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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) 24-5239

2. NAME AND ADDRESS OF FACILITY
(L3) Guardian Angels Health and Rehabilitation
(L4) 1500 East Third Avenue
(L5) Duluth STATE (L6) MN 55746

3. STATE VENDOR OR MEDICAID NO.
(L2) 863278200

4. TYPE OF ACTION
1. INITIAL SURVEY
2. RECERTIFICATION
3. TERMINATION
4. CHOW
5. VALIDATION
6. COMPLAINT
7. ON SITE VISIT
8. TERMINATION OF ICF BEDS
9. OTHER
7
(L8)

5. EFFECTIVE DATE FOR CHANGE OF OWNERSHIP
(L9)

TYPE
(L7) 2

7. PROVIDER/SUPPLIER CATEGORY
01 HOSPITAL; 02 SNF/ICF (DUALLY CERTIFIED); 03 SNF/ICF (DISTINCT PART); 04 SNF; 05 HHA; 06 LAB; 07 X-RAY; 08 OPT/SP; 09 ESRD; 10 ICF; 11 IMR; 12 RHC; 13 PTIP; 14 CORF; 15 ASC; 16 HOSPICE

9. FISCAL YEAR ENDING DATE
(L35) MONTH/DAY

6. DATE OF SURVEY
(L34) 03/28/2014

8. ACCREDITATION STATUS
(L10) 0 — 0 - UNACCREDITED; 1 - JCAH; 2 - AOA; 3 - OTHER

10. THE FACILITY IS CERTIFIED AS:
A. IN COMPLIANCE WITH PROGRAM REQUIREMENTS
COMPLIANCE BASED ON:
1. ____ ACCEPTABLE POC

AND/OR APPROVED WAIVERS OF THE FOLLOWING REQUIREMENTS:
2 ____ TECHNICAL PERSONNEL
____ 24 HR RN
4 ____ 7-DAY RN (RURAL SNF)
____ LIFE SAFETY CODE
6 ____ SCOPE OF SERVICE LIMITED
7 ____ MEDICAL DIRECTOR
8 ____ PATIENT ROOM
9 ____ BEDS PER ROOM

B. NOT IN COMPLIANCE WITH PROGRAM REQUIREMENTS AND/OR APPLIED WAIVERS:
(L12) A/B (IF APPLICABLE CODES 1-9)
A

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

12. TOTAL FACILITY BEDS
(L18) 96

13. TOTAL CERTIFIED BEDS
(L17) 96

14. LTC CERTIFIED BED BREAK DOWN	A. (L37) 18 SNF	B. (L38) 18/19 SNF	C. (L39) 19 SNF	D. (L42) ICF	E. (L43) IMR	F. SNF/ICF (L40) DUALLY CERT.
		96				

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1)
(L15) 1-YES 2-NO

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

See attached page(s).

17. SURVEYOR SIGNATURE
Patricia Halverson
Unit Supervisor
(L19) 03/30/2014 MM/DD/YY

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist06/19/2014
(L20) MM/DD/YY

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

19. DETERMINATION OF ELIGIBILITY
1-FACILITY IS ELIGIBLE TO PARTICIPATE
2-FACILITY IS NOT ELIGIBLE TO PARTICIPATE
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT

21. 1. STATEMENT OF FINANCIAL SOLVENCY (CMS-2572)
2. OWNERSHIP AND CONTROL INTEREST DISCLOSURE STATEMENT (CMS-1513)
3. BOTH OF THE ABOVE

22. ORIGINAL DATE OF PARTICIPATION
(L24) MM/DD/YY

23. LTC AGREEMENT BEGINNING DATE
(L41) MM/DD/YY

24. LTC AGREEMENT ENDING DATE
(L25) MM/DD/YY

25. LTC EXTENSION DATE
(L27) MM/DD/YY

27. ALTERNATIVE SANCTIONS
A. SUSPENSION OF ADMISSIONS
(L44) MM/DD/YY

B. RESCIND SUSPENSION DATE
(L45) MM/DD/YY

26. TERMINATION ACTION
VOLUNTARY
1- MERGER, CLOSURE
2- DISSATISFACTION WITH REIMBURSEMENT
3- RISK OF INVOLUNTARY TERMINATION
4- OTHER REASON FOR WITHDRAWAL
INVOLUNTARY
5- FAILURE TO MEET HEALTH/SAFETY
6- FAILURE TO MEET AGREEMENT
OTHER
7- PROVIDER STATUS CHANGE
(L30)

28. TERMINATION DATE
(L28) MM/DD/YY

29. INTERMEDIARY/CARRIER NO.
(L31) MM/DD/YY

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32) MM/DD/YY

32. DETERMINATION APPROVAL DATE
(L33) MM/DD/YY

DETERMINATION APPROVAL

FORM CMS1539 (7/84) (DESTROY PRIOR EDITIONS)

1. CMS REGIONAL OFFICE
2. SINGLE STATE AGENCY (DHS)
3. STATE SURVEY AGENCY (FILE)
4. STATE SURVEY AGENCY (DO)
5. COURTESY COPY

On March 28, 2014 a Post Certification Revisit (PCR) by review of the facility's plan of correction was completed. Based on the plan of correction, it was deteremined the deficiencies issued pursuant to the February 14, 2014 standard survey were corrected as of March 26, 2014. Refer to the CMS 2567b for the results of this revisit.Effective March 26, 2014, the facility is certified for 96 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN:) 24-5239

June 26, 2014

Mr. Geoffrey Ryan, Administrator
Guardian Angels Health & Rehab Center
1500 East Third Avenue
Hibbing, Minnesota 55746

Dear Mr. Ryan:

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 March 26, 2014, the above facility is recommended for:

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 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,

Mark Meath, Enforcement Specialist

Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215--9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

March 30, 2014

Mr. Geoffrey Ryan, Administrator
Guardian Angels Health & Rehabilitation Center
1500 East Third Avenue
Hibbing, Minnesota 55746

RE: Project Number S5239026

Dear Mr. Ryan:

On March 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 14, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 14, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 26, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 14, 2014, effective March 26, 2014 and therefore remedies outlined in our letter to you dated March 3, 2014, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File
5239r14.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245239	A. Building B. Wing	3/28/2014

Name of Facility	Street Address, City, State, Zip Code
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **03/26/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **03/26/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **03/26/2014**
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **03/24/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/26/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/26/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **03/26/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/26/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/26/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/26/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/24/2014**	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	Date:	Signature of Surveyor:	Date:
	MM/PH	03/30/2014	12835	03/28/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/14/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7JBJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00858

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245239**

2.STATE VENDOR OR MEDICAID NO.
(L2) **863278200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GUARDIAN ANGELS HEALTH & REHAB**
(L4) **CENTER 1500 EAST THIRD AVENUE**
(L5) **HIBBING, MN** (L6) **55746**

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 **02/14/2014** (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)
12/31

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
__X__ 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(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):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Cheryl Johnson, HFE NE II 03/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/07/2014 (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
10/01/1981
(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 04/08/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5239
Item 16 Continuation for CMS-1539

At the time of the standard survey completed 2/14/14, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3971

March 3, 2014

Mr. Geoffrey Ryan, Administrator
Guardian Angels Health & Rehabilitation Center
1500 East Third Avenue
Hibbing, Minnesota 55746

RE: Project Number S5239026

Dear Mr. Ryan:

On February 14, 2014, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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:

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

Phone: (218) 302-6151
Fax: (218) 723-2359

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 March 26, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 May 14, 2014 (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 August 14, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Enclosure

cc: Licensing and Certification File 5239s14.rtf

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 _____	02/14/2014

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 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (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.	F 000	OK 3-14-14 BLH	
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 safe self administration of medications for 1 of 3 residents (R31) observed to self-administer medications. Findings include: On 2/10/14, at 6:06 p.m. during the initial interview with R31, a small, white paper cup with 5 tablet and capsule medications was observed on R31's chair-side table. R31 was observed sitting in a recliner chair in the room. Next to the	F 176		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3-13-14

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 _____	02/14/2014

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 176	Continued From page 1 paper cup holding the medications, several plastic cups containing clear and red liquids were observed. During the interview, R31 was observed to take several of the medications out of the paper cup, place them into the mouth, and drink some of the clear liquid. R31 was then observed to remove one round, white tablet out of the mouth with the right hand, and place the tablet into a garbage can on the right side of R31's recliner chair. R31 completed the interview, and an empty white medication cup was observed on R31's chair-side table. Licensed practical nurse (LPN)-A, interviewed on 2/11/14, at 5:05 p.m., stated she left the cup of medications in R31's room the previous night while she went to get R31 something else to drink with the medications. When LPN-A returned to R31's room the door was closed. LPN-A further stated R31 often refused to take the medications when she was in the room. R31's annual Minimum Data Set (MDS) dated 11/19/13, indicated R 31 had moderate cognitive impairment. A Care Area Assessment (CAA) for self-administration of medications dated 11/12/13, indicated R31 did not have an order and did not wish to self administer medications or treatments. The CAA further indicated R31 had a BIMS [brief interview of mental status] of 10 which indicated R31 had moderate cognitive impairment and a contracture to the left hand decreasing R31's manual dexterity. The CAA further indicated R31 was not currently a candidate for self administration, and licensed staff were directed to store, document, and administer all medications and treatments per physician order daily.	F 176	**F176:** DON and/or designee will implement corrective action for resident (R31) affected by this practice by: • Resident (R31) assessed and determined to be unable to self-administer medications DON and/or designee will assess resident/residents having the potential to be affected by this practice including: • All other residents have potential to be affected by this practice • All plans of care will be reviewed to ensure appropriateness, accuracy of assessment, and assure a Physician's order is in place for those assessed to be able to self-administer medications DON and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff will be re-educated on self administration of medication policy and procedure beginning the week of 3-10-14	

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F 176	Continued From page 2 A Care Planning Report dated 12/31/12, indicated R31 did not wish to self administer medications, and directed nursing staff to administer, store and document all medications and treatments. R31 had no physician order to self-administer medications. A Medication Administration Record (MAR) dated 2/1/14, to 2/28/14, indicated R31 received 5 oral medications regularly designated for PM [evening] administration: Zoloft 50 mg, Vitamin C 500 mg, Flomax 0.5 mg, Lipitor 20 mg, and Vitamin D 2000 iu [international units]. On 2/13/14, at 3:45 p.m. the director of nursing (DON) stated medications should not be left at bedside, unless the resident had been assessed as able to self-administer and a physician's order had been obtained. The DON confirmed R31 did not have an order to self-administer medications. A Self Administration of Medication by Residents policy revised 11/2011, directed the interdisciplinary team would define what self-administration would be for the resident and would be responsible to determine what medications are safe for the resident to self administer. The policy further directed residents would not be permitted to administer or retain medication in their rooms unless so ordered by the attending physician and approved by the interdisciplinary team.	F 176	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 3 General Observation Audits will be completed weekly to ensure ongoing compliance is achieved, then 2 per quarter thereafter • The monitoring results will be reported to the Quality Assurance Process Improvement Committee and will make recommendations for ongoing monitoring Completion Date: 3-26-14	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		

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F 241	Continued From page 3 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to honor the right to be treated in a dignified manner regarding toileting concerns for 2 of 2 residents (R44, R159) who were reviewed for dignity. Findings include: On 2/10/14, at 5:17 p.m. during an initial resident interview, R159 reported an incident which occurred about 3 weeks prior when R159 waited for the call light to be answered for over 30 minutes. R159 stated she needed to use the bathroom and ended up getting up on her own as she needed to use the toilet very badly. During the interview R159's spouse was present and confirmed the incident. R159 that when the staff responded to the call light they scolded her for getting up without help, then the staff told R159 to just "go in your pants" and we will change you. R159 was not able to recall who said that to her. R159 stated they were continent of bowel and bladder and did not wear any type of incontinent product and would never just go in the bed or clothing. R159 stated the staff comment was upsetting and very undignified. R159's spouse stated they both could not believe some one would tell a resident to do that. R159's admission Minimum Data Set (MDS) dated 2/11/14, indicated R159's brief interview for mental status (BIMS) scored 7, indicating severe cognitive impairment. The MDS further indicated	F 241	**F241:** DON and/or designee will implement corrective action for resident (R44, R159) affected by this practice by: • Resident (R44) is toileted in a dignified manner according to his plan of care • Resident (R159) was toileted in a dignified manner according to her plan of care and was discharged to home on 2-14-14 DON and/or designee will assess residents having the potential to be affected by this practice including: • All other residents have potential to be affected by this practice DON and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff will be re-educated on dignity related to toileting starting the week of 3-10-14 • Residents will be reminded to report any concerns related to dignity at next resident council meeting	

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F 241	Continued From page 4 R159 required minimal assistance with toileting activities and was continent of bowel and bladder. A Care Planning Report dated 2/10/14, indicated R159 had short-term memory deficits with variable mental function with intervention of call bell placed within reach. The Care Planning Report further indicated R159 was alert and oriented to person with intermittent confusion to time/place, and was able to let needs be known verbally. The Care planning report indicated R159 was continent of bowel and bladder, did not use any incontinence products, and required staff to assist due to weakness and intermittent confusion. On 2/13/14, at 12:30 p.m. R159 was re-interviewed and stated the nursing assistant told her to pee her pants that night about 3 weeks ago. R159 repeated the same story told to the surveyor 3 days ago. R159 went on to state nothing like that incident has happened since and R159 was still not able to recall the name of the staff person or their face. On 2/13/14, at 3:30 p.m. the director of nursing (DON) stated she was not aware R159 was treated without regard during a night when R159 required assistance to get to the bathroom. The DON further stated even if a resident is cognitively impaired they should not be told to go in their pants. The DON confirmed the staff's behavior and statement to R159 was very undignified. On 2/13/14, at 4:15 p.m. registered nurse (RN)-D stated R159 has been continent of bowel and bladder and did not use any incontinent products. RN-D further stated she was not aware of any	F 241	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 4 interview audits per week addressing dignity related to toileting and other areas will be completed starting the week of 3-17-14 to ensure ongoing compliance, until compliance is achieved and then 4 quarterly thereafter • The monitoring results will be reported to the Quality Assurance Process Improvement Committee quarterly and will make ongoing recommendations for monitoring Completion Date: 3-26-14	

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F 241	Continued From page 5 incident involving R159 and toileting activities requiring staff assistance during a night about 3 weeks ago. RN-D confirmed R159's described incident constituted undignified staff treatment. On 2/13/14, at approximately 2:30 p.m. a copy of the facility's Arial Resident Call System log for 1/2014, was requested to determine potential long call light response times for R159. The log was not provided. A Resident's Right policy dated 5/2005, indicated rights of each resident would be protected and promoted and would include the right to privacy and respect. R44 indicated that staff does not answer his call light in a timely manner and he has been incontinent of bowel which makes him feel terrible. On 2/11/14, at 9:24 a.m. R44 was interviewed and stated there was not enough staff available to answer his call light in a timely manner. R44 further indicated staff would come in, shut his call light off, tell him they would be right back, and then not return to his room. R44 stated a few days ago he put his call light on because he had to use the toilet to have a bowel movement (bm). When staff did not answer his call light, he walked to the toilet alone, then stated he "caught hell" from staff because he is supposed to ask for help. R44 stated he has been incontinent of bowel on several occasions while waiting for his call light to be answered, and this makes him feel "terrible." R44's face sheet indicates diagnoses that include dementia, muscle weakness and abnormal gait. R44's admission minimum data set (MDS) dated	F 241		

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F 241	Continued From page 6 12/20/13, indicated moderate cognitive impairment. The MDS indicated R44 required extensive assistance of two staff for mobility and transfers, and was occasionally incontinent of bowel (one episode in the past seven days). The care plan dated 1/14/14, indicated R44 was incontinent of bowel with loose stools, was aware of the need to use the toilet, was on a scheduled toileting program and could use the call light to request to use the toilet. R44's care guide sheet directed one staff to assist to toilet upon rising, after brunch, before and after siesta snack, before and after dinner, before night cap snack and at bedtime. The comprehensive bowel and bladder assessment dated 12/20/13, indicated R44 was occasionally incontinent of bowel, was not on a bowel toileting program, and had regular bowel movements (at least one every three days). On 2/13/14, at 12:40 p.m. nursing assistant (NA)-E was interviewed and stated R44 is toileted every two hours and when he requests. NA-E further stated R44 will use his call light to request to use the toilet, and there are times when he has been incontinent before they can answer his call light. NA-E stated he is incontinent of bowel a couple times a week usually in the morning when he first wakes up. On 2/13/14, at 12:59 p.m. registered nurse (RN)-B was interviewed and stated R44 was incontinent of bowel several times a week. On 2/13/14, at approximately 2:30 p.m. a copy of the facility's Arial Resident Call System log for January and February 2014, was requested but not provided.	F 241		

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F 241	Continued From page 7 On 2/14/14, at 10:25 a.m. the director of nursing (DON) was interviewed and stated call lights should be answered in 8 minutes or less.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident choice for frequency of bathing was consistently honored for 1 of 3 residents (R26) who were reviewed for choices. Findings include: R26 was not consistently provided a shower/bath twice a week based on her bathing preferences. On 2/11/14 at 10:12 a.m. R26 stated, "I should get a shower twice a week. I don't always get that. I would have one three times a week, but they're too busy. They don't ask you. At home I took a shower at least three times a week." R26 stated she was supposed to receive a shower on Tuesdays and Saturdays, and indicated she had received her shower that morning (Tuesday).	F 246		

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F 246	Continued From page 8 A Progress Note dated 5/30/13, indicated R26 required physical assistance from staff with bathing. The quarterly Minimum Data Set (MDS) dated 1/31/14, indicated R26's diagnoses included anemia and hypertension (HTN). The MDS identified R26 had no cognitive impairment and required physical assistance from staff in part of the bathing activity with set-up help only. The bathing care plan printed 2/14/14, indicated R26 preferred showers; required assistance of two staff to transfer on and off the shower chair; and directed R26 should receive two showers a week on Tuesdays and Saturdays. The Bennett Park Bathing Schedule (no date), indicated R26 was only scheduled for a bath/shower on Tuesday Mornings. On 2/13/14, at 2:39 a.m. the registered nurse manager (RN)-B stated upon admission residents were informed showers/baths are once a week unless otherwise specified. RN-B stated R26, "Would have had to tell us she wanted two showers per week because otherwise we wouldn't have scheduled her for two." RN-B stated R26 was scheduled a Tuesday shower from the regular nursing assistants (NA's), and an extra one on Saturdays from the bath aide (the schedule was not provided). RN-B added, if R26 had requested to have a shower three times a week it would have been done. A Progress Note dated 11/29/13, indicated R26 had requested to have a shower twice a week. Review of the nursing assistant (NA) charting for December 2013, and January/February 2014, indicated R26 was provided only one shower during the weeks of 12/22/13, 12/29/13, 1/19/14, 1/26/14, and 2/2/14.	F 246	**F246:** DON and/or designee will implement corrective action for resident (R26) affected by this practice by: • Resident (R26) will continue to receive two baths per week per resident preference DON and/or designee will assess residents having the potential to be affected by this practice including: • All other residents have potential to be affected by this practice DON and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff will be re-educated on resident choice in bathing options and frequency beginning the week of 3-10-14	

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F 246	Continued From page 9 On 2/13/14, at 3:15 p.m. RN-B confirmed the documentation was inconsistent to indicate R26 had received two showers/baths a week. RN-B stated she was unsure why the showers/baths were not documented, and could not say if R26 was provided the showers or not.	F 246	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 4 resident interview audits per week addressing preference and frequency of bathing will be completed starting the week of 3-17-14 to ensure ongoing compliance, until compliance is achieved and then 4 quarterly thereafter • The monitoring results will be reported to the Quality Assurance Process Improvement Committee quarterly and will make ongoing recommendations for monitoring Completion Date: 3-26-14	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide comfortable bathroom sink water temperatures for 2 of 10 residents (R94, R16) rooms where water temperatures were checked. Findings include: R94 was interviewed on 2/12/14, at approximately 12:40 p.m. and stated he can not get hot water to wash up in the bathroom. R94 stated that he had informed facility staff. R94's annual minimum data set (MDS) dated 12/5/13, indicated he was alert, orientated and had no cognitive impairment. The water temperature was measured with the assistance of maintenance staff (MS)-A. The hot water was turned on in R94's bathroom sink and after running for 10 minutes the water temperature was 97.5 degrees Fahrenheit (F), and after running for 25 minutes the water temperature was 99 degrees F.	F 253	**F253:** Environmental Services Director and/or designee will implement corrective action for residents (R94) and (R16) affected by this practice by: • An additional circulating pump was installed on the hot water lines that service the area of Brooklyn and Wells Woodland. Temperatures through those areas are now reaching at a minimum 107 degrees. Environmental Services Director and/or designee will assess residents having the potential to be affected by this practice including: • All other residents are potentially affected by this practice.	

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F 253	Continued From page 10 R16 was interviewed on 2/12/14, at approximately 1:10 p.m. stated that they had to run the water for a long time before it gets warm. After running the hot water in the bathroom sink for 5 minutes the water temperature was 101.8 degrees F. R16 quarterly MDS dated 1/2/14, indicated moderate cognitive impairment. Nursing assistant (NA)-G, interviewed on the afternoon of 2/12/14, stated that he could get hot water most of the time on this wing and had to go to the public bath room at the end of the hall to get hot water. MS-A was interviewed on 2/13/14, at 4:00 p.m. and stated a recheck of R94's bath room water temperature that morning indicated 98 degrees F after running 10 minutes. The administrator was interviewed on 2/13/14, at 8:30 a.m. and stated they would look for a policy regarding water temperatures in resident rooms but didn't think there was one. The facility tries to keep the resident room hot water temperatures between 105 degrees and 115 degrees F.	F 253	Environmental Services Director and/or designee will implement measures to ensure that this practice does not recur including: • Domestic Water temps will be monitored on a weekly basis to ensure temperatures are maintained between 105 to 115 degrees as per regulation. Environmental Services Director and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Temperatures at all five nursing units in the facility will be checked to ensure the temperature range of 105 to 115 is being maintained. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 03-24-2014	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

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F 279	Continued From page 11 The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a care plan to address non-compliance with fluid restriction for 1 of 1 residents (R69) who was reviewed for dialysis services. Findings include: The physician's orders dated 12/11/13, indicated R69 was on a renal diet with a 1200 milliliter (ml) fluid restriction. The orders further identified R69 had diagnoses of end stage renal disease (ESRD) and hypertension (HTN). The quarterly Minimum Data Set (MDS) dated 12/13/13, indicated R69 had moderate cognitive impairment; was independent with eating and drinking; was on a therapeutic diet; and received dialysis services. The renal care plan dated 11/7/13, identified R69 received dialysis services and directed staff to record intake and output (I & O) totals due to a 1200 ml per day fluid restriction. The nutrition care plan revised 12/5/13, identified R69 received dialysis, and required a therapeutic diet with a	F 279	**F279:** DON and/or designee will implement corrective action for resident (R69) affected by this practice by: • A Physician's order to discontinue Resident (R69) food and fluid restrictions was obtained on 2-18-14 DON and/or designee will assess residents having the potential to be affected by this practice including: • All other residents who are on a food and fluid restriction have potential to be affected by this practice • Care plans of those who are currently on a food and fluid restriction have been reviewed to assure compliance DON and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff will be re-educated on dietary restrictions related to food and fluid intake beginning the week of 3-10-14	

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	245239	A. BUILDING _____ B. WING _____	02/14/2014

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 279	Continued From page 12 fluid restriction ordered by the physician. Goals included (but were not limited to) to have good diet compliance. The care plan directed a renal diet with a 1200ml fluid restriction; and one can of Nepro supplement twice a day (BID). On 2/12/14, at 8:04 a.m. R69 was observed in the room with a 1/2 full mug of tea (total 240 cc) and a large thermal pitcher 3/4 full of ice water on the bedside stand. R69 stated he was unaware of any fluid restrictions. R69 stated he drinks tea, and drinks his water throughout the day. R69 confirmed staff gave him the large thermal pitcher of ice water every day. There was no indication in the room that R69 was on a fluid restriction. R69 stated in the morning "I get tea and toast. That's all I want." No signs or symptoms of fluid overload were noted. On 2/13/14, at 8:54 a.m. R69 was observed in his room with a large pink thermal pitcher full of ice water and a 3/4 full 591 ml bottle of root beer on the bedside stand. R69 stated he buys root beer whenever he can (almost daily) in the machine on the unit. R69 stated he was not aware he was on any fluid restrictions and stated he received the ice water daily. R69 stated he drinks most of it, "I like the nice cold water with ice to drink." The Supplement Intake records for January and February 2014, indicated R69 drank 100% of the Nepro supplement twice a day (480 ml) on most days. The Oral Intake records for January and February 2014, were incomplete and lacked documentation for several day shift and afternoon shift fluid intakes. On 2/13/14, at 3:27 p.m. the registered nurse (RN)-E stated R69 was not on any special fluid	F 279	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 2 care plan audits regarding food and fluid restrictions will be completed weekly starting the week of 3-17-14 to ensure ongoing compliance, until compliance is achieved and then 2 quarterly thereafter • The monitoring results will be reported to the Quality Assurance Process Improvement Committee quarterly and will make ongoing recommendations for monitoring Completion Date: 3-26-14	

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F 279	Continued From page 13 restrictions and, "Pretty much does his own thing." On 2/13/14, at 3:31 p.m. nursing assistant (NA)-H stated R69 was on a fluid restriction, but was unsure as to how much fluid R69 could drink. NA-H stated R69 keeps track of it on his own. "He does his own thing and drinks what he wants. We don't always know." On 2/13/14, at 4:00 a.m. the dietary manager (DM) stated dietary staff doesn't put any fluids on the trays of residents with fluid restrictions. The nursing assistants (NA's) pass all the beverages and keep track. On 2/13/14, at 3:45 p.m. RN-A confirmed monitoring of R69's fluid intake had not been consistent. RN-A stated after talking with the staff he found that R69 was not always compliant with his fluid intake and drinks what he wants. RN-A confirmed R69's care plan did not address non-compliance with the fluid restriction.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed regarding shaving needs for 2 of 3 residents (R97, R69) reviewed for activities of	F 282	**F282:** DON and/or designee will implement corrective action for resident (R97, R69) affected by this practice by: • (R97) was shaved on 2-14-14 according to plan of care and staff continue to follow the plan of care for shaving • Resident (R69) was provided with pre-shave (R69) continues to refuse to allow staff to shave on a regular basis, care plan for (R69) was updated to reflect refusal of shaving	

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F 282	Continued From page 14 daily living. On 2/11/14, at 8:41 a.m. R97 was observed unshaven, with facial hair approximately 1/4 inch long. R97's diagnosis listing sheet included dementia without behavioral disturbances. The quarterly minimum data set (MDS) dated 1/28/14 indicated R97 was severely cognitively impaired, and required extensive assistance of one staff for grooming. R97's care plan dated 11/1/13, directed staff to shave R97's face every morning. On 2/14/14, at 10:23 a.m. the director of nursing (DON) was interviewed and stated she would expect staff to follow the care plan regarding shaving. R69 had several days growth of facial hair when he was interviewed on 2/12/14, at 8:00 a.m.. The February 13, Care Guide for grooming noted staff were to set R69 up at the bed side for daily hygiene, assist with perineum care, staff to comb and brush resident's hair and shave resident's face. The care plan dated February 13, 2014, directed facial hair removal on weekly bath days as well as daily. The care plan noted R69 refused shaving at times. The care plan noted staff should set him up at the bed side for daily hygiene. Interview with NA-D on 2/12/14, at 8:30 a.m. indicated R69 was shaved on bath days. Review of the "To Do List" (nursing assistant plan of care) indicated R69 needed to shave "continuously"	F 282	DON and/or designee will assess residents having the potential to be affected by this practice including: • Other residents who require assistance with shaving have potential to be affected by this practice • All plans of care related to shaving were reviewed for accuracy DON and/or designee will implement measures to ensure that this practice does not recur including: • All nursing staff will be re-educated on providing ADL's including shaving per policy and procedure the week of 3-10-14 DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 4 general observation audits of residents will be completed weekly starting the week of 3-17-14 to ensure ongoing compliance, until compliance is achieved and then 4 quarterly thereafter • The monitoring results will be reported to the Quality Assurance Process Improvement Committee quarterly and will make ongoing recommendations for monitoring Completion Date: 3-26-14	

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F 282	Continued From page 15 meaning daily.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not provide shaving assistance in accordance with the resident's assessed needs for 2 of 3 residents (R69, R97) reviewed for activities of daily living. Findings include: R69 was observed on 2/11/14, at 10:56 a.m. with several days growth of facial hair. R69 had several days growth of facial hair when he was interviewed on 2/12/14, at 8:00 a.m.. R69 stated the nursing assistants didn't know how to shave him. Stated that when they shave him it pulls his beard and it hurts like "h---" because their razors don't work. R69 stated he didn't have a razor in the facility or he could shave himself and it would be even better if they would just use that "Pre Shave" that he used at home, then they could shave him and it wouldn't pull at all. His face would be like a baby's bottom and he would use it every day. R69's significant change minimum data set	F 312	**F312:** DON and/or designee will implement corrective action for resident (R97, R69) affected by this practice by: • (R97) was shaved on 2-14-14 according to plan of care and staff continue to follow the plan of care for shaving • Resident (R69) was provided with pre-shave (R69) continues to refuse to allow staff to shave on a regular basis, care plan for (R69) was updated to reflect refusal of shaving DON and/or designee will assess residents having the potential to be affected by this practice including: • Other residents who require assistance with shaving have potential to be affected by this practice • All plans of care related to shaving were reviewed for accuracy DON and/or designee will implement measures to ensure that this practice does not recur including: • All nursing staff will be re-educated on providing ADL's including shaving per policy and procedure the week of 3-10-14	

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F 312	Continued From page 16 (MDS) dated 6/25/13, and the quarterly minimum data set (MDS) dated 12/11/13, indicated R69 was able to talk and understands others. R69 had moderate cognitive impairment and no behaviors or mood issues. The MDS indicated R69 needed extensive assistance of one staff for bathing, grooming and personal hygiene. The MDS identified diagnoses of congestive heart failure, renal failure, depression, and dementia. Nursing assistant (NA)-F, interviewed on 2/12/14, at 8:10 a.m. stated that R69 sometimes refuses to be shaved because the razor pulls hard on his beard. She states he lets it go too long and then the razor doesn't work right. The February 13, Care Guide for grooming noted staff were to set R69 up at the bed side for daily hygiene, assist with perineum care, staff to comb and brush resident's hair and shave resident's face. The care plan dated February 13, 2014, directed facial hair removal on weekly bath days as well as daily. The care plan noted R69 refused shaving at times. The care plan noted staff should set him up at the bed side for daily hygiene. Interview with NA-D on 2/12/14, at 8:30 a.m. indicated R69 was shaved on bath days. Review of the "To Do List" (nursing assistant plan of care) indicated R69 needed to shave "continuously" meaning daily. Interview on 2/13/14, at 9:58 a.m. with the director of nursing (DON) stated it was facility policy for every one to have their own razor.	F 312	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 4 general observation audits of residents will be completed weekly starting the week of 3-17-14 to ensure ongoing compliance, until compliance is achieved and then 4 quarterly thereafter • The monitoring results will be reported to the Quality Assurance Process Improvement Committee quarterly and will make ongoing recommendations for monitoring Completion Date: 3-26-14	

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F 312	Continued From page 17 The Electric Razor Policy dated 12/95, indicated that resident would provide their own electric shaver to be used for daily grooming. The policy indicated if a resident did not have a razor they should update Social Services and they would ask the family to provide one. In an emergency situation one specified electric razor under nursing supervision would be used and stored in the medication room and thoroughly cleaned and sanitized after use. On 2/11/14, at 8:41 a.m. R97 was observed unshaven with facial hair approximately 1/4 inch long. R97's diagnosis listing sheet included dementia without behavioral disturbances. The quarterly minimum data set (MDS) dated 1/28/14, indicated R97 was severely cognitively impaired, and required extensive assistance of one staff for grooming. R97's care plan dated 11/1/13, directed staff to shave resident's face every morning. The functional assessment completed 10/28/13, directed R97 to have extensive assistance of 1-2 staff for activities of daily living (ADLs). On 2/14/14, at 10:23 a.m. the director of nursing (DON) was interviewed and stated she would expect staff to shave R97 every morning as directed in the care plan.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		

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 329	Continued From page 18 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin was administered per physicians ordered parameters for 1 of 5 residents (R151) whose medications were reviewed. Findings include: A computer-generated diagnosis list dated 2/13/14, indicated R151's diagnoses included diabetes mellitus type 2. The admission Minimum Data Set (MDS) dated 12/23/13, indicated R151 was cognitively intact. A Care Planning Report dated 12/23/13, indicated	F 329	**F329:** DON and/or designee will implement corrective action for resident (R151) affected by this practice by: • Resident (R151) primary care physician was updated on insulin administration regimen 2-18-14 DON and/or designee will assess residents having the potential to be affected by this practice including: • All other residents have the potential to be affected by this practice DON and/or designee will implement measures to ensure that this practice does not recur including: • All nursing staff will be re-educated on Medication administration, refusal of medications, and Physician notification beginning the week of 3-17-14	

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F 329	Continued From page 19 R151 was to receive blood glucose (BG) monitoring q.i.d. [four times daily]. R151's Physician's Orders dated 1/3/14, directed Novolog insulin 17 units subcutaneous t.i.d [three times daily] before breakfast, lunch and dinner, hold if BG less than 120. A Medications Administration Record (MAR) dated 2/1/14, to 2/28/14, indicated R151 was receiving Accu-checks before meals and at hs [hour of sleep]. The MAR contained BG monitoring values written with nurses' initials, four times daily, with three readings less than 120: 2/7/14 at 0800 the BG was 117; 2/10/14 at 1600 the BG was 118; and 2/13/14 at 0800 the BG was 115. All other BG readings for 2/1/14, 0800 through 2/13/14 at 1000 were greater than 120. The MAR directed Novolog 17 units subcutaneous t.i.d with the times noted as AM, NOON, and 1600. The MAR dated from 2/1/14, AM through 2/13/14, NOON, contained 18 entries with the nurses' initials circled to indicate the dose was not administered. On the reverse side of the MAR, a lined page for documentation of PRN's [as needed], Refusals, Holds, etc was noted to contain 3 entries: 2/10/14 at 1630 "refused Novolog d/t [due to] low BG; 2/11/14 at 1630 "refused Novolog d/t low BG"; and 2/13/14 the AM dose, "Held Novolog d/t BG 115." R151's electronic progress notes for 2/2014, indicated 1 entry dated 2/4/14, addressing R151's refusal of another type of insulin. There was no documentation to address the remaining doses of Novolog insulin that were not administered. On 2/13/14, at 10:30 a.m. licensed practical nurse	F 329	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 4 Medication Administration audits will be completed weekly starting the week of 3-17-14 to ensure ongoing compliance, until compliance is achieved and then 4 quarterly thereafter • The monitoring results will be reported to the Quality Assurance Process Improvement Committee quarterly and will make ongoing recommendations for monitoring Completion Date: 3-26-14	

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F 329	Continued From page 20 (LPN)-B stated circled initials on the MAR indicated R151 did not receive the ordered dose of insulin. LPN-B stated the Novolog insulin was to be held if R151's blood glucose reading was below 120 and confirmed R151's blood glucose was not below 120 on the dates and times the Novolog insulin was not given. LPN-B further stated she was aware R151 had been refusing some doses of insulin due to concern with the BG going too low. LPN-B confirmed the facility's policy on resident refusal of medications or staff holding of medications was to document the refusal or the held medication and the reason why the medication was refused or held. LPN-B verified R151's medical record did not contain documentation of why the insulin was not given. On 2/13/14, at 3:30 p.m. the director of nursing (DON) stated all residents' refusals of medications and medications held according to physicians's orders should be documented in the MAR, and/or progress notes, and with the insulin held or refused, an update to physician should be sent. The DON verified R151's medical record lacked documentation of follow up regarding doses of Novolog insulin not administered as directed by physician's orders. A Medication Administration policy reviewed/revised 2/2011, directed the nurse was responsible to follow medication recommendations and physician orders in administering treatments/medications to the residents.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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 431	Continued From page 21 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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 interview and document review, the facility failed to ensure Fentanyl patches (narcotic used for pain) were disposed of in accordance with federal DEA (Drug Enforcement Agency)	F 431	**F431:** DON and/or designee will implement corrective action for the destruction of Fentanyl Patches by: • A policy and procedure was written for the destruction of Fentanyl patches DON and/or designee will assess residents having the potential to be affected by this practice including: • Few residents and all staff have the potential to be affected by this practice DON and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff will be educated on the Destruction of Fentanyl Patches Policy and Procedure starting the week of 3-10-14 DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 2 audits per week will be completed starting the week of 3-17-14 to ensure ongoing compliance, until compliance is achieved and then 2 quarterly thereafter • The monitoring results will be reported to the Quality Assurance Process Improvement Committee quarterly and will make ongoing recommendations for monitoring Completion Date: 3-26-14	

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F 431	Continued From page 22 regulations for 5 of 5 residents (R25, R56, R87, R42, R97) who were prescribed Fentanyl patches. Findings include: Used Fentanyl patches were not disposed of according to current standards of practice to decrease the risk of diversion. Licensed practical nurse (LPN)-B was observed during a medication administration observation on the Brooklyn unit on 2/12/14, at 8:49 a.m. LPN-B stated the used Fentanyl patches were disposed of in a small sharps container located on top of the medication cart. LPN-B stated the patches were not cut in half or folded, and disposal was not witnessed by another staff. LPN-B stated the sharps container was closed when full and given to maintenance for disposal. LPN-B confirmed R25 was administered Fentanyl patches from the Brooklyn unit medication cart. On 2/12/14, at 9:49 a.m. LPN-C stated the used Fentanyl patches were discarded in the sharps container on top of the medication cart; were not folded or cut, and disposal did not require a witness. LPN-C confirmed R56 was administered Fentanyl patches from the Home Acres medication cart. On 2/12/14, at 1:30 p.m. LPN-D stated she had not had to dispose of a Fentanyl patch in a long time as disposal was done on the afternoon shift, but thought the patches were just folded over and discarded in the garbage. LPN-D confirmed R87 was administered Fentanyl patches from the Bennett Park unit medication cart.	F 431		

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 _____	02/14/2014

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 431	Continued From page 23 On 2/12/14, at 1:30 P.M. LPN-E stated used Fentanyl patches were disposed of either in the sharps container on top of the medication cart or were flushed down the septic system. LPN-E stated the patches were not cut or folded, and disposal was not witnessed by another staff. LPN-E confirmed R42 and R97 were administered Fentanyl patches from the Merry View unit medication cart. On 2/12/14, at 1:37 p.m. the director of nursing (DON) stated the current method of disposal of used Fentanyl patches in the sharps containers. The DON was unsure if the disposal was witnessed. The DON stated all discontinued narcotics were disposed of by her and a qualified witness. The DON confirmed there was no tracking of the disposed used Fentanyl patches. On 2/12/14, at 2:58 p.m. the consultant pharmacist (CP) stated the current standard of practice for disposal of Fentanyl patches was to remove the patch from the resident and flush the patch in the sewer system. CP stated the disposal should be witnessed by two qualified staff and signed off in the narcotic book as disposed. CP confirmed he had not formally educated the facility regarding the new standard of practice for disposal of the used Fentanyl patches. The Destruction of medication policy revised 9/11, indicated all controlled substances would be destroyed by the DON or CP and a second nurse as a witness. Destruction would occur by flushing the controlled substances into the sewer system, and would be documented on the medical destruction form provided by the MN Board of Pharmacy.	F 431		

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 _____	02/14/2014

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

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F441:** DON and/or designee will implement corrective action for (R69) affected by this by: • The razor used by (R69) was cleaned per policy and procedure previous to his use on 2-13-14 DON and/or designee will assess residents having the potential to be affected by this practice including: • Other residents who do not have a personal razor are potentially affected by this practice DON and/or designee will implement measures to ensure that this practice does not recur including: • All nursing staff will be educated on electric razor use policy and procedure starting 3-17-14 DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 2 observational audits will be completed per week starting the week of 3-17-14 to ensure ongoing compliance, until compliance is achieved and then 2 quarterly thereafter • The monitoring results will be reported to the Quality Assurance Process Improvement Committee quarterly and will make ongoing recommendations for monitoring Completion Date: 3-26-14	

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 _____	02/14/2014

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 441	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, the facility did not follow their infection control policy to provide a clean and sanitized razor for 1 of 2 residents (R69) reviewed for activities of daily living. Findings include: R69 had several days growth of facial hair when he was interviewed on 2/12/14, at 8:00 a.m.. R69 stated the nursing assistants didn't know how to shave him. Stated that when they shave him it pulls his beard and it hurts like "h---" because their razors don't work. R69 stated he didn't have a razor of his own and used one provided by the facility. Interview on 2/12/14, at 8:10 a.m. with the nursing assistant (NA)-F who works with R69 on a regular basis stated that sometimes he refuses to be shaved because of the razor pulls hard on his beard. Stated that she has her own razor that she stored in the main bath/shower room and that was what she uses when she shaves residents. When NA-F's razor was observed, it was full of gray and black hairs. Interview on 2/12/14, at 8:30 a.m. with NA-D who was assisting R69 said that he would shave R69 on his shower days. Stated that he used the electric shaver that he gets from the LPN. When asked how the razor was cleaned NA-D stated that he uses brushes. State that some razors you can clean with water if they have a symbol on them.	F 441		

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 _____	02/14/2014

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 441	Continued From page 26 Registered nurse (RN)-A was interviewed on 2/12/14, at 8:40 a.m. about the use of community razors. RN-A found a white razor on the counter of the Medication room. The razor was opened and had fine hairs as if it was cleaned out with a brush. On 2/12/14, at 9:55 a.m. licensed practical nurse (LPN)-E stated she didn't know if there was facility policy directing cleaning of a community razor. LPN-E stated the staff uses the blue and black electric razor that was being charged in the medication room. The razor was opened and found to be dirty and very full of hair and gray fuzz. LPN-E stated that they only used this razor on residents in her group and that someone didn't clean it after it had been used. LPN-E did not know if there was a procedure for cleaning the community razors but she sometimes cleaned it with alcohol. Interview on 2/12/14, at 12:30 p.m. the assistant director of nursing stated that she did not know what the policy was for cleaning razors. Stated that as far as she knew there should not be a community shaver. Review of the Electric Razor Policy dated 12/95, indicated that resident would provide their own electric shaver to be used for daily grooming. The policy indicated if a resident did not have a razor they should update Social Services and they would ask the family to provide one. In an emergency situation one specified electric razor under nursing supervision would be used and stored in the medication room and thoroughly cleaned and sanitized after each use. After each use nursing staff would ensure the razor heads would be taken apart and cleaned with	F 441		

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 _____	02/14/2014

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 441	Continued From page 27 appropriate disinfectant which was noted to be super Sani Cloths. Interview on 2/13/14 at 9:58 a.m. with the director of nursing/infection control nurse indicated the razors should not be put away dirty. Facility policy directed each resident to have their own razor. Staff should not routinely use the emergency razor and the razor should be cleaned as directed by policy.	F 441		
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 observations and interview the facility failed to maintain a safe, functional, and comfortable environment for residents, staff and the public. Findings include: On 2/12/14 at 12:40 p.m., during the environmental tour with the maintenance supervisor (MS)-A the following concerns were noted: R130's room was observed to have a make-shift vent deflector made of card board held on to the ceiling with pealing black and clear tape. R130 said the vent was above her bed blew cold air on her. R130 stated that when she has visitors they	F 465		

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 _____	02/14/2014

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 465	Continued From page 28 always ask about the vent deflector. R130 stated a nurse put up the cardboard deflector about 4 months ago and it looks ugly. MS-A stated the heating company had been called to fix the problem but did not know the date. The heating company had not responded to date. Verification of communication with the heating company was requested but not provided. R160's door jams on both sides of the door were scrapped with sharp edges. One side was scrapped 1 and one half feet up from the floor and the other door jam was scraped and sharp 6 inches off of the floor. The painted burnt orange wall had two areas with primer and paint scraped off. The area near the clock measured 1.5 inches by 9 inches. The second area was on the wall below the light. R94's room also had missing paint and primer on the wall by the clock The 12 by 12 inch square floor tile had black glue seeping up between the tiles in a 8 by 5 foot area. MS-A stated at 1:30 p.m. that staff would scrape this black glue off the floor on a regular bases. State that they had asked the contractor about this, but had got no response to help with this issue. R110's room had 8 small scrapes of paint and dry wall paper missing from the wall in an area one foot by 7 inches by the bed. R31 had two areas with paint and primer scraped off the wall behind their chair in the room, one was 1/4 inch by 1.5 inches and the second one 1/4 inch by 1/2 inch wide. Interview on 2/12/14, at 2:30 p.m. with MS-A confirmed the above issues and had stated that	F 465	**F465:** ESD and/or designee will implement corrective action by: • The temporary air stop in resident room (R130) was taken down on 2-12-14, after our HVAC contractor completed the repairs to the air unit. • The door jams and paint chips in the resident rooms of (R160), (R94), (R110) and (R31) were repaired the week of 2-17-14. • The floor in the resident room of (R94) was stripped and waxed on 3-11-14. ESD and/or designee will assess residents having the potential to be affected by this practice including: • All resident and common areas can be potentially affected. ESD and/or designee will implement measures to ensure that this practice does not recur including: • All staff were re-educated on the importance of noting issues that require maintenance attention using the work order procedure. The ESD did a complete inspection of the resident rooms and common areas, and has developed a plan for the repair of others areas/items noted in his inspection.	

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 _____	02/14/2014

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

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F 465	Continued From page 29 the system to inform maintenance of these types of needed repairs was for staff to use the maintenance slips.	F 465	ESD and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • ESD will complete two building inspections per week, to look for other items that may need repair, touch up painting and ensure air vents are kept clear. This will continue until compliance is maintained, then monthly thereafter. Completion Date: 3-24-2014	

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

F5239026

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 _____	**02/11/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENT	**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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Guardian Angels Health & Rehab Center was found 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. 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. It is properly separated from the rest of the building. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 96 beds and had a census of 85 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is met.	K 000		

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

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.

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

F5239026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **02 - 2006 ADDITION** B. WING _____	**02/11/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS HEALTH & REHAB CENT	**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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Guardian Angels Care Center Building 2 was found 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 Guardian Angels Care Center Building 2 is a 1-story building with a partial basement, Type II(111), constructed in 2006. In 2011 another wing was constructed to "New", that is one story, with a small partial mechanical basement Type II(000) .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 96 beds and had a census of 85 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3971

March 3, 2014

Mr. Geoffrey Ryan, Administrator
Guardian Angels Health & Rehab Center
1500 East Third Avenue
Hibbing, Minnesota 55746

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5239026

Dear Mr. Ryan:

The above facility was surveyed on February 10, 2014 through February 14, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at:

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

Phone: (218) 302-6151
Fax: (218) 723-2359

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Patricia Halverson at the number above.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	02/14/2014

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/10/14, through 2/14/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	02/14/2014

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) COMPLETE DATE
2 000	Continued From page 1 Certification Program; 11 East Superior Street; Suite 290, Duluth, MN 55802	2 000	entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	02/14/2014

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2 555	Continued From page 2 practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a care plan to address non-compliance with fluid restriction for 1 of 1 residents (R69) who was reviewed for dialysis services. Findings include: The physician's orders dated 12/11/13, indicated R69 was on a renal diet with a 1200 milliliter (ml) fluid restriction. The orders further identified R69 had diagnoses of end stage renal disease (ESRD) and hypertension (HTN). The quarterly Minimum Data Set (MDS) dated 12/13/13, indicated R69 had moderate cognitive impairment; was independent with eating and drinking; was on a therapeutic diet; and received dialysis services. The renal care plan dated 11/7/13, identified R69 received dialysis services and directed staff to record intake and output (I & O) totals due to a 1200 ml per day fluid restriction. The nutrition care plan revised 12/5/13, identified R69 received dialysis, and required a therapeutic diet with a fluid restriction ordered by the physician. Goals included (but were not limited to) to have good diet compliance. The care plan directed a renal diet with a 1200ml fluid restriction; and one can of Nepro supplement twice a day (BID). On 2/12/14, at 8:04 a.m. R69 was observed in the room with a 1/2 full mug of tea (total 240 cc) and a large thermal pitcher 3/4 full of ice water on the	2 555		

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	00858	A. BUILDING: _____ B. WING _____	02/14/2014

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2 555	Continued From page 3	2 555		

bedside stand. R69 stated he was unaware of any fluid restrictions. R69 stated he drinks tea, and drinks his water throughout the day. R69 confirmed staff gave him the large thermal pitcher of ice water every day. There was no indication in the room that R69 was on a fluid restriction. R69 stated in the morning "I get tea and toast. That's all I want." No signs or symptoms of fluid overload were noted.

On 2/13/14, at 8:54 a.m. R69 was observed in his room with a large pink thermal pitcher full of ice water and a 3/4 full 591 ml bottle of root beer on the bedside stand. R69 stated he buys root beer whenever he can (almost daily) in the machine on the unit. R69 stated he was not aware he was on any fluid restrictions and stated he received the ice water daily. R69 stated he drinks most of it, "I like the nice cold water with ice to drink."

The Supplement Intake records for January and February 2014, indicated R69 drank 100% of the Nepro supplement twice a day (480 ml) on most days. The Oral Intake records for January and February 2014, were incomplete and lacked documentation for several day shift and afternoon shift fluid intakes.

On 2/13/14, at 3:27 p.m. the registered nurse (RN)-E stated R69 was not on any special fluid restrictions and, "Pretty much does his own thing."

On 2/13/14, at 3:31 p.m. nursing assistant (NA)-H stated R69 was on a fluid restriction, but was unsure as to how much fluid R69 could drink. NA-H stated R69 keeps track of it on his own. "He does his own thing and drinks what he wants. We don't always know."

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2 555	Continued From page 4 On 2/13/14, at 4:00 a.m. the dietary manager (DM) stated dietary staff doesn't put any fluids on the trays of residents with fluid restrictions. The nursing assistants (NA's) pass all the beverages and keep track. On 2/13/14, at 3:45 p.m. RN-A confirmed monitoring of R69's fluid intake had not been consistent. RN-A stated after talking with the staff he found that R69 was not always compliant with his fluid intake and drinks what he wants. RN-A confirmed R69's care plan did not address non-compliance with the fluid restriction. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures for the development of care plans. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 555		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan	2 565		

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2 565	Continued From page 5 was followed regarding shaving needs for 1 of 3 residents (R97) reviewed for activities of daily living. On 2/11/14, at 8:41 a.m. R97 was observed unshaven, with facial hair approximately 1/4 inch long. R97's diagnosis listing sheet included dementia without behavioral disturbances. The quarterly minimum data set (MDS) dated 1/28/14 indicated R97 was severely cognitively impaired, and required extensive assistance of one staff for grooming. R97's care plan dated 11/1/13, directed staff to shave R97's face every morning. On 2/14/14, at 10:23 a.m. the director of nursing (DON) was interviewed and stated she would expect staff to follow the care plan regarding shaving. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to inform staff on following the care plan. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 565		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and	2 835		

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	00858	A. BUILDING: _____ B. WING _____	02/14/2014

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2 835	Continued From page 6 considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to honor the right to be treated in a dignified manner regarding toileting concerns for 2 of 2 residents (R44, R159) who were reviewed for dignity. Findings include: On 2/10/14, at 5:17 p.m. during an initial resident interview, R159 reported an incident which occurred about 3 weeks prior when R159 waited for the call light to be answered for over 30 minutes. R159 stated she needed to use the bathroom and ended up getting up on her own as she needed to use the toilet very badly. During the interview R159's spouse was present and confirmed the incident. R159 that when the staff responded to the call light they scolded her for getting up without help, then the staff told R159 to just "go in your pants" and we will change you. R159 was not able to recall who said that to her. R159 stated they were continent of bowel and bladder and did not wear any type of incontinent product and would never just go in the bed or clothing. R159 stated the staff comment was upsetting and very undignified. R159's spouse stated they both could not believe some one would tell a resident to do that. R159's admission Minimum Data Set (MDS) dated 2/11/14, indicated R159's brief interview for mental status (BIMS) scored 7, indicating severe cognitive impairment. The MDS further indicated R159 required minimal assistance with toileting	2 835		

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	00858	A. BUILDING: _____ B. WING _____	02/14/2014

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2 835	Continued From page 7	2 835		

activities and was continent of bowel and bladder.

A Care Planning Report dated 2/10/14, indicated R159 had short-term memory deficits with variable mental function with intervention of call bell placed within reach. The Care Planning Report further indicated R159 was alert and oriented to person with intermittent confusion to time/place, and was able to let needs be known verbally. The Care planning report indicated R159 was continent of bowel and bladder, did not use any incontinence products, and required staff to assist due to weakness and intermittent confusion.

On 2/13/14, at 12:30 p.m. R159 was re-interviewed and stated the nursing assistant told her to pee her pants that night about 3 weeks ago. R159 repeated the same story told to the surveyor 3 days ago. R159 went on to state nothing like that incident has happened since and R159 was still not able to recall the name of the staff person or their face.

On 2/13/14, at 3:30 p.m. the director of nursing (DON) stated she was not aware R159 was treated without regard during a night when R159 required assistance to get to the bathroom. The DON further stated even if a resident is cognitively impaired they should not be told to go in their pants. The DON confirmed the staff's behavior and statement to R159 was very undignified.

On 2/13/14, at 4:15 p.m. registered nurse (RN)-D stated R159 has been continent of bowel and bladder and did not use any incontinent products. RN-D further stated she was not aware of any incident involving R159 and toileting activities requiring staff assistance during a night about 3

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	00858	A. BUILDING: _____ B. WING _____	02/14/2014

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2 835	Continued From page 8	2 835		

weeks ago. RN-D confirmed R159's described incident constituted undignified staff treatment.

On 2/13/14, at approximately 2:30 p.m. a copy of the facility's Arial Resident Call System log for 1/2014, was requested to determine potential long call light response times for R159. The log was not provided.

A Resident's Right policy dated 5/2005, indicated rights of each resident would be protected and promoted and would include the right to privacy and respect.

R44 indicated that staff does not answer his call light in a timely manner and he has been incontinent of bowel which makes him feel terrible.

On 2/11/14, at 9:24 a.m. R44 was interviewed and stated there was not enough staff available to answer his call light in a timely manner. R44 further indicated staff would come in, shut his call light off, tell him they would be right back, and then not return to his room. R44 stated a few days ago he put his call light on because he had to use the toilet to have a bowel movement (bm). When staff did not answer his call light, he walked to the toilet alone, then stated he "caught hell" from staff because he is supposed to ask for help. R44 stated he has been incontinent of bowel on several occasions while waiting for his call light to be answered, and this makes him feel "terrible."

R44's face sheet indicates diagnoses that include dementia, muscle weakness and abnormal gait. R44's admission minimum data set (MDS) dated 12/20/13, indicated moderate cognitive

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2 835	Continued From page 9	2 835		

impairment. The MDS indicated R44 required extensive assistance of two staff for mobility and transfers, and was occasionally incontinent of bowel (one episode in the past seven days). The care plan dated 1/14/14, indicated R44 was incontinent of bowel with loose stools, was aware of the need to use the toilet, was on a scheduled toileting program and could use the call light to request to use the toilet. R44's care guide sheet directed one staff to assist to toilet upon rising, after brunch, before and after siesta snack, before and after dinner, before night cap snack and at bedtime.

The comprehensive bowel and bladder assessment dated 12/20/13, indicated R44 was occasionally incontinent of bowel, was not on a bowel toileting program, and had regular bowel movements (at least one every three days).

On 2/13/14, at 12:40 p.m. nursing assistant (NA)-E was interviewed and stated R44 is toileted every two hours and when he requests. NA-E further stated R44 will use his call light to request to use the toilet, and there are times when he has been incontinent before they can answer his call light. NA-E stated he is incontinent of bowel a couple times a week usually in the morning when he first wakes up.

On 2/13/14, at 12:59 p.m. registered nurse (RN)-B was interviewed and stated R44 was incontinent of bowel several times a week.

On 2/13/14, at approximately 2:30 p.m. a copy of the facility's Arial Resident Call System log for January and February 2014, was requested but not provided.

On 2/14/14, at 10:25 a.m. the director of nursing

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2 835	Continued From page 10 (DON) was interviewed and stated call lights should be answered in 8 minutes or less. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure residents are treated with dignity. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 835		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility did not provide shaving assistance in accordance with the resident's assessed needs for 2 of 3 residents (R69, R97) reviewed for activities of daily living. Findings include: R69 was observed on 2/11/14, at 10:56 a.m. with several days growth of facial hair.	2 850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 850	Continued From page 11 R69 had several days growth of facial hair when he was interviewed on 2/12/14, at 8:00 a.m.. R69 stated the nursing assistants didn't know how to shave him. Stated that when they shave him it pulls his beard and it hurts like "h---" because their razors don't work. R69 stated he didn't have a razor in the facility or he could shave himself and it would be even better if they would just use that "Pre Shave" that he used at home, then they could shave him and it wouldn't pull at all. His face would be like a baby's bottom and he would use it every day. R69's significant change minimum data set (MDS) dated 6/25/13, and the quarterly minimum data set (MDS) dated 12/11/13, indicated R69 was able to talk and understands others. R69 had moderate cognitive impairment and no behaviors or mood issues. The MDS indicated R69 needed extensive assistance of one staff for bathing, grooming and personal hygiene. The MDS identified diagnoses of congestive heart failure, renal failure, depression, and dementia. Nursing assistant (NA)-F, interviewed on 2/12/14, at 8:10 a.m. stated that R69 sometimes refuses to be shaved because the razor pulls hard on his beard. She states he lets it go too long and then the razor doesn't work right. The February 13, Care Guide for grooming noted staff were to set R69 up at the bed side for daily hygiene, assist with perineum care, staff to comb and brush resident's hair and shave resident's face. The care plan dated February 13, 2014, directed facial hair removal on weekly bath days as well as daily. The care plan noted R69 refused shaving at	2 850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 850	Continued From page 12	2 850		

times. The care plan noted staff should set him up at the bed side for daily hygiene.

Interview with NA-D on 2/12/14, at 8:30 a.m. indicated R69 was shaved on bath days. Review of the "To Do List" (nursing assistant plan of care) indicated R69 needed to shave "continuously" meaning daily.

Interview on 2/13/14, at 9:58 a.m. with the director of nursing (DON) stated it was facility policy for every one to have their own razor.

The Electric Razor Policy dated 12/95, indicated that resident would provide their own electric shaver to be used for daily grooming. The policy indicated if a resident did not have a razor they should update Social Services and they would ask the family to provide one. In an emergency situation one specified electric razor under nursing supervision would be used and stored in the medication room and thoroughly cleaned and sanitized after use.

On 2/11/14, at 8:41 a.m. R97 was observed unshaven with facial hair approximately 1/4 inch long.

R97's diagnosis listing sheet included dementia without behavioral disturbances. The quarterly minimum data set (MDS) dated 1/28/14, indicated R97 was severely cognitively impaired, and required extensive assistance of one staff for grooming. R97's care plan dated 11/1/13, directed staff to shave resident's face every morning. The functional assessment completed 10/28/13, directed R97 to have extensive assistance of 1-2 staff for activities of daily living (ADLs).

On 2/14/14, at 10:23 a.m. the director of nursing

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2 850	Continued From page 13 (DON) was interviewed and stated she would expect staff to shave R97 every morning as directed in the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure all residents are shaved per their preference. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 850		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and documentation review, the facility did not follow their infection control policy to provide a clean and sanitized razor for 1 of 2 residents (R69) reviewed for activities of daily living. Findings include: R69 had several days growth of facial hair when he was interviewed on 2/12/14, at 8:00 a.m.. R69 stated the nursing assistants didn't know how to	21375		

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GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

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21375	Continued From page 14 shave him. Stated that when they shave him it pulls his beard and it hurts like "h---" because their razors don't work. R69 stated he didn't have a razor of his own and used one provided by the facility. Interview on 2/12/14, at 8:10 a.m. with the nursing assistant (NA)-F who works with R69 on a regular basis stated that sometimes he refuses to be shaved because of the razor pulls hard on his beard. Stated that she has her own razor that she stored in the main bath/shower room and that was what she uses when she shaves residents. When NA-F's razor was observed, it was full of gray and black hairs. Interview on 2/12/14, at 8:30 a.m. with NA-D who was assisting R69 said that he would shave R69 on his shower days. Stated that he used the electric shaver that he gets from the LPN. When asked how the razor was cleaned NA-D stated that he uses brushes. State that some razors you can clean with water if they have a symbol on them. Registered nurse (RN)-A was interviewed on 2/12/14, at 8:40 a.m. about the use of community razors. RN-A found a white razor on the counter of the Medication room. The razor was opened and had fine hairs as if it was cleaned out with a brush. On 2/12/14, at 9:55 a.m. licensed practical nurse (LPN)-E stated she didn't know if there was facility policy directing cleaning of a community razor. LPN-E stated the staff uses the blue and black electric razor that was being charged in the medication room. The razor was opened and found to be dirty and very full of hair and gray fuzz. LPN-E stated that they only used this razor	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	02/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21375	Continued From page 15 on residents in her group and that someone didn't clean it after it had been used. LPN-E did not know if there was a procedure for cleaning the community razors but she sometimes cleaned it with alcohol. Interview on 2/12/14, at 12:30 p.m. the assistant director of nursing stated that she did not know what the policy was for cleaning razors. Stated that as far as she knew there should not be a community shaver. Review of the Electric Razor Policy dated 12/95, indicated that resident would provide their own electric shaver to be used for daily grooming. The policy indicated if a resident did not have a razor they should update Social Services and they would ask the family to provide one. In an emergency situation one specified electric razor under nursing supervision would be used and stored in the medication room and thoroughly cleaned and sanitized after each use. After each use nursing staff would ensure the razor heads would be taken apart and cleaned with appropriate disinfectant which was noted to be super Sani Cloths. Interview on 2/13/14 at 9:58 a.m. with the director of nursing/infection control nurse indicated the razors should not be put away dirty. Facility policy directed each resident to have their own razor. Staff should not routinely use the emergency razor and the razor should be cleaned as directed by policy. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures on infection control measures and the cleaning of electrical razors. The director of	21375		

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	00858	A. BUILDING: _____ B. WING _____	02/14/2014

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21375	Continued From page 16 nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21375		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure baseline screening for tuberculosis (TB) symptoms for 2 of 5 residents (R55, R96) reviewed for immunizations.	21426		

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	00858	A. BUILDING: _____ B. WING _____	02/14/2014

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21426	Continued From page 17 Findings include: R55 was readmitted to the facility at the end of November, 2013. Medical record review indicated R55 had received Tubersol (a medical solution used to test for exposure to TB) intradermally on 11/25/13, with the result read on 11/27/13, with 0 mm of induration (negative result). A second tuberculin skin test (TST) was administered on 12/8/13, using Tubersol intradermally, and was read on 12/10/13, with 0 mm of induration. Review of R55's electronic medical record revealed no documentation of screening for symptoms of TB. R96 was admitted to the facility at the beginning of November, 2013. Review of R96's medical record revealed R96 had received a Mantoux (skin test to determine exposure to TB) on 11/18/13, and was read on 11/21/13, with 0 mm of induration. Review of R96's electronic medical record revealed a Tuberculosis Screening dated 11/17/13, with no answers to the screening questions completed. On 2/12/14, at appropriately 2:00 p.m. registered nurse (RN)-A stated R96 had been admitted to the facility during the TB solution shortage so R96 received only the first step TST. RN-A further stated a screening should have been completed for R96. On 2/13/14, at 9:45 a.m. the assistant director of nursing (ADON) provided a TB Screening form for R96 dated 11/17/13, and with a date entered 2/12/14, with the answers filled in. The ADON reported R55's medical record lacked documentation a TB Screening had been completed.	21426		

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21426	Continued From page 18 On 2/13/14, at 1:30 p.m. the director of nursing (DON) stated the date on the TB Screening form would be the resident's admission date and the date entered is the date the information was put into the computer to complete the TB screening form. The DON confirmed all residents admitted to the facility would have a TB Screening form completed and a 2-step Mantoux test given if the tuberculin serum was available. Review of the facility's Tuberculosis policy, dated 2013, indicated lack of direction related to the required TB risk assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures for tuberculosis screening per the Center for Disease Control recommendations. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide	21540		

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	00858	A. BUILDING: _____ B. WING _____	02/14/2014

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) COMPLETE DATE
21540	Continued From page 19 adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin was administered per physicians ordered parameters for 1 of 5 residents (R151) whose medications were reviewed. Findings include: A computer-generated diagnosis list dated 2/13/14, indicated R151's diagnoses included diabetes mellitus type 2. The admission Minimum Data Set (MDS) dated 12/23/13, indicated R151 was cognitively intact. A Care Planning Report dated 12/23/13, indicated R151 was to receive blood glucose (BG) monitoring q.i.d. [four times daily]. R151's Physician's Orders dated 1/3/14, directed Novolog insulin 17 units subcutaneous t.i.d [three times daily] before breakfast, lunch and dinner,	21540		

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	00858	A. BUILDING: _____ B. WING _____	02/14/2014

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21540	Continued From page 20 hold if BG less than 120. A Medications Administration Record (MAR) dated 2/1/14, to 2/28/14, indicated R151 was receiving Accu-checks before meals and at hs [hour of sleep]. The MAR contained BG monitoring values written with nurses' initials, four times daily, with three readings less than 120: 2/7/14 at 0800 the BG was 117; 2/10/14 at 1600 the BG was 118; and 2/13/14 at 0800 the BG was 115. All other BG readings for 2/1/14, 0800 through 2/13/14 at 1000 were greater than 120. The MAR directed Novolog 17 units subcutaneous t.i.d with the times noted as AM, NOON, and 1600. The MAR dated from 2/1/14, AM through 2/13/14, NOON, contained 18 entries with the nurses' initials circled to indicate the dose was not administered. On the reverse side of the MAR, a lined page for documentation of PRN's [as needed], Refusals, Holds, etc was noted to contain 3 entries: 2/10/14 at 1630 "refused Novolog d/t [due to] low BG; 2/11/14 at 1630 "refused Novolog d/t low BG"; and 2/13/14 the AM dose, "Held Novolog d/t BG 115." R151's electronic progress notes for 2/2014, indicated 1 entry dated 2/4/14, addressing R151's refusal of another type of insulin. There was no documentation to address the remaining doses of Novolog insulin that were not administered. On 2/13/14, at 10:30 a.m. licensed practical nurse (LPN)-B stated circled initials on the MAR indicated R151 did not receive the ordered dose of insulin. LPN-B stated the Novolog insulin was to be held if R151's blood glucose reading was below 120 and confirmed R151's blood glucose was not below 120 on the dates and times the Novolog insulin was not given. LPN-B further	21540		

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21540	Continued From page 21 stated she was aware R151 had been refusing some doses of insulin due to concern with the BG going too low. LPN-B confirmed the facility's policy on resident refusal of medications or staff holding of medications was to document the refusal or the held medication and the reason why the medication was refused or held. LPN-B verified R151's medical record did not contain documentation of why the insulin was not given. On 2/13/14, at 3:30 p.m. the director of nursing (DON) stated all residents' refusals of medications and medications held according to physicians's orders should be documented in the MAR, and/or progress notes, and with the insulin held or refused, an update to physician should be sent. The DON verified R151's medical record lacked documentation of follow up regarding doses of Novolog insulin not administered as directed by physician's orders. A Medication Administration policy reviewed/revised 2/2011, directed the nurse was responsible to follow medication recommendations and physician orders in administering treatments/medications to the residents. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure medications are given per the physician's parameters. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21540		

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21565	Continued From page 22	21565		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe self administration of medications for 1 of 3 residents (R31) observed to self-administer medications. Findings include: On 2/10/14, at 6:06 p.m. during the initial interview with R31, a small, white paper cup with 5 tablet and capsule medications was observed on R31's chair-side table. R31 was observed sitting in a recliner chair in the room. Next to the paper cup holding the medications, several plastic cups containing clear and red liquids were observed. During the interview, R31 was observed to take several of the medications out of the paper cup, place them into the mouth, and drink some of the clear liquid. R31 was then observed to remove one round, white tablet out of the mouth with the right hand, and place the tablet into a garbage can on the right side of R31's recliner chair. R31 completed the interview, and an empty white medication cup was observed on R31's chair-side table. Licensed practical nurse (LPN)-A, interviewed on 2/11/14, at 5:05 p.m., stated she left the cup of	21565		

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21565	Continued From page 23	21565		

medications in R31's room the previous night while she went to get R31 something else to drink with the medications. When LPN-A returned to R31's room the door was closed. LPN-A further stated R31 often refused to take the medications when she was in the room.

R31's annual Minimum Data Set (MDS) dated 11/19/13, indicated R 31 had moderate cognitive impairment.

A Care Area Assessment (CAA) for self-administration of medications dated 11/12/13, indicated R31 did not have an order and did not wish to self administer medications or treatments. The CAA further indicated R31 had a BIMS [brief interview of mental status] of 10 which indicated R31 had moderate cognitive impairment and a contracture to the left hand decreasing R31's manual dexterity. The CAA further indicated R31 was not currently a candidate for self administration, and licensed staff were directed to store, document, and administer all medications and treatments per physician order daily.

A Care Planning Report dated 12/31/12, indicated R31 did not wish to self administer medications, and directed nursing staff to administer, store and document all medications and treatments. R31 had no physician order to self-administer medications.

A Medication Administration Record (MAR) dated 2/1/14, to 2/28/14, indicated R31 received 5 oral medications regularly designated for PM [evening] administration: Zoloft 50 mg, Vitamin C 500 mg, Flomax 0.5 mg, Lipitor 20 mg, and Vitamin D 2000 iu [international units].

On 2/13/14, at 3:45 p.m. the director of nursing

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	00858	A. BUILDING: _____ B. WING _____	02/14/2014

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21565	Continued From page 24 (DON) stated medications should not be left at bedside, unless the resident had been assessed as able to self-administer and a physician's order had been obtained. The DON confirmed R31 did not have an order to self-administer medications. A Self Administration of Medication by Residents policy revised 11/2011, directed the interdisciplinary team would define what self-administration would be for the resident and would be responsible to determine what medications are safe for the resident to self administer. The policy further directed residents would not be permitted to administer or retain medication in their rooms unless so ordered by the attending physician and approved by the interdisciplinary team. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure residents are assessed and monitored to safely self-administer medications. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21565		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a	21630		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
21630	Continued From page 25 manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Fentanyl patches (narcotic used for pain) were disposed of in accordance with federal DEA (Drug Enforcement Agency) regulations for 5 of 5 residents (R25, R56, R87, R42, R97) who were prescribed Fentanyl patches. Findings include: Used Fentanyl patches were not disposed of according to current standards of practice to decrease the risk of diversion. Licensed practical nurse (LPN)-B was observed during a medication administration observation on the Brooklyn unit on 2/12/14, at 8:49 a.m. LPN-B stated the used Fentanyl patches were disposed	21630		

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21630	Continued From page 26 of in a small sharps container located on top of the medication cart. LPN-B stated the patches were not cut in half or folded, and disposal was not witnessed by another staff. LPN-B stated the sharps container was closed when full and given to maintenance for disposal. LPN-B confirmed R25 was administered Fentanyl patches from the Brooklyn unit medication cart. On 2/12/14, at 9:49 a.m. LPN-C stated the used Fentanyl patches were discarded in the sharps container on top of the medication cart; were not folded or cut, and disposal did not require a witness. LPN-C confirmed R56 was administered Fentanyl patches from the Home Acres medication cart. On 2/12/14, at 1:30 p.m. LPN-D stated she had not had to dispose of a Fentanyl patch in a long time as disposal was done on the afternoon shift, but thought the patches were just folded over and discarded in the garbage. LPN-D confirmed R87 was administered Fentanyl patches from the Bennett Park unit medication cart. On 2/12/14, at 1:30 P.M. LPN-E stated used Fentanyl patches were disposed of either in the sharps container on top of the medication cart or were flushed down the septic system. LPN-E stated the patches were not cut or folded, and disposal was not witnessed by another staff. LPN-E confirmed R42 and R97 were administered Fentanyl patches from the Merry View unit medication cart. On 2/12/14, at 1:37 p.m. the director of nursing (DON) stated the current method of disposal of used Fentanyl patches in the sharps containers. The DON was unsure if the disposal was witnessed. The DON stated all discontinued	21630		

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	00858	A. BUILDING: _____ B. WING _____	02/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21630	Continued From page 27 narcotics were disposed of by her and a qualified witness. The DON confirmed there would be no tracking of the disposed used Fentanyl patches, and verified security of the disposal could be at risk. On 2/12/14, at 2:58 p.m. the consultant pharmacist (CP) stated the current standard of practice for disposal of Fentanyl patches was to remove the patch from the resident and flush the patch in the sewer system. CP stated the disposal should be witnessed by two qualified staff and signed off in the narcotic book as disposed. CP confirmed he had not formally educated the facility regarding the new standard of practice for disposal of the used Fentanyl patches. The Destruction of medication policy revised 9/11, indicated all controlled substances would be destroyed by the DON or CP and a second nurse as a witness. Destruction would occur by flushing the controlled substances into the sewer system, and would be documented on the medical destruction form provided by the MN Board of Pharmacy. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to destroy used/unused medications. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	02/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21685	Continued From page 28	21685		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observations and interview the facility failed to maintain a safe, functional, and comfortable environment for residents, staff and the public. Findings include: On 2/12/14 at 12:40 p.m., during the environmental tour with the maintenance supervisor (MS)-A the following concerns were noted: R130's room was observed to have a make-shift vent deflector made of card board held on to the ceiling with pealing black and clear tape. R130 said the vent was above her bed blew cold air on her. R130 stated that when she has visitors they always ask about the vent deflector. R130 stated a nurse put up the cardboard deflector about 4 months ago and it looks ugly. MS-A stated the heating company had been called to fix the problem but did not know the date. The heating company had not responded to date. Verification of communication with the heating company was requested but not provided.	21685		

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21685	Continued From page 29 R160's door jams on both sides of the door were scrapped with sharp edges. One side was scrapped 1 and one half feet up from the floor and the other door jam was scraped and sharp 6 inches off of the floor. The painted burnt orange wall had two areas with primer and paint scraped off. The area near the clock measured 1.5 inches by 9 inches. The second area was on the wall below the light. R94's room also had missing paint and primer on the wall by the clock The 12 by 12 inch square floor tile had black glue seeping up between the tiles in a 8 by 5 foot area. MS-A stated at 1:30 p.m. that staff would scrape this black glue off the floor on a regular bases. State that they had asked the contractor about this, but had got no response to help with this issue. R110's room had 8 small scrapes of paint and dry wall paper missing from the wall in an area one foot by 7 inches by the bed. . R31 had two areas with paint and primer scraped off the wall behind their chair in the room, one was 1/4 inch by 1.5 inches and the second one 1/4 inch by 1/2 inch wide. Interview on 2/12/14, at 2:30 p.m. with MS-A confirmed the above issues and had stated that the system to inform maintenance of these types of needed repairs was for staff to use the maintenance slips. SUGGESTED METHOD OF CORRECTION: The environmental director or his designee could development and implement policies and procedures to maintain a clean, orderly and comfortable environment . The environmental director or his designee could then monitor the	21685		

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21685	Continued From page 30 appropriate environment for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21685		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to provide comfortable bathroom sink water temperatures for 2 of 10 residents (R94, R16) rooms where water temperatures were checked. Findings include: R94 was interviewed on 2/12/14, at approximately 12:40 p.m. and stated he can not get hot water to wash up in the bathroom. R94 stated that he had informed facility staff. R94's annual minimum data set (MDS) dated 12/5/13, indicated he was alert, orientated and had no cognitive impairment. The water temperature was measured with the assistance of maintenance staff (MS)-A. The hot water was turned on in R94's bathroom sink and after running for 10 minutes the water temperature was 97.5 degrees Fahrenheit (F), and after running for 25 minutes the water temperature was 99 degrees F. R16 was interviewed on 2/12/14, at approximately	21710		

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21710	Continued From page 31 1:10 p.m. stated that they had to run the water for a long time before it gets warm. After running the hot water in the bathroom sink for 5 minutes the water temperature was 101.8 degrees F. R16 quarterly MDS dated 1/2/14, indicated moderate cognitive impairment. Nursing assistant (NA)-G, interviewed on the afternoon of 2/12/14, stated that he could get hot water most of the time on this wing and had to go to the public bath room at the end of the hall to get hot water. MS-A was interviewed on 2/13/14, at 4:00 p.m. and stated a recheck of R94's bath room water temperature that morning indicated 98 degrees F after running 10 minutes. The administrator was interviewed on 2/13/14, at 8:30 a.m. and stated they would look for a policy regarding water temperatures in resident rooms but didn't think there was one. The facility tries to keep the resident room hot water temperatures between 105 degrees and 115 degrees F. SUGGESTED METHOD OF CORRECTION: The environmental director or his designee could development and implement policies and procedures to ensure hot water temperatures are between 105 degrees Fahrenheit and 115 degrees Fahrenheit. The environmental director or his designee could then monitor the appropriate hot water temperatures for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21710		