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	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Angels Care Center	400 Evans Avenue Elk River, MN 55330

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35992 Based on observation, interview, and document review the facility failed to provide assist with personal grooming for 1 of 1 residents, (R2), reviewed for personal appearance. Findings include: R2's quarterly Minimum Data Set (MDS) assessment of 11/16/24, identified R2 had brief interview for mental status (BIMS) score of 12. Although classified as moderate cognitive impairment, a score of 13 indicates intact cognition. A listing of R2's medical diagnoses included progressive neurological conditions, cerebral palsy (a group of conditions that affect movement and posture), dementia, and multiple sclerosis (MS-a disease that causes breakdown of the protective covering of nerves which can cause numbness, weakness, trouble walking, vision changes and other symptoms). The MDS indicated R2 had functional limitation of both upper extremities and was fully dependent of staff for all aspects of personal hygiene, including combing her hair, shaving, washing and drying face and hands. A review of R2's care plan, most recently revised on 6/3/24, indicated R2 had an ADL (activities of daily living-tasks of dressing, grooming, bathing, and mobility) self-care performance deficit r/t (related to) cerebral palsy. The care plan directed the staff to provide assist of one to complete personal hygiene. The care plan lacked description of what personal hygiene consisted of for R2. The care plan further identified R2 had a communication problem r/t aphasia (an impairment of person's ability to comprehend or formulate language because of damage to specific brain regions), slow speech, and no teeth. The care plan indicated R2 could be difficult to understand due to this. During observation and interview on 1/21/25, at 10:47 a.m. R2 was observed seated in her wheelchair in her room, watching television. R2's hair was observed to be neatly pulled back and she was neatly dressed. R2 was observed to have a patch of white whiskers under her chin which was approximately one inch in length, 1/4th inch in width, and 1/4th inch length of whiskers. R2 lacked dentures, and her speech pattern was difficult to understand due to difficulty with projection (ability to speak loudly/clearly) and when asked if she was bothered by her whiskers, R2 nodded her head yes. R2 stated staff offered to assist her with shaving her whiskers once in a while. R2 nodded her head yes when asked if she wanted to have her whiskers shaved by staff. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25, at 12:32 p.m. R2 was observed in her room at this time as she was receiving assistance with her noon meal from nursing assistant (NA)-A. R2 was noted to have whiskers present, without shaving completed. NA-A stated she had provided R2 with assist to complete morning cares. NA-A stated personal grooming was completed by staff, and shaving was generally completed in the morning. NA-A stated she had not completed personal shaving, although acknowledged the whiskers were present and were long. R2 affirmed to NA-A she wished to have her whiskers shaved, and directed NA-A to the lower drawer in her dresser where her razor was stored. On 1/23/25, at 4:37 p.m. was observed to be up in her chair, watching television. R2 had her hair pulled up on top of her head. Her facial hair had been shaved and R2 appeared neat and well groomed. When asked if it felt good to have shaving completed, R2 responded yeah. On 1/23/25, at 4:54 p.m. clinical manager (CM)-A stated she was unaware R2 had facial whiskers present, and indicated this should have been addressed with routine morning/evening cares provided by nursing assistants. CM-A stated at times R2 has refused assistance from certain staff, however, stated if that occurred, she would expect staff to request the assistance of another staff member to complete the task. CM-A stated it was important to assist with removal of facial hair for the dignity of the resident. CM-A stated although some residents may not wish to have this completed, R2 would want to have facial hair removed. The facility policy, Dignity, dated February 2024, identified that each resident shall be cared for in a manner that promotes and enhances his/her sense of well-being, level of satisfaction with life, and feeling of self worth and self esteem. The policy indicated when assisted with care, residents are supported in exercising their rights, and are groomed as they wished to be groomed (hair styles, nails, facial hair, etc.).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure the completed quarterly Minimum Data Set (MDS) was accurately coded to reflect hospice services for 1 of 1 resident (R15) reviewed for MDS' accuracy. Findings include: The CMS Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified each section of the MDS along with various instructions how to code and/or complete them. The section labeled, Section O: Special Treatments, Procedures, and Programs, listed directions to record any special treatments or programs the resident received during the specified time period (i.e., assessment reference date; ARD). This included, . Hospice Care, and outlined, Code residents identified as being in a hospice program . where any array of services is provided for the palliation and management of terminal illness . R15's quarterly MDS dated [DATE], identified diagnoses included progressive neurological conditions, neurogenic bladder, dementia, Parkinson's disease, depression, and manic disorder. At the time of survey, MDS failed to identify R15 received hospice care in section O- Special Treatments and Programs. R15's census report, printed 1/24/25, identified R15 was admitted to hospice services on 3/22/24. During interview on 1/23/25 at 4:36 p.m., director of reimbursement and MDS coordinator verified they had reviewed R15's MDS (dated 12/25/24) and stated hospice care should have been coded adding, That was a coding error. During interview on 1/24/25 at 2:40 p.m. the director of nursing (DON) stated MDS assessment accuracy was important because it needs to reflect the resident care needs and should be always submitted accurately. During interview on 1/24/25 at 11:08 a.m., regional clinical director stated facility did not have a policy on MDS and that they follow chapter two of the RAI manual.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 35992 Based on observation, interview, and document review, the facility failed to provide activities of daily living (ADL's-dressing, grooming, bathing, eating, and grooming) for 4 of 4 residents, (R57, R46, R16, R14) who were observed for assistance with eating. Findings include: R57: R57's significant change Minimum Data Set (MDS) assessment of 12/15/24 identified that R57 was rarely/never understood and had severe cognitive impairment. R57's medical diagnoses included Alzheimer's Disease/Dementia, anxiety disorder, metabolic encephalopathy (change in how your brain works due to an underlying condition), seizure disorder (a sudden change in behavior, movement or consciousness due to abnormal electrical activity in the brain)/epilepsy (a group of non-communicable neurological disorders characterized by recurrent seizures), malnutrition (imbalance between the nutrients your body needs to function and the nutrients it gets), dehydration (a lack of total body water that disrupts metabolic processes (set of life-sustaining chemical reactions in organisms), hyperosmolality (a condition of high osmolarity in the body, often caused by increased sodium or glucose levels), hypernatremia (a high level of sodium in the blood), fatigue, dysphagia (difficulty swallowing), contracture of the muscle of the upper arm, and failure to thrive. The MDS identified R57 is noted to have impaired functional movement of both arms and was totally dependent on staff for assistance with eating. R57's care plan, revised on 12/27/24, indicated R57 was unable to communicate her needs. Additionally, the care plan indicated R57 had a communication problem r/t (related to) dementia and indicated R57 was nonverbal and was unable to communicate needs. The care plan directed staff to anticipate R57's needs. The care plan also indicated R57 had an ADL self-care performance deficit r/t impaired cognition from early onset Alzheimer's. The care plan directed staff to assist R57 to have clothing protector at meals, and directed staff to provide assistance with eating. R46 R46's significant change MDS assessment of 11/12/24, identified R46 had severely impaired cognition. The MDS indicated R46 had the following medical diagnoses: non-traumatic brain dysfunction (brain damage caused by factors other than external trauma), arthritis, Alzheimer's disease/Dementia, malnutrition, age related macular degeneration (a condition that affects the middle part of your vision, and weight loss. The MDS indicated there were no limitations in range of motion. The MDS identified R46 required partial/moderate assistance with eating-which is identified as the helper does less than half the effort. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R46's care plan, revised on 12/3/24, indicated R46 had a deficit with ADL performance related to rheumatoid arthritis (a type of arthritis where your immune system attacks the tissue lining the joints on both sides of your body. It may affect other parts of the body.), memory loss and dementia. Staff were directed to provide physical assistance to eat. The care plan also indicated R46 had a potential for communication problem related to dementia, memory loss, and trouble word finding. Staff were directed to allow adequate time to respond, repeat as necessary, and not rush client. R16 R16's significant change MDS of 11/18/24 indicated moderate cognitive impairment. Her medical diagnoses included other neurological conditions, gastroesophageal reflux disease (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus), thyroid disorder (a problem when your thyroid is either too active, or not active enough, which affects your metabolism), dementia, Parkinson's disease (a movement disorder of the nervous system that worsens over time), malnutrition, metabolic encephalopathy, and a vitamin deficiency. R16 was noted to have bilateral (both sides) impairment in her upper extremities. The MDS indicated R16 required substantial/maximal assistance with eating, requiring assistance with more than half of the effort. R16's care plan, revised on 8/12/24, identified R16 had a deficit in ADL performance related to weakness and impaired mobility from Parkinson's disease and directed staff to provide assist of one with eating, while staff encouraged resident to do what she was able to with eating. The care plan identified R16 had a communication problem r/t Parkinson's, slow processing verbal information and response, anxiety/behaviors, jerking movements at times and shaking of extremities. The care plan directed staff to allow adequate time to respond, repeat information as necessary, and instructed staff not to rush R16 as she attempted to communicate her needs and wishes. R14 R14's quarterly MDS assessment of 11/12/24 indicated R14 had severe cognitive impairment. R14's medical diagnoses included: Alzheimer's Disease (neurological disorder which involves irreversible worsening changes in the ability to think and remember. It is the most common cause of dementia), dementia (the loss of the ability to reason, learn new skills, and plan and prioritize to the point which it interferes with a person's daily life and activities), malnutrition (imbalance between the nutrients your body needs to function and the nutrients it gets), chronic pain, dysphagia (difficulty with swallowing). MDS indicated there was no functional impairment with range of motion and required supervision or touching assistance, providing verbal cues or touch steadying assistance as resident completes activity. R14's care plan, revised 9/16/24, identified R14 had an ADL self-care performance deficit r/t multiple medical diagnoses which included osteoarthritis (a degenerative joint disease that can affect the many tissues of the joint), impaired cognition, glaucoma (an eye condition that damages the optic nerve which can lead to vision loss or blindness), The care plan directed staff R14 required assist of one staff members assistance staff to eat and was noted to eat slowly. The care plan identified R14 was able to communicate her needs and was able to hear with hearing aids. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/25, at 8:11 a.m. R57 and R57's tablemate's (R14, R16, and R46) were observed to have received their morning breakfast. R57 was served breakfast tray at this time. All residents (R57, R46, R14, and R16 were observed seated at the same table. There were no staff available at the table to assist with meals which were just served. Additionally, there were only two staff members observed in the dining room at the neighboring table assisting other residents. R16 was observed to pick up the sausage patty as a whole piece and took a bite. R16 then placed the sausage on the plate, and did not continue eating. While under constant observation, it was noted the staff had not arrived to provide any assistance to residents to eat. On 1/22/25, at 8:23 a.m. the residents continue to be seated in the dining room, with the food placed in front of them. There were no requests made by R57, R56, R14, and R16 for assistance with eating. The meals observed in front of the residents included cooked cereal, pureed eggs, pureed French toast sticks, solid French toast sticks, and one resident was served a solid sausage patty. On 1/22/25, at 8:27 a.m., 16 minutes after food was observed to be served, residents continued to sit at the table without assistance present. The food remained in front of the residents, uncovered. On 1/22/25, 8:28 a.m., it was observed room trays were set up for delivery, however, there were no additional staff available in the dining room to feed residents seated at the table. On 1/22/25, 8:31 a.m., registered nurses (RN)-C and RN-D arrived to aid residents R57, R56, R14, and R16 with their meals. This was 20 minutes after the initial service of the trays to these residents. RN's C & D proceeded to set up and begin to assist residents with meal without intervention due to length of time the food had been sitting out. A request was made by surveyor for trays to be temped due to the length of time food had been served, compared to the current time. The food was temped by the food production manager (FPM). Refer to citation 804 for further details. On 1/22/25, at 8:36 a.m. after fresh trays were served to the residents by FPM, RN's C and D proceeded to assist two residents. Upon interview after serving the fresh trays, FPM stated it was important to have staff able to assist residents prior to food being served as this was a quality concern and could impact the quality of life. FPM stated being served cold food starts off the day bad. FPM stated it was the expectation staff would be available to assist residents prior to the food being served. On 1/22/25, at 8:57 a.m. RN-C stated staff should be present to assist residents prior to service of the meals. RN-C stated residents should not be seated in front of their food without staff assistance. On 1/22/25, at 10:47 a.m. RN-D stated it is important to have staff available to aid with feeding residents prior to service of meal. RN-D stated if there was a delay with assistance of meal after it was dished, it would not be hot, and this would not be flavorful. If the staff were not here, the food should not have been served. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/25, at 12:04 p.m., Prep [NAME] (PC)-A stated the dietary staff are to serve the trays when the residents are seated at the table. PC-A stated she generally set up the residents who require assistance first. PC-A stated she served the residents requiring assistance, however, had not observed there were no staff available to assist the resident. On 1/22/25, at 1:55 p.m. the Certified Dietary Manager (CDM) stated it was her expectation that staff serve everyone at the table at the same time. If there were staff not available to assist the resident, the dietary staff should hold the plate until someone was able to assist them. On 1/22/25, at 3:18 p.m. the director of quality improvement (DQI), identified there were concerns with the residents sitting at the table, with food in front of them, where they can smell, and not be able to eat. DQI stated while the residents waited, and the food had been served, and was sitting uncovered, the food was getting cold. DQI stated it was necessary to determine a better prioritization of services provided at that time which delayed service of breakfast. On 1/22/25, at 3:24 p.m. clinical manager (CM)-A stated generally there were other staff members available to provide the residents assistance with the meal process. CM-A stated it did not go well this morning. CM-A expected dietary staff to wait until there were staff present before serving the meal. CM-A stated residents should not be served until staff are available to assist. On 1/24/25, at 4:00 p.m., the director of nursing (DON) stated she expected meals would not be placed in front of residents until there were staff available to provide assistance. A review of the facility policy, Assistance with Meals, dated February 2024, directed that facility staff will serve residents and will help residents who require assistance with eating. The policy further identified residents should receive the assistance with meals in a manner that meets the individual needs of each resident. The policy directed staff that residents who cannot feed themselves and need verbal cuing, or feeding assistance will be placed with staff for assistance, attention to safety, comfort, and dignity.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure medications were administered per physician's order for 1 of 1 resident (R21) reviewed for bowel management. Findings include: R21's quarterly Minimum Data Set (MDS) dated [DATE], identified R21 had intact cognition and required assistance with all activities of daily living (ADL)'s except upper body dressing, eating and oral hygiene. R21's diagnoses included neuromyelitis optica, hypertension, multi-drug-resistant organism (MDRO), paraplegia, malnutrition, cutaneous abscess of buttock and osteomyelitis. During review of R21's electronic medication record (EMR), R21 had an order for senna-docusate sodium oral tablet 8.6-50 mg (milligram) one tablet twice daily to prevent constipation, oxycodone 5 mg one tablet by mouth every four hours as needed for pain, and senna-docusate sodium oral tablet 8.6-50 mg one table by mouth as needed for constipation twice daily - take one or two tablets. R21's bowel record indicated R21's last bowel movement was on 1/16/25, indicating R21 had not had a bowel movement in six days. The facilities house standing orders indicated: Bowel: constipation (perform steps sequentially) 1. Consider rectal check to determine if impaction is present. 2. Encourage 2,000 ml (milliliter) daily fluid intake unless contraindicated. 3. Consult nutrition services for dietary recommendations. 4. Sennoside 8.6 mg, two tablets PO (my mouth) at HS (bedtime) prn x three days. If no bowel movement in three days - if not results, perform rectal check to determine if impaction is present - If no results within 24 hours, Bisacodyl suppository 10 mg PR (per rectum) daily PRN. 5. Administer MOM (milk of magnesia) 30 cc (cubic centimeters) (do not use magnesium-based products in patients with renal failure) PM day four if no results reattempt Sennoside 8.6 mg or Bisacodyl if no results after 24 hours and notify provider. 6. Monitor and record results from treatment. During review of R21's electronic health record (EHR), EHR lacked evidence of bowel management program being followed for R21. During interview on 1/21/25 at 1:22 p.m., R21 stated she was constipated due to the pain medication that she had been receiving. R21 stated she received scheduled Senna, but it was not working very well. R21 stated she had not had a bowel movement in several days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/22/25 at 2:37 p.m., registered nurse (RN)-B stated the night nurse runs a bowel movement report every night which indicated which residents did not have a bowel movement in a couple of days. RN-B stated if a resident is going on day three with no bowel movement, the facilities standing orders would be initiated which consisted of either as needed (PRN) Senna or MiraLAX. RN-B stated if a resident is going on day four with no bowel movement, the facilities standing orders would be initiated which consisted of PRN Dulcolax suppositories. RN-B stated R21 had scheduled senna and also had an order for one or two additional tablets PRN for constipation. RN-B confirmed R21's last bowel movement was on 1/16/24 at 7:43 p.m. RN-B stated R21 had not received any PRN medications since 1/16/24. During interview on 1/22/25 at 2:56 p.m., nurse manager (NM) stated if a resident did not have a bowel movement in three days, an PRN medication would be offered. NM stated if the resident did not have an order for a PRN medication the provider would be contacted. NM stated if resident had not had a bowel movement in several days, she would expect nursing to listen to bowel sounds and to perform a rectal check if resident would allow. NM reviewed R21's record and confirmed R21's last bowel movement was on 1/16/25 and last PRN medication was administered on 1/16/25. NM stated the night nurse reviews the bowel information and gives that information to the day nurse to administer medications. NM stated R21 should have been offered PRN Senna and other PRN medications per the standing orders as she is at a higher risk for constipation due to R21 receiving pain medication. NM stated it was important to monitor and administer PRN medications, so the resident does not get bloated, does not get a new diagnosis and especially for the resident's comfort. During interview on 1/24/25 at 2:35 p.m., director of nursing (DON) stated the aides chart resident's bowel movement in the point of care charting which relays that information to the nurses if it has been three days with no bowel movement. DON stated the nurse managers also oversees this. DON stated she would expect nursing to follow the protocol and offer PRN medications from the standing house orders which consisted of senna, MiraLAX, suppositories and/or edema. DON stated it was important so a resident does not get constipated and/or worse case scenario is they could end up with a small bowel obstruction. The facility Bowel Management policy, dated 11/24, indicated the facility will ensure that residents experience adequate bowel elimination. Bowel records will be reviewed by nursing. Residents will be monitored for lack of sufficient bowel movement. Upon identification of constipation, the nurse will conduct a GI assessment, implement PRN medication and/or implement house standing orders, and monitor for effectiveness.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35992 Based on observation, interview, and document review, the facility failed to ensure food was held at a steady temperature of greater than 140 degrees Fahrenheit for palatability, for 4 of 4 residents, (R57, R46, R16, R14) observed during the dining process. Findings include: R57: R57's significant change Minimum Data Set (MDS) assessment of 12/15/24 identified that R57 was rarely/never understood and had severe cognitive impairment. R57's medical diagnoses included Alzheimer's Disease/Dementia, anxiety disorder, metabolic encephalopathy (change in how your brain works due to an underlying condition), seizure disorder (a sudden change in behavior, movement or consciousness due to abnormal electrical activity in the brain)/epilepsy (a group of non-communicable neurological disorders characterized by recurrent seizures), malnutrition (imbalance between the nutrients your body needs to function and the nutrients it gets), dehydration (a lack of total body water that disrupts metabolic processes (set of life-sustaining chemical reactions in organisms), hyperosmolality (a condition of high osmolarity in the body, often caused by increased sodium or glucose levels), hypernatremia (a high level of sodium in the blood), fatigue, dysphagia (difficulty swallowing), contracture of the muscle of the upper arm, and failure to thrive. The MDS identified R57 is noted to have impaired functional movement of both arms and was totally dependent on staff for assistance with eating. R57's care plan, revised on 12/10/24, indicated R57 was unable to communicate her needs. R57's care plan directed staff to assist with eating. R57's care plan indicated R57 had potential nutritional problem r/t (related to) the diagnosis Alzheimer's, low BMI (Body Mass Index), and a Mini Nutritional Assessment (MNA) indicating malnutrition. R57 continued to meet GLIM (Global Leadership Initiative on Malnutrition Statement-a framework to guide malnutrition diagnosis) criteria for severe protein-calorie malnutrition r/t moderate fat loss and muscle loss, a BMI below 18.5, unintended weight loss, and low meal intakes. Staff were directed to provide/serve the diet as ordered and, provide and serve supplements as ordered. R46 (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R46's significant change MDS assessment of 11/12/24, identified R46 had severely impaired cognition. The MDS indicated R46 had the following medical diagnoses: non-traumatic brain dysfunction (brain damage caused by factors other than external trauma), arthritis, Alzheimer's disease/Dementia, malnutrition, age related macular degeneration (a condition that affects the middle part of your vision, and weight loss. The MDS indicated there were no limitations in range of motion. R46 was noted to require partial/moderate assistance-which is identified as the helper does less than half the effort. R46's care plan, revised on 12/3/24, indicated R46 had a deficit with ADL performance related to rheumatoid arthritis (a type of arthritis where your immune system attacks the tissue lining the joints on both sides of your body. It may affect other parts of the body.), memory loss and dementia. Staff were directed to provide with one assist to eat. The care plan also indicated R46 had a potential for communication problem related to dementia, memory loss, and trouble word finding. Staff were directed to allow adequate time to respond, repeat as necessary, and not rush client. R46's care plan directed staff to provide diet as ordered. Staff were directed to consult with dietitian to seek a change in diet/textures if there were chewing/swallowing problems identified. In addition, the care plan, revised on 11/11/24, indicated the resident had the potential for altered nutritional status related to variable intake, dementia, with the MNA (mini nutritional screening-a screening to help identify elderly people who are malnourished) indicating malnourished status. The care plan identified R46 continued to meet GLIM criteria (Global Leadership Initiative on Malnuutrition-a screening for malnutrition based on clnical findings and cause) for moderate protein calorie malnutrition related to BMI below 22 for age over 70 and muscle loss in dorsal hand and clavicle regions. The care plan indicated a supplement appeared necessary as evidenced by decreased appetite. The care plan directed the Registered Dietitian (RD) to evaluate and make change recommendations as needed. Staff were directed to provide and serve supplements as ordered. R16 R16's significant change MDS of 11/18/24 indicated moderate cognitive impairment. Her medical diagnoses included other neurological conditions, gastroesophageal reflux disease (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus), thyroid disorder (a problem when your thyroid is either too active, or not active enough, which affects your metabolism), dementia, Parkinson's disease (a movement disorder of the nervous system that worsens over time), malnutrition, metabolic encephalopathy, and a vitamin deficiency. R16 was noted to have bilateral (both sides) impairment in her upper extremities. The MDS indicated R16 required substantial/maximal assistance with eating, assistance with more than half of the effort. R16's care plan, revised on 8/12/24, identified R16 had a deficit in ADL performance related to weakness and impaired mobility from Parkinson's disease and directed staff to provide assist of one with eating, while staff encouraged resident to do what she was able to with eating. The care plan identified R16 had a communication problem r/t Parkinson's, slow processing verbal information and response, anxiety/behaviors, jerking movements at times and shaking of extremities. The care plan directed staff to allow adequate time to respond, repeat information as necessary, and instructed staff not to rush R16 as she attempted to communicate her needs and wishes. R16's care plan also identified the resident had GERD. The care plan went on to identify resident had potential nutritional problems r/t inadequate energy and protein intake r/t acute illness AEB (as evidenced by) significant weight loss, history of mechanically altered diet, and needed assist to eat. The care plan identified the MNA indicating malnourished status, although indicated R16 did not meet GLIM criteria for protein-calorie malnutrition. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R14 R14's quarterly MDS assessment of 11/12/24 indicated R14 had severe cognitive impairment. R14s medical diagnoses included: Alzheimer's Disease (neurological disorder which involves irreversible worsening changes in the ability to think and remember. It is the most common cause of dementia), dementia (the loss of the ability to reason, learn new skills, and plan and prioritize to the point which it interferes with a person's daily life and activities), malnutrition (imbalance between the nutrients your body needs to function and the nutrients it gets), chronic pain, dysphagia (difficulty with swallowing). MDS indicated there was no functional impairment with range of motion and required supervision or touching assistance, providing verbal cues or touching steadying assistance as resident completes activity. R14's care plan, revised 9/16/24, identified R14 had an ADL self-care performance deficit r/t multiple medical diagnoses which included osteoarthritis (a degenerative joint disease that can affect the many tissues of the joint), impaired cognition, glaucoma (an eye condition that damages the optic nerve which can lead to vision loss or blindness), The care plan directed staff to R14 required assist of one staff members assistance staff to eat and was noted to eat slowly. The care plan identified R14 was able to communicate her needs and was able to hear with hearing aids. The care plan went on further to identify R14 had a potential nutritional problem d/t altered cognition/mood, diagnosis including CHF (congestive heart failure-potential for weight fluctuations), dysphagia with R14 need for assist/cueing needed at meals, Alzheimer's, advanced age. On 1/22/25, at 8:11 a.m. R57 and R57's tablemate's (R14, R16, and R46) were observed to have received their morning breakfast. R57 was served breakfast tray at this time. All residents (R57, R46, R14, and R16 were observed seated at the same table. At this time, there were no staff available at the table to assist with meals which were served. Additionally, there were only two staff members observed in the dining room at the neighboring table assisting other residents. R16 was observed to pick up the sausage patty as a whole piece and took a bite. R16 then placed the sausage on the plate, and did not continue eating. While under constant observation, it was noted the staff had not arrived to provide any assistance to residents to eat. On 1/22/25, at 8:23 a.m. the residents continue to be seated in the dining room, with the food placed in front of them. There were no requests made by R57, R56, R14, and R16 for assistance with eating. The meals observed in front of the residents included cooked cereal, pureed eggs, pureed French toast sticks, solid French toast sticks, and sausage patty. On 1/22/25, at 8:27 a.m., 16 minutes after food was observed to be served, residents continue to sit at the table without assistance present. The food remains placed in front of the residents, uncovered. On 1/22/25, 8:28 a.m., it was observed room trays were set up for delivery, however, there were no additional staff available in the dining room to assist residents seated at the table. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/25, 8:31 a.m., registered nurses (RN)-C and D arrived to aid residents with their meals. This was 20 minutes after the initial service of the trays. Once the staff were seated and prepared to begin meal service assistance, a request was made of food production manager, (FPM) , to perform a temperature check on the food items present at the table. The following temperatures were obtained at 8:33 a.m. (22 minutes after meals were observed to be served): Cooked cereal: 123 degrees Fahrenheit Pureed eggs: 103 degrees Fahrenheit Scrambled eggs: 100 degrees Fahrenheit French toast sticks (pureed): 107 degrees Fahrenheit Oatmeal: 112 degrees Fahrenheit Solid French Toast sticks: 76 degrees Fahrenheit Ground sausage: 96 degrees Fahrenheit Per FPM, the required temperature food is to be served at is 140 degrees Fahrenheit. The temperatures obtained, although not long enough to place a risk for food borne illness, would definitely affect the palatability of the food. The concern would be as to the quality of the food received. This would impact the quality of life. FPM went on to state cold food starts the day off bad. FPM stated it was the expectation that staff would be ready to assist residents before the food was served. On 1/22/25, at 8:36 a.m. after fresh trays were served to the residents by FPM, RNs C & D proceeded to provide assistance to residents. On 1/22/25, at 8:57 a.m. RN-C stated staff should be present to assist residents prior to service of the meals. RN-C stated if the food was sitting in front of the residents when the staff were not present to assist the food could be cold, and would need to be sent back to the kitchen. On 1/22/25, at 10:47 a.m. RN-D stated it is important to have staff available to aid with feeding residents prior to service of meal. RN-D stated if there is a delay in service of meal after it is dished, it is not hot, and this was not flavorful. If the staff were not here, the food should not have been served. On 1/22/25, at 12:04 p.m., Prep [NAME] (PC)-A stated the dietary staff are to serve the trays when the residents are seated at the table. PC-A stated she generally sets up the residents who require assistance first. PC-A stated she served the residents requiring assistance, however, had not observed there were no staff available to assist the resident. On 1/22/25, at 1:55 p.m. the Certified Dietary Manager (CDM) stated it was her expectation that staff serve everyone at the table at the same time. If there were staff not available to assist the resident, the dietary staff should hold the plate until someone was able to assist them. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/25, at 3:18 p.m. the director of quality improvement (DQI), identified there were concerns with the residents sitting at the table, with food in front of them in, where they can smell,and not be able to eat. DQI stated the while the residents waited, and the food had been served, and was sitting uncovered, the food was getting cold. DQI stated it was necessary to determine a better prioritization of services provided at that time which delayed service of breakfast. On 1/22/25, at 3:24 p.m. clinical manager (CM)-A stated it did not go well this morning. CM-A stated residents should not be served until staff are available to assist. CM-A stated the food sitting out may have been cold. CM-A stated it may not be that great. On 1/24/25, at 4:00 p.m., the director of nursing (DON) stated it was her expectation that meals would not be placed in front of residents until there were staff available to provide assistance. Additionally, it would be her expectation that the food served would be provided for assistance at the required temperature. A facility policy, Temperature and Time Requirements for Food, revised February 2024, identified: Guardian Angels Care Center utilizes the Minnesota Department of Health Food and Safety guidelines to ensure the proper and consistent monitoring, and temperature control of food. The document indicated Hot holding food was to be maintained at 135 degrees Fahrnheit or above.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35992 Based on observation, interview and document review, the facility failed to consistently track and monitor dishwasher temperatures for both the wash and rinse cycles, and take timely action to correct the temperatures, for 1 of 1 dishwashers observed. This had the potential to affect all 108 current residents, as well as staff, who ate food served from dishes and tableware that were cleaned in the dishwasher. Findings include: On 1/21/25, at 9:32 a.m., during a brief initial tour with the interim culinary director (CD)-A and the certified dietary manager (CDM) an observation was made of completion of the dishwashing process. At that time, the temperatures for the morning cycle temperature check had not been logged. Dietary aide (DA)-B stated the wash temp was 150 degrees Fahrenheit, and the rinse temp was one hundred and eighty five-ish. DA-B stated the temperatures were to be 160 for wash, and 180 for the rinse cycle. Although able to state the desired temperatures for the wash and rinse cycle, DA-B stated she was unaware the temperatures were to be up to the desired temperatures before starting the dishwashing process and was unaware there were further interventions indicated if the machines did not reach the desired temperatures. CDM, who was present during the observation and interview, stated it appeared that staff were unaware of the need to run two or more racks through to bring the temperatures up to the desired temperatures prior to starting the dishwashing cycle, and instructed DA-B on this process. CDM stated if the dishwashing machine was not up to the required temperature when checked, the dishwasher would have to be run until the temp was up to the desired temp. If the temperature still did not get to the desired temp, the facility would have to reach out to the company and request a service call. CD stated if this could not be corrected, the facility would use the three section sink for cleaning of pots and pans, and implement use of Styrofoam plates. On 1/22/25, at 1:52 p.m. during a follow up observation, DA-C was observed as they completed the dishwashing process. A review of the recorded temperatures indicated the temp check for the wash temperature was 175, while the rinse cycle was at 178 degrees Fahrenheit. DA-C stated they were unaware of the need to run the racks through until the temperature met the desired temperatures of 160 for the wash cycle and 180 for the rinse cycle. CD-A was present and provided instruction to DA-C. A review of the dishwasher temps was completed for the period of 12/12/24 to 1/21/25. The facility documentation lacked logged results for the period of 1/1/25 through 1/7/25 (42 opportunities for documentation were missed). A review of the wash temps were completed and noted the temp was less than 160 on the following dates: 12/12/24: AM: 148 12/13/24: AM: 150, Supper: 155 12/14/24: AM: 152, Supper: 151 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12/15/24: Lunch: 150 12/17/24: AM: 150 12/18/24: AM: 152 12/19/24: Supper: 152 12/20/24: Lunch: 148, Supper: 149 12/21/24: AM: 150 12/23/24: AM: 148, Lunch: 151, Supper: 162 12/24/24: AM: 150, Lunch: 147 12/25/24: Lunch: 150 12/26/24: AM: 152, Lunch: 150, Supper: 153 12/27/24: AM:150, Supper: 159 12/29/24: AM: 150, Lunch:151 12/31/24: AM: 150, Supper: 153 1/9/26: Supper: 100 1/11/25: Supper: 100 1/12/25: Supper: 150 1/13/25: Supper: 140 1/14/25: Supper: 148 1/16/25: Supper:148 1/17/25: Supper:148 1/18/25: Supper: 148 1/19/25: Supper: 148 The wash temperature was below the desired range on 36 occassions during the period of 12/12/24 to 1/21/25. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility also lacked documentation for wash temperature checks on 27 opportunities during this period. This total, including the missing documentation for 1/1/25-1/7/25, would be 48 incidents when wash temperatures were not recorded. A review of the rinse documentation was noted to be less than 180 on the following dates: 12/13/24: Supper: 160 12/18/24: Supper: 169 1/8/25: Supper: 170 1/9/25: Supper: 170 1/10/25: Supper:170 1/12/25: Supper: 160 1/16/25: Supper: 150 1/17/25: Supper: 150 1/18/25: Supper: 154 1/19/25: Supper: 152 The rinse temperature was below the desired range of 180 degrees Fahrenheit on 10 occasions during the period of 12/12/24 to 1/14/25. The facility also lacked documentation for rinse temperature checks on 28 opportunities during this period. This total, including the missing documentation for 1/1/25-1/7/25, was 49 occasions where rinse temperatures were not recorded. On 1/23/25, at 8:50 a.m. the service representative (SR) for the dishwasher was present for a service call. At this time, the wash and rinse temps were checked three times. SR stated the required temp for washing of dishes was 160 degrees. SR went on to state The final rinse temperature can be no lower than one hundred and eighty degrees. SR stated it was recommended to run the dishwashing racks through a couple of times to get the temperature up to the appropriate temperature. SR stated the water has to be that hot to kill the bacteria, and stated If not sanitized properly, technically you're not washing. SR stated the potential implication of not having the correct temperatures was if temperatures are not at the 180 degrees People can get sick. That's the whole point of sanitizing. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/23/25, at 9:04 a.m. a review of the current logs was completed with CDM. CDM stated it appeared staff were not aware to run the dishwasher racks through the machine two or more times to get up to temperature. CDM stated the purpose of monitoring temperatures was to ensure the dishwasher was operating correctly to ensure that the dishes were cleaned and sanitized. CDM went on to state: If the dishes were not sanitized, and if the dishes were not clean, there was a risk, potential risk, for illness. CDM stated currently in the facility, she was aware of the presence of Covid and influenza, however, was unaware of any residents with Norovirus. CDM stated there were residents with Norovirus prior to January of 2025. CDM stated she was unaware of the length of time Norovirus could remain on dishes if not cleaned properly. On 1/23/25, at 9:54 a.m., CD stated he was not aware of any residents who require special precautions at this time. CD stated dietary is notified by infection preventionist of any new illnesses and if they need to use paper products to eliminate cross contamination. On 1/23/25, at 2:43 p.m., an email, dated 12/27/24 at 8:39 a.m., sent by the CD, was provided by the IP and administrator. The email stated In the event of instances like Norovirus that we have/had in the TCU, we would be using disposable items for meals wherever applicable. The email went on to state The [sic] reduces the amount of contact with items amongst the teams. As this surveyor had been told earlier by the CDM and CD there were no current cases which required disposable items, this was clarified with IP and administrator. The IP stated there was one case of Norovirus in the facility. IP stated use of disposable products was implemented when Norovirus was suspected. IP went on to state there were four total rooms where disposable dishes were being used. IP stated this was implemented upon suspicion of Norovirus. IP went on to state she was in contact with the CDM and CD and they were aware of people using paper products. Although paper products were used for those four residents as outlined by IP, the paper products were delivered on plastic trays which were washed through the communal dishwasher. On 1/24/25, at 10:13 a.m., surveyor stopped at the receptionist desk for directions. At that time, surveyor observed a credit card scanner on the counter top, and asked it's function. The receptionist stated it was for employees to pay for their meals when they eat the facility food. A facility policy, Dishwasher Temperature, undated, indicated the purpose of monitoring the dishwasher temperature was to ensure that proper infection control, cleaning and sanitizing of all dishware is achieved while using the automatic dish machine. The policy statement identified: The automatic dish machine will reach the appropriate temperature prior to washing and sanitizing to meet the guidelines. The procedure outlined prior to washing the dishes, the dish machine will be turned on and run through the cycles to identify wash and rinse temperatures. The procedure identified the wash cycle will reach and minimum temperature of 160 degrees and rinse cycle will reach and maintain a minimum temperature of 180 degrees. The procedure identified the dish machine will be monitored at each meal period to ensure proper wash and rinse temperatures are reached. If the temperature was below the specified temperatures for the wash and rinse cycle, the Engineering department will be notified immediately. The procedure went on to state dishes will not be washed until the dish machine reaches the appropriate temperature. The procedure further goes on to identify If needed, disposable dishes will be used until the proper repairs can be made, and the three-compartment sink method will be used for pots and pans. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The policy lacked direction to staff to run multiple racks prior to starting the process to bring the cycles up to the desired rinse cycles prior to starting the dishwashing process. Additionally, the policy lacked instruction to the staff to record the temperatures obtained on the dishwasher temperature logs upon obtaining the temperatures. The manufacturer manual from American Dish Service for Model ADC-44 High Temp Conveyor Dishmachines [sic], last revised 4/28/21, was received from the facility. The manual indicated the requirement at the dishmachine is 180 F (degrees Fahrenheit). The manual identified for high temp sanitizing, the measurement is taken at the manifold for a minimum of 180 F, not in or at the sprays. The manual indicated the temperature for hot water sanitizing in the wash cycle should be 160 F and 180 F for the rinse cycle for the hot water sanitizing.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview and document review the facility failed to implement infection control strategies for respiratory protection to mitigate the risk and spread of Influenza A and norovirus. In addition, the facility failed to ensure infection control measures were implemented to reduce the spread of Norovirus when the dishwasher temperature did not rise high enough to sanitize the dishes during the norovirus outbreak. As a result, the facility developed an influenza outbreak which included three residents (R26, R29, and R71) who tested positive for Influenza A, and two residents who were suspected to have Influenza A (R54, and R216) as well as 10 residents (R87, R207, R346, R54, R84, R85, R23, R205, R216 and R209) who showed signs and symptoms and/or were confirmed to have norovirus. The facility failed to ensure 12 of 12 employees, (registered nurse (RN)-E, cook (C)-A, dietary aide (DA)-D, laundry aide (LA)-B, nursing assistant (NA)-D, housekeeping aide (HA)-C, DA-E, NA-E, RN-F, NA-F, NA-G, and NA-H) who displayed signs and symptoms of potential Norovirus were restricted from and returned to work per the Centers for Disease Control (CDC) criteria. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility to vulnerable residents and the staff of the facility resulting in an immediate jeopardy (IJ) which placed all 108 residents at a high likelihood to for serious illness and/or death by contracting a communicable disease, including but not limited to Norovirus and/or Influenza. The IJ began on 1/21/25 when R26 was observed to have influenza-like symptoms, and the facility failed to implement appropriate transmission-based precautions to prevent spread of infection and failed to implement infection control surveillance to identify trends or patterns of potential infectious outbreaks. In addition, after the facility placed residents in isolation, staff were observed to not use the appropriate PPE and/or perform appropriate hand hygiene practices. Norovirus outbreak started in December and continued to spread in facility at the time of the recertification survey. The IJ was identified on 1/23/25, and the administrator, director of nursing (DON), director of quality improvement (DQI), infection preventionist (IP) and executive business director were notified of the IJ on 1/23/25 at 5:45 p.m. The IJ was removed on 1/24/25, at 1:45 p.m. , when the facility implemented actions to reduce/prevent the spread of illness, including Norovirus and Influenza A. However, noncompliance remained at the lower scope and severity, F, widespread, which indicated no actual harm with potential for more than minimal harm that was not IJ. Findings include: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The U.S. Centers for Disease Control and Prevention (CDC) identified Influenza is a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs. The Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities, dated 9/17/24, identified when there is influenza activity in the local community, active daily surveillance for influenza illness should be conducted among all new and current residents, healthcare personnel, and visitors of long-term care facilities, and should be continued until the end of influenza season. Healthcare personnel, and visitors who are identified with any illness symptoms should be excluded from the facility until their illness has resolved. Older adults and other long-term care residents, including those who are medically fragile and those with neurological or neurocognitive conditions, may manifest atypical signs and symptoms of influenza virus infection, and may not have fever. Ill residents should be placed on droplet precautions with room restriction and be excluded from participating in group activities. Influenza testing should occur when any resident has signs and symptoms of acute respiratory illness or influenza-like illness. Implement standard and droplet precautions for all residents with suspected or confirmed influenza. Standard precautions are intended to be applied to the care of all patients in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent. Implementation of Standard precautions constitute the primary strategy for the prevention of healthcare-associated transmission of infectious agents among patients and healthcare personnel. Standard precautions consist of performing hand hygiene, using personal protective equipment (PPE) whenever there is an expectation of possible exposure to an infection material, follow respiratory hygiene/cough etiquette principles and properly handle, clean and disinfect patient care equipment and instruments/devices. Clean and disinfect the environment appropriately. The U.S. Centers for Disease Control and Prevention (CDC) identified Norovirus as a very contagious virus that causes vomiting and diarrhea, that sometimes is called the stomach flu or the stomach bug; however, norovirus illness is not related to the flu. The flu is caused by the influenza virus. Norovirus causes acute gastroenteritis (inflammation of the stomach or intestines). Most people with norovirus illness get better within one to three days; but they can still spread the virus for a few days after. A person usually develops symptoms 12 to 48 hours after being exposed to norovirus. Most common symptoms: diarrhea, vomiting, nausea, stomach pain with other symptoms that may include fever, headache. The virus can be introduced into healthcare facilities by infected patients, staff, visitors, or contaminated foods. Compared with healthy people, norovirus illnesses can be more severe and occasionally even deadly in patients in hospitals or long-term care facilities. Anyone can get infected and sick with norovirus and people of all ages get infected during norovirus outbreaks. Older adults and people with weakened immune systems are more likely to develop severe infections. Norovirus spreads very easily and quickly in different ways. You can get norovirus by having direct contact with someone with norovirus, eating food or drinking liquids that are contaminated with norovirus and touching contaminated objects or surfaces and then putting your unwashed fingers in your mouth. A person can still spread norovirus for two weeks or more after they feel better. Influenza R26 (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R26's admission record, dated 1/24/25, identified R26 was [AGE] years old, resided in the 300's unit, and had diagnoses that included monoplegia of upper limb following cerebral infarction affecting right dominant side (paralysis of limb following stroke), major depression disorder, gastrointestinal hemorrhage (bleeding in the digestive tract, from the mouth to the anus), unspecified dementia and hypertension. R26's progress notes, dated 1/20/25 at 6:00 p.m., identified R26 had complaints of a cough and emesis. Vital signs were per R26's normal. R26's progress note, dated 1/21/25 at 12:15 a.m., identified R26 continued to cough, had increased respirations of 24 breaths per minute, and had oxygen saturations of 90% on room air. Provider was updated and sent orders to repeat COVID test and to perform a triple swab test (COVID, RSV and Influenza) in the morning. R26 was complaining of back and rib pain from coughing and Tylenol was administered per R26's request. R26's progress note, dated 1/21/28 at 11:28 a.m., identified R26 had a hoarse voice and dry cough and R26 started coughing last evening (1/20/25) after supper. Rapid COVID test was negative, and a triple swab was obtained and sent to the lab. Provider recommended to utilize Guaifenesin cough syrup order and to update provider with worsening condition. R26's progress note, dated 1/21/25 at 8:06 p.m., identified R26 was tested for Influenza A earlier today due to symptoms of a hoarse voice and ongoing cough. Results were received for R26, positive for Influenza A. Daughter was notified and requested R26 be administered Tamiflu. Provider was contacted to request order. Note also identified isolation precautions were implemented earlier today. R26's electronic health record (EHR) indicated monitoring of Influenza symptoms and vitals, and respiratory assessments were not initiated until 1/22/25 at 7:00 a.m. Care plan was not updated until 1/22/25. R26's care plan indicated R26 had identified infection related to positive Influenza with the following inventions initiated on 1/22/25: - Administer anti-infective as ordered by MD/NP. Monitor for effectiveness and side effects. - Monitor breath sounds (wheezes, rales, rhonchi, cough (productivity), respiratory rate (rhythm, quality) oxygen saturation, shortness of breath, changes in LOC, anxiety, or mental status changes. Monitor/document/report new or worsening respiratory alterations to MD/NP. - Monitor for GI symptoms including watery foul-smelling diarrhea. Monitor/document/report new or worsening gastrointestinal alterations to MD/NP. - Monitor for skin for redness, purulence, tenderness, warmth, new or increased swelling. Monitor/document/report new or worsening integumentary alterations to MD/NP. - Monitor vital signs per facility protocol and as needed. R26's electronic treatment administration record (TAR) indicated the following orders: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- R26 had a positive influenza test on 1/21/25 and R26 was in the contagious stage and required strict isolation as this is medically necessary at this time. Expected duration is at least through 1/28/25 @ 11:59 P. M., and 24 hours fever free. Treatment order was initiated on 1/22/25 at 3:00 p.m. R26's lab result report, dated 1/21/25, identified specimen was collected on 1/21/25 at 11:00 a.m., with lab receiving specimen on 1/21/25 at 4:58 p.m. Report also identified a reported date of 1/21/25 at 6:12 p.m., indicated R26 was positive for Influenza A. During observation and interview on 1/21/25 at 10:26 a.m., R26 stated he started coughing yesterday (1/20/25) and there was talk of sending him to the emergency room due to increased temperature but did not because his temperature went down. R26 was not on any precautions at the time of interview. During observation on 1/21/25 at 12:28 p.m., precautions outside R26's room were not in place. During interview on 1/21/25 at 12:32 p.m., registered nurse (RN)-A stated if a resident was exhibiting signs or symptoms of respiratory illness, the resident would be isolated right away. RN-A stated R26's symptoms started on 1/20/25 and confirmed there were no precautions in place for R26 at the time of the interview. During observation on 1/21/25 at 12:50 p.m., infection preventionist (IP) posted precaution signage outside of R26's room. R29 R29's admission record, dated 1/24/25, identified R29 was [AGE] years old, resided in the 300's unit, was receiving hospice services, and had d diagnoses that included Parkinson's disease without dyskinesia, mild cognitive impairment, acquired coagulation factor deficiency (rare condition that can lead to a bleeding due to a deficiency of a coagulation factor), hypertension, diverticulosis of large intestine (presence of one or more balloon-like sacs in the large intestine) and chronic kidney disease - stage three (condition characterized by a gradual loss of kidney function). R29's progress note, dated 1/21/25 at 3:28 p.m., identified R29 had signs/symptoms of runny nose, cough and malaise. Plan was to swab for COVID/Influenza and also obtain a triple swab for RSV/COVID/Influenza. R29 was isolated to room. R29's progress note, dated 1/21/25 at 4:43 p.m., identified rapid antigen influenza A&B and COVID test was conducted for symptoms of runny nose, cough and congestion which was negative. PCR was also obtained and sent to labs. R29 to be in isolation and on precautions while waiting for results. R29's electronic health record (EHR) indicated monitoring of Influenza symptoms and vitals, and respiratory assessments were not initiated until 1/22/25 at 7:00 a.m. R29's care plan indicated R29 had identified infection related to positive Influenza with the following inventions initiated on 1/22/25: - Administer anti-infective as ordered by MD/NP. Monitor for effectiveness and side effects. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- Monitor breath sounds (wheezes, rales, rhonchi, cough (productivity), respiratory rate (rhythm, quality) oxygen saturation, shortness of breath, changes in LOC, anxiety, or mental status changes. Monitor/document/report new or worsening respiratory alterations to MD/NP. - Monitor for GI symptoms including watery foul-smelling diarrhea. Monitor/document/report new or worsening gastrointestinal alterations to MD/NP. - Monitor for skin for redness, purulence, tenderness, warmth, new or increased swelling. Monitor/document/report new or worsening integumentary alterations to MD/NP. - Monitor vital signs per facility protocol and as needed. R29's electronic treatment administration record (TAR) indicated the following orders: - R29 had a positive influenza test on 1/21/25 and R29 was in the contagious stage and requires strict isolation as this is medically necessary at this time. Expected duration is at least through 1/28/25 @ 11:59 P. M., and 24 hours fever free. Treatment order was initiated on 1/22/25 at 7:00 a.m. R29's lab result report, dated 1/22/25, identified specimen was collected on 1/21/25 at 4:09 p.m., with lab receiving specimen on 1/22/25 at 12:08 a.m. Report also identified a reported date of 1/22/25 at 1:05 a.m., indicated R29 was positive for Influenza A. R71 R71's admission record, dated 1/24/25, identified R71 was [AGE] years old, resided in the 300's unit, and had diagnoses that included type II diabetes mellitus, emphysema (long-term lung condition that causes shortness of breath), paroxysmal atrial fibrillation (irregular heartbeat that comes and goes), hypertension (high pressure in the arteries (vessels that carry blood from the heart to the rest of the body) and pulmonary fibrosis (disease in which the lungs become scarred and damaged causing difficulty in breathing. R71's progress note, dated 1/18/25 at 7:02 p.m., identified R71 was not feeling well, was clammy, slow to respond, elevated blood pressure of 174/76 and an elevated temperature of 102.6. COVID test was negative. Provider was updated and sent orders for Ceftriaxone (antibiotic used to treat a wide variety of bacterial infections) 1 gram stat (immediately) and to repeat in 24 hours and to obtain a urine analysis and urine culture for presumed urinary tract infection. R71's progress note, dated 1/19/25 at 7:05 a.m., identified orders for COVID, RSV, and Influenza panel. R71's progress note, dated 1/19/25 at 8:24 a.m., identified R71 was having increased episodes of incontinence and increased weakness. Also identified that R71 was having episodes of coughing and barrier precautions were being used until lab results were received. Progress note did not specific which barrier precautions were in place. R71's progress note, dated 1/19/25 at 8:55 p.m., identified R71 had episodes of coughing during shift and also increased temperature of 100.1. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R71's progress note, dated 1/20/25 at 2:56 p.m., identified R71 had episodes of coughing noted throughout shift and that UA/UC final results and COVID, RSV and Influenza results were still pending. R71's progress note, dated 1/20/25 at 3:49 p.m., identified rapid antigen combo Influenza A&B/COVID test was completed with a faint line that appeared on the Influenza A line which indicated R71 was presumed positive for Influenza A and PCR (test that detects genetic material from a pathogen or abnormal cell sample) results were pending. R71's progress note, dated 1/20/25 at 6:15 p.m., identified provider was updated on lab results, which indicated R71 was positive for Influenza A. Order was received for Tamiflu 75 mg twice daily for five days. R71's electronic treatment administration record (TAR) indicated the following orders: - Monitoring of Influenza symptoms and vitals were initiated on 1/21/25 at 11:00 p.m., respiratory assessments initiated on 1/22/25 at 7:00 a.m. and care plan was updated on 1/22/25. - R71 had a positive influenza test on 1/18/25 and R71 was in the contagious stage and required strict isolation as this is medically necessary at this time. Expected duration was through 1/25/25 @ 11:59 P.M., and 24 hours fever free. Treatment order was initiated on 1/22/25. R71's care plan indicated R71 had an identified infection related to positive Influenza with the following inventions initiated on 1/22/25: - Administer anti-infective as ordered by MD/NP. Monitor for effectiveness and side effects. - Monitor breath sounds (wheezes, rales, rhonchi, cough (productivity), respiratory rate (rhythm, quality) oxygen saturation, shortness of breath, changes in LOC, anxiety, or mental status changes. Monitor/document/report new or worsening respiratory alterations to MD/NP. - Monitor for GI symptoms including watery foul-smelling diarrhea. Monitor/document/report new or worsening gastrointestinal alterations to MD/NP. - Monitor for skin for redness, purulence, tenderness, warmth, new or increased swelling. Monitor/document/report new or worsening integumentary alterations to MD/NP. - Monitor vital signs per facility protocol and as needed. R71's lab result report, dated 1/20/25, identified specimen was collected on 1/19/25 at 11:49 p.m., with lab receiving specimen on 1/20/25 at 4:26 p.m. Report also identified a reported date of 1/20/25 at 5:27 p.m., indicated R71 was positive for Influenza A. During observation on 1/21/25 at 10:01 a.m., R71 had three signs posted on the wall outside of door in the hallway. Signs identified: 1. Isolation - precautions - PPE requires - Refer to Precaution sign for required PPE. Additional information in tasks or chart. Start date: 1/18/25 - End date: 1/25/25 at 23:59. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. Stop - Droplet precautions - Everyone must: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. 3. Stop - Contact precautions - Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. During observation on 1/21/25 at 10:04 a.m., activity aide (AA)-A entered R71's room without donning personal protective equipment (PPE). AA-A leaned against the back of R71's recliner, rested arms on top of recliner, and touched the over-the-bed table. AA-A left R71's room and did not wash or sanitize hands. AA-A proceeded into two other resident rooms without washing or sanitizing hands and assisted one resident down the hallway in his wheelchair. AA-A also did not have a face mask on when entering R71's room or any of the other resident's room. During interview on 1/21/25 at 12:11 p.m., AA-A stated when a resident is on precautions we should wears masks, if a resident is not sick, I am not going to gown up. AA-A stated when a resident is on droplet precautions, she would wear a mask but if she was going to be in the room for 10-15 minutes she would then gown up. AA-A stated staff are to sanitize hands between each resident. AA-A confirmed she did not don PPE when entering R71's room nor did she sanitize hands between residents. AA-A stated they are notified of residents on precautions via email from administration and an isolation cart would be in place outside resident's room. AA-A confirmed isolation cart and signs were outside of R71's room but stated she missed seeing them. During observation on 1/22/25 at 8:57 a.m., NA-B donned gown, mask and gloves and entered R71's room with his breakfast tray. NA-B came out of R71's room with her gown still on, had removed mask and gloves in room prior to exiting. NA-B donned a new mask and gloves and removed another breakfast tray off the cart and entered R29's room wearing the same gown that was worn in R71's room. NA-B was holding tray, so it was touching NA-B's right shoulder region of gown. During interview on 1/22/25 at 8:38 a.m., IP stated if a resident was displaying signs/symptoms of respiratory/GI illness, she expected the nurse to move on it right away which consisted of notifying the provider, testing the resident immediately, complete point-of-care (POC) testing, place resident on isolation. Precautions should be initiated at that time also. IP stated R71 symptoms started on Monday 1/20/25, the triple swab for RSV, COVID and Influenza was already completed before she found out. IP stated on 1/21/25, R26 and R29 were having symptoms, so both R26 and R29 were placed in isolation and precautions were initiated. IP stated she would consider this an outbreak and is implementing facilities Influenza protocol which included prophylactic treatment of Tamiflu to all residents, who consented, whether or not they displayed symptoms. IP stated for residents who had roommates, she placed a divider between the residents, updated the roommate and educated them on the importance of wearing a mask and performing hand hygiene, put in an EnvironKlenz filter and UV light to help the healthy roommate. IP stated R71, who was the first case, does leave the facility frequently and R26's daughter indicated that she was ill. IP failed to indicate attempts were made to identify initial source of Influenza. IP confirmed precautions were not initiated timely for R26 and stated they should have been initiated immediately with onset of symptoms. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R35's progress note, dated 1/21/25 at 6:50 p.m., identified IP spoke with R35 (R71's roommate) regarding R71 being ill with a respiratory illness. IP explained single rooms were not available and encouraged resident to wear a mask in room and to keep the curtain drawn between areas. Identified an EnviroKlenz filter had been set up in room for further protection cleaning the air with a HEPA filter and UV light. IP also explained that additional cleaning would be conducted. IP asked R35 if he would prefer separating toileting activities with R35 stating that would not be necessary. During interview on 1/22/25 at 9:01 a.m., nursing assistant (NA)-B stated R26 started having symptoms when R71 did, which she believed was on Sunday 1/19/25. NA-B stated R26 is part of the group of men who sit together at meals where R71 also sat. NA-B stated precautions for R71 were put in place yesterday afternoon (1/21/25) when testing for Influenza A came back as positive. During interview on 1/22/25 at 11:03 a.m., IP stated facility was well stocked with PPE. IP stated she would expect staff to remove gown and gloves inside resident's room prior to exiting. Once outside of room, staff to remove mask and perform hand hygiene. IP stated staff should not wear gown outside of isolation room even if going into another isolation room due to the hallway being a public area and it was a way the illness could spread. IP stated staff could also get interrupted by needing to respond to an emergent issue and that would not be okay when wearing a contaminated gown from isolated room. R216 R216's admission record, dated 1/24/25, identified R216 was [AGE] years old, resided in the 500's unit, and had diagnoses that included hemiplegia affecting right dominant side, type 2 diabetes mellitus, morbid obesity, epilepsy (neurological disorder that cause seizures or unusual sensations and behaviors), hypertension, chronic diastolic heart failure (occurs when the heart muscle doesn't pump blood as well as it should), chronic kidney disease - stage three, and history of transient ischemic attack. R216's progress note, dated 1/23/25 at 8:16 a.m., identified a rapid antigen Influenza A&B/COVID test was obtained per provider's order for a new onset of cough and congestion. R216's progress note, dated 1/23/25 at 1:40 p.m., identified R216 had a new onset of cough and congestion with the provider recommended putting discharge on hold and ordered labs and chest x-ray. R216's electronic treatment administration record (TAR) indicated the following orders: - PCR COVID/Influenza A&B one time only for cough until 1/23/25 at 11:59 p.m. Treatment order was initiated on 1/23/25 at 11:00 a.m. - Outbreak monitoring - GI: temperature, presence/absence nausea, vomiting, diarrhea every shift. Treatment order was initiated on 1/23/25 at 3:00 p.m. - Outbreak monitoring - Respiratory: temperature, oxygen saturation, presence/absence of cough, congestion every shift. Treatment order was initiated on 1/23/25 at 3:00 p.m. R54 (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R54's admission record, dated 1/24/25, identified R54 was [AGE] years old, resided in the 500's unit, and had diagnoses that included metabolic encephalopathy (problems with your metabolism cause brain dysfunction), severe sepsis (serious condition in which the body responds improperly to an infection) with septic shock (serious medical condition that can occur when an infection in your body causes extremely low blood pressure and organ failure due to sepsis), heart failure, pulmonary edema (condition where fluid accumulates in lung tissues and causes shortness of breath, wheezing and coughing up blood), asthma (condition in which your airways narrow and swell and may produce extra mucus), chronic kidney disease - stage 3, sick sinus syndrome (abnormal heart rhythms resulting from the malfunction of hearts primary pacemaker) and adult failure to thrive (substantial decline in overall health and functional abilities). R54's progress note, dated 1/23/25 at 9:25 a.m., identified R54 had increased confusion and weepiness. R54's progress note, dated 1/23/25 at 11:46 a.m., identified R54 had signs/symptoms of increased confusion, elevated temperature and crackle sounds in lungs bilaterally. Provider was updated and orders were received to obtain a chest x-ray also obtain a triple swab for RSV/COVID/Influenza. R54 was isolated to room. R54's progress note dated 1/23/25 at 12:03 p.m., identified R54 was placed on droplet precautions when symptoms were reported, and testing occurred. R54's progress note, dated 1/23/25 at 12:04 p.m., identified chest x-ray was ordered and rapid antigen influenza A&B and COVID test was conducted. PCR was also obtained and sent to lab. R54's progress note dated 1/23/25 at 9:10 p.m., identified R54's functional status had declined and had declined supper. R54's progress note dated 1/23/25 at 11:44 p.m., identified R54 was diagnosed with Influenza A today. R54 lungs sounds were diminished at the bases and inspiratory wheezes were heard in the upper lobes. R54 had a small emesis following a few bites of yogurt. R54's progress note dated 1/23/25 at 12:04 p.m., identified chest x-ray was ordered and rapid antigen influenza A&B and COVID test was conducted. PCR was also obtained and sent to lab. R54's electronic health record (EHR) indicated monitoring of Influenza symptoms and vitals, and respiratory assessments were initiated on 1/23/25 at 3:00 p.m. R54's care plan indicated R54 had identified infection related to positive Influenza with the following inventions initiated on 1/23/25: - Adhere to droplet precautions. R54's electronic treatment administration record (TAR) indicated the following orders: - R29 had a positive influenza test on 1/23/25 and R54 was in the contagious stage and requires strict isolation as this is medically necessary at this time. Expected duration is at least through 1/30/25 and 24 hours fever free. Treatment order was initiated on 1/23/25 at 3:00 p.m. (continued on next page)

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R54's lab result report, dated 1/23/25, identified specimen was collected on 1/23/25 at 11:30 a.m., with lab receiving specimen on 1/23/25 at 6:45 p.m. Report also identified a reported date of 1/23/25 at 7:46 p.m., indicated R54 was positive for Influenza A. Norovirus R87 R87's admission record, dated 1/24/25, identified R87 was [AGE] years old, resided in the 400's unit, and had diagnoses that included orthopedic aftercare following surgical amputation, type 2 diabetes mellitus, pain, motor and sensory neuropathy (damage to nerves), drug induced constipation, and hypertension. R87's progress note dated 12/17/24 at 2:26 p.m., identified R87 developed symptoms of nausea and had a large emesis. R87's progress note dated 12/18/24 at 10:14 a.m., identified R87 was awake all-night vomiting and having episodes of loose stools and had been outside room for fresh air. R87's progress note dated 12/18/24 at 8:35 p.m., identified R87 had not been nauseated or had any additional episodes of emesis since early morning. R87's care plan indicated Norovirus is suspected with the following inventions initiated on 12/20/24: - Actively promote adherence to hand hygiene (soap and water) for resident, staff and visitors. - Contact precautions: Resident is to remain in room for a minimum of 72 hours after the resolution of symptoms to prevent further exposure of susceptible patients. - Monitor for signs and symptoms of dehydration. Update provider with concerns notes. Pale in color, dry skin, dizziness, weak, skin turgor. - Resident and staff to use soap and water for hand hygiene after providing care, having contact, or leaving the room with residents suspected or confirmed with norovirus. R87's electronic treatment administration record (TAR) indicated the following orders: - R87 was on isolation and on enteric contact precautions (gown and gloves when entered resident's room) for suspected or confirmed Norovirus infection. Continue isolation and precautions for 72-hours after symptoms end. Clean high-touch surfaces, vital sign instruments, and lifts with bleach wipes every shift for infection monitoring. Discontinue order once Norovirus isolation has ended. Treatment order was initiated on 12/20/24 at 7:00 a.m. and discontinued on 12/24/24 at 10:52 a.m. - Monitor for fever, nausea, vomiting and/or diarrhea every shift for five days and to write a progress note whether resident had symptoms or not. Treatment order was initiated on 12/20/24 at 7:00 a.m., and was discontinued on 12/24/24 at 10:52 a.m. (continued on next page)

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	01/24/2025

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R87's EHR lacked documentation that any testing was completed during this time. R207 R207's admission record, dated 1/24/25, identified R207 was [AGE] years old, resided in the 400's unit, and had diagnoses that included hypertension, chronic pain, depression, dementia, gallbladder disease and rheumatoid arthritis (chronic inflammatory disorder that affects the lining of your joints and can damage other body systems). R207's progress note dated 12/19/24, identified R207 developed symptoms on 12/19/24. Progress note did not identify specific symptoms. R207's care plan, print date of 1/29/25, lacked documentation regarding Norovirus. R207's electronic treatment administration record (TAR) indicated the following orders: - R207 is on isolation and on enteric contact precautions (gown and gloves when entered resident's room) for suspected or confirmed Norovirus infection. Continue isolation and precautions for 72-hours after symptoms end. Clean high-touch surfaces, vital sign instruments, and lifts with bleach wipes every shift for infection monitoring. Discontinue order once Norovirus isolation has ended. Treatment order was initiated on 12/20/24 at 3:00 p.m. and discontinued on 12/27/24 at 5:52 p.m. - Lab order for enteric stool panel one time only for diarrhea until 12/19/24 at 11:59 p.m. and to discontinue once complete. Treatment order was initiated on 12/16/24 at 11:15 a.m., staff documented completed on 12/19/24 at 2:05 p.m. - Notify MD in AM of positive Norovirus result. Treatment order was initiated on 12/20/24 at 1:30 a.m., staff documented completed on 12/20/24 at 10:15 a.m. - Monitor for fever, nausea, vomiting and/or diarrhea every shift for five days and to write a progres[TRUNCATED]