DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3XKK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00611

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245012**

2.STATE VENDOR OR MEDICAID NO.
(L2) **395040900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GUARDIAN ANGELS CARE CENTER**
(L4) **400 EVANS AVENUE**
(L5) **ELK RIVER, MN** (L6) **55330**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/06/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 07/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 07/18/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/29/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/01/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245012
July 18, 2016

Mr. Daniel Fair, Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

Dear Mr. Fair:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 28, 2016 the above facility is certified for or recommended for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 120 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 18, 2016

Mr. Daniel Fair, Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

RE: Project Number S5012027

Dear Mr. Fair:

On June 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 19, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 6, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 19, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 19, 2016, effective June 28, 2016 and therefore remedies outlined in our letter to you dated June 7, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245012	A. Building B. Wing	7/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	400 EVANS AVENUE ELK RIVER, MN 55330

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 06/16/2016	ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 06/16/2016	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 06/20/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 07/18/2016	SIGNATURE OF SURVEYOR 36536	DATE 07/06/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/19/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245012	A. Building 01 - MAIN BUILDING 01 B. Wing	7/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	400 EVANS AVENUE ELK RIVER, MN 55330

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 06/28/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 06/28/2016	ID Prefix Reg. # NFPA 101 LSC K0066	Correction Completed 06/28/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 07/18/2016	SIGNATURE OF SURVEYOR 36536	DATE 07/06/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/18/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245012	A. Building 02 - GUARDIAN ANGELS CARE CENTER B. Wing	7/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	400 EVANS AVENUE ELK RIVER, MN 55330

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0066	Correction Completed 06/28/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 07/18/2016	SIGNATURE OF SURVEYOR 36536	DATE 07/06/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/18/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3XKK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00611

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245012**

2.STATE VENDOR OR MEDICAID NO.
(L2) **395040900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GUARDIAN ANGELS CARE CENTER**
(L4) **400 EVANS AVENUE**
(L5) **ELK RIVER, MN** (L6) **55330**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/19/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Michelle Koch, HFE NE II 06/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 06/29/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/01/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 7, 2016

Mr. Daniel Fair, Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

RE: Project Number S5012027

Dear Mr. Fair:

On May 19, 2016, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537
gail.anderson@state.mn.us
Telephone: (218) 332-5140 Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 28, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 28, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 August 19, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 19, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

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 _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	400 EVANS AVENUE ELK RIVER, MN 55330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		6/16/16

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

Electronically Signed | 06/10/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the physician for 1 of 1 resident (R101) reviewed, who sustained a burn after spilling coffee onto his lap. Findings include: R101's quarterly Minimum Data Set (MDS), dated 3/2/16, indicated R101 had diagnoses which included Diabetes Mellitus, cardiovascular accident (CVA), and weakness. The MDS indicated R101 had long and short term memory problems with moderately impaired cognitive skills for daily decision making. The MDS further identified R101 required supervision with set up for eating. R101's undated care plan identified R101 had diabetes, post CVA, weakness and was disorientated to time and place, was forgetful and required staff assistance for all ADLS including set up for meals. During an observation on 5/16/16, at 3:11 p.m., R101 was seated in his wheelchair in his room, with his sweatpants pulled down to just above his	F 157	Guardian Angels Care Center strives to immediately notify the physician whenever there is an: " An accident involving the resident which results in injury and has the potential for requiring physician intervention; " A significant change in the resident□s physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); " A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); " A decision to transfer or discharge the resident from the facility; " Resident death R101□s physician was notified via written note of second degree burn secondary to coffee spill. Staff have been reeducated of the need to immediately notify the medical team (physician or NP) either by	

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F 157	Continued From page 2 knees. A white washcloth was noted on R101's left upper thigh. During an interview on 5/16/16, at 3:13 p.m., licensed practical nurse (LPN)-B stated R101 was at, "Coffee time a few minutes ago and spilled coffee on his lap." LPN-B stated the area was slightly pink, and she had placed a cool cloth on the area. A review of R101's Departmental notes included the following: 5/16/16, Around 2:45 PM [R101] was at coffee time and spilled hot coffee on his left upper/inner thigh. It measures about 16 inch (") long x 17 " wide. Cool washcloths were applied twice. [R101's family member] was called around 4:20 PM and was updated. He now has a small blister that is marked with a pen to see if it grows. Redness has diminished a lot. [R101] complained when wash clothes were applied and when writer looked at it. Will continue to monitor. 5/17/16, Continues to have lg [large] 16 x 17 cm [centimeter] reddedned [sic] area in left inner thigh with a 10.5 cc [cubic centimeter] long intact blister. Offered no complaints of discomfort when writer assessed area. Area open to air. Continue to monitor every shift until area healed. 5/17/16, 9:51 p.m.- Resident has a 8.5 cm L [length] x 2 cm W [width] blister on his upper/inner left thigh. Will continue to monitor. 5/18/16, 10:00 a.m.- NP [nurse practitioner] updated on redness and lg intact blister left inner thigh. New order from [NP] to leave area open to air, update NP if blister opens for further orders. Monitor closely report and record any changes. 5/18/16, 1:53 p.m.- Continues with a area of redness (streak/line) 11.0 long x 3.0 cm wide with	F 157	telephone or in person to ensure appropriate interventions are prescribed. Guardian Angels Care Center has developed a policy entitled Notification of Changes in Condition Physician and Family. All licensed nursing staff will be informed/trained on this policy. Nurse Unit Managers will audit all incident reports and changes in condition to ensure immediate notification of the physician. Results of these audits will be monitored by the Director of Nursing and reported in the Quality Assurance meeting.	

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F 157	Continued From page 3	F 157		

a 10.0 x 2.5 cm fluid filled intact blister in inner left thigh. [NP] here to see [R101]. No new orders at this time. Monitor blister closely and update NP if blister opens for further treatment.

A review of R101's Resident Incident Report, dated 5/16/16, included, Resident was at coffee time and spilled hot coffee on his left upper/inner thigh. 16" long x 17" wide, residents left upper/inner thigh as of 8PM has a blister on it. Writer marked it to see if it will grow. The report further included a family member was notified of the incident on 5/16/16, at 4:20 p.m., and the physician was notified on 5/16/16 with no time of day identified. Further, the report identified in house treatment would be completed.

During interview on 5/18/16, at 1:35 p.m., registered nurse (RN)-A stated, although the Resident Incident Report indicated R101's physician was notified of the incident on 5/16/16, "That is when the nurse put it on the NP board. It wasn't the doctor that was notified." RN-A stated, "Things that are not urgent are put on the board and they [NP] see it when they come in." RN-A confirmed "[NP] just saw it today."

During a telephone interview on 5/18/16, at 2:57 p.m., NP stated she was notified about R101's incident today when she visited the facility. NP indicated she assessed the blister to R101's upper left thigh, and described the blister as, "Intact," and, "Approximately 2 cm in height," but indicated the size of the blister was difficult to assess because R101 wouldn't stand. NP further described the blister as, "Moderate, stage two." NP indicated she felt she should have been notified of the incident when it occurred.

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F 157	Continued From page 4 A facility policy was requested but not provided.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an assessment was completed to determine safe medication administration for 1 of 1 residents (R111) observed to self administer medication through a nebulizer (breathing treatment). Findings include: R111's quarterly Minimum Data Set (MDS), dated 4/22/16, identified R111 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). During observation on 5/18/16, at 7:37 a.m., licensed practical nurse (LPN)-A was observed to administer oral medications for R111 in his room. LPN-A completed a check of R111's oxygen saturation level (level of oxygen in your blood) by applying a plastic clip on R111's finger and completed R11's respiration count (frequency of breaths per minute). LPN-A set up R111's nebulizer equipment to complete his nebulizer treatment and immediately after set up of the nebulizer treatment, LPN-A left the room. R111 was observed to complete the nebulizer	F 176	F176 Guardian Angels Care Center endeavors to assess all residents for safe self-administration of medications. R111 was left unobserved during administration of a nebulizer treatment. Staff have been educated regarding the need to assess each resident for safety prior to self-administration of medications; the need for the physician order to self-administer medications. R111 has been assessed and found capable of being left unattended during his nebulizer administration. A physician□s order has been obtained for this. A 100% audit will be conducted of all residents on nebulizer treatments and all residents with orders to self-administer medications. The audit will include completion of the appropriate assessment tool and presence of the physician orders to self-administer. Nurse Unit Managers will perform weekly audits of all residents started on nebulizer treatments or with self-administration of medication orders to ensure ongoing compliance. Results of	6/16/16

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F 176	Continued From page 5 treatment alone. On 5/18/16, at 7:53 a.m. LPN-A returned to R11's room to see if nebulizer treatment was complete and the nebulizer cup was not empty at that time. LPN-A immediately exited R111's room again and R111 continued to self administer the nebulizer . LPN-A stated she would return to the room again in a few minutes to discontinue nebulizer treatment and obtain oxygen saturation levels and respiratory count. Review of R111's clinical record lacked documentation of an assessment of R111's ability to safely self administer nebulizer treatments. On 5/18/16, at 7: 48 a.m., LPN-A and registered nurse (RN)-A reviewed R111's clinical record and confirmed a self administration of medication (SAM) assessment for R111 had not been completed. RN-A stated R111 had been transferred to their unit from the transitional care unit and this had been inadvertently missed. RN-A stated she would proceed with completion of an self administration of medication assessment and seek orders accordingly. Review of R111's Medication Sheet identified Albuterol Nebs (nebulization treatment) 2.5 mg/3 ml to be administered BID (twice a day) for SOB (shortness of breath) with a start date of 5/2/16 per physician's orders. R111's physician orders did not identify an order to self administer his own nebulizer medications. R111's care plan, dated 1/18/16, identified R111 had "impaired decision making and cognition", and instructed staff to, "Monitor and provide a safe environment, direct and cue as indicated."	F 176	these audits will be monitored by the Director of Nursing and reported in the Quality Assurance meeting. Completion date: 6/27/16	

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F 176	Continued From page 6 R111s care plan did not identify R111 was safe to self administer his own nebulizer medication. A facility Self-Administration of Medications policy, dated 6/11, identified, "A comprehensive assessment will be completed by the I.D. (InterDisciplinary) team. If approved., an order will be obtained stating that resident may self administer medications and which medications may be administered.". The policy also directed that the care plan will reflect self-administration of medication. and and ongoing review of self administration of medications will be conducted quarterly.	F 176		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary conditions for 5 of 5 resident rooms (R117-2, R303-2, R313-1 R509-1, and R106-1) and 1 resident dayroom reviewed in the facility. Findings include: On 5/19/16, at 9:29 a.m. an environmental tour of the facility was conducted with maintenance supervisor (MS) and the MS confirmed the following findings:	F 465	Guarding Angels Care Center strives to maintain its physical facilities for the benefit of our residents, visitors and employees. A facility policy and accompanying environmental audit tool for upkeep and maintenance of walls, floors in resident rooms and common areas has been implemented. The Director of Maintenance will oversee the performance of the ongoing audits and recording of same. Results of these environmental audits will be monitored by the Administrator and reported at the	6/20/16

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F 465	Continued From page 7 In R117-2 , a large 7 x 7 centimeter (cm) dark brown stain located in the middle of residents room on carpeted floor. Also in R100's bathroom, there was a 3 foot long large gouge exposing sheetrock near the bottom of the bathroom wall. In R303-2 , a 6 x 2 cm gouge exposing sheetrock was located on the corner wall near residents bathroom. After MS inspected area, he stated the area would "need to be repaired" and a wall guard added to prevent any further damage to wall. In R313-1 , a 11 x 14 cm scrape with large gouges exposing sheetrock was located next to residents bed. Upon inspected MS stated, "we need to repair the area." In R509-1, a 1 foot black scrape on the corner of residents room. MS confirmed that area would need to be repaired and a wall guard placed over the area as soon as possible. On the 300 wing of the facility, a large dark brown stain in the carpet was 2 x 2 feet which was located next to the nursing station by the dayroom. MS confirmed that the carpet appeared dirty and needed to be spot cleaned. In R106-1 bathroom, his commode had 1 foot of dark brown rust on each of the supporting legs. MS stated, "it should probably should be replaced" and "I am unsure if that surface could be cleaned." During interview on 5/19/16, at 1:26 p.m. housekeeping supervisor (HS) stated the rusted commode would, "not be considered a cleanable	F 465	Quality Assurance meetings. Completion dates for specific items noted on survey: R 117-2 (this oldest part of the facility is currently under moratorium renovation) scheduled to be re-carpeted by July 1, 2016. R 117 bathroom will be completely renovated by July 1, 2016 as well. R 303-2, 313-1 we will apply high density resin sheet to select areas of the walls where damage to sheet rock walls from bed rails occurs on a routine basis - by July 15, 2016. 300 wing hallway at dayroom/nurses station. This entire area is scheduled for new carpet - by September 1, 2016. R 509-1 the referenced black scuff mark was removed day of survey May 18, 2016. Wall guards are being applied where needed on an ongoing basis as identified per facility policy and ongoing audits. R-106-1 bathroom commode has been replaced. A commode audit will be done under the supervision of Lora Denis, Director of Housekeeping & Laundry, and all rusty commodes will be replaced.	

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F 465	Continued From page 8 surface" and needed to be replaced as soon as possible. On 5/19/16, at 9:29 a.m. MS confirmed all of the findings listed above. MS stated the usual facility practice was for facility staff to notify maintenance with paper slips which were picked up three times a day by maintenance staff. He further stated the maintenance slips would often get misplaced by facility staff and the facility is working on implementing a computerized system in the future. MS was unsure of how often facility maintenance completed a walk through of resident room's to look for potential issues. A facility policy on maintenance of resident rooms and common areas was requested, but was not provided during survey.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/18/2016**

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K 000	INITIAL COMMENTS Bldg 1 FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Guardian Angels Care Center Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/28/2016

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.

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Guardian Angels Care Center is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1965 and was determined to be of Type II (111) construction. In 1974 a single story addition was constructed to the East Wing and determined to be of Type II (111) construction. Also, in 1995 an addition was constructed to the East Wing and determined to be of Type II (111). Another addition was constructed in 2007 to the Northeast Wing and determined to be Type V (111) with a 2 hour separation. Because the original building and the 1 addition built in 2007 are of different construction types and separated, the facility was surveyed as two buildings. The building is fully sprinkler protected throughout. The facility has a fire alarm system	K 000		

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K 000	Continued From page 2 with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 120 beds and had a census of 112 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain 1 exit in accordance with the egress requirements of NFPA 101 Life Safety Code (00) section 7.2.1.3, floor level. This decficient practice could affect the safe and efficient exiting of, staff and visitors. Findings include: On the facility tour between 8:00 am to 2:00 pm on 05/18/2016 observations and staff interview revealed the exterior walking surface at the exit of the ad-min wing exceeded the allowable height difference before a bevel or ramp is required. This deficient condition was verified by the Maintenance Supervisor.	K 038	Exterior sidewalk cited will be corrected to meet egress code. Director of maintenance will oversee this correction and monitor for ongoing compliance. This will be completed by July 31, 2016	6/28/16
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper	K 056		6/28/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE ELK RIVER, MN 55330**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 3 switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99) section 5-13.6.3. The failure to install and maintain the sprinkler system in compliance with NFPA 13 (99) could allow fire and smoke to spread throughout the areas adjacent to the store room and could affect an undetermined amount of visitors and staff of the facility. Findings include: On the facility tour between 8:00 am to 2:00 pm on 05/18/2016 observations and staff interview revealed HVAC ducting is blocking the sprinkler heads above the shelving in the basement level storage room of the existing building. This deficient condition was verified by the Maintenance Supervisor	K 056	Additional sprinkler heads will be added in the area cited to meet code. Director of maintenance will oversee this correction which will be completed by July 1, 2016	
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING	K 066		6/28/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/18/2016**

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K 066	Continued From page 4 or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to follow the smoking regulations which all rooms where oxygen is in use must be posted as "No Smoking" except in no smoking facilitites signs are placed at all major entrances secondary signs are not required per the Life Safety Code, NFPA 101 (00) section 19.7.4, and NFPA 99 (99) section 8-3.1.11.3 This deficient practice could cause the spread of fire to accelerate throughout the facility and affect the safety of all 112 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 2:00 pm on 05/18/2016 observations and staff interview revealed, several resident rooms throughout were using oxygen without signs posted at the room doors. "No smoking oxygen in use" signs were not posted on all major entrances as is required when resident room doors are not individually posted. This deficient condition was verified by the	K 066	Oxygen is used by our clients throughout the building at various times all your long. 'No Smoking' signs with the international symbol for no smoking have been posted at all major entrances. The administrator will monitor for ongoing compliance.	

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	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/18/2016**

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K 066	Continued From page 5 Maintenance Supervisor	K 066		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **02 - GUARDIAN ANGELS CARE CENTER** B. WING _____	**05/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE ELK RIVER, MN 55330**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	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 Bldg 2 FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Guardian Angels Care Center Building 2 (2007 addition) was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/28/2016

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
	245012	A. BUILDING **02 - GUARDIAN ANGELS CARE CENTER** B. WING _____	**05/18/2016**

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Guardian Angels Care Center Building 2 is a 1-story building with a partial basement built in 2007 and was determined to be of Type V (111) construction. The building is fully sprinkled protected throughout. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 120 beds and had a census of 112 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations shall be adopted and shall include not less than the following provisions:	K 066		6/28/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **02 - GUARDIAN ANGELS CARE CENTER** B. WING _____	**05/18/2016**

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K 066	Continued From page 2 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99) (2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to follow the smoking regulations to post "No Smoking" signs at all major entrances when not labeling individual resident rooms with oxygen in use per the Life Safety Code, NFPA 101 (00) section 18.7.4, and NFPA 99 (99) section 8-3.1.11.3 This deficient practice could cause the spread of fire to accelerate throughout the facility and affect the safety of all 112 residents and an undetermined amount of staff and visitors. Findings include:	K 066	Oxygen is used by our clients throughout the building in a very us times all your long. 'No Smoking' signs with the international symbol for no smoking have been posted at all major entrances. The administrator will monitor for ongoing compliance.	

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K 066	Continued From page 3 On the facility tour between 8:00 am to 2:00 pm on 05/18/2016 observations and staff interview revealed "No smoking oxygen in use" signs were not posted on all the entrances as is required when resident room doors are not individually posted. This deficient condition was verified by the Maintenance Supervisor	K 066		