ongoing basis, and medication-related would be assessed as appropriate to th assurance) commit consulting pharmac procedure was prov received a new me to ensure the order (i.e. dose, route, etc current clinical prace ensure the resident ordered medication A facility policy on co order transcription was ever provided of The IJ which began 7/30/20, at 2:25 p.n implemented a rem completing education electronic health sy transcription, and e clarification. On 7/3 p.m. staff members transcription and al	ion Monitoring policy, dated facility employed a system to usage is evaluated on an when a significant problem is identified, the issue , documented and reported, ie physician, the QA (quality tee, the pharmacy and cist and the FDA, if needed. A vided to follow when a resident dication order which directed ed specifics of the medication c.) are in agreement with stice and guidelines, and thas no listed allergies to the dist of the medication c.) are transcription and allergy was requested, however, none or received.	F 7	760				
F 880 SS=F	Infection Prevention		F٤	80				8/21/20

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		I AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245012	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS CARE CE	ENTER			00 EVANS AVENUE ELK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From page	ge 17	F 8	80			
	infection prevention designed to provide comfortable environ development and tr diseases and infect	tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ransmission of communicable ions.					
	program. The facility must es	n prevention and control tablish an infection prevention n (IPCP) that must include, at owing elements:					
	infections and comr residents, staff, volu individuals providing arrangement based	g, investigating, and controlling municable diseases for all unteers, visitors, and other g services under a contractual l upon the facility assessment ng to §483.70(e) and following					
	procedures for the p but are not limited to (i) A system of surve possible communication infections before the persons in the facilit (ii) When and to wh communicable dise reported; (iii) Standard and tra- to be followed to pre-	eillance designed to identify able diseases or ey can spread to other ty; iom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245012	B. WING			( 07/3	; 30/2020
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	ENTER			00 EVANS AVENUE LK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	<ul> <li>(A) The type and dudepending upon the involved, and</li> <li>(B) A requirement t least restrictive poscircumstances.</li> <li>(V) The circumstance must prohibit emploid disease or infected contact with resider contact with resider contact will transmit (vi)The hand hygier by staff involved in the staff perform the prevention and COVID-19. This had a staff perform the staff performs th</li></ul>	aration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility by ees with a communicable skin lesions from direct the disease; and he procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the aken by the facility. Adle, store, process, and as to prevent the spread of eview. duct an annual review of its heir program, as necessary. NT is not met as evidenced ion, interview, and document illed to ensure all staff entering in actively screened (other hed the screening process) for potential transmission of d the potential to affect all 103 in the facility at the time of the	Fδ	380	F880 Guardian Angels Care Center strive adhere to all infection control standa accordance with state and federal regulations and current standards of practice. All residents have the potential to b impacted by not actively screening entering the facility. Staff at screening desk have been	ards in of e	

Event ID:9E4B11

Facility ID: 00611

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TATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245012	B. WING			C 30/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	011	50/2020
	AN ANGELS CARE C	ENTER		400 EVANS AVENUE ELK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 880	On 7/27/20, at 1:00 unidentified screen- to use an infrared th own temperatures a survey team obtain directed, gave the s COVID-19 screenir were directed to wa screener failed to v and did not review to before placing them table. On 7/28/20, at 7:30 facility and filled out The unidentified sc screening table bet take your own temp sheet." The screen sheet and without r questions or the ter screening form in a With interview on 7 aide (DA)-A stated facility at 5:45 a.m. not a COVID-19 sc screening table; thu temperature and fill had been on the screen further into the facili screener at the ent weeks" ago that had temperatures and 0	<ul> <li>p.m. the COVID-19</li> <li>er instructed the survey team hermometer to obtain their after entering the facility. The ed their own temperatures as screener their completed ng questionnaire form, and ait for the administrator. The erbalize any other instructions the COVID-19 screening forms in face down on the screening</li> <li>a.m. surveyor entered the ta COVID-19 screening form. reener who sat at the nind a clear divider stated "you berature and write it on the er then took the screening eviewing the responses to the mperature placed the pile face down.</li> <li>/28/20, at 7:52 a.m., dietary they had initially entered the on 7/28/20 in which there was reener present at the entrance us, DA-A had taken their own led out the screening log that reening log they would not enter ity. There had been a rance prior to about "two d electronically recorded staff COVID-19 screening r, DA-A stated this had</li> </ul>	F 88	<ul> <li>retrained on process and require active screening of staff and all or enter facility.</li> <li>The facility will position a barrier etc.) in the front entry to "funnel" directly to screening area. The b be easily moveable and not creat obstruction that would prevent egan emergency or create a fire ha All staff will be trained on the nee actively screened prior to moving front entry way. Staff will be train must wait until they are actively s prior to entering past front lobby a Staff schedules and screening he been reviewed to ensure coverage screening area.</li> <li>Screening results will be conduct the Administrator and reported to committee.</li> <li>The QAA Committee (subset) ha and discussed RCA factors impast screening concerns and as the rerecommended use of a reminder to funnel staff toward the screening The team is aware that their staff intervention will be responsible for staff and others home if screening process is failed.</li> <li>Correction date: 8/26/2020</li> </ul>	thers that (table, staff arrier will e an ress in zard. d to be beyond ed they creened area. ours have ge at weekly e ted by the QAA s met cting esult has barrier ng table. ermine ning staff sending	

Facility ID: 00611

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	08/24/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) I	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
	245012	B. WING				C 30/2020
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GUARDIAN ANGELS CARE CENTE	R			00 EVANS AVENUE LK RIVER, MN 55330		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	T BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
<ul> <li>employees that were almost COVID-19 screening split information entered into staff or new staff utilized was to take their own ternshowed the screener who reading on the thermominative verbally stated the terns screener without showing the screener without showing During interview on 7/28 housekeeper (HSKP)-A entered the facility at app 7/28/20, in which there with the screener present at the of thus, HSKP-A had taken and filled out the screening table. HSF "sometimes someone is not." There had been a screening table prior to "to 2 weeks" ago.</li> <li>When interviewed on 7/2 HSKP-B voiced when the 7/28/20 they had taken the with the infrared thermore thermometer reading to present at the screening table prior to screening table the more thermometer reading to the screening table the screening table thermore thermometer reading to the screening table thermore thermometer reading to present at the screening table prior to screening table thermore thermometer reading to present at the screening table thermore thermometer reading to present at the screening table thermore thermometer reading to present at the screening table thermore thermometer reading to present at the screening table thermore thermo</li></ul>	<ul> <li>/28/20, at 7:52 a.m. two the facility and took their screening table. They berature reading to the</li> <li>28/20, at 7:56 a.m. Inistrator (TMA)-A voiced eady on the Excel readsheet had their it; visitors, vendors, pool I a paper form. Everyone mperature; some staff nat the temperature eter was but usually they emperature to the fig the reading.</li> <li>6/20, at 8:37 a.m., stated they had initially proximately 5:00 a.m. on was not a COVID-19 entrance screening table; in their own temperature ing log that had been on KP-A explained there and sometimes screener at the entrance 'probably week and a half</li> <li>28/20, at 8:41 a.m. ey had arrived to work on their own temperature meter; showed the the screener that was</li> </ul>	F8	880			

Facility ID: 00611

If continuation sheet Page 21 of 25

		HAND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245012	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GUARDI	AN ANGELS CARE C	ENTER			00 EVANS AVENUE LK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	Continued From pa screening station.	ige 21	F 8	80			
	During interview on assistant (NA)-A sta the facility at approx in which there had us screener present at thus, NA-A had take filled out the screen screening table. NA- couple weeks" in witheir own temperatus screening log. NA-A dietary" had informed start doing the screen NA-A denied they himember's self screate the administrator or When interviewed of stated after entering their shift they were to answer COVID-1 take their own temp showed the thermo or just verbally state temperature reading On 7/28/20, at 9:38 interviewed after the own temperature and screening log at the prior to the start of the were not in the areates stated they have table filled out the screen	a 7/28/20, at 8:44 a.m. nursing ated they had initially entered ximately 5:10 a.m. on 7/28/20, not been a COVID-19 t the entrance screening table; en their own temperature and hing log that had been on the A-A voiced "it has been a hich they have been taking ure and filling out the paper A explained "someone in ed them that they needed to being process themselves. had confirmed the dietary staff ening practice instructions with r the director of nursing (DON). on 7/28/20, at 8:48 a.m. RN-F g the facility at the beginning of e to stop at the screening table 19 screening questions and berature; they either then ometer reading to the screener ed to the screener what the g was. B a.m. cook (C)-A was ey were observed to take their nd fill out the COVID-19 e COVID-19 screening station, their shift. Screening station, their shift. Screening station, their shift. Screening station, their own temperature and hing log as "sometimes they times they are not."					
	When interviewed of	on 7/28/20, at 12:47 p.m. the					

If continuation sheet Page 22 of 25

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE CONSTRUCTION	· · ·	TE SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	со	MPLETED
		245012	B. WING		07	C 7/ <b>30/2020</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		130/2020
GUARDI	AN ANGELS CARE C	CENTER		400 EVANS AVENUE ELK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 880	nurse unit manage stated "it is okay to knows what the sy stated when staff h been "good at repo When interviewed DON stated staff w screening complet beginning of their s He explained the s with active screen and shift change; h state exact time fra responsible for sta screening station w designated staff m would either sit at screening station. staff used hand sa temperature as pa to the screener be station screen. Sta thermometer readi answer the screen screening station staff, such as the r "the non-peak time completed their se DON voiced, "Nob without a reception	age 22 er/registered nurse (RN)-D o self-screen" and "everyone imptoms are." RN-D further had been symptomatic they had orting it and going home." on 7/30/20, at 11:30 a.m., the vere expected to have active red two times a day; at the shift and "about 4 hours later." coreening station was staffed ers at 5:45 a.m. "busier times" however, he was unable to ames. The receptionist was ff screening when the was not staffed with another rember; where the receptionist the receptionist desk or the The DON further explained unitizer and then took their own rt of the screening process due ing behind the screening aff were expected to show the ing to the screener and would ing questions verbally. The cord the answers and onically. The paper screening g station was for screening receptionist, to fill out during es of the day" and when staff cond screening mid shift. The ody walks in the building hist or screener there." "Self not have happened, it is not a	F 8	80		

If continuation sheet Page 23 of 25

		I AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245012	B. WING				C 30/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	ENTER			400 EVANS AVENUE ELK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	log into the electron Additionally, the DC of resident COVID- 6/5/20. Follow up te additional residents along with another provided a list of 8 a positive for COVID- 7/27/20. The dedica COVID-19 unit had testing in which the worked the COVID- door that led direct they screened there entrance. During interview on administrator states screening location w times: 5:45 a.m. to "soft time" from 9:0 staff), 2:00 p.m. to 10:15 p.m. to 11:15 screened night staff stated active screen occur at the start of screening staff were another staff to per screening staff were another staff to per screening staff or so and know not to co symptoms." In addi is good about the s what is expected."	<ul> <li>Anic spread sheet.</li> <li>DN stated the first facility case 19 had been confirmed on esting on 7/22/20, confirmed 3 with positive test results, resident on 7/25/20. He staff members who had tested 19 from 7/2/20 through ated staff who worked on the all tested negative with facility DON explained the staff who -19 unit entered through a y to the COVID-19 unit where and not at the main facility</li> <li>7/30/20, at 2:13 p.m. the d the main facility entrance was staffed at the following 9:00 a.m. (station screener), a 0 a.m. to 2:00 p.m. (office 7:00 p.m. (station screener), 5 p.m. (evening supervisor f). The administrator further ning was expected to always the staffs' shift and if e not present, staff were to call form the screening. The ad been staffed with an active s a day; however, "Staff have long they know the process me into work if having tion, he explained, "Everyone creening process and knows The mid-day paper screening ed once the information was</li> </ul>	F8	380			

Facility ID: 00611

If continuation sheet Page 24 of 25

		AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C			
		245012	B. WING				30/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDIAN ANGELS CARE CENTER			400 EVANS AVENUE ELK RIVER, MN 55330				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ige 24	F٤	380			
	Preparedness/Emp indicated "employed arrival to work using regarding travel, red COVID-19 or other themselves have re- temperatures are m greater) at the start allowed to work who The policy failed to employee) was exp employee screening identify the screening who worked on the The MDH Covid-19 Term Care Facilitie facility should "Activa and symptoms of ill shift. In addition to screening for other personnel including home care, dialysis surveyors, chaplain [Active screening m should physically m	Coronavirus/COVID-19 bloyee Illness, dated 5/7/20, es are being screened on g screening questionnaire cently being near anyone with respiratory illness or if they espiratory illness. All employee nonitored for fever (100.0 or of their shift. Staff will not o do not pass the screening." identify who (self or other bected to conduct the gs and the location of gs. The policy also failed to ng process required for staff designated COVID-19 unit. • Toolkit- Information for Long s dated 6/5/20, identified the vely screen all staff for fever lness before starting each facility staff, conduct health essential health care g therapy personnel, hospice, a ombudsman, state a t end of life, mortician, etc. neans that a trained person nonitor temperature of staff g and ask questions regarding ad symptoms.]"					

Facility ID: 00611

If continuation sheet Page 25 of 25



Electronically delivered August 14, 2020

Administrator Guardian Angels Care Center 400 Evans Avenue Elk River, MN 55330

Re: State Nursing Home Licensing Orders Event ID: 9E4B11

Dear Administrator:

The above facility was surveyed on July 27, 2020 through July 30, 2020 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 <u>only a suggestion</u> 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 <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>. 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.

Guardian Angels Care Center August 14, 2020 Page 2 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:

Susie Haben, Unit Supervisor St. Cloud A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 3333 West Division Street, Suite 212 St. Cloud, Minnesota 56301 Email: susie.haben@state.mn.us Phone: 320-223-7356

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us

Minnesc	<u>ota Department of He</u>	ealth				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED
					c c	
		00611	B. WING			0/2020
	PROVIDER OR SUPPLIER	STREET AF		STATE, ZIP CODE		
	I NOVIDEIN OIN OUT I EIEIN		NS AVENUE			
GUARDI	AN ANGELS CARE C	ENTER	ER, MN 5533	0		
			-	PROVIDER'S PLAN OF CORRECTI		()(5)
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
		CORRECTION ORDER				
		CONNECTION ORDER				
	In accordance with	Minnesota Statute, section				
		ction order has been issued				
		y. If, upon reinspection, it is				
		iency or deficiencies cited				
		ected, a fine for each violation				
	not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of					
	the Minnesota Dep					
	Determination of whether a violation has been					
	corrected requires	compliance with all e rule provided at the tag				
		le number indicated below.				
		ns several items, failure to				
		the items will be considered				
		Lack of compliance upon				
		iny item of multi-part rule will				
		ment of a fine even if the item				
	corrected.	uring the initial inspection was				
	concoled.					
	You may request a	hearing on any assessments				
	that may result fron	n non-compliance with these				
		at a written request is made to				
		hin 15 days of receipt of a				
	notice of assessme	ent for non-compliance.				
	INITIAL COMMEN	TS:				
		20, a survey was conducted				
	by surveyors from t	he Minnesota Department of				
		termine compliance for state				
	licensure in conjuct					
	H5012038C, H5012	H5012036C, H5012037C,				
		20030.				
linnocata D	anartmant of Llasth					
	epartment of Health Y DIRECTOR'S OR PROVII	DER/SUPPLIER REPRESENTATIVE'S SIG	SNATURE	TITLE	(	(X6) DATE

Electronically Signed

If continuation sheet 1 of 23

### PRINTED: 08/24/2020 FORM APPROVED

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1)         PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00611			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		DENTITION TONIDER.	A. BUILDING:		C	
		B. WING			07/30/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
UARDI	AN ANGELS CARE C	FNTFR	NS AVENUE			
			ER, MN 55330			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	FION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	issued. Please indi correction that you and identify the dat Minnesota Departn the State Licensing federal software. To assigned to Minnes Nursing Homes. Th appears in the far lo Tag." The state stat listed in the "Summ column and replace the correction orde the findings which a statute after the stat as evidence by." For	owing correction orders are cate your electronic plan of have reviewed these order, we when they will be corrected. In the of Health is documenting of Correction Orders using ag numbers have been sota state statutes/rules for ne assigned tag number eft column entitled " ID Prefix atute/rule out of compliance is hary Statement of Deficiencies es the "To Comply" portion of r. This column also includes are in violation of the state atement, "This Rule is not met pollowing the surveyors findings Method of Correction and rrection.				
	receipt of State lice the Minnesota Dep Informational Buller http://www.health.s obul.htm The State delineated on the a Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must ther State licensure pro completion date, th corrected prior to e Minnesota Department PLEASE DISREGA	tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are ittached Minnesota lith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for n indicate in the electronic cess, under the heading le date your orders will be lectronically submitting to the nent of Health.				
	FOURTH COLUMN	N WHICH STATES,				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3	) DATE SURVEY COMPLETED
		00611	B. WING		C 07/30/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
GUARDI	AN ANGELS CARE CI	ENTER	NS AVENUE ER, MN 5533	30	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	"PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREMI CORRECTION FO	ge 2 IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF IE STATUTES/RULES.	2 000		
21375	MN Rule 4658.0800 Program Subpart 1. Infectio home must establis	D Subp. 1 Infection Control; on control program. A nursing sh and maintain an infection signed to provide a safe and	21375		8/21/20
	This MN Requireme by: Based on observati review the facility fa the facility had beer facility staff perform the prevention and COVID-19. This had	ent is not met as evidenced on, interview, and document niled to ensure all staff entering n actively screened (other ned the screening process) for potential transmission of d the potential to affect all 103 n the facility at the time of the		Corrected 8/26/2020.	
	Findings include:				
	unidentified screene to use an infrared th own temperatures a survey team obtaine directed, gave the s COVID-19 screenin were directed to wa screener failed to ve	p.m. the COVID-19 er instructed the survey team hermometer to obtain their after entering the facility. The ed their own temperatures as screener their completed ag questionnaire form, and hit for the administrator. The erbalize any other instructions the COVID-19 screening forms			

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00611	B. WING		07/	30/2020
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	ENTER	NS AVENUE ER, MN 55330	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From page 3		21375			
	before placing then table.	n face down on the screening				
	facility and filled ou The unidentified sc screening table bet take your own temp sheet." The screen sheet and without r questions or the ter screening form in a With interview on 7 aide (DA)-A stated facility at 5:45 a.m. not a COVID-19 sc screening table; thu temperature and fill had been on the screen further into the facil screener at the ent weeks" ago that ha temperatures and C questions; however stopped for unknow	/28/20, at 7:52 a.m., dietary they had initially entered the on 7/28/20 in which there was reener present at the entrance us, DA-A had taken their own led out the screening log that reening table. DA-A explained ed that if a staff member wrote ening log they would not enter ity. There had been a rance prior to about "two d electronically recorded staff COVID-19 screening r, DA-A stated this had wn reasons.				
	employees walked own temperature at	on 7/28/20, at 7:52 a.m. two into the facility and took their t the screening table. They temperature reading to the				
	trained medication employees that we COVID-19 screenir	on 7/28/20, at 7:56 a.m. administrator (TMA)-A voiced re already on the Excel ng spreadsheet had their I into it; visitors, vendors, pool				

STATEMEN	ta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/30/2020	
		00611	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	FNTFR	NS AVENUE ER, MN 55330	I		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21375	was to take their ov showed the screen reading on the ther just verbally stated screener without sh During interview on housekeeper (HSK entered the facility 7/28/20, in which the screener present at thus, HSKP-A had and filled out the sc the screening table "sometimes someo not." There had bee screening table priot to 2 weeks" ago. When interviewed of HSKP-B voiced wh 7/28/20 they had ta	ilized a paper form. Everyone wn temperature; some staff er what the temperature mometer was but usually they the temperature to the				
	thermometer readir present at the scree their own temperati	ng to the screener that was ening station and recorded ure and screening answers on had been located at the				
	assistant (NA)-A sta the facility at appro- in which there had screener present a thus, NA-A had tak	7/28/20, at 8:44 a.m. nursing ated they had initially entered ximately 5:10 a.m. on 7/28/20, not been a COVID-19 t the entrance screening table; en their own temperature and ning log that had been on the				
	screening table. NA couple weeks" in w	A-A voiced "it has been a hich they have been taking ure and filling out the paper				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00611	B. WING		07/30/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
UARDI	AN ANGELS CARE C	FNTER	NS AVENUE ER, MN 55330	)		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC <sup>\</sup>	HE APPROPRIATE	COMPLET DATE
21375	Continued From pa	age 5	21375			
	dietary" had inform start doing the scre NA-A denied they h member's self scre the administrator o When interviewed stated after enterin their shift they were to answer COVID- take their own tem showed the thermo	A explained "someone in led them that they needed to beening process themselves. had confirmed the dietary staff eening practice instructions with or the director of nursing (DON) on 7/28/20, at 8:48 a.m. RN-F ing the facility at the beginning of e to stop at the screening table 19 screening questions and perature; they either then ometer reading to the screener ted to the screener what the ing was.	f			
	interviewed after th own temperature a screening log at the prior to the start of were not in the start of were not in the are stated they have ta filled out the screen are here and some	3 a.m. cook (C)-A was ney were observed to take their and fill out the COVID-19 e COVID-19 screening station, their shift. Screening station. C-A aken their own temperature and ning log as "sometimes they etimes they are not." on 7/28/20, at 12:47 p.m. the				
	nurse unit manage stated "it is okay to knows what the syn stated when staff h been "good at repo	on 7/30/20, at 11:30 a.m., the				
	DON stated staff w screening complete beginning of their s He explained the s	vere expected to have active ed two times a day; at the shift and "about 4 hours later." creening station was staffed ers at 5:45 a.m. "busier times"				

		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:				
		00611	B. WING	B. WING		C 07/30/2020	
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
	ROVIDER OR SUFFLIER		NS AVENUE	TATE, ZIF CODE			
UARDI	AN ANGELS CARE C	:FNTER	ER, MN 55330	)			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE	
21375	Continued From pa	age 6	21375				
	and shift change; however, he was unable to state exact time frames. The receptionist was						
		ff screening when the					
	screening station v	vas not staffed with another					
		ember; where the receptionist					
		he receptionist desk or the The DON further explained					
		nitizer and then took their own					
		rt of the screening process due	9				
		ing behind the screening					
		ff were expected to show the ng to the screener and would					
		ing questions verbally. The					
	screener would red	cord the answers and					
		onically. The paper screening					
		g station was for screening eceptionist, to fill out during					
		es of the day" and when staff					
		cond screening mid shift. The					
	DON voiced, "Nob	ody walks in the building					
		ist or screener there." "Self					
		not have happened, it is not a					
		er, he further voiced there no one is up there [at the					
		nd "someone will come back					
		ne information on the screening	3				
	log into the electro	nic spread sheet.					
	Additionally, the D	ON stated the first facility case					
		-19 had been confirmed on					
		esting on 7/22/20, confirmed 3					
		s with positive test results, resident on 7/25/20. He					
		staff members who had tested	1 I				
		-19 from 7/2/20 through					
	7/27/20. The dedic	ated staff who worked on the					
		all tested negative with facility	/				
		e DON explained the staff who					
	worked the OOM	-19 unit entered through a					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		00611	B. WING			C 07/30/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	ENTER	NS AVENUE ER, MN 55330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 7	21375			
	they screened there entrance.	e and not at the main facility				
	screening location v times: 5:45 a.m. to "soft time" from 9:0 staff), 2:00 p.m. to 10:15 p.m. to 11:15 screened night staf stated active screen occur at the start of screening staff were another staff to per screening station has screener 19.5 hours been doing it for so and know not to con symptoms." In addi is good about the s what is expected." forms were discard entered into the ele spreadsheet.	d the main facility entrance was staffed at the following 9:00 a.m. (station screener), a 0 a.m. to 2:00 p.m. (office 7:00 p.m. (station screener), 5 p.m. (evening supervisor f). The administrator further ning was expected to always f the staffs' shift and if e not present, staff were to cal form the screening. The ad been staffed with an active s a day; however, "Staff have long they know the process me into work if having tion, he explained, "Everyone creening process and knows The mid-day paper screening ed once the information was ictronic screening				
	Preparedness/Emp indicated "employed arrival to work using regarding travel, red COVID-19 or other	bloyee Illness, dated 5/7/20, es are being screened on g screening questionnaire cently being near anyone with respiratory illness or if they				
	temperatures are m greater) at the start allowed to work wh The policy failed to	espiratory illness. All employee nonitored for fever (100.0 or of their shift. Staff will not o do not pass the screening." identify who (self or other pected to conduct the				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		00611	B. WING		07/	07/30/2020	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
GUARDI	AN ANGELS CARE C	ENTER	NS AVENUE ER, MN 55330	I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21375		ge 8 ng process required for staff designated COVID-19 unit.	21375				
	Term Care Facilitie facility should "Activ and symptoms of ill shift. In addition to screening for other personnel including home care, dialysis surveyors, chaplain [Active screening m should physically m	Toolkit- Information for Long s dated 6/5/20, identified the vely screen all staff for fever lness before starting each facility staff, conduct health essential health care therapy personnel, hospice, a ombudsman, state a t end of life, mortician, etc. heans that a trained person ionitor temperature of staff g and ask questions regarding d symptoms.]"					
	director of nursing ( inservice staff rega screening requirem ongoing compliance	THOD OF CORRECTION: The (DON), or designee, could rding active COVID-19 ents; then audit to ensure e. R CORRECTION: Twenty-one					
21545		0 A.B.C Medication Errors	21545			8/21/20	
	percent as describe Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long incorporated by refe purposes of this pa	on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of as Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was	•				

9E4B11

If continuation sheet 9 of 23

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMI	E SURVEY PLETED
		00611	B. WING		07/30/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	ENTER	NS AVENUE ER, MN 5533(	0		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLET DATE
21545	Continued From pa	age 9	21545			
	<ul> <li>(2) the adminimedications.</li> <li>B. It is free of a error. A significant (1) an error discomfort or jeopa safety; or</li> <li>(2) medicati requires the medic be titrated to a spemedication error correct toxicity. All medicati prescribed. An inderror report must be that occurs. Any significant resident or the resident reactions or physician or the phrescribed. An increport must be filed occurs. Any significant reactions of physician or the phresident or the resident reactions of the phresident or the resident reactions of physician or the phresident or the resident reactions of physician or the phresident or the resident or the residen</li></ul>	sidents in the nursing home; or stration of expired any significant medication medication error is: which causes the resident ardizes the resident's health or on from a category that usually ation in the resident's blood to cific blood level and a single buld alter that level and urrence of symptoms or tions are administered as cident report or medication error ignificant medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record. ons are administered as ident report or medication error d for any medication error that cant medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record. ent medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation he resident's clinical record.		Corrocted 8/26/2020		
	Based on interview facility failed to ens blood clotting was	and document review, the sure medication to prevent administered in accordance ers for 1 of 1 residents (R1)		Corrected 8/26/2020		

STATE FORM

9E4B11

If continuation sheet 10 of 23

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00611		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/30/2020		
	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		400 EVA	NS AVENUE				
GUARDI	AN ANGELS CARE C	ENTER	ER, MN 55330	)			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21545	Continued From pa	ge 10	21545				
	ordered aspirin was significant medicati resulted in an imme for R1 when the fac systemic action(s) t factors which contri- potential for similar subsequent medica The IJ began on 5/0 for a daily dosing of anti-inflammatory m blood clots from for inadvertently discor receiving the ordere 5/29/20. On 5/29/20 and left-sided weak Emergency Departs hospitalized for stro the error and discor contributed to the e electronic medical n failed to address th and/or education to ensure similar error residents at risk of administrator and d notified of the IJ for The IJ was remove implemented a rem non-compliance rer actual harm that is G). Findings include: On 7/28/20, at 1:30 (FM)-A was intervie sustained a medica nursing home wher was not provided to	red a stroke after their s not provided resulting in a on error. These findings ediate jeopardy (IJ) situation cility failed to take adequate, to educate staff to potential ibuted to the error causing the reoccurrences and further ation errors. 6/20, when physician orders f aspirin (non-steroidal nedication which helps prevent ming in the arteries) were nationed resulting in R1 not ed medication from 5/7/20 to 0, R1 developed facial droop cness; was transferred to the ment (ED) and subsequently oke. The facility investigated vered factor(s) which error, including potential record (EMR) issues, and e factors with a systemic fix o staff whom process orders to rs did not reoccur and placed harm or injury. The facility lirector of nursing (DON) were R1 on 7/29/20, at 2:16 p.m. d on 7/30/20, when the facility ioval plan; however, mained at an isolated scope of not immediate jeopardy (Level p.m. R1's family member ewed. FM-A explained R1 had ation error while residing at the n her physician ordered aspirin o her and she subsequently FM-A explained the nursing					

9E4B11

If continuation sheet 11 of 23

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00044	B. WING		С	
		00611			07/	30/2020
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	ENTER	NS AVENUE ER, MN 55330	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIESID(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXREGULATORY OR LSC IDENTIFYING INFORMATION)TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
21545	Continued From pa	age 11	21545			
	home had followed and they voiced R1 accidentally discon listed aspirin allerg actually ordered. T weeks of aspirin do the error contribute and since the strok on her own and ne basic cares. Furthe about the situation think there was "ob nursing home with R1's admission Mir 4/28/20, identified I required extensive daily living (ADLs). neurological diagna aphasia, hemiplegi anticoagulation me during the review p R1's post-hospitaliz dated 4/22/20, iden discharged to the r hospitalized due to hematoma. R1's ho being complicated dictation directed to (an anticoagulant r The report identifie regarding continua risk." R1's dischar home were listed w [milligrams] 1 tal meal," along with a dictation reading, " dose of aspirin 12/ A Physician's Telep	I up with him about the error; I's ordered aspirin had been tinued instead of just R1's y, which is what had been his caused R1 to miss several osing. FM-A voiced he believed ad to R1 suffering the stroke; ie, R1 is no longer able to live eds more help to complete er, FM-A expressed frustration and voiced the error made him oviously a problem" at the their order processing. himum Data Set (MDS), dated R1 had intact cognition and assistance with activities of Further, R1 had no oses recorded (i.e. stroke, a) and received edication(s) only on one (1) day period. zation After Discharge Orders, htified R1 was being hursing home after being a fall and fracture with a ospitalization was listed as due to atrial fibrillation, and o hold R1's warfarin sodium medication) for a set period. d, "May need discussion tion of [warfarin] given high fall ge medications to the nursing which included, "aspirin 81 mg blet by mouth once daily with a l listed allergy to aspirin with *patient tolerating daily 14/16." ohone Orders, dated 5/4/20, for R1 which read, "Start				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C 07/30/2020	
		00611	B. WING			
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BUARDI	AN ANGELS CARE C	ENTER	IS AVENUE R, MN 55330	)		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21545	Continued From pa	age 12	21545			
	Afib [atrial fibrillatio which causes rapid A subsequent Phys dated 5/6/20, identi to DC [discontinue] order was provided The order was sign including station set However, a Discon 5/6/20, identified lid discontinued R1's of with dictation preset R1's Medication Act dated 5/1/20 to 5/3 medications while a provided aspirin 81 5/4/20 and 5/5/20. started 5/6/20, was provide aspirin 325 for atrial fibrillation. on 5/6/20; however discontinue date of aspirin were provid MAR. R1's progress note a.m. which recorde orientated and nee with her walker. A progress note on SBAR (Situation, E Recommendations recorded as having weakness and left- the restroom. The re saying, "I don't kno physician (MD)-A w	n 5/6/2020. Dx: [diagnosis] n; an abnormal heath rhythm d, irregular beating]." sician's Telephone Orders, ified an order which read, "OK [ aspirin alergy [sic]." The d by the nurse practitioner (NP). hed by various staff members, ecretary (SS)-B. tinue Order report, dated censed practical nurse (LPN)-A ordered aspirin 325 mg QD ent, "Per NP directive". dministration Record (MAR), 1/20, identified R1's provided at the nursing home. R1 was mg on 5/1/20, 5/2/20, 5/3/20, Further, an additional order, dentified which directed to f mg by mouth one time a day A single dose was provided r, the order then listed a 5/6/20. No further doses of ed to R1 according to the f, recorded on 5/29/20, at 10:41 ed R1 as being alert and ding only assistance of one f 5/29/20, at 2:37 p.m. listed an Background, Assessment and h note was completed. R1 was g developed left-sided sided facial droop while using nurse was unable to obtain a n R1, and R1 was recorded as w what is happening." R1's vas contacted and R1 was sent for evaluation via ambulance.				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/30/2020	
		00611	B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	FNTER	NS AVENUE ER, MN 55330	)		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLE <sup>-</sup> DATE
21545	Continued From pa	age 13	21545			
	with a chief complative condition," with of ability to underst left-sided weakness. The report identifies warfarin due to have 4/18/20, and she weakness. The report identifies warfarin due to have 4/18/20, and she weakness and left. "Plisted all of R1's meadministered by the list lacked any physic report continued are allergy to aspirin we myalgia; however, read, "*patient toler 12/14/16." Further, problems with subsee ach one. This incluses and left was admitted to the R1's Hospital Disclidentified R1 was compared by the listed as having atriangles of right for the nursing diagnosis of right for the nursing diagnosis of right for the nursing diagnosis of fall with and feels she should time and to use AS	29/20, identified R1 presented aint of weakness. R1 was a poor historian upon ED, " due to the acuity of a slurred speech, aphasia (loss tand or express speech) and s being recorded as present. d R1 had been taken off her ving sustained multiple falls on vas given TPA (thrombolytic blood clots) in the ED. A readmission Medications," edications which were being e nursing home; however, the sician orders for aspirin. The nd listed R1 as having an ith a reaction of rash and dictation was present which rating daily doses of aspirin the report listed R1's medical sequent plan(s) to address luded, "Acute stroke," which g caused by ischemia supply) and left-sided facial droop were present. R1 e hospital. harge Summary, dated 6/1/20, discharged from the hospital g home with a principal rontal stroke with residual facia ria (slurred speech). R1 was rial fibrillation and dictation ] had been stopped recently n injury. Neurology consulted ild remain off [warfarin] at this GA [aspirin]." Further, a series cations were listed which				
	included new order Take 1 tablet by m	rs for, "aspirin 325 mg tablet outh once daily with a meal." ad allergies on the report				

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00611	B. WING			C 30/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	ENTER	NS AVENUE ER, MN 55330	)		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	HE APPROPRIATE	COMPLET DATE
21545	Continued From pa	age 14	21545			
	present which read doses of aspirin 12 On 6/1/20, a progre re-admitted to the r hospital. The note of readmission due to left sided facial dro R1 was now listed a all transfers using a A completed State investigation, dated completed investigation, dated completed investigation, dated completed investigation admitted to the nur- record identified R1 however, the provid bleeding so it was p orders were receive aspirin dosing from on 5/6/20. On the s was identified and a discontinue the aller to the station secre- the listed allergy and to confirm. However medical system (Pot the nurse to confirm resulting in the nurse the aspirin dose ord report outlined R1 to of condition and su 5/29/20, and listed, functional decline d report listed section to prevent reoccurr and other residents education was prov- committed the erro what actions had b	ess note identified R1 was nursing home from the putlined, "Resident is a a recent stroke. Resident has oping and weakness." Further, as needing assist of two with				

Iinnesota Department of He FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00611	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/30/2020	
AME OF PROVIDER OR SUPPLIER		DDRESS, CITY, S <sup>-</sup> <b>NS AVENUE</b>	TATE, ZIP CODE		
UARDIAN ANGELS CARE C	FNTER	ER, MN 55330	I		
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE	(X5) COMPLET DATE
			DEFICIENCY	() ()	
21545 Continued From pa	age 15	21545			
actions or evidence the facility to help a identified findings of not allowing nurses removed; nor was completed education the incident regard clarified if they are During interview or registered nurse (F able to view reside system; however, v adjust allergy orde significant medication included the incorre of insulin, warfarin RN-C stated she w process for reportine medication errors a provided any recent transcription and p When interviewed explained the facilii processing. The S electronic health sy completes a secont order is then listed orders are then pa final check. RN-E st to discontinue an a would act on the out they're not a physic	n 7/28/20, at 7:57 a.m. RN)-C stated the nurses were nt allergies in the computer voiced she did not know how to rs. RN-C explained a ion error would be one which ect administration or omission or other "high risk meds." vas not sure on the facility' ng or investigating significant and added she had not been at training or education on orde rocessing. on 7/28/20, at 8:47 a.m. RN-E ty' process for order S enters the orders into the ystem, and the floor nurse then id check for accuracy. The as "active" in the system. The ssed to the night nurse for a stated if they received an order illergy for a resident, they rder and not question it, as cian; however, afterwards up with the provider about the -E stated she had not been	r			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		COM	E SURVEY PLETED C
		00611	B. WING			30/2020
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
UARDI	AN ANGELS CARE C	:FNTFR	NS AVENUE ER, MN 55330	)		
TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)						(X5)
				CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLE <sup>-</sup> DATE
21545	Continued From pa	age 16	21545			
	system; however, \$	SS-A voiced she was				
		ng so. As a result, SS-A stated				
		urse to change the order				
		g it. During subsequent				
		20 at 9:10 a.m., SS-A stated				
	she could not reca	Il receiving any new guidance				
		allergy or order processing				
	within the past sev					
		n 7/28/20, at 9:30 a.m. SS-B				
		aware of any issues or errors				
		onic health system when				
	-	ied or removed. SS-B stated				
		R1 had sustained a				
		lespite being the SS who d the order for R1 on 5/6/20 to				
		pirin allergy) and verified she				
		any re-education or new				
		processing regarding allergies				
		ers since R1's incident.				
		7 a.m. R1's medical doctor				
		ewed and verified she was				
		physician while R1 resided at				
		MD-A explained R1 admitted				
	to the nursing hom	e on 4/22/20, and upon				
		arfarin sodium was on hold as				
		an internal hematoma (type of				
		due to a fall which is why she				
		zed. R1 had several "heart				
		trial fibrillation, carotid artery	<u>.</u>			
		hary artery disease (CAD), all c	1			
		1's risk of stroke; so R1 had				
		a daily dosing of aspirin 81 D-A stated she had numerous				
		1 and her responsible party as				
		bout R1's anticoagulation "in				
		r frequent falls. As a result, a				
		e to start R1 on a full-strength				
		er was provided on 5/4/20 to				
		rin dosing from 81 mg to 325				
		daily basis. MD-A explained a				

STATE FORM

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If continuation sheet 17 of 23

STATEMEN	ta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED C 07/30/2020	
		00611	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	ENTER	NS AVENUE ER, MN 55330	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
	Continued From page 17 situation then arose where they identified R1's medical record had a listed allergy to aspirin; however, it was determined to not be accurate and a separate order was written on 5/6/20 to remove the listed allergy. MD-A verified the order written on 5/6/20 was meant to remove the aspirin allergy; however, not meant to remove the medication administration order. MD-A explained she was aware an error then occurred where the medication itself along with the identified allergy were both discontinued, which resulted in R1 getting little to no dosing of the ordered aspirin through 5/29/20. MD-A expressed on 5/29/20, she had seen R1 for a visit earlier in the day and R1 had no visible signs of distress outside of complaints of knee pain; however, afterwards R1 then developed difficulty speaking and left-sided					
	and diagnosed with she learned R1 had stroke, she reviewe discovered the asp then e-mailed the n concern about the e likely the first time t notified an error had if R1 had been prov	subsequently sent to the ED a a stroke. MD-A stated when d been hospitalized for a ed her medication list and irin was not being given. MD-A bursing home and expressed error which MD-A voiced was the nursing home had been d happened. MD-A explained vided the ordered aspirin der on 5/4/20 called for, it				
	would have provide against stroke addi risk of stroke to hav reviewed R1's risk omitted aspirin wou "significant" medica expressed regret a were multiple oppo	ed R1 "some protection" ng, "I do think it increased her /e nothing [medication]." MD-A factors and stated she felt the				
	provided and correctit." Further, MD-A s	ct it adding, "None of us saw tated she was not aware of rect request" of the physician				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		00611	B. WING		07/30/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
GUARD	AN ANGELS CARE C	ENTER	NS AVENUE ER, MN 55330	I	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
21545	Continued From pa	ge 18	21545		
	prevent future error surrounding R1's in she was not sure w policies the nursing on since the incider On 7/29/20, at 10:4 and verified he proo which called to disc LPN-A expressed h specifics of the ever entry and subseque acknowledged he w occurred as he had explained the educ merely a telephone directed him to "dou if unsure of them. L no education or furt ensure allergy orde prevent errors or co record system. LPN had an aspirin aller order on 5/6/20; ho recall specifics whic processing as it wa On 7/29/20, at 11:0 director of nursing ( explained R1's unit vacation currently a received notification error involving R1's vulnerable adult (V/ error was reviewed corresponding staff the process used for	vas aware an error had I been educated on it. LPN-A ation the facility provided was discussion which they uble check and clarify" orders .PN-A stated he had received ther instruction on how to rs are processed correctly to onfusion in the electronic V-A voiced he was unaware R <sup>-</sup> gy when he processed the wever, reiterated he could not ch happened with the order s "so long ago." 7 a.m. the administrator and (DON) were interviewed. They manager, whom was on and not available for interview, n on 5/29/20 of a medication aspirin. As a result, a A) report was made and the with the physician and involved. The DON explained or order processing included cks" by the nurses after the			

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00611	B. WING		07/	30/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	FNTFR	NS AVENUE ER, MN 55330	1		
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21545	Continued From pa	ige 19	21545			
	system; however, th "process failed" reg aspirin error. The ir explained the facilit investigation pertain and discovered an record system (Poir readily display when so they notified the "trying to get that fix "bottom line" of the R1's physician order discontinue the asp questioned it" inste- medication versus At 11:15 a.m. the d the interview and ver R1's medication error an accident." R1 ha it was changed to a however, there was R1's record so the written an order to d written order was a secretary whom dis system and the nur behind later on to c transcription." How system does not log discontinued; so thi order and, in error, meant to discontinu allergy was no long not provided any as on 5/29/20, which c contact the unit ma investigation was si revealed those deta	n with their order check he DON acknowledged the parding the incident with R1's interview continued and they by had completed an ning to R1's medication error issue with their electronic ntClickCare) where it did not n allergies were discontinued, software developer and were ked." The DON added the error was the nurse mis-read er on 5/6/20 (directing to birin allergy) and "should have ad of discontinuing the the allergy. irector of quality (DOQ) joined biced the incident pertaining to ror was the "true definition of ad been taken off warfarin and a daily aspirin regimen; is a listed allergy to aspirin on nurse practitioner (NP) had discontinue the allergy. The cted on by the station scontinued the allergy in the se, LPN-A, then followed complete the process and "final ever, the electronic record g or record when an allergy is is caused the nurse to read the the nurse thought the order ue the medication itself as the er listed. R1 subsequently was spirin and sustained a stroke caused R1's physician to nager about the error and an tarted into the incident which ails. DOQ expressed that "in ls" the NP could have				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
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	PROVIDER OR SUPPLIER		DRESS CITY S	TATE, ZIP CODE	07/30/2020		
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GUARDI	AN ANGELS CARE C	FNTFR	ER, MN 55330	)			
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21545	Continued From pa	age 20	21545				
	regret as everyone thought was the rig The interview conti error, DOQ express re-education with the involved with the end LPN-A; however, the re-education for the in the facility who p was a "unique situal require whole-hous stated she felt the fit the incident was re- overall system for a adequate; however system had "failed reiterated had the end shown recently disc error likely would n voiced they had real company regarding not received a resp proceed or amend questioned on any place to help ensur occur until the soft feedback, they exp were asked to "kee The DOQ voiced si order transcription and balance" to en- investigation identifi overall process. For to the medical direct neither him or the fi with the physician g questions on the cli	er to be clearer, and expressed involved was "doing what they that thing." nued, and, as a result of the sed they had completed some he person(s) immediately rror, including the NP and hey had not conducted any e other staff members working rocess orders as R1's error ation" and they felt it didn't se education or alert. DOQ facility' systemic response to viewing and affirming their order transcription was r, DOQ acknowledged the us" with R1's incident and she electronic software system continued allergy orders, the ot have ever happened. DOQ ached out to the software g their findings; however, had bonse from them on how to the identified issue. When stop-gap measures put into re other similar errors did not ware company provided ressed the unit manager staff ep an eye on it going forward." he felt the facility had a solid process in place for "check sure order accuracy and their fied there "wasn't a flaw" in the urther, the facility did reach out ctor of the campus; however, facility had done any follow-up group(s), despite some arity of the provider order, as ad" the order and not the					

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED			
			A. BOILDING.			С			
		00611	B. WING		07/	30/2020			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE					
GUARDIAN ANGELS CARE CENTER     400 EVANS AVENUE ELK RIVER, MN 55330									
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21545	Continued From pa	age 21	21545						
	4:35 p.m. the facilit expressed she had medication errors, started in April 202 only CP the facility been involved with nurses or SS staff issues with transcri reviewed R1's med she had noticed R1 discontinued, it wor would have question history. Further, CF comment on how F have contributed to however, verified s conversations or comment	via telephone on 7/29/20, at y' consulting pharmacist (CP) not been updated on any including R1's error, since she 0, and verified she was the used. CP stated she had not any education processes for regarding medication orders or iption/order processing. CP lical record and expressed if I's aspirin had been uld have been something she oned given R1's medical P voiced she was unable to R1's aspirin omission could o her subsequent stroke; he had not had any onsultation from the facility rder transcription and							
	6/15, identified the assure medication ongoing basis, and medication-related would be assessed as appropriate to th assurance) commit consulting pharmad procedure was pro received a new me to ensure the order (i.e. dose, route, et current clinical prace ensure the residen ordered medication A facility policy on o	problem is identified, the issue I, documented and reported, he physician, the QA (quality ttee, the pharmacy and cist and the FDA, if needed. A vided to follow when a resident dication order which directed red specifics of the medication c.) are in agreement with ctice and guidelines, and t has no listed allergies to the	t						

Innesota Department of He TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
IND FLAN OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
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AME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
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	ELK RIV	ER, MN 55330			(1-1-1)
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21545 Continued From pa	ige 22	21545			
7/30/20, at 2:25 p.n implemented a rem completing educative electronic health sy transcription, and e clarification. On 7/3 p.m. staff members transcription and al interviewed and ver provided. SUGGESTED MET director of nursing, applicable policies a orders are transcrib correctly; then insel compliance.	n on 5/6/20, was removed on n. when the facility hoval plan which included on to staff regarding the vstem and allergy order aducation regarding order 30/20, from 1:10 p.m. to 2:18 is involved with order lergy order processing were rified education had been THOD OF CORRECTION: The or designee, could review and procedures to ensure bed and implemented rvice staff and audit to ensure R CORRECTION: Twenty-one				