STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Angels Care Center	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and record review, the facility failed to follow physician orders and ensure provider was notified of resident refusals for continuous positive airway pressure (CPAP) orders for 1 of 1 residents (R2) reviewed respiratory care. Findings include: R2's admission Minimal Data Set (MDS) dated [DATE], indicated R2 had diagnoses of pulmonary fibrosis (condition where the lungs become scarred and thickened, making it difficult to breathe), acute and chronic respiratory failure, chronic obstructive pulmonary disease, and obstructive sleep apnea (sleep disorder where breathing repeatedly pauses or slows down during sleep due to a blockage of the upper airway). Further, MDS revealed R2 had exhibited behavior related to rejection of care. R2's medication administration record (MAR) and treatment administration record (TAR) dated April 2025, revealed R2 had physician order's directing staff to record hours R2 kept his CPAP (a machine that uses mild alit pressure to keep breathing airways open while you sleep) on, chart when refuses every night shift dated 3/31/25. R2's MAR/TAR revealed on two occasions R2 had refused, and 10 occasions was documented as 0 hours worn. R2 also had an order to remove R2's CPAP at 8:00 a.m. which was documented as completed from 4/4/25 through 4/7/25. R1's care plan revised 4/21/25, identified R2 had a behavior problem as evidenced by increased agitation, restlessness, fidgeting, pulling off clothes, pulling at drainage tube, and self-transferring. R2's care plan directed staff when refusing cares or tasks to ensure safety, attempt to re-approach, offer alternate caregiver, offer choices, and notify charge nurse. Further, R2's care plan revealed R2 had an altered respiratory status and difficulty breathing. R2's respiratory interventions included CPAP use and R2 had the right to refuse but staff were to encourage use while in bed. On 4/23/25 at 11:14 a.m., licensed practical nurse (LPN)-A stated family member (FM)-A arrived at the facility on 4/7/25, and was upset R2 did not have his CPAP on and/or in his room. LPN-A stated this was her first time working with R2 and was not aware he required a CPAP, but LPN-A stated she would go look in R2's old room for it. LPN-A stated she found the CPAP and brought it to R2's current room. LPN-A confirmed she had observed R2 on the morning of 4/7/25, in bed without a CPAP on. Further, LPN-A stated she was informed R2 had a history of refusing the CPAP, but with R2's respiratory diagnoses he should have still been offered to wear it. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. Building B. Wing	04/24/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 12:05 p.m., FM-A stated R2 had end stage lung disease and tested positive for COVID-19 on 4/4/35, which R2 then had to move to the isolation unit into a private room. FM-A stated she arrived at the facility in the morning of 4/7/25, and noted R2 did not have his CPAP machine. FM-A stated R2's CPAP was not new for him, and he had an order to wear the CPAP at night while sleeping due to his sleep apnea, however when R2 moved rooms on 4/4/25, staff did not bring his CPAP to his new room. Further, FM-A stated R2 would often decline to wear the CPAP or remove it himself, but he should still be offered to wear it. On 4/23/25 at 1:54 p.m. nurse practitioner (NP) stated R2 had an order to wear his CPAP at night because he had a diagnosis of sleep apnea. NP stated she was not aware of R2 refusing to wear the CPAP. On 4/23/25 at 2:50 p.m., registered nurse (RN)-A stated R2 had an order to wear his CPAP at night, however R2 had a history of refusing to wear the CPAP or removing the CPAP himself during the night. RN-A stated staff would still be expected to offer R2 his CPAP and document all refusals in R2's MAR/TAR, and RN-A confirmed staff would be expected to notify the provider of consistent refusals. On 4/23/25 at 4:35 p.m., combined interview with director of nursing (DON) and administrator revealed R2 was moved from the 100 unit on the evening of 4/3/25, to the 500 unit. DON and administrator stated during the transition to the other unit, R2's CPAP was not transferred to the new room and was not available for R2. Further, DON and administrator stated there were reports from the 100-unit staff R2 would often refuse to wear his CPAP, however DON and administrator confirmed R2's provider had not been updated regarding R2's consistent refusals as expected. In addition, DON and administrator confirmed staff had documented in R2's MAR/TAR for CPAP completion 4/4/25 through 4/7/25, however R2 did not have his CPAP in his room at the time. DON and administrator stated staff had not been re-educated regarding following physician orders and updating provider related to consistent refusals. On 4/24/25 at approximately 12:50 p.m., requested facility policy related to refusal of physician orders and notifying physician from administrator and DON, however facility failed to provide a copy.