

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, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us



Electronically delivered

October 12, 2020

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

Re: Reinspection Results

Event ID: 9E4B12

Dear Administrator:

On September 9, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 9, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Alison Helm, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us



Electronically delivered August 14, 2020

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

RE: CCN: 245012

Cycle Start Date: June 29, 2020

Dear Administrator:

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

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

#### REMOVAL OF IMMEDIATE JEOPARDY

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

As a result of the survey findings:

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

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

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

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

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

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

#### SUBSTANDARD QUALITY OF CARE (SQC)

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

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

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

#### ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

How corrective action will be accomplished for those residents found to have been affected by the

deficient practice.

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

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

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

#### DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301

Email: susie.haben@state.mn.us

Phone: 320-223-7356

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 29, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

#### **APPEAL RIGHTS**

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

### Tamika.Brown@cms.hhs.gov

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

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

#### (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

PRINTED: 08/24/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245012	B. WING			C 07/30/2020		
	PROVIDER OR SUPPLIER  AN ANGELS CARE C	ENTER		STREET ADDRESS, CITY, STATE, 2 400 EVANS AVENUE ELK RIVER, MN 55330	IP CODE	, 077	00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE	
F 000	was completed at y the Minnesota Dep conduct complaint Angels Care Center compliance with 42 for Long Term Care In addition, a COVI Control survey was MDH to determine Infection Control. Gwas found not to be requirement.  The survey resulted at F760 when a resulting in a signification resulting in a signification resulting in a signification of the survey resulted at F760 when a resulting in a signification of the survey resulted at F760 when a resulting in a signification of the survey resulted and investigation of the survey resulted and was hose completed an investigation of the potential electronic human error, result additional medication and director of nursult of the survey of the surve	0/20, an abbreviated survey your facility by surveyors from artment of Health (MDH) to investigation(s). Guardian r was found not to be in 2 CFR Part 483, Requirements	FC					
LABORATOR'	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE			(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14

days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**Electronically Signed** 

08/21/2020

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245012	B. WING _			C 30/2020
	PROVIDER OR SUPPLIER  AN ANGELS CARE C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330	, <u> </u>	<u> </u>
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F 000	The following compsubstantiated: H5012037C; with a H5012038C; with a	deficiency issued at F760. deficiency issued at F760. deficiency issued at F760.	F 00	0		
F 730 SS=C	as your allegation of Department's accelenrolled in ePOC, yat the bottom of the form. Your electron be used as verificated.  Upon receipt of an on-site revisit of your validate substantial regulations has been your verification.  Nurse Aide Peform CFR(s): 483.35(d)(7) Regulation with the facility must confevery nurse aide months, and must peducation based or	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.  acceptable electronic POC, an ur facility may be conducted to compliance with the en attained in accordance with  Review-12 hr/yr In-Service 7)  ular in-service education.  Implete a performance review at least once every 12 provide regular in-service in the outcome of these is training must comply with the	F 73	0		8/21/20

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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				E	LK RIVER, MN 55330		
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F 730	Continued From pa	ge 2	F 7	30			
	by: Based on interview	<i>ı</i> and document review, the			F730		
		ure an annual performance					
		ted for 1 of 3 nursing			Guardian Angels Care Center strive	es to	
		vhose files were reviewed.			adhere to Nurse Assistant, Registe		
		o affect all 103 residents			performance reviews and In-service	Э	
	residing in the facili	ty during the abbreviated			education requirements.		
	survey.				Recent performance review for NA	-C has	
					been completed.		
	Findings include:				Performance reviews will be comp		
	Di.a. a. Ala a. a.la.la a.a.a.i.a	-tl			for all Nursing Assistant, Registered		
		ated survey, from 7/27/20 to			are employed greater than 90 days	. PAS	
		vas requested demonstrating performance evaluation for			will be completed by 8/26/2020. Training/inservice needs will be cor	nniled	
	several NA(s), inclu				based on performance review as w		
	30 (014) ((3), 111010	ading 147 t O.			employee feedback to determine a		
	A provided Annual	Employee Performance			necessary changes or additions in		
		ed for NA-C. The review was			education programs.		
		ed on 11/21/17 (over two years			The Administrator will be provided I	ist of	
		rformance reviews were			pending NAR performance reviews		
	provided during the	abbreviated survey period.			Human Resources) and will follow	up with	
					the Director of Nursing and the Nur	se Unit	
		p.m. the director of nursing			Managers for ongoing completion.		
		ed nurse unit managers (RN)			QAA Committee (subset) has met	and	
		interviewed and explained the			discussed RCA factors impacting		
		formance evaluation			performance reviews including rece		
		an evaluation is due, a			commitments necessitated by Covi		
		ed from human resources via a			The QAA Committee understands to		
		hich outlines whom and what 60-Day, Annual) is needed.			significance of performance review the need to develop a stronger che		
	,	ployed by the nursing home			balance system for completion. Any		
		nd HR had provided the most			overdue NAR performance reviews		
		eview they had (dated			WEEKS OVERDUE) will be reported		
		id RN-B expressed they were			the Administrator at QAA Committee		
		's annual performance reviews			meetings.	. =	
		ince then, and added NA-C			<del>-</del>		
		ull-time at the nursing home.			Correction date: 8/26/2020		
		ed it was important to ensure					
		views were completed timely					

PRINTED: 08/24/2020 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245012	B. WING _			C 30/2020	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330			
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F 760	"meeting expectation A provided Perform 5/2017, identified re summarize an emp work-related factors "Reviews will be do near the employee' date," and, " will employee's direct s head." Residents are Free CFR(s): 483.45(f)(2) The facility must en §483.45(f)(2) Residented are residented in the relation of the relat	re [NA] competent" and ons" in their job duties.  lance Reviews policy, dated eviews were done to aloyee's performance and other is. The policy directed, one on an annual basis on or is employment anniversary be completed by an upervisor and/or department of Significant Med Errors (2).  Issure that itslents are free of any significant of and document review, the ure medication to prevent administered in accordance or for 1 of 1 residents (R1) or ed a stroke after their is not provided resulting in a conform. These findings ediate jeopardy (IJ) situation collity failed to take adequate, to educate staff to potential isoluted to the error causing the reoccurrences and further	F 76		esidents errors. om the e with a I stoke sarthria. ervices es ers esidents d for all rders are	8/21/20	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/24/2020 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			Olv	IB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (	(X3) DATE SURVEY COMPLETED	
		245012	B. WING	i		07/3	30/2020
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					00 EVANS AVENUE		
GUARDI	AN ANGELS CARE C	ENTER					
					ELK RIVER, MN 55330		
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F 760	Continued From pa	nne 4	F	760			
	·	-	' '	00	station appretaries were trained to		
		ntinued resulting in R1 not			station secretaries were trained to	r to	
		ed medication from 5/7/20 to			question any ambiguous orders prior	110	
		O, R1 developed facial droop iness; was transferred to the			processing.  Medical providers will receive		
		ment (ED) and subsequently			communication regarding the need t	0	
		oke. The facility investigated			provide clarity in all written, verbal ar		
		vered factor(s) which			telephone orders.	i i d	
		error, including potential			Retraining will be done with the night	t	
		record (EMR) issues, and			nurses to review all orders processe		
		e factors with a systemic fix			preceding day. Processing will invol		
		staff whom process orders to			reviewing:		
		rs did not reoccur and placed			A) Copies of orders from telephone	9	
	residents at risk of	harm or injury. The facility			orders		
	administrator and d	lirector of nursing (DON) were			B) Order listing report		
		R1 on 7/29/20, at 2:16 p.m.			<ul><li>C) Allergy report (new addition to re</li></ul>	eview	
		d on 7/30/20, when the facility			process).		
		ioval plan; however,			The order transcription process has		
		mained at an isolated scope of			updated to include the requirement f		
		not immediate jeopardy (Level			person check at the time of process	ing	
	G).				(station secretary and nurse or two		
	<b>F</b> ' I' ' I I				nurses). This process will be forced		
	Findings include:				through the EMR.		
	On 7/20/20 at 1:20	n m P1's family mamber			The QAA Committee (subset) has m		
		p.m. R1's family member weed. FM-A explained R1 had			and discussed RCA factors impacting transcription errors. The QAA Comm	_	
	, ,	ation error while residing at the			identified the reason for the error is	muee	
		her physician ordered aspirin			isolated, however the electronic syst	tem	
		her and she subsequently			and human error have the potential		
		M-A explained the nursing			make an error. Additional checks wil		
		up with him about the error;			beneficial. Chart audits will be condu		
		's ordered aspirin had been			for accuracy in order transcription. A		
		tinued instead of just R1's			audit will be conducted weekly for ei		
		y, which is what had been			weeks. If no issues are identified the		
		nis caused R1 to miss several			audits will be reduced to 5% for the		
		sing. FM-A voiced he believed			remainder of the year.		
		d to R1 suffering the stroke;			Weekly audits will be conducted by I	Nurse	
		e, R1 is no longer able to live			Unit Manager or Director of Nursing.		
		eds more help to complete			Audit results will be reported at the C		
		r, FM-A expressed frustration			Committee meeting by the Director of		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  IG	COMPLETED		
		245012	B. WING _			C / <b>30/2020</b>	
	PROVIDER OR SUPPLIER  AN ANGELS CARE C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330	1 011	00/2020	
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F 760	about the situation think there was "ob nursing home with R1's admission Mir 4/28/20, identified I required extensive daily living (ADLs). neurological diagnosticated aphasia, hemiplegicanticoagulation meduring the review proportion of the propor	and voiced the error made him viously a problem" at the their order processing.  Inimum Data Set (MDS), dated R1 had intact cognition and assistance with activities of Further, R1 had no oses recorded (i.e. stroke, a) and received dication(s) only on one (1) day veriod.  Itation After Discharge Orders, atified R1 was being a fall and fracture with a ospitalization was listed as due to atrial fibrillation, and of hold R1's warfarin sodium nedication) for a set period.  Itation of [warfarin] given high fall ge medications to the nursing which included, "aspirin 81 mg olet by mouth once daily with a listed allergy to aspirin with *patient tolerating daily	F 76	Nursing. Correction date: 8/26/2020			
		ified an order which read. "OK					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED C		
		245012	B. WING_		07	/30/2020	
	PROVIDER OR SUPPLIER  AN ANGELS CARE C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CO 400 EVANS AVENUE ELK RIVER, MN 55330	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 760	to DC [discontinue] order was provided The order was sign including station seems of the order of the order was provided at the order of the	aspirin alergy [sic]." The by the nurse practitioner (NP). ed by various staff members,	F 70	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245012	B. WING		07	C / <b>30/2020</b>
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CO 400 EVANS AVENUE ELK RIVER, MN 55330			
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F 760	R1's corresponding Physical, dated 5/2 with a chief compresentation to the her condition," with of ability to understeft-sided weakned. The report identifity warfarin due to ha 4/18/20, and she therapy to dissolv section labeled, "I listed all of R1's madministered by the list lacked any phyreport continued a allergy to aspiring myalgia; however read, "*patient tole 12/14/16." Further problems with subseach one. This individual was admitted to the R1's Hospital Discidentified R1 was back to the nursing diagnosis of right droop and dysarth listed as having a read, " [warfaring because of fall with and feels she shottime and to use A she with the state of the she was admitted to use A she with a she with the she was a she with	ng ED Admission History & '29/20, identified R1 presented laint of weakness. R1 was g a poor historian upon e ED, " due to the acuity of the slurred speech, aphasia (loss stand or express speech) and ass being recorded as present. ed R1 had been taken off her aving sustained multiple falls on was given TPA (thrombolytic e blood clots) in the ED. A Preadmission Medications," nedications which were being the nursing home; however, the system orders for aspirin. The and listed R1 as having an with a reaction of rash and the individual of the ind	F 7	760		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  AN ANGELS CARE C	ENTER		40	TREET ADDRESS, CITY, STATE, ZIP CODE DO EVANS AVENUE LK RIVER, MN 55330	1 077	50/2020
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F 760	included new order. Take 1 tablet by more Further, the outlined continued to list aspresent which read doses of aspirin 12. On 6/1/20, a progre re-admitted to the readmission due to left sided facial drock R1 was now listed a all transfers using a A completed investigation, dated completed investigation, date	s for, "aspirin 325 mg tablet buth once daily with a meal." d allergies on the report birin with the same dictation, "*patient tolerating daily 1/14/16."  The sess note identified R1 was bursing home from the butlined, "Resident is a a recent stroke. Resident has being and weakness." Further, as needing assist of two with	F 7	60			

PRINTED: 08/24/2020 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 400 EVANS AVENUE ELK RIVER, MN 55330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 760	and other resident education was procommitted the errowhat actions had be reoccurrence to ot "N/a [not applicable actions or evidence the facility to help identified findings not allowing nurse removed; nor was completed education the incident regard clarified if they are clarified if they are During interview or registered nurse (lable to view resides system; however, adjust allergy ordes significant medical included the incorrof insulin, warfarin RN-C stated she was process for reportion medication errors provided any recent ranscription and publication the facilic processing. The Selectronic health is completes a second order is then listed orders are then patinal check. RN-E	rence to the subjected resident s. The facility identified vided to the nurse, LPN-A, who or; however, the field to write been taken to prevent hers was completed with only, e.g" The report lacked any e of a systemic response by alert or educate staff to their of the electronic health system is to confirm allergies are there evidence of any ion to other staff not involved in ding ensuring orders are unclear.  In 7/28/20, at 7:57 a.m.  RN)-C stated the nurses were ent allergies in the computer voiced she did not know how to ers. RN-C explained a tion error would be one which rect administration or omission or other "high risk meds." was not sure on the facility' ng or investigating significant and added she had not been int training or education on order	F 7	60			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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	PROVIDER OR SUPPLIER  AN ANGELS CARE C	ENTER		400	EET ADDRESS, CITY, STATE, ZIP CODE  EVANS AVENUE  K RIVER, MN 55330	1 017.	00,2020	
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F 760	would act on the or they're not a physic would then follow-up order. Further, RN-provided any re-educated processing with the	der and not question it, as sian; however, afterwards up with the provider about the E stated she had not been ucation or new guidance on ithin the past several weeks.  On 7/28/20, at 9:20 a.m. SS-A is) had rights and access to thin the electronic health in the electronic health in the electronic health is S-A voiced she was up so. As a result, SS-A stated were to change the order up it. During subsequent it. During subsequent it. On at 9:10 a.m., SS-A stated it receiving any new guidance allergy or order processing	F 7	60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  AN ANGELS CARE C	ENTER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	issues" including at stenosis and corons which increased R1 orders in place for a milligrams (mg). MI discussions with R1 she was worried ab general" due to her decision was made aspirin and an orde increase R1's aspir mg provided on a distuation then arose medical record had however, it was det and a separate orderemove the listed a written on 5/6/20 waspirin allergy; how medication adminis she was aware an emedication itself allowere both disconting getting little to no do through 5/29/20. MI she had seen R1 for R1 had no visible sicomplaints of knee then developed diffi weakness. R1 was and diagnosed with she learned R1 had stroke, she reviewed discovered the aspit then e-mailed the noncern about the elikely the first time to which is the stroke of the service we discovered the first time to likely the first time to which is the stroke of the service we discovered the first time to likely the first time to which is the stroke of the service we discovered the serv	ge 11  ded. R1 had several "heart rial fibrillation, carotid artery ary artery disease (CAD), all of its risk of stroke; so R1 had a daily dosing of aspirin 81  D-A stated she had numerous and her responsible party as out R1's anticoagulation "in frequent falls. As a result, a to start R1 on a full-strength r was provided on 5/4/20 to in dosing from 81 mg to 325 aily basis. MD-A explained a where they identified R1's a listed allergy to aspirin; ermined to not be accurate er was written on 5/6/20 to llergy. MD-A verified the order as meant to remove the tration order. MD-A explained error then occurred where the tration order which resulted in R1 osing of the ordered aspirin D-A expressed on 5/29/20, or a visit earlier in the day and igns of distress outside of pain; however, afterwards R1 iculty speaking and left-sided subsequently sent to the ED a stroke. MD-A stated when I been hospitalized for a stroke. MD-A stated when I been hospitalized for a stroke more and expressed error which MD-A voiced was he nursing home and expressed error which MD-A voiced was he nursing home had been d happened. MD-A explained	F	760			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	CON	TE SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGELS CARE CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 760  Continued From page 12  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-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 ther 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				STREET ADDRESS, CITY, STATE, ZIP ( 400 EVANS AVENUE ELK RIVER, MN 55330	•	
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 760	if R1 had been proveveryday, as the or would have provide against stroke addrisk of stroke to har eviewed R1's risk omitted aspirin wor "significant" medicexpressed regret awere multiple opposite the provided and correst." Further, MD-As there being "any distaff to modify any prevent future errosurrounding R1's in she was not sure a policies the nursing on since the incide.  On 7/29/20, at 10:4 and verified he prowhich called to distance the incide of the eventry and subsequance acknowledged he concurred as he had explained the education or furensure allergy order prevent errors or crecord system. LP	vided the ordered aspirin rder on 5/4/20 called for, it ed R1 "some protection" ing, "I do think it increased her ve nothing [medication]." MD-A factors and stated she felt the ald be considered a ation error for R1. MD-A about the error and voiced there ortunities for staff, including he aspirin was not being ect it adding, "None of us saw stated she was not aware of rect request" of the physician of their procedures to help rs with circumstances neident; however, MD-A stated	F 76			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG	, ,	TE SURVEY MPLETED
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	245012  AME OF PROVIDER OR SUPPLIER  GUARDIAN ANGELS CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330		100/2020
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 760	recall specifics whi processing as it was On 7/29/20, at 11:0 director of nursing explained R1's unit vacation currently a received notification error involving R1's vulnerable adult (Verror was reviewed corresponding staft the process used for multiple "chart che orders are entered secretary staff. The R1 as being "isolat widespread concersystem; however, to "process failed" recaspirin error. The intexplained the facili investigation pertain and discovered and record system (Porreadily display whe so they notified the "trying to get that fi "bottom line" of the R1's physician orded discontinue the aspuestioned it" instemedication versus At 11:15 a.m. the of the interview and versus and accident." R1 his medication eran accident." R1 his	ch happened with the order as "so long ago."  77 a.m. the administrator and (DON) were interviewed. They a manager, whom was on and not available for interview, non 5/29/20 of a medication as aspirin. As a result, a (A) report was made and the lawith the physician and finvolved. The DON explained or order processing included ocks" by the nurses after the into the system by the station by expressed the incident with ed" and didn't feel there was an with their order check the DON acknowledged the garding the incident with R1's interview continued and they they had completed an ining to R1's medication error issue with their electronic ant Click Care) where it did not an allergies were discontinued, a software developer and were exed." The DON added the error was the nurse mis-read er on 5/6/20 (directing to orin allergy) and "should have the allergy.  Ilirector of quality (DOQ) joined oiced the incident pertaining to ror was the "true definition of	F 76			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C			
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	NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGELS CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 760  Continued From page 14 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 "fir transcription." However, the electronic record system does not log or record when an allergy i discontinued; so this caused the nurse to read to order and, in error, the nurse thought the order meant to discontinue the medication itself as the allergy was no longer listed. R1 subsequently we 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 are 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 expresse regret as everyone involved was "doing what the thought was the right thing."  The interview continued, and, as a result of the error, DOQ expressed they had completed som 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			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330	•	
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 760	however, there was R1's record so the written an order to written an order to written order was a secretary whom dis system and the numbehind later on to obtain the discontinued; so the order and, in error, meant to discontinual largy was no long not provided any as on 5/29/20, which contact the unit mainvestigation was servealed those detained the best of all workers, worded the orderegret as everyone thought was the right of the interview continual largy was no long not provided any as on 5/29/20, which contact the unit mainvestigation was servealed those detained the orderegret as everyone thought was the right of the interview continuation of the involved with the electron of the interview whole-hous stated she felt the fincident was reoverall system for a dequate; however system had "failed reiterated had the details and the server of the system and "failed reiterated had the details and the system had "failed reiterated had the details and the system had "failed reiterated had the details and the system had "failed reiterated had the details and the system had "failed reiterated had the details and the system had "failed reiterated had the details and the system had "failed reiterated had the system had "failed reiterated	s a listed allergy to aspirin on nurse practitioner (NP) had discontinue the allergy. The octed on by the station scontinued the allergy in the rese, LPN-A, then followed complete the process and "final ever, the electronic record g or record when an allergy is is caused the nurse to read the the nurse thought the order use the medication itself as the per listed. R1 subsequently was spirin and sustained a stroke caused R1's physician to mager about the error and an tarted into the incident which ails. DOQ expressed that "in dis" the NP could have or to be clearer, and expressed involved was "doing what they that thing."  nued, and, as a result of the sed they had completed some the person(s) immediately ror, including the NP and they had not conducted any the other staff members working rocess orders as R1's error ation" and they felt it didn't	F 7	60		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  G	CON	TE SURVEY MPLETED	
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F 760	voiced they had re company regarding not received a response or amend questioned on any place to help ensu occur until the soft feedback, they expwere asked to "kee The DOQ voiced sorder transcription and balance" to en investigation identioverall process. For the medical direntity response on the country that the physician questions on the country that the facility "authors provider.  When interviewed 4:35 p.m. the facility expressed she had medication errors, started in April 202 only CP the facility been involved with nurses or SS staff issues with transcrive wed R1's medication errors, started in April 202 only CP the facility been involved with nurses or SS staff issues with transcrive wed R1's medication. Further, Clicomment on how I have contributed to the company of the comment on how I have contributed to the company of the comment on how I have contributed to the company of the comment on how I have contributed to the company of the company o	age 15 not have ever happened. DOQ ached out to the software g their findings; however, had conse from them on how to the identified issue. When stop-gap measures put into re other similar errors did not ware company provided cressed the unit manager staff ep an eye on it going forward." The felt the facility had a solid process in place for "check asure order accuracy and their fied there "wasn't a flaw" in the further, the facility did reach out cotor of the campus; however, facility had done any follow-up group(s), despite some larity of the provider order, as ed" the order and not the  via telephone on 7/29/20, at ty' consulting pharmacist (CP) donot been updated on any including R1's error, since she and verified she was the rused. CP stated she had not any education processes for regarding medication orders or ription/order processing. CP dical record and expressed if 1's aspirin had been suld have been something she oned given R1's medical P voiced she was unable to R1's aspirin omission could the subsequent stroke; she had not had any	F 76				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  IG	) COM	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER  AN ANGELS CARE C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330		.00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 760	regarding allergy of processing.  A provided Medicar 6/15, identified the assure medication ongoing basis, and medication-related would be assessed as appropriate to the assurance) commit consulting pharmac procedure was provedure was provedure was provedure to ensure the order (i.e. dose, route, et current clinical pracensure the resident ordered medication.  A facility policy on conder transcription was ever provided.  The IJ which began 7/30/20, at 2:25 p.r. implemented a rem completing education electronic health systranscription, and eclarification. On 7/3 p.m. staff members transcription and all interviewed and verification.	cion Monitoring policy, dated facility employed a system to usage is evaluated on an when a significant problem is identified, the issue depreciation, the QA (quality the physician, the QA (quality the physician, the QA (quality the pharmacy and cist and the FDA, if needed. A wided to follow when a resident dication order which directed ed specifics of the medication co.) are in agreement with the tice and guidelines, and thas no listed allergies to the modern transcription and allergy was requested, however, none or received.	F 76			
F 880 SS=F	provided. Infection Preventio CFR(s): 483.80(a)(		F 88	30		8/21/20

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION  G	` '	TE SURVEY MPLETED
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	PREFIX TAG  (24) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 development and transmission of communica diseases and infections.  §483.80(a) Infection prevention and control program.  The facility must establish an infection prevent and control program (IPCP) that must include a minimum, the following elements:  §483.80(a) (1) A system for preventing, identifying, reporting, investigating, and control infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contrac arrangement based upon the facility assessm conducted according to §483.70(e) and follow accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must inclubut are not limited to:  (i) A system of surveillance designed to identif 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 precaut to be followed to prevent spread of infections;  (iv)When and how isolation should be used fo			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330		
PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	§483.80 Infection of The facility must es infection prevention designed to provide comfortable environdevelopment and to diseases and infection program. The facility must estand control program a minimum, the following statement of the facility must estand control program a minimum, the following statement of the facility must estand control program a minimum, the following statement of the facility must estand control program a minimum, the following statement of the facility must estand control program a minimum, the following statement of the facility of the facili	control stablish and maintain an and control program a safe, sanitary and ment and to help prevent the ransmission of communicable tions.  In prevention and control stablish an infection prevention in (IPCP) that must include, at owing elements:  In the for preventing, go, investigating, and controlling municable diseases for all unteers, visitors, and other go services under a contractual drupon the facility assessmenting to §483.70(e) and following standards;  I we illance designed to identify table diseases or ey can spread to other ity;  I wom possible incidents of ease or infections should be ransmission-based precautions event spread of infections; isolation should be used for a	F 88			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION (	X3) DATE SURVEY COMPLETED
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F 880	Continued From pa	age 18	F 88	0	
r oou	(A) The type and d depending upon the involved, and (B) A requirement least restrictive posticized in the contact with reside contact with reside contact will transmer (vi) The hand hygie by staff involved in §483.80(a)(4) A system of the corrective actions to the corrective actions to the correction.  §483.80(e) Linens. Personnel must have transport linens so infection.  §483.80(f) Annual The facility will contact the corrective actions to the corrective actions to the correction.	uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility oyees with a communicable skin lesions from direct ints or their food, if direct interest into the disease; and ine procedures to be followed direct resident contact.  In the disease is and in the procedures to be followed direct resident contact.  In the disease is and in the procedures to be followed direct resident contact.  In the disease is and in the procedures to be followed direct resident contact.  In the disease is and in the procedure is a facility in the facility.  In the store, process, and in the spread of its in the program, as necessary.  In the program, as necessary.  In the procedure is not met as evidenced it in the procedure	F 88	F880	
	the facility had bee facility staff perform the prevention and COVID-19. This ha	ailed to ensure all staff entering n actively screened (other ned the screening process) for potential transmission of ad the potential to affect all 103 n the facility at the time of the survey.		Guardian Angels Care Center strives adhere to all infection control standa accordance with state and federal regulations and current standards of practice.  All residents have the potential to be impacted by not actively screening a entering the facility.	erds in

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CLIVILI	13 FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION  NG	СОМ	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
				400 EVANS AVENUE			
GUARDI	AN ANGELS CARE C	ENTER		ELK RIVER, MN 55330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	On 7/27/20, at 1:00 unidentified screened to use an infrared the own temperatures a survey team obtained directed, gave the screener failed to was creener failed to was creening them table.  On 7/28/20, at 7:30 facility and filled our The unidentified so screening table bet take your own temps heet." The screenes heet and without requestions or the terscreening form in a with interview on 7 aide (DA)-A stated facility at 5:45 a.m. not a COVID-19 so screening table; the temperature and fill had been on the screener at the entime weeks" ago that hat temperatures and the country of the control of th	p.m. the COVID-19 er instructed the survey team hermometer to obtain their after entering the facility. The ed their own temperatures as screener their completed ng questionnaire form, and hit for the administrator. The erbalize any other instructions the COVID-19 screening forms in face down on the screening  a.m. surveyor entered the that a COVID-19 screening form. The treener who sat at the hind a clear divider stated "you be returned and write it on the er then took the screening eviewing the responses to the imperature placed the	F 88	retrained on process and requactive screening of staff and a enter facility.  The facility will position a barriete.) in the front entry to "funnedirectly to screening area. The be easily moveable and not crobstruction that would prevent an emergency or create a fire. All staff will be trained on the ractively screened prior to movifront entry way. Staff will be trained on the ractively screened prior to movifront entry way. Staff will be trained on the ractively screened prior to movifront entry way. Staff will be trained on the received to ensure cove screening area.  Screening results will be audite via review of reports and real trained to actual pass/fail of screening to actual pass/fail of screen. Screening will be responsible for staff and others home if screen process is failed.  Correction date: 8/26/2020	er (table, el" staff e barrier will eate an egress in hazard. Heed to be ing beyond ained they by screened by area. Hours have rage at ed weekly ime lucted by I to the QAA has met pacting e result has der barrier ening table. Laff determine eening staff or sending		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C				
		245012	B. WING _		07	//30/2020	
	PROVIDER OR SUPPLIER  AN ANGELS CARE C			STREET ADDRESS, CITY, STATE, ZIP COD 400 EVANS AVENUE ELK RIVER, MN 55330	•		
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F 880	Continued From pa	age 20	F 88	0			
	employees walked own temperature a then verbalized the screener.	on 7/28/20, at 7:52 a.m. two into the facility and took their it the screening table. They e temperature reading to the					
	trained medication employees that we COVID-19 screening information entered staff or new staff under was to take their of showed the screen reading on the their just verbally stated	on 7/28/20, at 7:56 a.m. administrator (TMA)-A voiced are already on the Excel ng spreadsheet had their d into it; visitors, vendors, pool tilized a paper form. Everyone wn temperature; some staff are what the temperature rmometer was but usually they the temperature to the					
	During interview or housekeeper (HSk entered the facility 7/28/20, in which the screener present at thus, HSKP-A had and filled out the se the screening table "sometimes some not." There had be	howing the reading.  17/28/20, at 8:37 a.m., 17/28/20,					
	HSKP-B voiced wh 7/28/20 they had to with the infrared th thermometer readi present at the scre their own temperat	on 7/28/20, at 8:41 a.m. nen they had arrived to work on aken their own temperature ermometer; showed the ng to the screener that was ening station and recorded ure and screening answers on thad been located at the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C				
		245012	B. WING				30/2020
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			400	REET ADDRESS, CITY, STATE, ZIP CODE  EVANS AVENUE  K RIVER, MN 55330	,	
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	screening station.  During interview on assistant (NA)-A stathe facility at approxin which there had screener present at thus, NA-A had tak filled out the screen screening table. NA couple weeks" in witheir own temperate screening log. NA-A dietary" had informate start doing the screening log. NA-A denied they have the administrator of the work of the state of the start of were not in the area stated they have ta filled out the screen are here and some	7/28/20, at 8:44 a.m. nursing ated they had initially entered ximately 5:10 a.m. on 7/28/20, not been a COVID-19 the entrance screening table; en their own temperature and sing log that had been on the A-A voiced "it has been a hich they have been taking are and filling out the paper A explained "someone in ed them that they needed to ening process themselves. and confirmed the dietary staff ening practice instructions with the director of nursing (DON). On 7/28/20, at 8:48 a.m. RN-F of the facility at the beginning of to stop at the screening table of screening questions and perature; they either then meter reading to the screener ed to the screener what the gwas.  a.m. cook (C)-A was ey were observed to take their and fill out the COVID-19 cOVID-19 screening staff a of the screening station. C-A ken their own temperature and sing log as "sometimes they	F8	80			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	СОМ	E SURVEY PLETED
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	PROVIDER OR SUPPLIER  AN ANGELS CARE C	ENTER		400	REET ADDRESS, CITY, STATE, ZIP CODE 0 EVANS AVENUE LK RIVER, MN 55330	, 077	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	stated "it is okay to knows what the syr stated when staff h been "good at repo When interviewed of	r/registered nurse (RN)-D self-screen" and "everyone mptoms are." RN-D further ad been symptomatic they had rting it and going home."  on 7/30/20, at 11:30 a.m., the	F 8	.80			
	screening completed beginning of their so the explained the so with active screened and shift change; however the state exact time from the screening station with the screening station with the screening station. The staff used hand sand the screening station screening station screen. Staff thermometer reading answer the screening screener would recompleted their second the screening staff, such as the result of the screening staff, such as the screening staff, such as the result of the screening staff, such as the result of the screening staff, such as the result of the screening staff, such as t	ere expected to have active ed two times a day; at the hift and "about 4 hours later." creening station was staffed rs at 5:45 a.m. "busier times" owever, he was unable to mes. The receptionist was if screening when the reas not staffed with another ember; where the receptionist he receptionist desk or the The DON further explained nitizer and then took their own to f the screening process due ing behind the screening ff were expected to show the ing to the screener and would ing questions verbally. The ord the answers and onically. The paper screening get station was for screening eceptionist, to fill out during so of the day" and when staff cond screening mid shift. The ody walks in the building list or screener there." "Self ot have happened, it is not a ter, he further voiced there in one is up there [at the					
	screening should no free for all;" howeve were "times when r screening table]" ar	ot have happened, it is not a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, , ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245012	B. WING			1	30/2020
	PROVIDER OR SUPPLIER  AN ANGELS CARE C	ENTER		400	REET ADDRESS, CITY, STATE, ZIP CODE  EVANS AVENUE  K RIVER, MN 55330	, 077	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	log into the electron Additionally, the DC of resident COVID-6/5/20. Follow up to additional residents along with another provided a list of 8 spositive for COVID-7/27/20. The dedica COVID-19 unit had testing in which the worked the COVID-door that led directly they screened there entrance.  During interview on administrator stated screening location of times: 5:45 a.m. to "soft time" from 9:0 staff), 2:00 p.m. to 10:15 p.m. to 11:15 screened night staff stated active screening staff were another staff to per screening station has creener 19.5 hours been doing it for so and know not to consymptoms." In additing good about the swhat is expected."	ON stated the first facility case 19 had been confirmed on esting on 7/22/20, confirmed 3 is with positive test results, resident on 7/25/20. He staff members who had tested 19 from 7/2/20 through ated staff who worked on the all tested negative with facility DON explained the staff who 19 unit entered through a y to the COVID-19 unit where and not at the main facility entrance was staffed at the following 9:00 a.m. (station screener), a 0 a.m. to 2:00 p.m. (office 7:00 p.m. (station screener), a 0 a.m. (evening supervisor f). The administrator further ning was expected to always a the staffs' shift and if the not present, staff were to call form the screening. The add been staffed with an active a day; however, "Staff have long they know the process me into work if having tion, he explained, "Everyone creening process and knows The mid-day paper screening ed once the information was	F8	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGELS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  400 EVANS AVENUE  ELK RIVER, MN 55330			
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F 880	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 8	80			



Electronically delivered August 14, 2020

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

Re: State Nursing Home Licensing Orders

Event ID: 9E4B11

#### Dear Administrator:

The above facility was surveyed on July 27, 2020 through July 30, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 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, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
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		00611	B. WING			0/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
GUARDIAN ANGELS CARE CENTER  400 EVANS AVENUE ELK RIVER, MN 55330							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 000	2 000 Initial Comments						
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and may of lack of compliance. re-inspection with a	hether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will					
		ment of a fine even if the item uring the initial inspection was					
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.					
	by surveyors from t Health (MDH) to de licensure in conjuct	20, a survey was conducted he Minnesota Department of etermine compliance for state ion with complaint H5012036C, H5012037C,					

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 08/21/20

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
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		00611	B. WING		07/3	0/2020		
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2 000	issued. Please indic correction that you and identify the date. Minnesota Department the State Licensing federal software. To assigned to Minnesota Department of Minnesota Department of the management of the findings which a statute after the State lice the Minnesota Department of State lice the Minnesota Department of Hearyou electronically. It is necessary for State licensure proceedings of the State licensure proceedings of the Minnesota Department of the Minnesota Departm	owing correction orders are cate your electronic plan of have reviewed these order, e when they will be corrected.  The ent of Health is documenting Correction Orders using ag numbers have been ot a state statutes/rules for the assigned tag number efft column entitled "ID Prefix attute/rule out of compliance is ary Statement of Deficiencies" as the "To Comply" portion of the state tement, "This Rule is not met following the surveyors findings the method of Correction and the test of the electronic insure orders consistent with artment of Health in 14-01, available at the electronic insure orders are tached Minnesota attached Minnesota attached Minnesota attached Minnesota attached more plan of correction at Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading attached of Health.	2 000					
	PLEASE DISREGA	RD THE HEADING OF THE						

Minnesota Department of Health

STATE FORM 9E4B11 If continuation sheet 2 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
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	APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREMI CORRECTION FO	N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES.				
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			8/21/20
	home must establis	on control program. A nursing th and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review the facility fa the facility had beer facility staff perform the prevention and COVID-19. This had	ent is not met as evidenced on, interview, and document illed to ensure all staff entering a actively screened (other led the screening process) for potential transmission of d the potential to affect all 103 in the facility at the time of the survey.		Corrected 8/26/2020.		
	Findings include:					
	unidentified screened to use an infrared the own temperatures a survey team obtained directed, gave the SCOVID-19 screening were directed to was screener failed to very the unidentified to very the screener failed to very the unidentified to use the unidentified to very the unidentified to very the unidentified to very the unique	p.m. the COVID-19 er instructed the survey team nermometer to obtain their after entering the facility. The ed their own temperatures as creener their completed g questionnaire form, and it for the administrator. The erbalize any other instructions the COVID-19 screening forms				

Minnesota Department of Health

STATE FORM 9E4B11 If continuation sheet 3 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	·	
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	before placing them face down on the screening table.					
	facility and filled out The unidentified so screening table bet take your own tempsheet." The screen sheet and without requestions or the terscreening form in a With interview on 7 aide (DA)-A stated facility at 5:45 a.m. not a COVID-19 so screening table; the temperature and fill had been on the so it had been assume a "yes" on the screen at the entry weeks" ago that had temperatures and COVID-19 screener at the entry weeks ago that had temperatures and COVID-19 screener at the entry weeks ago that had temperatures and COVID-19 screener at the entry weeks ago that had temperatures and COVID-19 screener at the entry weeks ago that had temperatures and COVID-19 screener at the entry weeks ago that had temperatures and COVID-19 screener at the entry weeks ago that had temperatures and COVID-19 screener at the entry weeks ago that had temperatures and COVID-19 screener at the entry weeks ago that had temperatures and COVID-19 screener at the entry weeks ago that had temperatures and COVID-19 screener at the entry weeks ago that had temperatures and COVID-19 screener at the entry weeks ago that had temperatures and COVID-19 screener at the entry weeks ago that had been as summer at the entry weeks ago that had temperatures and COVID-19 screener at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had been as summer at the entry weeks ago that had b	/28/20, at 7:52 a.m., dietary they had initially entered the on 7/28/20 in which there was reener present at the entrance is, DA-A had taken their own ed out the screening log that reening table. DA-A explained at that if a staff member wrote ening log they would not enter ity. There had been a rance prior to about "two delectronically recorded staff COVID-19 screening part of the prior to a screening part of the prior to about "two delectronically recorded staff covid-19 screening part of the prior to about "two delectronically recorded staff covid-19 screening part of the prior to a sc				
	employees walked own temperature at	on 7/28/20, at 7:52 a.m. two into the facility and took their the screening table. They temperature reading to the				
	trained medication a employees that wer COVID-19 screening	on 7/28/20, at 7:56 a.m. administrator (TMA)-A voiced re already on the Excel rg spreadsheet had their into it; visitors, vendors, pool				

Minnesota Department of Health

STATE FORM 9E4B11 If continuation sheet 4 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  AN ANGELS CARE C	ENTER 400 EVAN	DRESS, CITY, S IS AVENUE ER, MN 5533	STATE, ZIP CODE		
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21375	staff or new staff ut was to take their ow showed the screene reading on the therr just verbally stated screener without shousekeeper (HSK entered the facility a 7/28/20, in which the screener present at thus, HSKP-A had the screening table "sometimes someonot." There had been showed the screener beautiful to the screener present at the screening table sometimes someonot."	ilized a paper form. Everyone on temperature; some staff er what the temperature mometer was but usually they the temperature to the	21375			
	HSKP-B voiced who 7/28/20 they had ta with the infrared the thermometer readir present at the screetheir own temperate the paper form that screening station.  During interview on assistant (NA)-A state facility at approximation which there had a screener present at thus, NA-A had take filled out the screen screening table. NA	on 7/28/20, at 8:41 a.m. en they had arrived to work on ken their own temperature ermometer; showed the ag to the screener that was ening station and recorded are and screening answers on had been located at the  7/28/20, at 8:44 a.m. nursing ated they had initially entered kimately 5:10 a.m. on 7/28/20, not been a COVID-19 at the entrance screening table; en their own temperature and ing log that had been on the A-A voiced "it has been a hich they have been taking				

Minnesota Department of Health

STATE FORM 9E4B11 If continuation sheet 5 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUF	PLIER		DRESS, CITY, S	TATE, ZIP CODE		
GUARDIAN ANGELS CA	RE CENTER		R, MN 55330	)		
PREFIX (EACH DEF	CIENCY MUST B	OF DEFICIENCIES E PRECEDED BY FULL FIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
dietary" had instart doing the NA-A denied member's set the administration when intervies stated after endier shift their to answer CO take their own showed the thor just verball temperature in the control of the stated and the stated they have a control of the stated they have a control of the stated they have a control of the stated when stated "it is old knows what the stated when sheen "good and the stated when sheen "good and the stated screening control of the stated screening control of the stated when sheen "good and the stated when sheen "good and the stated screening control of the stated when sheen "good and the stated screening control of the stated when sheen "good and the stated	NA-A explated formed them ascreening properties and fill of a tree and fill of at the COVII at t	ined "someone in a that they needed to process themselves. firmed the dietary staff practice instructions with rector of nursing (DON).  /20, at 8:48 a.m. RN-Ficility at the beginning of a at the screening table ening questions and exithey either then reading to the screener excreener what the  ook (C)-A was exposed to take their at the COVID-19 D-19 screening staff screening station, ift. Screening staff screening station. C-A fir own temperature and as "sometimes they ney are not."  /20, at 12:47 p.m. the ered nurse (RN)-D reen" and "everyone are." RN-D further anymptomatic they had and going home."	21375			

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Minnesota Department of Health

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, ,	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00611	B. WING		07/3	60/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	ENTER 400 EVAN	IS AVENUE			
GUANDI	AN ANGLES CARE OF	ELK RIVE	R, MN 5533	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From pa	ge 6	21375			
	and shift change; he state exact time fra responsible for staff screening station we designated staff me would either sit at the screening station. It staff used hand sare temperature as pare to the screener being station screen. Staff thermometer reading answer the screening screener would receive temperature electror log at the screening staff, such as the result of the screening should not free for all; however were "times when rescreening should not free for all; however were "times when rescreening table]" are later and record the log into the electror Additionally, the DC of resident COVID-6/5/20. Follow up to additional residents along with another provided a list of 8 spositive for COVID-7/27/20. The dedication of the covided a list of 8 spositive for COVID-7/27/20. The dedication of the covided states in which the worked the COVID-7/27/20 in the dedication of the covided states in which the worked the COVID-7/27/20.	owever, he was unable to mes. The receptionist was a screening when the as not staffed with another ember; where the receptionist he receptionist desk or the The DON further explained nitizer and then took their own to five the screening process due to go behind the screening frocess due to the screening process due to the screener and would the go to the screener and would the guestions verbally. The cord the answers and conically. The paper screening to station was for screening to the day" and when staff cond screening mid shift. The body walks in the building st or screener there." "Self to thave happened, it is not a ter, he further voiced there and "someone will come back the information on the screening				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					C	
		00611	B. WING			0/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	ENTER 400 EVAN	S AVENUE			
OOAINDI	AN ANOLLO DANL O	ELK RIVE	R, MN 5533	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 7	21375			
	they screened there and not at the main facility entrance.					
	administrator stated screening location with times: 5:45 a.m. to "soft time" from 9:0 staff), 2:00 p.m. to 10:15 p.m. to 11:15 screened night staff stated active screen occur at the start of screening staff were another staff to per screening station has screener 19.5 hours been doing it for so and know not to consymptoms." In adding good about the swhat is expected."	7/30/20, at 2:13 p.m. the d the main facility entrance was staffed at the following 9:00 a.m. (station screener), a 0 a.m. to 2:00 p.m. (office 7:00 p.m. (station screener), p.m. (evening supervisor f). The administrator further ning was expected to always the staffs' shift and if e not present, staff were to call form the screening. The ad been staffed with an active a day; however, "Staff have long they know the process me into work if having tion, he explained, "Everyone creening process and knows The mid-day paper screening ed once the information was ctronic screening				
	Preparedness/Emp indicated "employed arrival to work using regarding travel, red COVID-19 or other themselves have retemperatures are migreater) at the start allowed to work who The policy failed to employee) was expemployee screening	Coronavirus/COVID-19 cloyee Illness, dated 5/7/20, es are being screened on g screening questionnaire cently being near anyone with respiratory illness or if they espiratory illness. All employee nonitored for fever (100.0 or of their shift. Staff will not o do not pass the screening." identify who (self or other sected to conduct the gs and the location of gs. The policy also failed to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND FLAN	OF CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING:	A. BUILDING:		COMPLETED	
		00611	B. WING		07/3	3 <mark>0/2020</mark>	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GUARDIA	AN ANGELS CARE C	FNTFR	IS AVENUE R, MN 5533	0			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21375	who worked on the The MDH Covid-19 Term Care Facilitie facility should "Activand symptoms of ill shift. In addition to screening for other personnel including home care, dialysis surveyors, chaplain [Active screening m should physically m entering the buildin other COVID-relate SUGGESTED MET director of nursing of inservice staff regal screening requirem ongoing compliance	ng process required for staff designated COVID-19 unit.  Toolkit- Information for Long s dated 6/5/20, identified the vely screen all staff for fever lness before starting each facility staff, conduct health essential health care therapy personnel, hospice, ombudsman, state at end of life, mortician, etc. neans that a trained person nonitor temperature of staff g and ask questions regarding and symptoms.]"  THOD OF CORRECTION: The (DON), or designee, could rding active COVID-19 lents; then audit to ensure	21375				
21545	MN Rule 4658.1320	O A.B.C Medication Errors	21545			8/21/20	
	percent as describe Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long incorporated by refe purposes of this pa (1) a discrepa	ust ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of as Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was at medications are actually					

Minnesota Department of Health

STATE FORM 9E4B11 If continuation sheet 9 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00611	B. WING			C <b>30/2020</b>
	PROVIDER OR SUPPLIER  AN ANGELS CARE C	ENTER 400 EVA	DDRESS, CITY,  INS AVENUE  ER, MN 5533	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21545	(2) the administ medications.  B. It is free of a serror. A significant (1) an error of discomfort or jeopal safety; or  (2) medication requires the medication error conceptiate a reoccut toxicity. All medicate prescribed. An incomprescribed and the error report must be that occurs. Any singuistican or the phyresident or the resident reactions of the phyresident or the phyresident or the phyresident or the phyresident or the resident or t	didents in the nursing home; or stration of expired any significant medication medication error is: which causes the resident ardizes the resident's health or on from a category that usually ation in the resident's blood to diffic blood level and a single ould alter that level and currence of symptoms or dient are administered as dident report or medication errors or must be reported to the dent's legal guardian or entative and an explanation error are administered as dident report or medication error dentative and an explanation error are administered as dent report or medication error that cant medication errors or must be reported to the dent's legal guardian or entative and an explanation error that cant medication errors or must be reported to the dent's legal guardian or entative and an explanation or entative and an explanation deresident's clinical record.				
	by: Based on interview facility failed to ens blood clotting was a	and document review, the ure medication to prevent administered in accordance rs for 1 of 1 residents (R1)		Corrected 8/26/2020		

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				LETED
						`
		00611	B. WING		1	30/2020
NAME OF I		STREET AD		CTATE ZID CODE		
NAIVIE OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GUARDI	AN ANGELS CARE C	FNTFR	IS AVENUE R, MN 5533	0		
0/10/15	CLIMMA DV CTA					()(5)
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEI ICIENCI)		
21545	Continued From pa	ge 10	21545			
	reviewed who suffe	red a stroke after their				
		ediate jeopardy (IJ) situation				
	for R1 when the fac	cility failed to take adequate,				
		o educate staff to potential				
		ntinued resulting in Ŕ1 not				
		ed medication from 5/7/20 to				
	and/or education to	staff whom process orders to				
		•				
	G).	, , , , ,				
	Findings include:					
		p.m. R1's family member				
21343	reviewed who suffe ordered aspirin was significant medicatiresulted in an imme for R1 when the fact systemic action(s) the factors which contripotential for similar subsequent medication. The IJ began on 5/6 for a daily dosing of anti-inflammatory medication for a discover ceeiving the ordered for street and left-sided weak Emergency Departit hospitalized for street and/or education to ensure similar error residents at risk of administrator and discover and medication for the IJ was remove implemented a remon-compliance reproduced for the IJ for The IJ was remove implemented a remon-compliance reproduced in the IJ for The IJ was remove implemented a remon-compliance reproduced for 7/28/20, at 1:30 (FM)-A was interviewed a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was remove implemented a medication of the IJ for The IJ was rem	red a stroke after their is not provided resulting in a on error. These findings ediate jeopardy (IJ) situation cility failed to take adequate, to educate staff to potential buted to the error causing the reoccurrences and further action errors.  6/20, when physician orders aspirin (non-steroidal nedication which helps prevent ming in the arteries) were natioused resulting in R1 not ed medication from 5/7/20 to 0, R1 developed facial droop ness; was transferred to the ment (ED) and subsequently size. The facility investigated wered factor(s) which rror, including potential record (EMR) issues, and the factors with a systemic fix staff whom process orders to be did not reoccur and placed tharm or injury. The facility irector of nursing (DON) were R1 on 7/29/20, at 2:16 p.m. d on 7/30/20, when the facility oval plan; however, mained at an isolated scope of not immediate jeopardy (Level	Z1040			

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iviinneso	Minnesota Department of Health						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
					(	:	
		00611	B. WING		07/30/2020		
					, 0.70	0,2020	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GUARDI	AN ANGELS CARE C	FNTFR	NS AVENUE				
		ELK RIVE	ER, MN 5533	0			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE	
IAG	TREGOE TOTAL OTTE		TAG	DEFICIENCY)	140412		
21545	Continued From pa	ge 11	21545				
	home had followed	up with him about the error;					
		's ordered aspirin had been					
		tinued instead of just R1's					
		y, which is what had been					
		nis caused R1 to miss several					
	weeks of aspirin do	sing. FM-A voiced he believed					
		d to R1 suffering the stroke;					
	and since the stroke	e, R1 is no longer able to live					
		eds more help to complete					
	basic cares. Furthe	r, FM-A expressed frustration					
		and voiced the error made him					
		viously a problem" at the					
		their order processing.					
		nimum Data Set (MDS), dated					
		R1 had intact cognition and					
		assistance with activities of					
	daily living (ADLs).						
		oses recorded (i.e. stroke,					
	aphasia, hemiplegia						
		dication(s) only on one (1) day					
	during the review p						
		ration After Discharge Orders,					
	dated 4/22/20, iden	ursing home after being					
		a fall and fracture with a					
	•	espitalization was listed as					
		due to atrial fibrillation, and					
		hold R1's warfarin sodium					
		nedication) for a set period.					
		d, "May need discussion					
		ion of [warfarin] given high fall					
		ge medications to the nursing					
		hich included, "aspirin 81 mg					
		olet by mouth once daily with a					
		listed allergy to aspirin with					
		*patient tolerating daily					
	dose of aspirin 12/1						
	•	phone Orders, dated 5/4/20,					
		or R1 which read "Start					

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aspirin 325 mg EC [enteric coated] PO QD [by

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Minnesota Department of Health							
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00611	B. WING		07/3	0/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
		400 FVAN	IS AVENUE	,			
GUARDI	AN ANGELS CARE C	ELK RIVE	R, MN 5533	0			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21545	Continued From pa	ge 12	21545				
	mouth everyday] or Afib [atrial fibrillation which causes rapid A subsequent Physicated 5/6/20, identified to DC [discontinue] order was provided The order was sign including station se However, a Discontinued R1's of with dictation prese R1's Medication Addated 5/1/20 to 5/3 medications while a provided aspirin 81 5/4/20 and 5/5/20. Istarted 5/6/20, was provide aspirin 325 for atrial fibrillation. on 5/6/20; however discontinue date of aspirin were provided MAR. R1's progress note a.m. which recorded orientated and need with her walker. A progress note on SBAR (Situation, Execommendations recorded as having weakness and left-state the restroom. The rest of vital signs on saying, "I don't know physician (MD)-A with the hospital ED for the set of the spital ED for the set of the set of the spital ED for the set of the set o	n 5/6/2020. Dx: [diagnosis] n; an abnormal heath rhythm , irregular beating]." ician's Telephone Orders, fied an order which read, "OK aspirin alergy [sic]." The by the nurse practitioner (NP). ed by various staff members,					

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Minnesc	<u>ita Department of He</u>	ealth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	_ETED
		00611	B. WING		1	
		00611			07/3	0/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		400 FVAN	IS AVENUE			
GUARDIAN ANGELS CARE CENTER			R, MN 5533	0		
			1			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
17.0		,	17.0	DEFICIENCY)		
21545	Continued From pa	ige 13	21545			
	Dhysical dated 5/2	9/20, identified R1 presented				
		int of weakness. R1 was				
		a poor historian upon				
		ED, " due to the acuity of				
		slurred speech, aphasia (loss				
		and or express speech) and				
		s being recorded as present.				
		d R1 had been taken off her				
		ing sustained multiple falls on				
		as given TPA (thrombolytic				
		blood clots) in the ED. A				
		eadmission Medications,"				
		edications which were being				
	administered by the	e nursing home; however, the				
	list lacked any phys	sician orders for aspirin. The				
	report continued an	nd listed R1 as having an				
	allergy to aspirin wi	th a reaction of rash and				
		dictation was present which				
		ating daily doses of aspirin				
		the report listed R1's medical				
		equent plan(s) to address				
		uded, "Acute stroke," which				
		caused by ischemia				
		supply) and left-sided				
		facial droop were present. R1				
	was admitted to the					
		narge Summary, dated 6/1/20,				
		ischarged from the hospital				
		home with a principal				
		ontal stroke with residual facial				
		ia (slurred speech). R1 was				
		ial fibrillation and dictation				
		had been stopped recently				
		injury. Neurology consulted				
		Id remain off [warfarin] at this				
		A [aspirin]." Further, a series				
		ations were listed which				
		s for, "aspirin 325 mg tablet				
		outh once daily with a meal."				
	Further, the outline	d allergies on the report				

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Minnesc	Minnesota Department of Health						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					С		
		00611	B. WING		07/30/2020		
			1		1 0170	.0,2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GUARDI	AN ANGELS CARE C	ENTER 400 EVAN	IS AVENUE				
COARDI	AN ANOLLO GAILL O	ELK RIVE	R, MN 5533	0			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE	
TAG	REGULATORT OR L	SCIDENTIFTING INFORMATION)	TAG	DEFICIENCY)	FRIATE	DAIL	
21545	Continued From pa	ge 14	21545				
	continued to list asp	oirin with the same dictation					
	present which read	, "*patient tolerating daily					
	doses of aspirin 12	/14/16."					
		ess note identified R1 was					
		nursing home from the					
		outlined, "Resident is a					
		a recent stroke. Resident has					
		oping and weakness." Further,					
		as needing assist of two with					
	all transfers using a						
		agency (SA) submitted l 6/4/20, identified the facility'					
		ation into the incident. R1					
		sing home on 4/22/20, and the					
		had been on warfarin;					
		der was concerned for					
		placed on hold. On 5/4/20,					
		ed to increase R1's daily					
		81 mg to 325 mg beginning					
		ame date, R1's aspirin allergy					
	was identified and a	an order was received to					
	discontinue the alle	rgy. These orders were given					
		tary to process who removed					
		d gave the orders to the nurse					
		r, the facility' electronic					
		ointClickCare) did not allow for					
		n allergies had been removed					
		se inadvertently discontinuing					
		der instead of the allergy. The					
		hen presented with a change bsequent thrombotic stroke on					
		"[R1] has experienced a					
		ue to the incident". The					
		n(s) to describe action(s) taken					
		ence to the subjected resident					
		The facility identified					
		rided to the nurse, LPN-A, who					
		r; however, the field to write					
		een taken to prevent					
		ners was completed with only,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
	00611		B. WING		C 07/30/2020		
NAME OF		CTDEET AD		STATE ZID CODE	•		
NAIVIE OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GUARDI	AN ANGELS CARE C	FNTFR	IS AVENUE R, MN 5533	0			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21545	Continued From pa	ge 15	21545				
	"N/a [not applicable actions or evidence the facility to help a identified findings on tallowing nurses removed; nor was to completed education the incident regardiclarified if they are application of the incident regardiclarified if they are application of the incident regardiclarified if they are applicated included the incorresponding to the incident medication errors approvided any recent ranscription and provided any recent ranscription and providers are then passinal check. RN-E stotiscontinue and would act on the orthey're not a physic would then follow-u order. Further, RN-provided any re-educated processing would recent in the provided any re-educated processing would re-educated processi	e.]." The report lacked any of a systemic response by lert or educate staff to their of the electronic health system to confirm allergies are here evidence of any on to other staff not involved in ng ensuring orders are unclear.  7/28/20, at 7:57 a.m.  N)-C stated the nurses were nt allergies in the computer oiced she did not know how to s. RN-C explained a on error would be one which ect administration or omission or other "high risk meds." as not sure on the facility ng or investigating significant added she had not been t training or education on order					
		6) had rights and access to thin the electronic health					

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Minnesota Department of Health							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00611	B. WING		07/3	) 0/2020	
NAME OF	PROVIDER OR SUPPLIER	etpeet an	DDESS CITY S	STATE, ZIP CODE			
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GUARDI	AN ANGELS CARE C	FNTFR	R, MN 5533	0			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21545	Continued From pa	ge 16	21545				
	system; however, Suncomfortable doing she would ask a nuinstead of her doing interview, on 7/29/2 she could not recal or re-education on within the past seven During interview on voiced she was una involving the electroallergies are modified she was not aware medication error (doriginally processed discontinue the asphad not been given guidance on order or medication order on 7/29/20, at 9:57 (MD)-A was intervied R1's primary care put the nursing home. It to the nursing home. It to the nursing home admission, R1's was R1 had sustained a internal bleeding) dhad been hospitalized issues" including at stenosis and coron which increased R2 orders in place for a milligrams (mg). Midiscussions with R2 she was worried abgeneral" due to her decision was made aspirin and an orderincrease R1's aspir	SS-A voiced she was g so. As a result, SS-A stated rse to change the order g it. During subsequent 0 at 9:10 a.m., SS-A stated receiving any new guidance allergy or order processing					

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
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NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
GUARDIAN ANGELS CARE CEN	NTFR	S AVENUE R, MN 5533	0				
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21545 Continued From page	e 17	21545					
situation then arose we medical record had a however, it was detern and a separate order remove the listed aller written on 5/6/20 was aspirin allergy; however medication administration itself along were both discontinue getting little to no dosi through 5/29/20. MD-/she had seen R1 for a R1 had no visible sign complaints of knee pathen developed difficut weakness. R1 was sut and diagnosed with a she learned R1 had be stroke, she reviewed I discovered the aspirint then e-mailed the nurse concern about the errolikely the first time the notified an error had he if R1 had been provided would have provided against stroke adding risk of stroke to have reviewed R1's risk factomitted aspirin would "significant" medication expressed regret about were multiple opportulation has been provided and correct in the set of the s	where they identified R1's listed allergy to aspirin; mined to not be accurate was written on 5/6/20 to ergy. MD-A verified the order meant to remove the ver, not meant to remove the ation order. MD-A explained for then occurred where the g with the identified allergy ed, which resulted in R1 ing of the ordered aspirin A expressed on 5/29/20, a visit earlier in the day and as of distress outside of ain; however, afterwards R1 alty speaking and left-sided absequently sent to the ED a stroke. MD-A stated when been hospitalized for a her medication list and a was not being given. MD-A rsing home and expressed for which MD-A voiced was a nursing home had been happened. MD-A explained led the ordered aspiring and stated she felt the be considered a on error for R1. MD-A out the error and voiced there unities for staff, including						

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AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		00611	B. WING		07/3	0/2020		
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NAIVIL OI I	-NOVIDEN ON SUFFEIEN		IS AVENUE	STATE, ZIF CODE				
GUARDIAN ANGELS CARE CENTER			R, MN 5533	0				
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21545	Continued From pa	ge 18	21545					
	staff to modify any prevent future error surrounding R1's in she was not sure w policies the nursing on since the incider On 7/29/20, at 10:4 and verified he processifies of the eventry and subseque acknowledged he woccurred as he had explained the education or further and the explained the education or further and the education of the education of the education of 5/6/20; however, and the education of 1/29/20, at 11:0 director of nursing (explained R1's unither and the education currently areceived notification error involving R1's vulnerable adult (Verror was reviewed corresponding staff the process used for multiple "chart checorders are entered"	of their procedures to help is with circumstances cident; however, MD-A stated that new procedures or staff may have been directed into help avoid further errors. In a.m. LPN-A was interviewed beesed R1's order from 5/6/20, continue R1's aspirin allergy. The was unable to recall into surrounding the order ent error; however, was aware an error had been educated on it. LPN-A action the facility provided was discussion which they uble check and clarify" orders PN-A stated he had received ther instruction on how to resort are processed correctly to onfusion in the electronic N-A voiced he was unaware R1 gy when he processed the wever, reiterated he could not be happened with the order is "so long ago."  7 a.m. the administrator and (DON) were interviewed. They manager, whom was on and not available for interview, and or by the physician and apprinted the phys						
	orders are entered secretary staff. The							

Minnesota Department of Health

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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00611		B. WING		07/30/2020			
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
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21545	Continued From pa	ige 19	21545				
	widespread concer	n with their order check					
		he DON acknowledged the					
		garding the incident with R1's					
		nterview continued and they					
		y had completed an					
		ning to R1's medication error					
		issue with their electronic					
	record system (Poir	ntClickCare) where it did not					
		n allergies were discontinued,					
		software developer and were					
	"trying to get that fix	xed." The DON added the					
	"bottom line" of the	error was the nurse mis-read					
	R1's physician orde	er on 5/6/20 (directing to					
	discontinue the asp	oirin allergy) and "should have					
	questioned it" instead	ad of discontinuing the					
	medication versus	the allergy.					
	At 11:15 a.m. the d	irector of quality (DOQ) joined					
		oiced the incident pertaining to					
		ror was the "true definition of					
		ad been taken off warfarin and					
		ı daily aspirin regimen;					
		s a listed allergy to aspirin on					
		nurse practitioner (NP) had					
		discontinue the allergy. The					
		cted on by the station					
		scontinued the allergy in the					
		se, LPN-A, then followed					
		complete the process and "final					
		ever, the electronic record					
		g or record when an allergy is					
		is caused the nurse to read the	7				
		the nurse thought the order ue the medication itself as the					
		er listed. R1 subsequently was	<b>^</b>				
		spirin and sustained a stroke					
		caused R1's physician to					
		nager about the error and an					
		tarted into the incident which					

the best of all worlds" the NP could have

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		00611	B. WING		C 07/30/2020	
		00611	J		07/3	0/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		400 EVAN	S AVENUE			
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	OLIMANA DV OTA					4.5
(X4) ID PREFIX	_	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
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				DEFICIENCY)		
04545	0 " 15	00	04545			
21545	Continued From pa	ge 20	21545			
	re-worded the orde	r to be clearer, and expressed				
		involved was "doing what they				
	thought was the rig					
		nued, and, as a result of the				
		sed they had completed some				
		ne person(s) immediately				
		ror, including the NP and				
		ey had not conducted any				
		e other staff members working				
		rocess orders as R1's error				
		tion" and they felt it didn't				
		e education or alert. DOQ				
		acility' systemic response to				
		viewing and affirming their				
		order transcription was				
		, DOQ acknowledged the				
		us" with R1's incident and she				
		electronic software system				
		continued allergy orders, the				
		ot have ever happened. DOQ				
		iched out to the software				
		their findings; however, had				
		onse from them on how to				
		the identified issue. When				
	•					
		stop-gap measures put into e other similar errors did not				
		vare company provided				
		ressed the unit manager staff				
		p an eye on it going forward." ne felt the facility had a solid				
		orocess in place for "check sure order accuracy and their				
		ied there "wasn't a flaw" in the				
		urther, the facility did reach out				
		ctor of the campus; however,				<b> </b>
		acility had done any follow-up				<b> </b>
		group(s), despite some				<b> </b>
		arity of the provider order, as				
		d" the order and not the				
	provider.					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			71. BOILDING.		С		
	00611		B. WING		07/30/2020		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CHARRI	AN ANCELS CARE C	ENTER 400 EVAN	S AVENUE				
GUARDI	AN ANGELS CARE C	ELK RIVE	R, MN 5533	0			
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21545	When interviewed va 4:35 p.m. the facility expressed she had medication errors, istarted in April 2020 only CP the facility been involved with nurses or SS staff rissues with transcrireviewed R1's med she had noticed R1 discontinued, it wou would have question history. Further, CF comment on how R have contributed to however, verified sl conversations or coregarding allergy or processing.  A provided Medicate 6/15, identified the assure medication ongoing basis, and medication-related would be assessed as appropriate to the assurance) commit consulting pharmac procedure was providered a new medication of the consure the order (i.e. dose, route, etc. do	via telephone on 7/29/20, at y' consulting pharmacist (CP) not been updated on any including R1's error, since she D, and verified she was the used. CP stated she had not any education processes for regarding medication orders or ption/order processing. CP ical record and expressed if 's aspirin had been all have been something she and given R1's medical Proceed she was unable to R1's aspirin omission could her subsequent stroke; the had not had any onsultation from the facility order transcription and when a significant problem is identified, the issue, documented and reported, the physician, the QA (quality tee, the pharmacy and cist and the FDA, if needed. A wided to follow when a resident dication order which directed ed specifics of the medication order which directed ed specifics of the medication order transcription and allergy order transcription and allergy order transcription and allergy order transcription and allergy or the physician and allergy order transcription and allergy order transcription and allergy or the physician and allergy order transcription and allergy or the physician and allergy or the physician and allergy order transcription and allergy or the physician and allergy order transcription and allergy or the physician and allergy order transcription and allergy order transcription and allergy	21545				
	A facility policy on o	order transcription and allergy was requested, however, none					

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  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)  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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGELS CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  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)  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							
GUARDIAN ANGELS CARE CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) 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			00611	B. WING		07/3	0/2020
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  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	GUARDI	AN ANGELS CARE C	FNTFR		0		
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	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
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	The IJ which began 7/30/20, at 2:25 p.n implemented a rem completing educative electronic health systranscription, and eclarification. On 7/3 p.m. staff members transcription and al interviewed and verprovided. SUGGESTED MET director of nursing, applicable policies are transcrible correctly; then insection compliance.	n on 5/6/20, was removed on m. when the facility hoval plan which included on to staff regarding the estem and allergy order education regarding order 80/20, from 1:10 p.m. to 2:18 is involved with order lergy order processing were rified education had been THOD OF CORRECTION: The or designee, could review and procedures to ensure bed and implemented rvice staff and audit to ensure	21545			

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