Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 10, 2024

Administrator
Guardian Angels Health & Rehab Center
1500 East Third Avenue
Hibbing, MN 55746

RE: CCN: 245239
Cycle Start Date: July 17, 2024

Dear Administrator:

On August 15, 2024, we notified you a remedy was imposed. On September 3, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 3, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 17, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 15, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 31, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 24, 2024

Administrator
Guardian Angels Health & Rehab Center
1500 East Third Avenue
Hibbing, MN 55746

RE: CCN: 245239
Cycle Start Date: July 17, 2024

Dear Administrator:

On July 17, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Office: 218-302-6186 Mobile: 651-279-5375

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 17, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 17, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 7/14/24 to 7/17/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/14/24 to 7/17/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52395788C(MN00104916). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)	F 636		8/27/24

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

Electronically Signed | 08/01/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 1 §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 2 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document reviewed the facility failed to comprehensively assess and document a resident with a contracture to the right hand. This affected 1 of 3 residents (R8) reviewed for limited range of motion. Findings include: R8's admission Minimal Data Set (MDS) dated 5/30/24, identified R8 had minimal cognitive impairment. Diagnoses included bilateral lower extremity amputations, anemia, and renal insufficiency. The MDS also indicated R8 had no functional limitation to range of motion to the upper extremities which included the shoulder, elbow, wrist, or hand.	F 636	F636 R8 will have a new assessment completed identifying contracture to right hand and fingers by the Nurse Manager. All residents with contractures have potential to be impacted by this deficient practice. MDS 3.0 Assessment policy was reviewed by the ADON with no changes needed. All Nurse Mangers who complete comprehensive assessments will be educated by the DON and/or designee on the MDS 3.0 Assessment including to ensure they are assessing for contractures on admission and all correlating assessments based on the MDS schedule and that if they identify a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 3 R8's admission assessment dated 5/24/24, indicated R8 had no impairments to his upper extremity which included the shoulder, elbow, wrist, or hand. During an observation on 7/14/24 at 2:03 p.m., R8 was noted to have a contracture to his right hand and fingers on the right hand. During an interview on 7/14/24 at 2:05 p.m., R8 stated the contracture to his right had and fingers had been there for over 2 years. On 7/16/24 at 1:18 p.m., registered nurse (RN)-C stated the nurse mangers perform the admission assessments when the resident comes into the facility and would document any resident contractures under the upper and lower extremity areas of the assessment. RN-C reviewed R8's medical records and acknowledged no contractures were documented for R8. RN-C stated she was not aware R8 had any contractures. RN-C then went to R8's room and confirmed there was a contracture to the right hand and fingers. During an interview on 7/16/24 at 2:18 p.m., the MDS coordinator (MDSC) stated data placed on the MDS was based on the resident assessments and notes entered by staff. MDSC reviewed R8's medical records and acknowledge there was no documentation that R8 had a contracture when admitted to the facility. During an interview on 7/17/24 at 1:18 p.m., the assistant director of nursing (ADON) stated nursing staff needed to make sure all assessments are completely and accurately so	F 636	contracture that this is documented in the resident assessment in the electronic health record. All current residents will be visually assessed by the Nurse Manager to identify if they have a contracture, if they do have a contracture Nurse Manager to review their most recent assessment to determine if contracture was identified in assessment, if it was not, the Nurse Manager will complete a new comprehensive assessment identifying the contracture. DON and/or designee will randomly audit comprehensive assessments to ensure that resident□s assessment accurately reflects residents□ status of having/not having a contracture 3x/week x 3 weeks, 2x/week x 2 weeks, then weekly thereafter starting August 12th, 2024. Audit results will be brought to the QAPI committee quarterly for review and further recommendations. Completion date: August 27th 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 4 the MDS can be filled out accurately. Facility policy MDS 3.0 Assessment last reviewed 10/13/21, indicated the facility would conduct comprehensive, accurate and standardized assessments of each resident.	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 5 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to comprehensively assess and care plan services for 2 of 3 residents (R162, R8) reviewed for care plan accuracy. Findings include: R162: R162's admission Minimum Data Set (MDS) dated 7/12/24, reflected a facility entry date of 7/3/24, identified impaired cognition, diagnoses of lung and colon cancer, and R162 received hospice services. R162's care plan dated 7/3/24, did not include a focus for hospice care and coordination. A document, St. Croix Hospice IDG Comprehensive Assessment and Plan of Care Report identified a hospice admission of 2/1/24.	F 656	F656 R162□s care plan was updated by the Nurse Manager to reflect hospice services. All residents who receive hospice services have potential to be impacted by this deficient practice. Person Centered Care Planning policy was reviewed by the ADON with no changes needed. All Nurse Mangers who complete care plans will be educated on Person Centered Care Planning policy, including completing a hospice care plan for all residents on hospice by the DON and/or designee. All current residents who are currently on hospice will have their care plans reviewed to ensure they have a hospice care plan by the Nurse Managers and/or designee, updates to be made as needed. DON and/or designee will randomly audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 6 During an interview on 7/17/24 at 1:00 p.m., registered nurse (RN)-A confirmed R162's care plan did not contain hospice and R162 was on hospice services upon admission on 7/3/24. During an interview on 7/17/24 at 1:00 p.m., the director of nursing (DON) stated she would expect there to be a line item for hospice in the care plan because it was important for coordination of care. A document, Person Centered Care Planning dated 12/18/23, identified its purpose was to provide guidance to care center staff developing the resident's person-centered care plan and directs the user to describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. R8: R8's admission Minimal Data Set (MDS) dated 5/30/24 indicated R8 had minimal cognitive impairment. Diagnoses included bilateral lower extremity amputations, anemia, and renal insufficiency. The MDS also indicated R8 was always continent of bowel and bladder. R8's Bowel and Bladder Risk Assessment dated 5/30/24, indicated R8 was always continent of bowel and bladder. R8's comprehensive care plan dated 6/4/24 indicated R8 was always incontinent of bowel and had no toileting plan. Interventions included check and change per protocol and provide peri-care after each incontinent episode. During an interview on 7/14/24 at 2:05 p.m., R8	F 656	care plans to ensure hospice services is care planned for those who are receiving hospice services 3x/week x 3 weeks, 2x/week x 2 weeks, then weekly thereafter starting August 12th, 2024. Audit results will be brought to the QAPI committee quarterly for review and further recommendations. R8 will have a new Bowel and Bladder assessment completed by the Nurse Manager and care plan will be updated with any changes needed based on assessment. All residents have potential to be impacted by this deficient practice. Person Centered Care Planning policy was reviewed by the ADON with no changes needed. All Nurse Mangers who complete bowel and bladder care plans will be educated on the Person Centered Care Planning policy, including ensuring the bowel and bladder care plan matches the bowel and bladder assessment for the resident by the DON and/or designee. All current resident□s bowel and bladder care plans will be reviewed to ensure that the bowel and bladder care plan matches the bowel and bladder assessment by the Nurse Manager and/or designee. DON and/or designee will randomly audit bowel and bladder care plans to ensure they match the resident□s bowel and bladder assessment 3x/week x 3 weeks, 2x/week x 2 weeks, then weekly thereafter starting August 12th, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 7 stated he was always continent of bowel and bladder. During an interview on 7/16/24 at 1:18 p.m., registered nurse (RN)-C stated the nurse managers performed the bowel and bladder assessments upon admission and then would also build the comprehensive assessments based on the assessments and the information off the MDS. RN-C reviewed R8's medical record and acknowledged the care plan stated R8 was totally incontinent of bowel even though all the assessments and MDS indicated he was totally continent of bowel and bladder. During an interview on 7/17/24 at 1:18 p.m., the assistant director of nursing (ADON) stated nursing staff needed to make the care plan was built on the actual admission assessments, MDS forms and resident wants so staff know how best to care for the resident. Facility policy Person Centered Care Planning last reviewed 4/20/23, indicated the care plan would include an accurate assessment of needs the resident would have while in the facility.	F 656	Audit results will be brought to the QAPI committee quarterly for review and further recommendations. Completion date: August 27th 2024	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow provider orders for residents requiring weight monitoring for 2 of 4 residents (R42, R33) reviewed for unnecessary medications. Findings include: R42: R42's admission Minimum Data Set (MDS) dated 4/23/24, identified impaired cognition and diagnoses of Alzheimer's dementia, diabetes mellitus, and chronic obstructive pulmonary disease (COPD), and atherosclerotic heart disease (a condition that causes a narrowing of the arteries). R42's care plan dated 4/17/24, did not address obtaining or assessing resident's weight. R42's provider orders contained an order for weekly weights starting 5/6/24. Review of R42's electronic medical record (EMR), identified no weight entries from 6/28/24 to 7/14/24. During an interview on 7/16/24 at 1:43 p.m., nursing assistant (NA)-A stated the nursing aids were responsible for weighing the residents and recording the number on the bath sheet and the nurse will enter that in their chart. During an interview on 7/17/24 at 8:44 a.m., dietician (DT)-A explained she was responsible for assessing resident's weights for gain or loss	F 684	F684 R42 Nutrition care plan was updated to reflect intervention of weekly weighing resident by the ADON. All nursing staff will be educated on weighing residents per care center policy or by Provider order by the DON and/or designee. R33 Nutrition care plan was reviewed by ADON and updated to reflect weekly weight monitoring. All residents have potential to be impacted by this deficient practice. Weight Monitoring Program policy was reviewed by the ADON with no changes needed. All nursing staff will be educated on the Weight Monitoring Program policy, including that all residents are to be weighed based on care center policy or provider orders by the DON and/or designee. DON and/or designee will randomly audit resident weights to ensure they are being completed and documented per care center policy or provider orders 3x/week x 3 weeks, 2x/week x 2 weeks, then weekly thereafter starting August 12th, 2024. Audit results will be brought to the QAPI committee quarterly for review and further recommendations. Completion date: August 27th 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9	F 684		

and calculate the percentage. DT-A got the data from the EMR, if the data wasn't there then she would go to the nursing stations and look for the bath sheets where the NAs recorded the weight. Sometimes those didn't make it into the computer, and sometimes there weren't weights on the bath sheet. She worked with nursing staff to try and obtain the weights. DT-A stated R42 could be difficult to get weights on because he would often refuse. The DT-A offered that she had been on vacation at the end of June and beginning of July during the period the weights were not obtained.

During an interview on 7/17/24 at 9:43 a.m., registered nurse (RN)-B stated she wasn't sure about the gap in weights because she had been on vacation.

R33:

R33's Quarterly Minimum Data Set (MDS) dated 5/14/24, identified impaired cognition. Diagnoses included diabetes and Parkinson's disease.

R33's care plan dated 2/19/24, indicated a cardiovascular care plan related to congestive heart failure. Interventions included monitor weights weekly or per provider order.

R33's provider orders dated 7/17/24 lacked specific provider orders for weights.

R33's electronic medical record (EMR) from 5/1/24 to 7/17/24 indicated missing weights as followed:

- The week beginning 7/7/24.
- The week beginning 6/23/24.
- The week beginning 5/19/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 - The week beginning 5/5/24. - The week beginning 4/28/24. - The week beginning 4/21/24. During an interview on 7/16/24 at 10:43 a.m., nursing assistant (NA)-A stated the nursing aids were responsible for weighing the residents and recording the number on the bath sheet and the nurse will enter that in their chart. NA-A confirmed R33 was a weekly weight. During an interview on 7/16/24 at 1:43 p.m., registered nurse (RN)-C stated weights were done weekly on bath day unless the provider specifically ordered weights done more or less frequently. RN-C reviewed R33's EMR and acknowledged there were weights missing on some of the weeks since April. During an interview on 7/17/24 at 1:18 p.m., the assistant director of Nursing (ADON) confirmed all weights were performed weekly by the aides on the resident's assigned bath day, and then would be documented by the nurse who worked that shift. The ADON expected all weights to be obtained per policy and/or provider order each week and documented each week. A document, Weight Monitoring Program dated 1/18/21, identified the care center will monitor weights of individuals receiving services to prevent unintended weight loss and medically significant weight gain. The policy declared residents with services will be weighed weekly, as needed, or as ordered by the provider. Weight data will be assessed, tracked, and entered in the EMR weekly, unless otherwise indicated by provider.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 11	F 732		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever	F 732		8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 12 is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure required nurse staff data was posted daily before each shift, including over the weekend. This had the potential to affect all 61 residents, staff, and visitors who wish to review this information. Findings include: During observation on 7/14/24 at 1:40 p.m., a nursing staff data posting was in a plastic holder on the wall near the main entrance and next to the administrator's office. The posting labeled "Guardian Angels Health & Rehab Daily Nurse staffing" was dated 7/11/24. On 7/16/24 at 8:46 a.m., the administrator confirmed an updated/current nurse staff data sheet was not posted at the beginning of the shift on 7/12/24, 7/13/24, or 7/14/24. Administrator stated it was the responsibility of the scheduler to complete and post the nurse staff data sheets, but the scheduler was not at the facility on the 12th, 13th, or 14th . During interview on 7/17/24 at 10:05 a.m., scheduler explained when she was not at the facility, she will leave the completed nurse staff data sheets in the "supervisors' book." On weekdays, when/if she was not at the facility, the director or assistant director of nursing post the nurse staff data sheets, and on weekends the charge nurse will post the nurse staff data sheets. Scheduler further explained the nurse staff data sheets have "sometimes" not been posted on the weekends. The weekend staff data sheets will	F 732	F732 Nursing Staff Posting policy was reviewed by the ADON with no changes needed. All residents have potential to be impacted by this deficient practice. DON and/or designee will educate the Scheduler and all licensed nurses on the Nursing Staff Posting policy and process. Random audits checking that the nursing staff hour posting has been posted daily per care center policy will be completed 3x/week x 3 weeks, 2x/week x 2 weeks, then weekly thereafter starting August 12th. 2024. Audit results will be brought to the QAPI committee quarterly for review and further recommendations. Completion date: August 27th 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 13 remain in the "supervisors' book" and need to be added to the plastic holder on Monday mornings. States weekend staff have been educated on the need to post the staff data sheets daily. During interview on 7/17/24 at 11:46 a.m., assistant director of nursing (ADON) confirmed the nurse staff data sheets were "sometimes not posted on the weekends." ADON expects the staff data sheets to be posted daily. During interview on 7/17/24 at 12:07 p.m., the administer stated having the expectation of the nurse staff data sheets being posted daily. It was important to post nurse staff data sheets daily so residents and families have up to date staffing information. A facility policy, Nursing Staff Posting dated 12/18, identified the facility will post daily staffing level for review of residents and families.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 14 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a rationale was documented for the order of an as needed (PRN) psychotropic (effecting the chemical makeup of the brain) medication beyond 14 days for 1 of 5 residents	F 758	F758 R32 received an order 7/18/24 from the Provider to continue with PRN Ativan for one year. All residents who have orders for PRN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 15 (R32) reviewed for unnecessary medications. Findings include: R32's quarterly Minimum Data Set (MDS) dated 5/15/24, identified severe cognitive impairment and had diagnoses of Alzheimer's disease, dementia, displaced fracture of the right femur, and history of breast and colon cancers. R32's physician order dated 10/5/2022 with no end date, identified Ativan oral tablet 0.5 milligrams (mg) give by mouth PRN up to every four hours for anxiety and hallucinations. R32's medication administration record (MAR) for 7/1/24 to 7/14/24 identified R32 receiving PRN Ativan 14 times. During an interview on 7/17/24 at 12:16 p.m., assistant director of nursing (ADON) stated the interdisciplinary team (IDT) consults with pharmacy every month to go over pharmacy review recommendations. ADON further stated R32's order for Ativan PRN should have been discussed in monthly meeting with pharmacy. ADON confirmed order did not have an end date, and did not have a provider rationale for extended use of medication. State Operations Manual from the Centers for Medicare & Medicaid Services dated 2/3/23, identifies "§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days... if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN	F 758	psychotropic medications have potential to be impacted by this deficient practice. Psychotropic Medication policy was reviewed by the ADON with no changes needed. All licensed nurses will be educated on the Psychotropic Medication Policy, including that all PRN psychotropic drugs are limited to 14 days, if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order by the DON and/or designee. All current residents who currently have orders for PRN psychotropic medications will be reviewed to ensure they have duration for use identified by the Nurse Manager and/or designee. If they do not, then the Nurse Manager and/or designee will fax the provider for order clarifications. DON and/or designee will randomly audit PRN psychotropic medications to ensure they have a duration identified 3/week x 3 weeks, 2x/week x 2 weeks, then weekly thereafter starting August 12th, 2024. Audit results will be brought to the QAPI committee quarterly for review and further recommendations. Completion date: August 27th 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 16 order."	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure unauthorized staff, visitors, and residents did not have access to medication storage area. This practice had the potential to affect all residents on the 400 hallway. Findings include	F 761	F761 The Medication Storage Policy was reviewed by the ADON with no changes needed. All residents have potential to be impacted by this deficient practice. All licensed nurses will be educated on	8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 17 During observation on 7/16/24 at 7:18 a.m., the 400 hallway medication storage area doorway was completely open with no staff around the medication storage area or the nurses desk next to the medication storage area. During observation on 7/16/24 at 8:33 a.m. the 400 hallway medication storage area doorway was open and nursing staff were not around the medication storage area. The nurse manager was in her office, next to the medication storage area but had her back facing her door and the medication storage area. During an interview on 7/16/24 at 8:37 a.m., registered nurse (RN)-C confirmed the medication storage room was open and no staff were around except her, with her back facing the medication storage room. RN-C stated it was the responsibility of the nurse working the cart to make sure the medication storage room is secured when they are not around the room. During an interview on 7/16/24 at 11:16 a.m., licensed practical nurse (LPN)-B confirmed she had left the door open and walked away to administer medications when the doors were observed open. LPN-B stated it was the cart nurses responsibility to secure the door when not in the room, but did feel the nurse manager in there office was secure enough to allow the door to be left open. During an interview on 7/17/2024 at 1:18 p.m. the assistant director of nursing (ADON) stated an expectation all medication storage area doors would remain shut and secured when the cart nurse was not in the rooms so no other staff,	F 761	the Medication Storage Policy, including ensuring that the medication room is to be always locked and door closed at all times when the licensed nurse is not present by the DON and/or designee. DON and/or designee will randomly audit medications rooms to ensure the door is locked and closed at all times when a licensed nurse is not present 3/week x 3 weeks, 2x/week x 2 weeks, then weekly thereafter starting August 12th, 2024. Audit results will be brought to the QAPI committee quarterly for review and further recommendations. Completion date: August 27th 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 18 residents, or visitors could access anything stored in the room. Facility policy Medication Storage, last reviewed 4/11/23, indicated the medicaion room was to be locked and door closed at all times when the licensed nures was not present.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced	F 880	F880 All staff will be educated on Enhanced	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20 barrier precautions (EBP) were followed for 2 of 3 residents (R42, R21) who had an indwelling catheter. In addition, the facility failed to ensure EBP were put in place for 1 of 1 resident (R12) with a chronic wound. The deficient practices had the potential to place these residents at an increased risk for transmission of infection. Findings include: R42: R42's admission Minimum Data Set (MDS) dated 4/23/24, identified impaired cognition and diagnoses of diabetes mellitus, benign prostatic hypertrophy (BPH, enlargement of the prostate), and urinary retention. The MDS further indicated R42 had an indwelling urinary catheter and needed staff assistance with dressing, grooming, bathing, transferring and toileting. R42's provider orders dated 4/24/24, identified an order for enhanced barrier precautions due to an indwelling urinary catheter. Gown and gloves must be worn when providing personal care or emptying the catheter bag. R42's care plan dated 4/17/24, identified the need for enhanced barrier precautions due to chronic indwelling urinary catheter. Gown and gloves were to be employed when performing high-contact resident care activities. During an observation on 7/15/24 at 1:17 p.m., nursing assistant (NA)-A entered R42's room without donning a gown or gloves. A sign was observed on the outside of the room indicating enhanced barrier precautions were in place for R42 with personal protective equipment (PPE)	F 880	Barrier Precautions policy and utilizing the appropriate PPE for residents on Enhanced Barrier Precautions including R42 and R21. All residents who are on Enhanced Barrier Precautions have potential to be impacted by this deficient practice. The Enhanced Barrier Precautions Policy was reviewed by the ADON with no changes needed. All staff will be educated on the Enhanced Barrier Precautions Policy, including utilizing the appropriate PPE for residents on Enhanced Barrier Precautions by the DON and/or designee. DON and/or designee will randomly audit appropriate PPE usage for residents on Enhanced Barrier Precautions to ensure compliance 3/week x 3 weeks, 2x/week x 2 weeks, then weekly thereafter starting August 12th, 2024. Audit results will be brought to the QAPI committee quarterly for review and further recommendations. R12 care plan was updated by ADON to reflect Enhanced Barrier Precautions and PPE and signage was provided to resident by ADON on 7/17/24. All residents who should be on Enhanced Barrier Precautions have potential to be impacted by this deficient practice. The Enhanced Barrier Precautions Policy was reviewed by the ADON with no changes needed. All licensed nurses will be educated on the Enhanced Barrier Precautions Policy, including when residents need to be placed on Enhanced Barrier Precautions,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21 supplies outside of their room. At 1:20 p.m., licensed practical nurse (LPN)-A knocked on R42's door. NA-A who was not wearing a gown, answered the door and told LPN-A she needed five more minutes. At 1:25 p.m., an unidentified NA went into the room and shut door. There was a driver waiting to take R42 to an appointment. LPN-A came back to the door with a brief, opened the door and handed it to NA-A and then shut the door. During an interview on 7/16/24 at 9:53 a.m., NA-A confirmed she had helped R42 on the toilet without wearing a gown. NA-A stated she should have worn a gown because it was important for infection control. R21: R21's annual Minimum Data Set (MDS) dated 3/27/24, identified impaired cognition and diagnoses of obstructive uropathy, depression, spondylosis with radiculopathy lumbar region (degeneration of lower spinal discs resulting in nerve compression and pain or tingling that extends into the hips or down the legs). The MDS further indicated R21 had an indwelling urinary catheter and needed staff assistance with dressing, grooming, bathing, transferring and toileting. R21's provider order with a start date of 4/11/24, identified an order for enhanced barrier precautions due to an indwelling urinary catheter. R21's undated care plan, identified the need for enhanced barrier precautions due to indwelling urinary catheter. Gown and gloves were to be employed when performing high-contact resident	F 880	implementing appropriate PPE/bins/signage, and updating the care plan and orders that the resident is on Enhanced Barrier Precautions by the DON and/or designee. All current residents who meet the criteria for Enhanced Barrier Precautions will be reviewed to ensure they have the appropriate PPE/bins/signage in place, care plan and orders reflect Enhanced Barrier Precautions. DON and/or designee will randomly audit residents who meet criteria for Enhanced Barrier Precautions to ensure appropriate PPE/bins/signage is in place and care plan and orders reflect Enhanced Barrier Precautions 3x/week x 3 weeks, 2x/week x 2 weeks, then weekly thereafter starting August 12th, 2024. Audit results will be brought to the QAPI committee quarterly for review and further recommendations. Completion date: August 27th 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22 care activities. During observation on 7/15/24 at 1:49 p.m., NA-A entered R21's room without donning a gown or gloves. There was a sign posted on R21's door declaring enhanced barrier precautions were in place. Personal protective equipment (PPE) supplies were in a cart outside of R21's room. Without wearing a gown or gloves, NA-A began to reposition R21 by removing the pillows between R21's knees and under R21's hips. On 7/15/24 at 1:52 p.m., NA-B entered R21's room to assist with repositioning. NA-B donned a gown and gloves prior to entering R21's room. On 7/15/24 at 1:54 p.m., NA-A observed NA-B enter R21's room wearing a gown and gloves, confirmed with NA-B PPE was required for repositioning, exited the room, preformed hand hygiene, and re-entered the room donning a gown and gloves. During interview on 7/15/24 at 1:58 p.m., NA-A stated she should wear a gown and gloves "anytime (her) body may come in to contact with R21's body" which would include repositioning. NA-A stated she should have worn a gown and gloves because it was important for infection control. R12: R12's significant change Minimum Data Set (MDS) dated 5/22/24, identified R12 as cognitively intact with diagnoses of myelodysplastic syndrome (group of disorders caused by immature blood cells), essential thrombocythemia (body forms too many platelets, which can cause blood clots), type 2 diabetes,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23 heart failure, kidney disease, and one stage 3 pressure ulcer that was not present upon admission. R12's physician's orders dated 7/16/24, instructed "wound care to buttocks: cleanse areas with wound wash, pat dry, apply single or double layer of AquaCell to wound beds. Cover with Tegaderm bordered foam 3X week and PRN (as needed) for saturation or loss of patency." Order further instructed to complete wound care on Sundays, Tuesdays, and Fridays. Order lacked direction on enhanced barrier precautions. R12's care plan dated 5/22/24, identified goals of pressure wound healing and to remain free of infection. During an observation on 7/16/24 at 9:44 a.m., R12's room did not have an EBP sign on door, and no PPE was available outside of resident's room. During an observation on 7/1724 at 8:56 a.m., R12's room did not have an EBP sign on door, and no PPE was available outside of resident's room. During interview on 7/17/24 at 10:29 a.m., registered nurse (RN)-B stated criteria for being placed on EBP which included wounds, indwelling foley catheters, surgical wounds, and dialysis ports. RN-B confirmed R12 as not being on EBP. RN-B further stated she was unsure if R12 should be on EBP or not. RN-B also stated she expected staff to follow protocol and wear PPE for personal cares of residents in EBP. During interview on 7/16/24 at 1:52 p.m.,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24 assistant nursing director (ADON) stated facility staff have received training on EBP and staff were expected to follow precautions when providing personal cares to a resident. During interview on 7/17/24 at 10:38 a.m., ADON further stated criteria for a resident to be on EBP which included chronic wounds, feeding tube, dialysis ports, surgical wounds, and pressure ulcers. ADON confirmed R12 had a pressure ulcer with wound care directions in care plan and provider's order. ADON further confirmed R12 was not on EBP list kept by her and did not have orders for EBP. R12 was not on EBP and due to R12's pressure ulcer he should be. Enhanced Barrier Precautions policy dated 3/25/24, identified "EBP should also be used for residents with chronic wounds and/or indwelling medical devices." EBP policy further identified chronic wounds as "pressure ulcer, diabetic foot ulcer, unhealed surgical wound, and venous statis ulcer." EBP policy also identified "Post the appropriate signage on the door and in the resident's chart. The signage should indicate when to wear PPE."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	**1500 EAST THIRD AVENUE** **HIBBING, MN 55746**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/15/2024. At the time of this survey, Guardian Angels Health & Rehab Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 08/01/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	**1500 EAST THIRD AVENUE** **HIBBING, MN 55746**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Guardian Angels Health and Rehab Center, is a 1-story building with a small partial basement. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1968, 73, & 91 additions were constructed to the building that was determined to be of Type II(111) construction. In 1990 a Type V (111) administrative wing (non resident use area) was constructed. In	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	**1500 EAST THIRD AVENUE** **HIBBING, MN 55746**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 2006 a 1-story building with a partial basement was added that was determined to be of Type II(111) constructed. In 2011 another wing was constructed that is a one story building with a small partial mechanical basement that was determined to be of Type II(000). The facility has a capacity of 75 beds and had a census of 63 at the time of the survey.	K 000		
K 225 SS=F	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not properly maintain enclose stairways used for exits and smoke proof enclosures in accordance with NFPA 101 (2012), Life Safety Code, section 7.1.3.2.1. These deficient findings could an isolated impact on the residents within the facility. Findings include: On 07/15/2024 between 0900am and 01:00pm, it was revealed by observation that storage materials	K 225	K225- Obstruction of Egress on the stairway from basements 1.Storage materials were removed from the areas noted. 2.All egress areas will be checked for storage materials and removed if found. 3.Maintenance staff education will be completed on storage materials in stair wells 4.A checklist will be implemented to ensure stairwells remain free of storage 5.Audits will be completed monthly by the	8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	**1500 EAST THIRD AVENUE** **HIBBING, MN 55746**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 225	Continued From page 3 had been placed in the both exit stairwell leading from the lower level by the kitchen. These materials need to be stored in other areas to provide clear egress from the lower level. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 225	Environmental Services Director or designee. 6. Audit results will be brought to the QAPI committee quarterly for review and further recommendations.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321		8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	**1500 EAST THIRD AVENUE** **HIBBING, MN 55746**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 4 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a patterned impact on the residents within the facility. Findings include: On 07/15/2024 between 0900am and 01:00pm, it was revealed by observation that room 98C and room 508 which are both being used as storage rooms did not have a self-closing device. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 321	K321- Missing self-closing hinges on storage areas. Room 508, and 98c in the kitchen 1.Auto closing door hinges on room 508 and 98c were installed. 2.All doors will be checked for the need of self-closing hinges. Auto self-closing door hinges will be installed if required. 3.Maintenance staff will be educated on the regulations of self-closing door hinges 4.A checklist will be implemented to audit self-closing door hinges 5.Audits will be completed monthly by the Environmental Services Director or designee. 6.Audit results will be brought to the QAPI committee quarterly for review and further recommendations.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)	K 372		8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	**1500 EAST THIRD AVENUE** **HIBBING, MN 55746**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 5 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/15/2024 between 0900am and 01:00pm it was revealed by observation that there was a penetration running from one smoke compartment to another above the following doors: 1) South end of Wells Wing 2) North end of Wells Wing 3) Kitchen Storage Closet An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 372	K372- Missing fire caulking in smoke barrier. South Wells woodland, North Wells Woodland, and kitchen chemical storage 1.Fire Caulking in identified areas were Immediately corrected with fire-resistant putty on penetrated areas 2.All smoke barriers will be checked for penetrations and corrected if found. 3.Maintenance staff will be educated on the regulations of smoke barrier penetrations 4.A checklist will be implemented to audit smoke barriers 5.Audits will be completed monthly by the Environmental Services Director or designee. 6.Audit results will be brought to the QAPI committee quarterly for review and further recommendations.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K 712		8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	**1500 EAST THIRD AVENUE** **HIBBING, MN 55746**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 6 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/15/2024 between 0900am and 01:00pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: second shift, first quarter 02/27/24 - 17:14, second quarter 05/29/24 - 16:10, third quarter 08/23/23 17:03 and fourth quarter 17:21. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 712	K0712 Fire Drills 1.Fire drill will be conducted under varied times and conditions 2..Maintenance staff will be educated on fire drills times bieng varied 3.A checklist will be implemented to audit fire drill times 4.Audits will be completed monthly by the Environmental Services Director or designee. 5. Audit results will be brought to the QAPI committee quarterly for review and further recommendations.	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings	K 753		8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	**1500 EAST THIRD AVENUE** **HIBBING, MN 55746**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 753	Continued From page 7 and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/15/2024 between 0900am and 01:00pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: second shift, first quarter 02/27/24 - 17:14, second quarter 05/29/24 - 16:10, third quarter 08/23/23 17:03 and fourth quarter 17:21. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 753	Per conversation with Fire Marshal. This deficiciency should be removed and not be cited as the facility was in compliance at the time of survey. The facility will continue to meet the requirements regarding combustable decorations.	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely	K 761		8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENTER	**1500 EAST THIRD AVENUE** **HIBBING, MN 55746**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 8 inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/15/2024 between 0900am and 01:00pm, it was revealed by observation that the following fire doors and/or fire door frames were missing door rating tags. 1) Fire doors leading to Homemaker Wing- missing tags on door frame An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 761	K761- Door Frame leading to Home Acres missing 90-Minute fire rating plate 1.Door frames identified will be rated and tagged with a fireproof plate. 2.All doors/door frames will be checked for fireproof plates. Any doors and/or door frames found out of compliance will be corrected. 3.Maintenance staff will be educated on the regulations of doors /door frame rating requirements. 4.A checklist will be implemented to audit doors and doors and/or door frames ratings are in place. 5.Audits will be completed monthly by the Environmental Services Director or designee. 6. Audit results will be brought to the QAPI committee quarterly for review and further recommendations.	