DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 07/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE ELK RIVER, MN 55330**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/27/20 to 7/30/20, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct complaint investigation(s). Guardian Angels Care Center was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. In addition, a COVID-19 Focused Infection Control survey was conducted at the facility by MDH to determine compliance with §483.80 Infection Control. Guardian Angels Care Center was found not to be in compliance with the requirement. The survey resulted in an immediate jeopardy (IJ) at F760 when a resident's ordered aspirin was not administered in accordance with physician orders resulting in a significant medication error. The resident subsequently developed symptoms of a stroke and was hospitalized. The facility completed an investigation into the incident and identified potential contributing factors to the error; however, no systemic actions were taken to educate staff on these factors, which included potential electronic software malfunction and human error, resulting in the potential for additional medication errors. The administrator and director of nursing (DON) were notified of the IJ for R1 on 7/29/20, at 2:16 p.m. The IJ was removed on 7/30/20, at 2:25 p.m.; however, non-compliance remained at an isolated scope with actual harm which is not immediate jeopardy (Level G). An extended survey was conducted on 7/30/20.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/21/2020

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F 000	Continued From page 1 The following complaint(s) were found to be substantiated: H5012037C; with a deficiency issued at F760. H5012038C; with a deficiency issued at F760. H5012039C; with a deficiency issued at F760. The following complaint(s) were found unsubstantiated: H5012036C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 730 SS=C	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced	F 730		8/21/20

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F 730	Continued From page 2 by: Based on interview and document review, the facility failed to ensure an annual performance review was conducted for 1 of 3 nursing assistants (NA-C) whose files were reviewed. This had potential to affect all 103 residents residing in the facility during the abbreviated survey. Findings include: During the abbreviated survey, from 7/27/20 to 7/30/20, evidence was requested demonstrating the last completed performance evaluation for several NA(s), including NA-C. A provided Annual Employee Performance Review was reviewed for NA-C. The review was signed as completed on 11/21/17 (over two years prior). No other performance reviews were provided during the abbreviated survey period. On 7/30/20, at 2:35 p.m. the director of nursing (DON) and registered nurse unit managers (RN) -A and RN-B were interviewed and explained the process for NA performance evaluation completion. When an evaluation is due, a message is received from human resources via a "PayCor" system which outlines whom and what review (i.e. 30-Day, 60-Day, Annual) is needed. NA-C had been employed by the nursing home for "a few years," and HR had provided the most recent completed review they had (dated 11/21/17). RN-A and RN-B expressed they were not sure why NA-C's annual performance reviews had been missed since then, and added NA-C continued to work full-time at the nursing home. Further, RN-A voiced it was important to ensure NA performance reviews were completed timely	F 730	F730 Guardian Angels Care Center strives to adhere to Nurse Assistant, Registered performance reviews and In-service education requirements. Recent performance review for NA-C has been completed. Performance reviews will be completed for all Nursing Assistant, Registered that are employed greater than 90 days. PA's will be completed by 8/26/2020. Training/inservice needs will be compiled based on performance review as well employee feedback to determine any necessary changes or additions in annual education programs. The Administrator will be provided list of pending NAR performance reviews (by Human Resources) and will follow up with the Director of Nursing and the Nurse Unit Managers for ongoing completion. QAA Committee (subset) has met and discussed RCA factors impacting performance reviews including recent time commitments necessitated by Covid-19. The QAA Committee understands the significance of performance reviews and the need to develop a stronger check and balance system for completion. Any overdue NAR performance reviews (> 2 WEEKS OVERDUE) will be reported by the Administrator at QAA Committee meetings. Correction date: 8/26/2020	

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F 730	Continued From page 3 to "make sure they're [NA] competent" and "meeting expectations" in their job duties. A provided Performance Reviews policy, dated 5/2017, identified reviews were done to summarize an employee's performance and other work-related factors. The policy directed, "Reviews will be done on an annual basis on or near the employee's employment anniversary date," and, " ... will be completed by an employee's direct supervisor and/or department head."	F 730		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication to prevent blood clotting was administered in accordance with physician orders for 1 of 1 residents (R1) reviewed who suffered a stroke after their ordered aspirin was not provided resulting in a significant medication error. These findings resulted in an immediate jeopardy (IJ) situation for R1 when the facility failed to take adequate, systemic action(s) to educate staff to potential factors which contributed to the error causing the potential for similar reoccurrences and further subsequent medication errors. The IJ began on 5/6/20, when physician orders for a daily dosing of aspirin (non-steroidal anti-inflammatory medication which helps prevent blood clots from forming in the arteries) were	F 760	F760 Guardian Angels Care Center strives to adhere to practices that ensure residents are free of significant medication errors. Resident (R1) was discharged from the hospital back to the nursing home with a principle diagnosis of right frontal stoke with residual facial droop and dysarthria. R1 was provided rehabilitation services and made improvements and was discharged home on 7/24/2020. Review of medication/allergy orders changes did not yield any other residents were impacted by errors. Staff training has been conducted for all licensed nurses to ensure that orders are written clearly. Licensed nurses and	8/21/20

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F 760	Continued From page 4 inadvertently discontinued resulting in R1 not receiving the ordered medication from 5/7/20 to 5/29/20. On 5/29/20, R1 developed facial droop and left-sided weakness; was transferred to the Emergency Department (ED) and subsequently hospitalized for stroke. The facility investigated the error and discovered factor(s) which contributed to the error, including potential electronic medical record (EMR) issues, and failed to address the factors with a systemic fix and/or education to staff whom process orders to ensure similar errors did not reoccur and placed residents at risk of harm or injury. The facility administrator and director of nursing (DON) were notified of the IJ for R1 on 7/29/20, at 2:16 p.m. The IJ was removed on 7/30/20, when the facility implemented a removal plan; however, non-compliance remained at an isolated scope of actual harm that is not immediate jeopardy (Level G). Findings include: On 7/28/20, at 1:30 p.m. R1's family member (FM)-A was interviewed. FM-A explained R1 had sustained a medication error while residing at the nursing home when her physician ordered aspirin was not provided to her and she subsequently suffered a stroke. FM-A explained the nursing home had followed up with him about the error; and they voiced R1's ordered aspirin had been accidentally discontinued instead of just R1's listed aspirin allergy, which is what had been actually ordered. This caused R1 to miss several weeks of aspirin dosing. FM-A voiced he believed the error contributed to R1 suffering the stroke; and since the stroke, R1 is no longer able to live on her own and needs more help to complete basic cares. Further, FM-A expressed frustration	F 760	station secretaries were trained to question any ambiguous orders prior to processing. Medical providers will receive communication regarding the need to provide clarity in all written, verbal and telephone orders. Retraining will be done with the night nurses to review all orders processed the preceding day. Processing will involve reviewing: A) Copies of orders from telephone orders B) Order listing report C) Allergy report (new addition to review process). The order transcription process has been updated to include the requirement for two person check at the time of processing (station secretary and nurse or two nurses). This process will be forced through the EMR. The QAA Committee (subset) has met and discussed RCA factors impacting transcription errors. The QAA Committee identified the reason for the error is isolated, however the electronic system and human error have the potential to make an error. Additional checks will be beneficial. Chart audits will be conducted for accuracy in order transcription. A 10 % audit will be conducted weekly for eight weeks. If no issues are identified the audits will be reduced to 5% for the remainder of the year. Weekly audits will be conducted by Nurse Unit Manager or Director of Nursing. Audit results will be reported at the QAA Committee meeting by the Director of	

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F 760	Continued From page 5 about the situation and voiced the error made him think there was "obviously a problem" at the nursing home with their order processing. R1's admission Minimum Data Set (MDS), dated 4/28/20, identified R1 had intact cognition and required extensive assistance with activities of daily living (ADLs). Further, R1 had no neurological diagnoses recorded (i.e. stroke, aphasia, hemiplegia) and received anticoagulation medication(s) only on one (1) day during the review period. R1's post-hospitalization After Discharge Orders, dated 4/22/20, identified R1 was being discharged to the nursing home after being hospitalized due to a fall and fracture with a hematoma. R1's hospitalization was listed as being complicated due to atrial fibrillation, and dictation directed to hold R1's warfarin sodium (an anticoagulant medication) for a set period. The report identified, "May need discussion regarding continuation of [warfarin] given high fall risk." R1's discharge medications to the nursing home were listed which included, "aspirin 81 mg [milligrams] ... 1 tablet by mouth once daily with a meal," along with a listed allergy to aspirin with dictation reading, " ... *patient tolerating daily dose of aspirin 12/14/16." A Physician's Telephone Orders, dated 5/4/20, identified an order for R1 which read, "Start aspirin 325 mg EC [enteric coated] PO QD [by mouth everyday] on 5/6/2020. Dx: [diagnosis] Afib [atrial fibrillation; an abnormal heath rhythm which causes rapid, irregular beating]." A subsequent Physician's Telephone Orders, dated 5/6/20, identified an order which read, "OK	F 760	Nursing. Correction date: 8/26/2020	

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F 760	Continued From page 6	F 760		

to DC [discontinue] aspirin alergy [sic]." The order was provided by the nurse practitioner (NP). The order was signed by various staff members, including station secretary (SS)-B.

However, a Discontinue Order report, dated 5/6/20, identified licensed practical nurse (LPN)-A discontinued R1's ordered aspirin 325 mg QD with dictation present, "Per NP directive".

R1's Medication Administration Record (MAR), dated 5/1/20 to 5/31/20, identified R1's provided medications while at the nursing home. R1 was provided aspirin 81 mg on 5/1/20, 5/2/20, 5/3/20, 5/4/20 and 5/5/20. Further, an additional order, started 5/6/20, was identified which directed to provide aspirin 325 mg by mouth one time a day for atrial fibrillation. A single dose was provided on 5/6/20; however, the order then listed a discontinue date of 5/6/20. No further doses of aspirin were provided to R1 according to the MAR.

R1's progress note, recorded on 5/29/20, at 10:41 a.m. which recorded R1 as being alert and orientated and needing only assistance of one with her walker.

A progress note on 5/29/20, at 2:37 p.m. listed an SBAR (Situation, Background, Assessment and Recommendations) note was completed. R1 was recorded as having developed left-sided weakness and left-sided facial droop while using the restroom. The nurse was unable to obtain a set of vital signs on R1, and R1 was recorded as saying, "I don't know what is happening." R1's physician (MD)-A was contacted and R1 was sent to the hospital ED for evaluation via ambulance.

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R1's corresponding ED Admission History & Physical, dated 5/29/20, identified R1 presented with a chief complaint of weakness. R1 was recorded as being a poor historian upon presentation to the ED, " ... due to the acuity of her condition," with slurred speech, aphasia (loss of ability to understand or express speech) and left-sided weakness being recorded as present. The report identified R1 had been taken off her warfarin due to having sustained multiple falls on 4/18/20, and she was given TPA (thrombolytic therapy to dissolve blood clots) in the ED. A section labeled, "Preadmission Medications," listed all of R1's medications which were being administered by the nursing home; however, the list lacked any physician orders for aspirin. The report continued and listed R1 as having an allergy to aspirin with a reaction of rash and myalgia; however, dictation was present which read, "*patient tolerating daily doses of aspirin 12/14/16." Further, the report listed R1's medical problems with subsequent plan(s) to address each one. This included, "Acute stroke," which was listed as being caused by ischemia (inadequate blood supply) and left-sided weakness and left facial droop were present. R1 was admitted to the hospital.

R1's Hospital Discharge Summary, dated 6/1/20, identified R1 was discharged from the hospital back to the nursing home with a principal diagnosis of right frontal stroke with residual facial droop and dysarthria (slurred speech). R1 was listed as having atrial fibrillation and dictation read, " ... [warfarin] had been stopped recently because of fall with injury. Neurology consulted and feels she should remain off [warfarin] at this time and to use ASA [aspirin]." Further, a series of discharge medications were listed which

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included new orders for, "aspirin 325 mg tablet ... Take 1 tablet by mouth once daily with a meal." Further, the outlined allergies on the report continued to list aspirin with the same dictation present which read, "*patient tolerating daily doses of aspirin 12/14/16."

On 6/1/20, a progress note identified R1 was re-admitted to the nursing home from the hospital. The note outlined, "Resident is a readmission due to a recent stroke. Resident has left sided facial drooping and weakness." Further, R1 was now listed as needing assist of two with all transfers using a mechanical lift.

A completed State agency (SA) submitted investigation, dated 6/4/20, identified the facility' completed investigation into the incident. R1 admitted to the nursing home on 4/22/20, and the record identified R1 had been on warfarin; however, the provider was concerned for bleeding so it was placed on hold. On 5/4/20, orders were received to increase R1's daily aspirin dosing from 81 mg to 325 mg beginning on 5/6/20. On the same date, R1's aspirin allergy was identified and an order was received to discontinue the allergy. These orders were given to the station secretary to process who removed the listed allergy and gave the orders to the nurse to confirm. However, the facility' electronic medical system (PointClickCare) did not allow for the nurse to confirm allergies had been removed resulting in the nurse inadvertently discontinuing the aspirin dose order instead of the allergy. The report outlined R1 then presented with a change of condition and subsequent thrombotic stroke on 5/29/20, and listed, "[R1] has experienced a functional decline due to the incident ...". The report listed section(s) to describe action(s) taken

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to prevent reoccurrence to the subjected resident and other residents. The facility identified education was provided to the nurse, LPN-A, who committed the error; however, the field to write what actions had been taken to prevent reoccurrence to others was completed with only, "N/a [not applicable]." The report lacked any actions or evidence of a systemic response by the facility to help alert or educate staff to their identified findings of the electronic health system not allowing nurses to confirm allergies are removed; nor was there evidence of any completed education to other staff not involved in the incident regarding ensuring orders are clarified if they are unclear.

During interview on 7/28/20, at 7:57 a.m. registered nurse (RN)-C stated the nurses were able to view resident allergies in the computer system; however, voiced she did not know how to adjust allergy orders. RN-C explained a significant medication error would be one which included the incorrect administration or omission of insulin, warfarin or other "high risk meds." RN-C stated she was not sure on the facility' process for reporting or investigating significant medication errors and added she had not been provided any recent training or education on order transcription and processing.

When interviewed on 7/28/20, at 8:47 a.m. RN-E explained the facility' process for order processing. The SS enters the orders into the electronic health system, and the floor nurse then completes a second check for accuracy. The order is then listed as "active" in the system. The orders are then passed to the night nurse for a final check. RN-E stated if they received an order to discontinue an allergy for a resident, they

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would act on the order and not question it, as they're not a physician; however, afterwards would then follow-up with the provider about the order. Further, RN-E stated she had not been provided any re-education or new guidance on order processing within the past several weeks.

When interviewed on 7/28/20, at 9:20 a.m. SS-A expressed they (SS) had rights and access to change allergies within the electronic health system; however, SS-A voiced she was uncomfortable doing so. As a result, SS-A stated she would ask a nurse to change the order instead of her doing it. During subsequent interview, on 7/29/20 at 9:10 a.m., SS-A stated she could not recall receiving any new guidance or re-education on allergy or order processing within the past several weeks.

During interview on 7/28/20, at 9:30 a.m. SS-B voiced she was unaware of any issues or errors involving the electronic health system when allergies are modified or removed. SS-B stated she was not aware R1 had sustained a medication error (despite being the SS who originally processed the order for R1 on 5/6/20 to discontinue the aspirin allergy) and verified she had not been given any re-education or new guidance on order processing regarding allergies or medication orders since R1's incident.

On 7/29/20, at 9:57 a.m. R1's medical doctor (MD)-A was interviewed and verified she was R1's primary care physician while R1 resided at the nursing home. MD-A explained R1 admitted to the nursing home on 4/22/20, and upon admission, R1's warfarin sodium was on hold as R1 had sustained an internal hematoma (type of internal bleeding) due to a fall which is why she

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had been hospitalized. R1 had several "heart issues" including atrial fibrillation, carotid artery stenosis and coronary artery disease (CAD), all of which increased R1's risk of stroke; so R1 had orders in place for a daily dosing of aspirin 81 milligrams (mg). MD-A stated she had numerous discussions with R1 and her responsible party as she was worried about R1's anticoagulation "in general" due to her frequent falls. As a result, a decision was made to start R1 on a full-strength aspirin and an order was provided on 5/4/20 to increase R1's aspirin dosing from 81 mg to 325 mg provided on a daily basis. MD-A explained a 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 weakness. R1 was subsequently sent to the ED and diagnosed with a stroke. MD-A stated when she learned R1 had been hospitalized for a stroke, she reviewed her medication list and discovered the aspirin was not being given. MD-A then e-mailed the nursing home and expressed concern about the error which MD-A voiced was likely the first time the nursing home had been notified an error had happened. MD-A explained

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if R1 had been provided the ordered aspirin everyday, as the order on 5/4/20 called for, it would have provided R1 "some protection" against stroke adding, "I do think it increased her risk of stroke to have nothing [medication]." MD-A reviewed R1's risk factors and stated she felt the omitted aspirin would be considered a "significant" medication error for R1. MD-A expressed regret about the error and voiced there were multiple opportunities for staff, including herself, to notice the aspirin was not being provided and correct it adding, "None of us saw it." Further, MD-A stated she was not aware of there being "any direct request" of the physician staff to modify any of their procedures to help prevent future errors with circumstances surrounding R1's incident; however, MD-A stated she was not sure what new procedures or policies the nursing staff may have been directed on since the incident to help avoid further errors.

On 7/29/20, at 10:41 a.m. LPN-A was interviewed and verified he processed R1's order from 5/6/20, which called to discontinue R1's aspirin allergy. LPN-A expressed he was unable to recall specifics of the events surrounding the order entry and subsequent error; however, acknowledged he was aware an error had occurred as he had been educated on it. LPN-A explained the education the facility provided was merely a telephone discussion which they directed him to "double check and clarify" orders if unsure of them. LPN-A stated he had received no education or further instruction on how to ensure allergy orders are processed correctly to prevent errors or confusion in the electronic record system. LPN-A voiced he was unaware R1 had an aspirin allergy when he processed the order on 5/6/20; however, reiterated he could not

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recall specifics which happened with the order processing as it was "so long ago."

On 7/29/20, at 11:07 a.m. the administrator and director of nursing (DON) were interviewed. They explained R1's unit manager, whom was on vacation currently and not available for interview, received notification on 5/29/20 of a medication error involving R1's aspirin. As a result, a vulnerable adult (VA) report was made and the error was reviewed with the physician and corresponding staff involved. The DON explained the process used for order processing included multiple "chart checks" by the nurses after the orders are entered into the system by the station secretary staff. They expressed the incident with R1 as being "isolated" and didn't feel there was a widespread concern with their order check system; however, the DON acknowledged the "process failed" regarding the incident with R1's aspirin error. The interview continued and they explained the facility had completed an investigation pertaining to R1's medication error and discovered an issue with their electronic record system (PointClickCare) where it did not readily display when allergies were discontinued, so they notified the software developer and were "trying to get that fixed." The DON added the "bottom line" of the error was the nurse mis-read R1's physician order on 5/6/20 (directing to discontinue the aspirin allergy) and "should have questioned it" instead of discontinuing the medication versus the allergy.

At 11:15 a.m. the director of quality (DOQ) joined the interview and voiced the incident pertaining to R1's medication error was the "true definition of an accident." R1 had been taken off warfarin and it was changed to a daily aspirin regimen;

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however, there was a listed allergy to aspirin on R1's record so the nurse practitioner (NP) had written an order to discontinue the allergy. The written order was acted on by the station secretary whom discontinued the allergy in the system and the nurse, LPN-A, then followed behind later on to complete the process and "final transcription." However, the electronic record system does not log or record when an allergy is discontinued; so this caused the nurse to read the order and, in error, the nurse thought the order meant to discontinue the medication itself as the allergy was no longer listed. R1 subsequently was not provided any aspirin and sustained a stroke on 5/29/20, which caused R1's physician to contact the unit manager about the error and an investigation was started into the incident which revealed those details. DOQ expressed that "in the best of all worlds" the NP could have re-worded the order to be clearer, and expressed regret as everyone involved was "doing what they thought was the right thing."

The interview continued, and, as a result of the error, DOQ expressed they had completed some re-education with the person(s) immediately involved with the error, including the NP and LPN-A; however, they had not conducted any re-education for the other staff members working in the facility who process orders as R1's error was a "unique situation" and they felt it didn't require whole-house education or alert. DOQ stated she felt the facility' systemic response to the incident was reviewing and affirming their overall system for order transcription was adequate; however, DOQ acknowledged the system had "failed us" with R1's incident and she reiterated had the electronic software system shown recently discontinued allergy orders, the

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error likely would not have ever happened. DOQ voiced they had reached out to the software company regarding their findings; however, had not received a response from them on how to proceed or amend the identified issue. When questioned on any stop-gap measures put into place to help ensure other similar errors did not occur until the software company provided feedback, they expressed the unit manager staff were asked to "keep an eye on it going forward." The DOQ voiced she felt the facility had a solid order transcription process in place for "check and balance" to ensure order accuracy and their investigation identified there "wasn't a flaw" in the overall process. Further, the facility did reach out to the medical director of the campus; however, neither him or the facility had done any follow-up with the physician group(s), despite some questions on the clarity of the provider order, as the facility "authored" the order and not the provider.

When interviewed via telephone on 7/29/20, at 4:35 p.m. the facility' consulting pharmacist (CP) expressed she had not been updated on any medication errors, including R1's error, since she started in April 2020, and verified she was the only CP the facility used. CP stated she had not been involved with any education processes for nurses or SS staff regarding medication orders or issues with transcription/order processing. CP reviewed R1's medical record and expressed if she had noticed R1's aspirin had been discontinued, it would have been something she would have questioned given R1's medical history. Further, CP voiced she was unable to comment on how R1's aspirin omission could have contributed to her subsequent stroke; however, verified she had not had any

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F 760	Continued From page 16 conversations or consultation from the facility regarding allergy order transcription and processing. A provided Medication Monitoring policy, dated 6/15, identified the facility employed a system to assure medication usage is evaluated on an ongoing basis, and when a significant medication-related problem is identified, the issue would be assessed, documented and reported, as appropriate to the physician, the QA (quality assurance) committee, the pharmacy and consulting pharmacist and the FDA, if needed. A procedure was provided to follow when a resident received a new medication order which directed to ensure the ordered specifics of the medication (i.e. dose, route, etc.) are in agreement with current clinical practice and guidelines, and ensure the resident has no listed allergies to the ordered medication. A facility policy on order transcription and allergy order transcription was requested, however, none was ever provided or received. The IJ which began on 5/6/20, was removed on 7/30/20, at 2:25 p.m. when the facility implemented a removal plan which included completing education to staff regarding the electronic health system and allergy order transcription, and education regarding order clarification. On 7/30/20, from 1:10 p.m. to 2:18 p.m. staff members involved with order transcription and allergy order processing were interviewed and verified education had been provided.	F 760		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/21/20

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F 880	Continued From page 17 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 18 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure all staff entering the facility had been actively screened (other facility staff performed the screening process) for the prevention and potential transmission of COVID-19. This had the potential to affect all 103 residents residing in the facility at the time of the COVID-19 focused survey. Findings include:	F 880	F880 Guardian Angels Care Center strives to adhere to all infection control standards in accordance with state and federal regulations and current standards of practice. All residents have the potential to be impacted by not actively screening all staff entering the facility. Staff at screening desk have been	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19 On 7/27/20, at 1:00 p.m. the COVID-19 unidentified screener instructed the survey team to use an infrared thermometer to obtain their own temperatures after entering the facility. The survey team obtained their own temperatures as directed, gave the screener their completed COVID-19 screening questionnaire form, and were directed to wait for the administrator. The screener failed to verbalize any other instructions and did not review the COVID-19 screening forms before placing them face down on the screening table. On 7/28/20, at 7:30 a.m. surveyor entered the facility and filled out a COVID-19 screening form. The unidentified screener who sat at the screening table behind a clear divider stated "you take your own temperature and write it on the sheet." The screener then took the screening sheet and without reviewing the responses to the questions or the temperature placed the screening form in a pile face down. With interview on 7/28/20, at 7:52 a.m., dietary aide (DA)-A stated they had initially entered the facility at 5:45 a.m. on 7/28/20 in which there was not a COVID-19 screener present at the entrance screening table; thus, DA-A had taken their own temperature and filled out the screening log that had been on the screening table. DA-A explained it had been assumed that if a staff member wrote a "yes" on the screening log they would not enter further into the facility. There had been a screener at the entrance prior to about "two weeks" ago that had electronically recorded staff temperatures and COVID-19 screening questions; however, DA-A stated this had stopped for unknown reasons.	F 880	retrained on process and requirement for active screening of staff and all others that enter facility. The facility will position a barrier (table, etc.) in the front entry to “funnel” staff directly to screening area. The barrier will be easily moveable and not create an obstruction that would prevent egress in an emergency or create a fire hazard. All staff will be trained on the need to be actively screened prior to moving beyond front entry way. Staff will be trained they must wait until they are actively screened prior to entering past front lobby area. Staff schedules and screening hours have been reviewed to ensure coverage at screening area. Screening results will be audited weekly via review of reports and real time monitoring. Audits will be conducted by the Administrator and reported to the QAA committee. The QAA Committee (subset) has met and discussed RCA factors impacting screening concerns and as the result has recommended use of a reminder barrier to funnel staff toward the screening table. The team is aware that their staff intervention will be needed to determine actual pass/fail of screen. Screening staff members will be responsible for sending staff and others home if screening process is failed. Correction date: 8/26/2020	

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	245012	A. BUILDING _____ B. WING _____	C 07/30/2020

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During observation on 7/28/20, at 7:52 a.m. two employees walked into the facility and took their own temperature at the screening table. They then verbalized the temperature reading to the screener.

When interviewed on 7/28/20, at 7:56 a.m. trained medication administrator (TMA)-A voiced employees that were already on the Excel COVID-19 screening spreadsheet had their information entered into it; visitors, vendors, pool staff or new staff utilized a paper form. Everyone was to take their own temperature; some staff showed the screener what the temperature reading on the thermometer was but usually they just verbally stated the temperature to the screener without showing the reading.

During interview on 7/28/20, at 8:37 a.m., housekeeper (HSKP)-A stated they had initially entered the facility at approximately 5:00 a.m. on 7/28/20, in which there was not a COVID-19 screener present at the entrance screening table; thus, HSKP-A had taken their own temperature and filled out the screening log that had been on the screening table. HSKP-A explained "sometimes someone is there and sometimes not." There had been a screener at the entrance screening table prior to "probably week and a half to 2 weeks" ago.

When interviewed on 7/28/20, at 8:41 a.m. HSKP-B voiced when they had arrived to work on 7/28/20 they had taken their own temperature with the infrared thermometer; showed the thermometer reading to the screener that was present at the screening station and recorded their own temperature and screening answers on the paper form that had been located at the

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F 880	Continued From page 21	F 880		

screening station.

During interview on 7/28/20, at 8:44 a.m. nursing assistant (NA)-A stated they had initially entered the facility at approximately 5:10 a.m. on 7/28/20, in which there had not been a COVID-19 screener present at the entrance screening table; thus, NA-A had taken their own temperature and filled out the screening log that had been on the screening table. NA-A voiced "it has been a couple weeks" in which they have been taking their own temperature and filling out the paper screening log. NA-A explained "someone in dietary" had informed them that they needed to start doing the screening process themselves. NA-A denied they had confirmed the dietary staff member's self screening practice instructions with the administrator or the director of nursing (DON).

When interviewed on 7/28/20, at 8:48 a.m. RN-F stated after entering the facility at the beginning of their shift they were to stop at the screening table to answer COVID-19 screening questions and take their own temperature; they either then showed the thermometer reading to the screener or just verbally stated to the screener what the temperature reading was.

On 7/28/20, at 9:38 a.m. cook (C)-A was interviewed after they were observed to take their own temperature and fill out the COVID-19 screening log at the COVID-19 screening station, prior to the start of their shift. Screening staff were not in the area of the screening station. C-A stated they have taken their own temperature and filled out the screening log as "sometimes they are here and sometimes they are not."

When interviewed on 7/28/20, at 12:47 p.m. the

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nurse unit manager/registered nurse (RN)-D stated "it is okay to self-screen" and "everyone knows what the symptoms are." RN-D further stated when staff had been symptomatic they had been "good at reporting it and going home."

When interviewed on 7/30/20, at 11:30 a.m., the DON stated staff were expected to have active screening completed two times a day; at the beginning of their shift and "about 4 hours later." He explained the screening station was staffed with active screeners at 5:45 a.m. "busier times" and shift change; however, he was unable to state exact time frames. The receptionist was responsible for staff screening when the screening station was not staffed with another designated staff member; where the receptionist would either sit at the receptionist desk or the screening station. The DON further explained staff used hand sanitizer and then took their own temperature as part of the screening process due to the screener being behind the screening station screen. Staff were expected to show the thermometer reading to the screener and would answer the screening questions verbally. The screener would record the answers and temperature electronically. The paper screening log at the screening station was for screening staff, such as the receptionist, to fill out during "the non-peak times of the day" and when staff completed their second screening mid shift. The DON voiced, "Nobody walks in the building without a receptionist or screener there." "Self screening should not have happened, it is not a free for all;" however, he further voiced there were "times when no one is up there [at the screening table]" and "someone will come back later and record" the information on the screening

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log into the electronic spread sheet.

Additionally, the DON stated the first facility case of resident COVID-19 had been confirmed on 6/5/20. Follow up testing on 7/22/20, confirmed 3 additional residents with positive test results, along with another resident on 7/25/20. He provided a list of 8 staff members who had tested positive for COVID-19 from 7/2/20 through 7/27/20. The dedicated staff who worked on the COVID-19 unit had all tested negative with facility testing in which the DON explained the staff who worked the COVID-19 unit entered through a door that led directly to the COVID-19 unit where they screened there and not at the main facility entrance.

During interview on 7/30/20, at 2:13 p.m. the administrator stated the main facility entrance screening location was staffed at the following times: 5:45 a.m. to 9:00 a.m. (station screener), a "soft time" from 9:00 a.m. to 2:00 p.m. (office staff), 2:00 p.m. to 7:00 p.m. (station screener), 10:15 p.m. to 11:15 p.m. (evening supervisor screened night staff). The administrator further stated active screening was expected to always occur at the start of the staffs' shift and if screening staff were not present, staff were to call another staff to perform the screening. The screening station had been staffed with an active screener 19.5 hours a day; however, "Staff have been doing it for so long they know the process and know not to come into work if having symptoms." In addition, he explained, "Everyone is good about the screening process and knows what is expected." The mid-day paper screening forms were discarded once the information was entered into the electronic screening spreadsheet.

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F 880	Continued From page 24 A facility provided Coronavirus/COVID-19 Preparedness/Employee Illness, dated 5/7/20, indicated "employees are being screened on arrival to work using screening questionnaire regarding travel, recently being near anyone with COVID-19 or other respiratory illness or if they themselves have respiratory illness. All employee temperatures are monitored for fever (100.0 or greater) at the start of their shift. Staff will not allowed to work who do not pass the screening." The policy failed to identify who (self or other employee) was expected to conduct the employee screenings and the location of employee screenings. The policy also failed to identify the screening process required for staff who worked on the designated COVID-19 unit. The MDH Covid-19 Toolkit- Information for Long Term Care Facilities dated 6/5/20, identified the facility should "Actively screen all staff for fever and symptoms of illness before starting each shift. In addition to facility staff, conduct health screening for other essential health care personnel including therapy personnel, hospice, home care, dialysis, ombudsman, state surveyors, chaplain at end of life, mortician, etc. [Active screening means that a trained person should physically monitor temperature of staff entering the building and ask questions regarding other COVID-related symptoms.]"	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/27/20 to 7/30/20, a survey was conducted by surveyors from the Minnesota Department of Health (MDH) to determine compliance for state licensure in conjuction with complaint investigation(s) for H5012036C, H5012037C, H5012038C, H5012039C.	2 000		

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2 000	Continued From page 1 As a result, the following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

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2 000	Continued From page 2 "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.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure all staff entering the facility had been actively screened (other facility staff performed the screening process) for the prevention and potential transmission of COVID-19. This had the potential to affect all 103 residents residing in the facility at the time of the COVID-19 focused survey. Findings include: On 7/27/20, at 1:00 p.m. the COVID-19 unidentified screener instructed the survey team to use an infrared thermometer to obtain their own temperatures after entering the facility. The survey team obtained their own temperatures as directed, gave the screener their completed COVID-19 screening questionnaire form, and were directed to wait for the administrator. The screener failed to verbalize any other instructions and did not review the COVID-19 screening forms	21375	Corrected 8/26/2020.	8/21/20

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before placing them face down on the screening table.

On 7/28/20, at 7:30 a.m. surveyor entered the facility and filled out a COVID-19 screening form. The unidentified screener who sat at the screening table behind a clear divider stated "you take your own temperature and write it on the sheet." The screener then took the screening sheet and without reviewing the responses to the questions or the temperature placed the screening form in a pile face down.

With interview on 7/28/20, at 7:52 a.m., dietary aide (DA)-A stated they had initially entered the facility at 5:45 a.m. on 7/28/20 in which there was not a COVID-19 screener present at the entrance screening table; thus, DA-A had taken their own temperature and filled out the screening log that had been on the screening table. DA-A explained it had been assumed that if a staff member wrote a "yes" on the screening log they would not enter further into the facility. There had been a screener at the entrance prior to about "two weeks" ago that had electronically recorded staff temperatures and COVID-19 screening questions; however, DA-A stated this had stopped for unknown reasons.

During observation on 7/28/20, at 7:52 a.m. two employees walked into the facility and took their own temperature at the screening table. They then verbalized the temperature reading to the screener.

When interviewed on 7/28/20, at 7:56 a.m. trained medication administrator (TMA)-A voiced employees that were already on the Excel COVID-19 screening spreadsheet had their information entered into it; visitors, vendors, pool

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staff or new staff utilized a paper form. Everyone was to take their own temperature; some staff showed the screener what the temperature reading on the thermometer was but usually they just verbally stated the temperature to the screener without showing the reading.

During interview on 7/28/20, at 8:37 a.m., housekeeper (HSKP)-A stated they had initially entered the facility at approximately 5:00 a.m. on 7/28/20, in which there was not a COVID-19 screener present at the entrance screening table; thus, HSKP-A had taken their own temperature and filled out the screening log that had been on the screening table. HSKP-A explained "sometimes someone is there and sometimes not." There had been a screener at the entrance screening table prior to "probably week and a half to 2 weeks" ago.

When interviewed on 7/28/20, at 8:41 a.m. HSKP-B voiced when they had arrived to work on 7/28/20 they had taken their own temperature with the infrared thermometer; showed the thermometer reading to the screener that was present at the screening station and recorded their own temperature and screening answers on the paper form that had been located at the screening station.

During interview on 7/28/20, at 8:44 a.m. nursing assistant (NA)-A stated they had initially entered the facility at approximately 5:10 a.m. on 7/28/20, in which there had not been a COVID-19 screener present at the entrance screening table; thus, NA-A had taken their own temperature and filled out the screening log that had been on the screening table. NA-A voiced "it has been a couple weeks" in which they have been taking their own temperature and filling out the paper

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screening log. NA-A explained "someone in dietary" had informed them that they needed to start doing the screening process themselves. NA-A denied they had confirmed the dietary staff member's self screening practice instructions with the administrator or the director of nursing (DON).

When interviewed on 7/28/20, at 8:48 a.m. RN-F stated after entering the facility at the beginning of their shift they were to stop at the screening table to answer COVID-19 screening questions and take their own temperature; they either then showed the thermometer reading to the screener or just verbally stated to the screener what the temperature reading was.

On 7/28/20, at 9:38 a.m. cook (C)-A was interviewed after they were observed to take their own temperature and fill out the COVID-19 screening log at the COVID-19 screening station, prior to the start of their shift. Screening staff were not in the area of the screening station. C-A stated they have taken their own temperature and filled out the screening log as "sometimes they are here and sometimes they are not."

When interviewed on 7/28/20, at 12:47 p.m. the nurse unit manager/registered nurse (RN)-D stated "it is okay to self-screen" and "everyone knows what the symptoms are." RN-D further stated when staff had been symptomatic they had been "good at reporting it and going home."

When interviewed on 7/30/20, at 11:30 a.m., the DON stated staff were expected to have active screening completed two times a day; at the beginning of their shift and "about 4 hours later." He explained the screening station was staffed with active screeners at 5:45 a.m. "busier times"

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and shift change; however, he was unable to state exact time frames. The receptionist was responsible for staff screening when the screening station was not staffed with another designated staff member; where the receptionist would either sit at the receptionist desk or the screening station. The DON further explained staff used hand sanitizer and then took their own temperature as part of the screening process due to the screener being behind the screening station screen. Staff were expected to show the thermometer reading to the screener and would answer the screening questions verbally. The screener would record the answers and temperature electronically. The paper screening log at the screening station was for screening staff, such as the receptionist, to fill out during "the non-peak times of the day" and when staff completed their second screening mid shift. The DON voiced, "Nobody walks in the building without a receptionist or screener there." "Self screening should not have happened, it is not a free for all;" however, he further voiced there were "times when no one is up there [at the screening table]" and "someone will come back later and record" the information on the screening log into the electronic spread sheet.

Additionally, the DON stated the first facility case of resident COVID-19 had been confirmed on 6/5/20. Follow up testing on 7/22/20, confirmed 3 additional residents with positive test results, along with another resident on 7/25/20. He provided a list of 8 staff members who had tested positive for COVID-19 from 7/2/20 through 7/27/20. The dedicated staff who worked on the COVID-19 unit had all tested negative with facility testing in which the DON explained the staff who worked the COVID-19 unit entered through a door that led directly to the COVID-19 unit where

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they screened there and not at the main facility entrance.

During interview on 7/30/20, at 2:13 p.m. the administrator stated the main facility entrance screening location was staffed at the following times: 5:45 a.m. to 9:00 a.m. (station screener), a "soft time" from 9:00 a.m. to 2:00 p.m. (office staff), 2:00 p.m. to 7:00 p.m. (station screener), 10:15 p.m. to 11:15 p.m. (evening supervisor screened night staff). The administrator further stated active screening was expected to always occur at the start of the staffs' shift and if screening staff were not present, staff were to call another staff to perform the screening. The screening station had been staffed with an active screener 19.5 hours a day; however, "Staff have been doing it for so long they know the process and know not to come into work if having symptoms." In addition, he explained, "Everyone is good about the screening process and knows what is expected." The mid-day paper screening forms were discarded once the information was entered into the electronic screening spreadsheet.

A facility provided Coronavirus/COVID-19 Preparedness/Employee Illness, dated 5/7/20, indicated "employees are being screened on arrival to work using screening questionnaire regarding travel, recently being near anyone with COVID-19 or other respiratory illness or if they themselves have respiratory illness. All employee temperatures are monitored for fever (100.0 or greater) at the start of their shift. Staff will not allowed to work who do not pass the screening." The policy failed to identify who (self or other employee) was expected to conduct the employee screenings and the location of employee screenings. The policy also failed to

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21375	Continued From page 8 identify the screening process required for staff who worked on the designated COVID-19 unit. The MDH Covid-19 Toolkit- Information for Long Term Care Facilities dated 6/5/20, identified the facility should "Actively screen all staff for fever and symptoms of illness before starting each shift. In addition to facility staff, conduct health screening for other essential health care personnel including therapy personnel, hospice, home care, dialysis, ombudsman, state surveyors, chaplain at end of life, mortician, etc. [Active screening means that a trained person should physically monitor temperature of staff entering the building and ask questions regarding other COVID-related symptoms.]" SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could inservice staff regarding active COVID-19 screening requirements; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually	21545		8/21/20

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21545	Continued From page 9 administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication to prevent blood clotting was administered in accordance with physician orders for 1 of 1 residents (R1)	21545	Corrected 8/26/2020	

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reviewed who suffered a stroke after their ordered aspirin was not provided resulting in a significant medication error. These findings resulted in an immediate jeopardy (IJ) situation for R1 when the facility failed to take adequate, systemic action(s) to educate staff to potential factors which contributed to the error causing the potential for similar reoccurrences and further subsequent medication errors.
The IJ began on 5/6/20, when physician orders for a daily dosing of aspirin (non-steroidal anti-inflammatory medication which helps prevent blood clots from forming in the arteries) were inadvertently discontinued resulting in R1 not receiving the ordered medication from 5/7/20 to 5/29/20. On 5/29/20, R1 developed facial droop and left-sided weakness; was transferred to the Emergency Department (ED) and subsequently hospitalized for stroke. The facility investigated the error and discovered factor(s) which contributed to the error, including potential electronic medical record (EMR) issues, and failed to address the factors with a systemic fix and/or education to staff whom process orders to ensure similar errors did not reoccur and placed residents at risk of harm or injury. The facility administrator and director of nursing (DON) were notified of the IJ for R1 on 7/29/20, at 2:16 p.m. The IJ was removed on 7/30/20, when the facility implemented a removal plan; however, non-compliance remained at an isolated scope of actual harm that is not immediate jeopardy (Level G).
Findings include:
On 7/28/20, at 1:30 p.m. R1's family member (FM)-A was interviewed. FM-A explained R1 had sustained a medication error while residing at the nursing home when her physician ordered aspirin was not provided to her and she subsequently suffered a stroke. FM-A explained the nursing

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home had followed up with him about the error; and they voiced R1's ordered aspirin had been accidentally discontinued instead of just R1's listed aspirin allergy, which is what had been actually ordered. This caused R1 to miss several weeks of aspirin dosing. FM-A voiced he believed the error contributed to R1 suffering the stroke; and since the stroke, R1 is no longer able to live on her own and needs more help to complete basic cares. Further, FM-A expressed frustration about the situation and voiced the error made him think there was "obviously a problem" at the nursing home with their order processing.

R1's admission Minimum Data Set (MDS), dated 4/28/20, identified R1 had intact cognition and required extensive assistance with activities of daily living (ADLs). Further, R1 had no neurological diagnoses recorded (i.e. stroke, aphasia, hemiplegia) and received anticoagulation medication(s) only on one (1) day during the review period.

R1's post-hospitalization After Discharge Orders, dated 4/22/20, identified R1 was being discharged to the nursing home after being hospitalized due to a fall and fracture with a hematoma. R1's hospitalization was listed as being complicated due to atrial fibrillation, and dictation directed to hold R1's warfarin sodium (an anticoagulant medication) for a set period. The report identified, "May need discussion regarding continuation of [warfarin] given high fall risk." R1's discharge medications to the nursing home were listed which included, "aspirin 81 mg [milligrams] ... 1 tablet by mouth once daily with a meal," along with a listed allergy to aspirin with dictation reading, " ... *patient tolerating daily dose of aspirin 12/14/16."

A Physician's Telephone Orders, dated 5/4/20, identified an order for R1 which read, "Start aspirin 325 mg EC [enteric coated] PO QD [by

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mouth everyday] on 5/6/2020. Dx: [diagnosis] Afib [atrial fibrillation; an abnormal heath rhythm which causes rapid, irregular beating]."
A subsequent Physician's Telephone Orders, dated 5/6/20, identified an order which read, "OK to DC [discontinue] aspirin alergy [sic]." The order was provided by the nurse practitioner (NP). The order was signed by various staff members, including station secretary (SS)-B.
However, a Discontinue Order report, dated 5/6/20, identified licensed practical nurse (LPN)-A discontinued R1's ordered aspirin 325 mg QD with dictation present, "Per NP directive".
R1's Medication Administration Record (MAR), dated 5/1/20 to 5/31/20, identified R1's provided medications while at the nursing home. R1 was provided aspirin 81 mg on 5/1/20, 5/2/20, 5/3/20, 5/4/20 and 5/5/20. Further, an additional order, started 5/6/20, was identified which directed to provide aspirin 325 mg by mouth one time a day for atrial fibrillation. A single dose was provided on 5/6/20; however, the order then listed a discontinue date of 5/6/20. No further doses of aspirin were provided to R1 according to the MAR.
R1's progress note, recorded on 5/29/20, at 10:41 a.m. which recorded R1 as being alert and orientated and needing only assistance of one with her walker.
A progress note on 5/29/20, at 2:37 p.m. listed an SBAR (Situation, Background, Assessment and Recommendations) note was completed. R1 was recorded as having developed left-sided weakness and left-sided facial droop while using the restroom. The nurse was unable to obtain a set of vital signs on R1, and R1 was recorded as saying, "I don't know what is happening." R1's physician (MD)-A was contacted and R1 was sent to the hospital ED for evaluation via ambulance.
R1's corresponding ED Admission History &

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Physical, dated 5/29/20, identified R1 presented with a chief complaint of weakness. R1 was recorded as being a poor historian upon presentation to the ED, " ... due to the acuity of her condition," with slurred speech, aphasia (loss of ability to understand or express speech) and left-sided weakness being recorded as present. The report identified R1 had been taken off her warfarin due to having sustained multiple falls on 4/18/20, and she was given TPA (thrombolytic therapy to dissolve blood clots) in the ED. A section labeled, "Preadmission Medications," listed all of R1's medications which were being administered by the nursing home; however, the list lacked any physician orders for aspirin. The report continued and listed R1 as having an allergy to aspirin with a reaction of rash and myalgia; however, dictation was present which read, "*patient tolerating daily doses of aspirin 12/14/16." Further, the report listed R1's medical problems with subsequent plan(s) to address each one. This included, "Acute stroke," which was listed as being caused by ischemia (inadequate blood supply) and left-sided weakness and left facial droop were present. R1 was admitted to the hospital.

R1's Hospital Discharge Summary, dated 6/1/20, identified R1 was discharged from the hospital back to the nursing home with a principal diagnosis of right frontal stroke with residual facial droop and dysarthria (slurred speech). R1 was listed as having atrial fibrillation and dictation read, " ... [warfarin] had been stopped recently because of fall with injury. Neurology consulted and feels she should remain off [warfarin] at this time and to use ASA [aspirin]." Further, a series of discharge medications were listed which included new orders for, "aspirin 325 mg tablet ... Take 1 tablet by mouth once daily with a meal." Further, the outlined allergies on the report

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continued to list aspirin with the same dictation present which read, "*patient tolerating daily doses of aspirin 12/14/16."
On 6/1/20, a progress note identified R1 was re-admitted to the nursing home from the hospital. The note outlined, "Resident is a readmission due to a recent stroke. Resident has left sided facial drooping and weakness." Further, R1 was now listed as needing assist of two with all transfers using a mechanical lift.
A completed State agency (SA) submitted investigation, dated 6/4/20, identified the facility' completed investigation into the incident. R1 admitted to the nursing home on 4/22/20, and the record identified R1 had been on warfarin; however, the provider was concerned for bleeding so it was placed on hold. On 5/4/20, orders were received to increase R1's daily aspirin dosing from 81 mg to 325 mg beginning on 5/6/20. On the same date, R1's aspirin allergy was identified and an order was received to discontinue the allergy. These orders were given to the station secretary to process who removed the listed allergy and gave the orders to the nurse to confirm. However, the facility' electronic medical system (PointClickCare) did not allow for the nurse to confirm allergies had been removed resulting in the nurse inadvertently discontinuing the aspirin dose order instead of the allergy. The report outlined R1 then presented with a change of condition and subsequent thrombotic stroke on 5/29/20, and listed, "[R1] has experienced a functional decline due to the incident ...". The report listed section(s) to describe action(s) taken to prevent reoccurrence to the subjected resident and other residents. The facility identified education was provided to the nurse, LPN-A, who committed the error; however, the field to write what actions had been taken to prevent reoccurrence to others was completed with only,

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"N/a [not applicable]." The report lacked any actions or evidence of a systemic response by the facility to help alert or educate staff to their identified findings of the electronic health system not allowing nurses to confirm allergies are removed; nor was there evidence of any completed education to other staff not involved in the incident regarding ensuring orders are clarified if they are unclear.

During interview on 7/28/20, at 7:57 a.m. registered nurse (RN)-C stated the nurses were able to view resident allergies in the computer system; however, voiced she did not know how to adjust allergy orders. RN-C explained a significant medication error would be one which included the incorrect administration or omission of insulin, warfarin or other "high risk meds." RN-C stated she was not sure on the facility' process for reporting or investigating significant medication errors and added she had not been provided any recent training or education on order transcription and processing.

When interviewed on 7/28/20, at 8:47 a.m. RN-E explained the facility' process for order processing. The SS enters the orders into the electronic health system, and the floor nurse then completes a second check for accuracy. The order is then listed as "active" in the system. The orders are then passed to the night nurse for a final check. RN-E stated if they received an order to discontinue an allergy for a resident, they would act on the order and not question it, as they're not a physician; however, afterwards would then follow-up with the provider about the order. Further, RN-E stated she had not been provided any re-education or new guidance on order processing within the past several weeks.

When interviewed on 7/28/20, at 9:20 a.m. SS-A expressed they (SS) had rights and access to change allergies within the electronic health

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system; however, SS-A voiced she was uncomfortable doing so. As a result, SS-A stated she would ask a nurse to change the order instead of her doing it. During subsequent interview, on 7/29/20 at 9:10 a.m., SS-A stated she could not recall receiving any new guidance or re-education on allergy or order processing within the past several weeks.

During interview on 7/28/20, at 9:30 a.m. SS-B voiced she was unaware of any issues or errors involving the electronic health system when allergies are modified or removed. SS-B stated she was not aware R1 had sustained a medication error (despite being the SS who originally processed the order for R1 on 5/6/20 to discontinue the aspirin allergy) and verified she had not been given any re-education or new guidance on order processing regarding allergies or medication orders since R1's incident.

On 7/29/20, at 9:57 a.m. R1's medical doctor (MD)-A was interviewed and verified she was R1's primary care physician while R1 resided at the nursing home. MD-A explained R1 admitted to the nursing home on 4/22/20, and upon admission, R1's warfarin sodium was on hold as R1 had sustained an internal hematoma (type of internal bleeding) due to a fall which is why she had been hospitalized. R1 had several "heart issues" including atrial fibrillation, carotid artery stenosis and coronary artery disease (CAD), all of which increased R1's risk of stroke; so R1 had orders in place for a daily dosing of aspirin 81 milligrams (mg). MD-A stated she had numerous discussions with R1 and her responsible party as she was worried about R1's anticoagulation "in general" due to her frequent falls. As a result, a decision was made to start R1 on a full-strength aspirin and an order was provided on 5/4/20 to increase R1's aspirin dosing from 81 mg to 325 mg provided on a daily basis. MD-A explained a

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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 weakness. R1 was subsequently sent to the ED and diagnosed with a stroke. MD-A stated when she learned R1 had been hospitalized for a stroke, she reviewed her medication list and discovered the aspirin was not being given. MD-A then e-mailed the nursing home and expressed concern about the error which MD-A voiced was likely the first time the nursing home had been notified an error had happened. MD-A explained if R1 had been provided the ordered aspirin everyday, as the order on 5/4/20 called for, it would have provided R1 "some protection" against stroke adding, "I do think it increased her risk of stroke to have nothing [medication]." MD-A reviewed R1's risk factors and stated she felt the omitted aspirin would be considered a "significant" medication error for R1. MD-A expressed regret about the error and voiced there were multiple opportunities for staff, including herself, to notice the aspirin was not being provided and correct it adding, "None of us saw it." Further, MD-A stated she was not aware of there being "any direct request" of the physician

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	00611	A. BUILDING: _____ B. WING _____	C 07/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	400 EVANS AVENUE ELK RIVER, MN 55330

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staff to modify any of their procedures to help prevent future errors with circumstances surrounding R1's incident; however, MD-A stated she was not sure what new procedures or policies the nursing staff may have been directed on since the incident to help avoid further errors.
On 7/29/20, at 10:41 a.m. LPN-A was interviewed and verified he processed R1's order from 5/6/20, which called to discontinue R1's aspirin allergy. LPN-A expressed he was unable to recall specifics of the events surrounding the order entry and subsequent error; however, acknowledged he was aware an error had occurred as he had been educated on it. LPN-A explained the education the facility provided was merely a telephone discussion which they directed him to "double check and clarify" orders if unsure of them. LPN-A stated he had received no education or further instruction on how to ensure allergy orders are processed correctly to prevent errors or confusion in the electronic record system. LPN-A voiced he was unaware R1 had an aspirin allergy when he processed the order on 5/6/20; however, reiterated he could not recall specifics which happened with the order processing as it was "so long ago."
On 7/29/20, at 11:07 a.m. the administrator and director of nursing (DON) were interviewed. They explained R1's unit manager, whom was on vacation currently and not available for interview, received notification on 5/29/20 of a medication error involving R1's aspirin. As a result, a vulnerable adult (VA) report was made and the error was reviewed with the physician and corresponding staff involved. The DON explained the process used for order processing included multiple "chart checks" by the nurses after the orders are entered into the system by the station secretary staff. They expressed the incident with R1 as being "isolated" and didn't feel there was a

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widespread concern with their order check system; however, the DON acknowledged the "process failed" regarding the incident with R1's aspirin error. The interview continued and they explained the facility had completed an investigation pertaining to R1's medication error and discovered an issue with their electronic record system (PointClickCare) where it did not readily display when allergies were discontinued, so they notified the software developer and were "trying to get that fixed." The DON added the "bottom line" of the error was the nurse mis-read R1's physician order on 5/6/20 (directing to discontinue the aspirin allergy) and "should have questioned it" instead of discontinuing the medication versus the allergy.

At 11:15 a.m. the director of quality (DOQ) joined the interview and voiced the incident pertaining to R1's medication error was the "true definition of an accident." R1 had been taken off warfarin and it was changed to a daily aspirin regimen; however, there was a listed allergy to aspirin on R1's record so the nurse practitioner (NP) had written an order to discontinue the allergy. The written order was acted on by the station secretary whom discontinued the allergy in the system and the nurse, LPN-A, then followed behind later on to complete the process and "final transcription." However, the electronic record system does not log or record when an allergy is discontinued; so this caused the nurse to read the order and, in error, the nurse thought the order meant to discontinue the medication itself as the allergy was no longer listed. R1 subsequently was not provided any aspirin and sustained a stroke on 5/29/20, which caused R1's physician to contact the unit manager about the error and an investigation was started into the incident which revealed those details. DOQ expressed that "in the best of all worlds" the NP could have

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re-worded the order to be clearer, and expressed regret as everyone involved was "doing what they thought was the right thing."
The interview continued, and, as a result of the error, DOQ expressed they had completed some re-education with the person(s) immediately involved with the error, including the NP and LPN-A; however, they had not conducted any re-education for the other staff members working in the facility who process orders as R1's error was a "unique situation" and they felt it didn't require whole-house education or alert. DOQ stated she felt the facility' systemic response to the incident was reviewing and affirming their overall system for order transcription was adequate; however, DOQ acknowledged the system had "failed us" with R1's incident and she reiterated had the electronic software system shown recently discontinued allergy orders, the error likely would not have ever happened. DOQ voiced they had reached out to the software company regarding their findings; however, had not received a response from them on how to proceed or amend the identified issue. When questioned on any stop-gap measures put into place to help ensure other similar errors did not occur until the software company provided feedback, they expressed the unit manager staff were asked to "keep an eye on it going forward." The DOQ voiced she felt the facility had a solid order transcription process in place for "check and balance" to ensure order accuracy and their investigation identified there "wasn't a flaw" in the overall process. Further, the facility did reach out to the medical director of the campus; however, neither him or the facility had done any follow-up with the physician group(s), despite some questions on the clarity of the provider order, as the facility "authored" the order and not the provider.

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21545	Continued From page 21 When interviewed via telephone on 7/29/20, at 4:35 p.m. the facility' consulting pharmacist (CP) expressed she had not been updated on any medication errors, including R1's error, since she started in April 2020, and verified she was the only CP the facility used. CP stated she had not been involved with any education processes for nurses or SS staff regarding medication orders or issues with transcription/order processing. CP reviewed R1's medical record and expressed if she had noticed R1's aspirin had been discontinued, it would have been something she would have questioned given R1's medical history. Further, CP voiced she was unable to comment on how R1's aspirin omission could have contributed to her subsequent stroke; however, verified she had not had any conversations or consultation from the facility regarding allergy order transcription and processing. A provided Medication Monitoring policy, dated 6/15, identified the facility employed a system to assure medication usage is evaluated on an ongoing basis, and when a significant medication-related problem is identified, the issue would be assessed, documented and reported, as appropriate to the physician, the QA (quality assurance) committee, the pharmacy and consulting pharmacist and the FDA, if needed. A procedure was provided to follow when a resident received a new medication order which directed to ensure the ordered specifics of the medication (i.e. dose, route, etc.) are in agreement with current clinical practice and guidelines, and ensure the resident has no listed allergies to the ordered medication. A facility policy on order transcription and allergy order transcription was requested, however, none was ever provided or received.	21545		

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21545	Continued From page 22 The IJ which began on 5/6/20, was removed on 7/30/20, at 2:25 p.m. when the facility implemented a removal plan which included completing education to staff regarding the electronic health system and allergy order transcription, and education regarding order clarification. On 7/30/20, from 1:10 p.m. to 2:18 p.m. staff members involved with order transcription and allergy order processing were interviewed and verified education had been provided. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review applicable policies and procedures to ensure orders are transcribed and implemented correctly; then inservice staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		