

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245012	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Guardian Angels Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Evans Avenue Elk River, MN 55330	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0806</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>47083</p> <p>Based on interview and document review, the facility failed to ensure residents with food allergies received the appropriate meal tray for 1 of 3 residents (R1) reviewed for food allergies. This resulted in an Immediate Jeopardy (IJ) when R1 ingested an allergen, and was hospitalized in an intensive care unit (ICU). The provider had already implemented corrective action prior to the investigation, so the deficiency is issued as past non-compliance.</p> <p>The IJ began on 7/10/24, at 5:04 p.m., when R1 was served and consumed food she was known to be allergic to. The administrator and director of nursing (DON) were informed of the IJ on 7/17/24 at 4:05 p.m. The facility implemented corrective action on 7/11/24, prior to the start of the survey and was therefore Past Non-compliance.</p> <p>Findings include:</p> <p>R1's Face Sheet indicated she was admitted to the facility at 2:00 p.m. on 7/10/24.</p> <p>R1's care plan dated 7/10/24 indicated she had an allergy to shellfish.</p> <p>R1's meal tray ticket dated 7/10/24 indicated she had an allergy to shellfish.</p> <p>On 7/10/24, at 5:04 p.m., R1 was served a dinner tray by nursing assistant (NA)-A which included shrimp pasta salad.</p> <p>On 7/10/24, a progress note indicated at approximately 6:20 p.m., after eating the shrimp pasta salad, R1 began feeling diaphoretic and nauseous. R1 reported stomach pain and was unable to take a deep breath. Licensed practical nurse (LPN)-A determined R1 had consumed shrimp pasta for dinner. LPN-A administered epinephrine (medication used to treat serious allergic reactions), administered oxygen, and called 911.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0806</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 7/16/24, at 12:31 p.m., R1 was interviewed and stated she arrived at the facility earlier on 7/10/24. Her supper tray was delivered to her on 7/10/24 with her name on it. It was a cold pasta salad, which she thought had chicken in it. After she finished eating her supper, she began feeling very hot. She rang her call light, and the aide came in. The aide called for the nurse, who quickly realized R1 had consumed shrimp and had a shellfish allergy. The nurse administered her epinephrine shot, and called 911 right away. The ambulance arrived quickly and she was transported to the hospital where she spent a few days in the ICU.</p> <p>07/16/24, at 2:05 p.m., dietary aide (DA)-A stated she plated R1's food in the kitchen, and she did not put the pasta salad on her tray. The cook pointed out R1's allergy, and directed her to give R1 a sandwich, not the pasta.</p> <p>On 7/16/24, at 2:51 p.m., nursing assistant (NA)-stated she served R1 her tray, which included shrimp pasta. She looked at the meal ticket, and it did not indicate R1 had any allergies. Later, she went to check on R1 and found her to be sweating profusely. R1 told her she didn't feel well and felt like she might throw up. She got LPN-A to come assess R1 at that time.</p> <p>On 7/16/24, at 3:22 p.m., the director of dining (DOD) stated DA-A prepared the trays for R1's unit on 7/10/24 for supper. He directed DA-A to provide R1 with a sandwich due to her shell fish allergy. All trays are provided with a meal ticket, and R1's meal ticket on 7/10/24 indicated her shellfish allergy.</p> <p>On 7/16/24, at 3:48 p.m., registered nurse (RN)-A stated he conducted interviews with the nursing staff immediately following the medical emergency due to R1 ingesting the shrimp pasta on 7/10/24. He spoke with NA-A who stated she delivered the supper tray, but did not remember seeing a meal ticket on the tray. LPN-A provided R1 with appropriate medical interventions. RN-A stated immediate education was provided to all staff working at that time.</p> <p>On 7/16/24, at 4:08 p.m., RN-B stated he was notified of the event immediately after it happened. He notified the physician, the medical director, the director of nursing (DON), the administrator, the state agency (SA), and family. The facility began auditing process of trays, and education for nursing and dietary department on 7/11/24.</p> <p>On 7/17/24, at 7:52 a.m., the administrator stated the facility finished their investigation and were unable to determine what happened. It was inconclusive. Dietary staff said they prepped the tray correctly. NA-A stated she didn't remember if there was a meal ticket on the tray or not.</p> <p>On 7/17/24, at 10:42 a.m., LPN-A stated NA-A informed her R1 was dripping with sweat and didn't feel well around 6:20 p.m. R1's color did not look good. LPN-A stated she had received R1's medications from the pharmacy approximately 15 minutes earlier. She recalled an epinephrine pen indicated for a shell fish allergy. That's when she asked if R1 ate the shrimp pasta salad for supper. She administered the resident's albuterol inhaler, epinephrine, and applied oxygen, while another nurse called 911. R1 was sent to the hospital via ambulance.</p> <p>On 7/17/24, at 10:58 a.m., the DON stated the internal investigation was inconclusive. The facility had been auditing of meal trays and education has been in process since 7/11/24. EpiPens were available in the emergency kits, and the nurses were knowledgeable on how and when to use them.</p> <p>(continued on next page)</p>		

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