		TO BE COMPLETE				<u>l'AL</u>		
1. MEDICARE/MEDICAID PROVID		2. NAME AND ADDR		KVEIF	AGENC I	4. TYPE OF ACTION		
(L1) 24-5239		(L3) Guardian A	ngels Health and l	Rehabilit	1. INITIAL SURVEY 2. RECERTIFICATION 3. TERMINATION			
3. STATE VENDOR OR MEDICAID	NO.		-	<u>rtenaemi</u>	ation	4. CHOW 5. VALIDATION		
(L2) 863278200		(L4) 1500 East T		ATE (I	6. COMPLAINT			
		(L5) Duluth			.6) 746	8. TERMINATION OF ICF BEDS 9. OTHER 7		
5. EFFECTIVE DATE FOR CHANGE	E OF OWNERSHIP	7. P	ROVIDER/SUPPLIER C	ATEGORY		(L8)		
(L9)		02 5	HOSPITAL 04 SNF SNF/ICF 05 HHA (DUALLY 06 LAB	09 ESRD 10 ICF 11 IMR	14 CORF 15 ASC 16 HOSPICE	9. FISCAL YEAR ENDING DATE (L35) MONTH/DAY		
6. DATE OF SURVEY		03 5	CERTIFIED) 07 X-RAY SNF/ICF 08 OPT/SP	12 RHC	10 HOST ICI	(ESS) MONTH/DAT		
(L34) 03/28/2014 8. ACCREDITATION STATUS		2 (	DISTINCT PART)	•				
		A. IN COMPLIANCE WI		AND/0	OR APPROVED W	AIVERS OF THE FOLLOWING		
(L10) <u>0</u> 0 - UNACCREDI' 2 - AOA	TED 1 - JCAH 3 - OTHER	PROGRAM REQUIRE COMPLIANCE BASE	EMENTS		IREMENTS:			
11. LTC PERIOD OF CERTIFICATION		1. <u>A</u> CCEPTAB	LE POC	2	TECHNICA			
From (a) To (b)					PERSONNE 24 HR RN	SERVICE LIMITED  7 MEDICAL DIRECTOR		
12. TOTAL FACILITY BEDS		, vom vo gove	DV 7 . 137.00	4 —	7-DAY RN (RURAL SN	8 PATIENT		
(L18) <u>96</u>			PLIANCE AM REQUIREMENTS LIED WAIVERS:		LIFE SAFE	ΓΥ 9 BEDS PER		
13. TOTAL CERTIFIED BEDS			ABLE CODES 1-9)		CODE	ROOM		
(L17) 96								
14. LTC A. (L37) B. (	(L38) C. (L39)	D. (L42)	A E. (L43)	F. SNF	/ICF (L40)	15. FACILITY MEETS		
CERTIFIED 18 SNF 18/ BED 18	19 SNF 19 SNF	ICF	IMR		LY CERT.	1861 (e) (1) or 1861 (j) (1)		
BREAK DOWN	96					(L15) 1-YES 2-NO		
See attached page(s).  17. SURVEYOR SIGNATURE Patricia Halverson Unit Supervisor (L19)	03/30/2014 MM/DD/YY	] [L2	STATE SURVEY AGEN Mark Meath Enforcement Spec	ialist06/1	19/2014 Mi	M/DD/YY		
PAR	T II - TO BE COMP	LETED BY CMS RE	EGIONAL OFFIC	E OR SII	NGLE STA	IE AGENCY		
19. DETERMINATION OF ELIGIBI	ILITY	20.			21. 1. STATEMENT OF FINANCIAL SOLVENCY (CMS-2572)			
1-FACILITY IS ELIGIBLE TO P	ARTICIPATE	COMPLIAN	CE WITH			HIP AND CONTROL INTEREST DISCLOSURE ENT (CMS-1513)		
2-FACILITY IS NOT ELIGIBLE	TO PARTICIPATE		ITS ACT		3. BOTH OF	THE ABOVE		
(L21)				_				
22. ORIGINAL DATE OF PARTICIPATION	23. LTC AGREEME BEGINNING DA		C AGREEMENT DING DATE		26. TERMINA	TION ACTION		
(L24) MM/DD/YY	(L41) MM/DD/YY	(L25)	MM/DD/YY	-	1- MERGER, 2- DISSATIS	CLOSURE 5- FAILURE TO MEET		
	27. ALTERNATIVE S	ANCTIONS			WITH REI	MBURSEMENT 6- FAILURE TO MEET NVOLUNTARY AGREEMENT		
25. LTC EXTENSION DATE	A. SUSPENSION OF	ADMISSIONS B. RESO	CIND SUSPENSION I	DATE	TERMINA 4- OTHER RI	TION <u>OTHER</u>		
(L27) MM/DD/YY	(L44) MM/DD/YY	(L45) MM	I/DD/YY	_	FOR WITE	IDRAWAL CHANGE		
28. TERMINATION DATE	29. INTERMEDIAR	Y/CARRIER NO.	30. REMARKS		(L30)			
(L28) MM/DD/YY	(L31) MM/DD/YY							
31. RO RECEIPT OF CMS-1539		ON APPROVAL DATE						
(L32) MM/DD/YY	(L33) MM/DD/YY							
			DETERMINATIO	N APPRO	VAI.			
			PETERMINATIO	11 ALL KU	· AL			

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

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.



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 Weath, 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

Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245239	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/28/2014
Name	of Facility		Street Address, City, State, Zip Code	
Gl	JARDIAN ANGELS HEALTH & REHAB CI	ENTER	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	ltem		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0176		03/26/2014		ID Prefix	F0241		03/26/2014		ID Prefix	F0246		03/26/2014
ū	483.10(n)				•	483.15(a)					483.15(e)(1)		_
LSC					LSC				┿.	LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0253		03/24/2014		ID Prefix	F0279		03/26/2014		ID Prefix	F0282		03/26/2014
Reg. #	483.15(h)(2)				Reg.#	483.20(d), 483.20(k)(1	)			Reg. #	483.20(k)(3)(ii)		
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix	F0312		Completed 03/26/2014		ID Prefix	F0329		Completed <b>03/26/2014</b>		ID Prefix	F0431		Completed 03/26/2014
	483.25(a)(3)					483.25(I)					483.60(b), (d), (e	٠,	_ ********
LSC	463.25(a)(3)				LSC	465.25(1)				LSC		<b>∌</b> )	_
	-					-			-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0441		03/26/2014		ID Prefix	F0465		03/24/2014		ID Prefix			_
	483.65					483.70(h)				Reg. #			_
LSC					LSC				⊥.	LSC			_
			Correction Completed					Correction Completed					Correction Completed
ID Prefix					ID Prefix			. Completed		ID Prefix			
Reg. #					Reg.#								
LSC					LSC					LSC			_ _
									T				
Reviewed By	, Re	viewed E	Зу	Da	te:	Signature of S	Surve	yor:				Date:	
State Agency	, N	MM/P	H	03	/30/20	14		1283	35			03/2	8/2014
Reviewed By	, Re	viewed E	Зу	Dat	te:	Signature of S	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed	d on:				Check for	r any	Uncorrected	Defic	iencies. Was	a Summary of	1	
	2/14/201	14				Uncor	recte	d Deficiencies	(CN	IS-2567) Sent	to the Facility?	YES	NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAL PART I - TO BE COMPI

D CERTIFICATION AND TRANSMITTAL	ID: 7JBJ
LETED BY THE STATE SURVEY AGENCY	Facility ID: 00858

							•	
1. MEDICARE/MEDICAID PROVI	DER NO.	3. NAME AND AI				4. TYPE OF AC	TION: <u>2</u> (L8)	
(L1) <b>245239</b>					LTH & REHAB	1. Initial	2. Recertification	
2.STATE VENDOR OR MEDICAII (L2) <b>863278200</b>	O NO.	(L4) CENTER		THIRL		3. Termination 5. Validation	4. CHOW	
		(L5) HIBBING			(L6) 55746	7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE O (L9)	F OWNERSHIP	7. PROVIDER/SU  01 Hospital	PPLIER CATEGO 05 HHA	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey	After Complaint	
6. DATE OF SURVEY <b>02</b>	/14/2014 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR E	NDING DATE: (L35)	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID			ADING DATE. (L33)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICAT	ION	10.THE FACILITY	' IS CERTIFIED	AS:		"		
From (a):		X A. In Complian	nce With		And/Or Approved Waivers C		irements:	
To (b):			equirements e Based On:		2. Technical Personne		f Services Limit	
12.Total Facility Beds	<b>96</b> (L18)	^	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural S	7. Medical NF)8. Patient l		
					5. Life Safety Code	9. Beds/R	oom	
13.Total Certified Beds	<b>96</b> (L17)		npliance with Progrents and/or Applie		* Code:	(L12)		
14. LTC CERTIFIED BED BREAKI	OOWN				15. FACILITY MEETS			
18 SNF 18/19 SNI	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
96								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY RE	EMARKS (IF APPLICA	ABLE SHOW LTC C	ANCELLATION	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	CY APPROVAL	Date:	
Cheryl Johnson, HF	E NE II	0	03/10/2014	(L19)	Kate JohnsTon, En	forcement Spe	ecialist 04/07/2014 (L20)	
PA	ART II - TO BE C	COMPLETED B	SY HCFA RE	GIONAI	L OFFICE OR SINGLE	STATE AGENC	Y	
19. DETERMINATION OF ELIGIE	BILITY		IPLIANCE WITH	CIVIL	21. 1. Statement of Fin	•		
1. Facility is Eligible to	Participate	RIGH	ITS ACT:		<ol> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>			
2. Facility is not Eligib	(L21)					<del></del>		
	(E21)							
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION	N:	(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	TE .	VOLUNTARY 0	<u>INVO</u>	LUNTARY	
10/01/1981					01-Merger, Closure		l to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbur		l to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Terminat 04-Other Reason for Withdrawa	OTHE	_	
	A. Suspension	of Admissions:	(T. 4.4)		04-Other Reason for Withdrawa	07-Pro	ovider Status Change	
(L27)	B. Rescind Su	spension Date:	(L44)			00 710		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)	Posted 04/08/20	014 CO.		
31. RO RECEIPT OF CMS-1539								
	32.	. DETERMINATION	OF APPROVAL	DATE				
	(L32)	. DETERMINATION	I OF APPROVAL	(L33)	DETERMINATION API	PROVAL		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00858

**C&T REMARKS - CMS 1539 FORM** 

STATE AGENCY REMARKS

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.



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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

RIVED OME

PRINTED: 03/03/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	MAR_1 4 2014	COMI	PLETED
		245239	B. WING	MN Dept of Health Deluth	02/1	14/2014
	PROVIDER OR SUPPLIER	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE ·	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	тѕ	F 00	0		
F 176 SS=D	WILL SERVE AS Y COMPLIANCE UP ACCEPTANCE. YO BOTTOM OF THE CMS-2567 FORM Y VERIFICATION OF  UPON RECEIPT O ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA ACCORDANCE W 483.10(n) RESIDE DRUGS IF DEEME  An individual reside the interdisciplinary	F COMPLIANCE.  OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.  NT SELF-ADMINISTER	F 17	6 PLH		
	by: Based on observareview, the facility administration of m (R31) observed to Findings include: On 2/10/14, at 6:06 interview with R31, 5 tablet and capsuon R31's chair-side sitting in a recliner	NT is not met as evidenced ation, interview, and document failed to ensure safe self nedications for 1 of 3 residents a self-administer medications.  6 p.m. during the initial, a small, white paper cup with le medications was observed et able. R31 was observed chair in the room. Next to the				
LABORATOR	V DIRECTOR'S OR PROVI	DER/SLIPPLIER REPRESENTATIVE'S SIG	SNATURE	TITLE	~~~~	(X6) DATE

(X2) MULTIPLE CONSTRUCTION

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245239	B. WING	;		02/	14/2014
	PROVIDER OR SUPPLIER  AN ANGELS HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 55746				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 176	paper cup holding plastic cups contain observed. During observed to take sof the paper cup, putrink some of the cobserved to remove the mouth with the tablet into a garbage R31's recliner chain interview, and an expression was observed on Fulcensed practical 2/11/14, at 5:05 p. medications in R31 while she went to gwith the medication R31's room the dostated R31 often rewhen she was in the R31's annual Minimal	the medications, several ning clear and red liquids were the interview, R31 was everal of the medications out place them into the mouth, and clear liquid. R31 was then be one round, white tablet out of right hand, and place the ge can on the right side of the empty white medication cup R31's chair-side table.  Increase (LPN)-A, interviewed on the medication cup of the cup of the state of the cup of the c	ı	176	F176: DON and/or designee will corrective action for resident (R31) at this practice by:  Resident (R31) assessed and determined to be unable to sadminister medications  DON and/or designee will assess resident/residents having the potentiaffected by this practice including:  All other residents have potentiaffected by this practice All plans of care will be reviewensure appropriateness, accurassessment, and assure a Phyorder is in place for those assibe able to self-administer medication of medication procedure that this practice does not including:  Nursing staff will be re-educated administration of medication procedure beginning the west 14	elf- ial to be intial to be wed to uracy of ysician's sessed to edications t measures recur ated on self	f

PRINTED: 03/03/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

F CORRECTION	IDENTIFICATION NUMBER:				1PLETED
	245239	B. WING		02/	14/2014
			STREET ADDRESS, CITY, STATE, ZIP COD 1500 EAST THIRD AVENUE HIBBING, MN 55746		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	X (EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE
A Care Planning R R31 did not wish to and directed nursin document all medi had no physician of medications.  A Medication Admi 2/1/14, to 2/28/14, medications regular [evening] administ 500 mg, Flomax 0 Vitamin D 2000 iu  On 2/13/14, at 3:4 (DON) stated medication, unless the as able to self-administration policy revised 11/2 interdisciplinary te self-administration would be responsimedications are sandminister. The performance with a same provided in the interdisciplinary te self-administer. The performance with a same provided in the interdisciplinary te 483.15(a) DIGNIT INDIVIDUALITY	report dated 12/31/12, indicated of self administer medications, and staff to administer, store and cations and treatments. R31 order to self-administer  rinistration Record (MAR) dated indicated R31 received 5 oral arry designated for PM ration: Zoloft 50 mg, Vitamin C .5 mg, Lipitor 20 mg, and [international units].  5 p.m. the director of nursing ications should not be left at the resident had been assessed in inster and a physician's order d. The DON confirmed R31 did to self-administer medications.  on of Medication by Residents and would define what a would define what a would be for the resident and ble to determine what are for the resident to self olicy further directed residents witted to administer or retain a rooms unless so ordered by sician and approved by the am.  Y AND RESPECT OF	d	actions to ensure the effectivener actions including:  • 3 General Observation Aucompleted weekly to enscompliance is achieved, to quarter thereafter  • The monitoring results were to the Quality Assurance Improvement Committee recommendations for one monitoring  Completion Date: 3-26-14	ss of these udits will be ure ongoing hen 2 per ill be reported Process and will make	
	PROVIDER OR SUPPLIER AN ANGELS HEALTH  SUMMARY ST (EACH DEFICIENCE REGULATORY OR  Continued From particles of the sum of	PROVIDER OR SUPPLIER  AN ANGELS HEALTH & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  483.15(a) DIGNITY AND RESPECT OF	ROVIDER OR SUPPLIER  AN ANGELS HEALTH & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a	PROVIDER OR SUPPLIER  AN ANGELS HEALTH & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 regularly designated for PM [evening] administration: Zoloft 50 mg, Nitamin 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 to self administer or retain medication in their rooms unless so ordered by the attending physician and approved by the interdisciplinary team.  48.3 16/30 DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a	ROYIDER OR SUPPLIER  AN ANGELS HEALTH & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)  COntinued From page 2  A Care Planning Report dated 12/31/12, indicated R31 did not wish to self administer, store and document all medications and treatments. R31 had no physician order to self-administer, store and document all medications and treatments. R31 had no physician order to self-administer medications regularly designated for PM [evening] administration: Zoloft 50 mg, Vitamin C 200 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 jeth at bead sobtained. 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-administer; or tealin medication 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 interdisciplinary team would administer or retain medication in their rooms unless so ordered by the interdisciplinary team and approved by the interdisciplinary team and approved by the interdisciplinary team.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245239	B. WING		02/14/201	14
	PROVIDER OR SUPPLIER  AN ANGELS HEALTH	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPL	(5) LETION ATE
F 241	full recognition of h  This REQUIREMEI by: Based on observareview, the facility for treated in a dignific concerns for 2 of 2 were reviewed for comparison of the call light to be minutes. R159 states bathroom and endeath of the call light to be minutes. R159 states bathroom and endeath of the call light to be minutes. R159 states bathroom and endeath of the call light to be minuted to use the interview R159 confirmed the incident responded to the call light to be minuted. R159 states without higher light may be stated they will be stated th	ident's dignity and respect in is or her individuality.  NT is not met as evidenced tion, interview, and document failed to honor the right to be d manner regarding toileting residents (R44, R159) who dignity.  Y. p.m. during an initial resident forted an incident which reeks prior when R159 waited be answered for over 30 ted she needed to use the ed up getting up on her own as the toilet very badly. During is spouse was present and ent. R159 that when the staff all light they scolded her for nelp, then the staff told R159 to its" and we will change you. To recall who said that to her. Were continent of bowel and the wear any type of incontinent never just go in the bed or ed the staff comment was undignified. R159's spouse and not believe some one	F 2	F241: DON and/or designee will imple corrective action for resident (R44, R. affected by this practice by:  Resident (R44) is toileted in a manner according to his plane. Resident (R159) was toileted dignified manner according to of care and was discharged to 2-14-14.  DON and/or designee will assess reside having the potential to be affected by practice including:  All other residents have pote affected by this practice.  DON and/or designee will implement to ensure that this practice does not including:  Nursing staff will be re-educed dignity related to toileting staweek of 3-10-14.  Residents will be reminded to any concerns related to dignit resident council meeting.	dignified of care in a o her plan o home on dents o this ntial to be measures recur ted on orting the	
	dated 2/11/14, indic mental status (BIM	Minimum Data Set (MDS) cated R159's brief interview for S) scored 7, indicating severe nt. The MDS further indicated				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION ING	(X3) DATE SUR' COMPLETE	
		245239	B. WING		02/14/20	14
	PROVIDER OR SUPPLIER  AN ANGELS HEALTH	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1500 EAST THIRD AVENUE HIBBING, MN 55746		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE COM	(X5) PLETION DATE
F 241	A Care Planning Re R159 had short-ter variable mental fun bell placed within re Report further indicoriented to person time/place, and wa verbally. The Care R159 was continer use any incontinent to assist due to we confusion.  On 2/13/14, at 12:3 re-interviewed and told her to pee her ago. R159 repeate surveyor 3 days agnothing like that in R159 was still not a staff person or their On 2/13/14, at 3:30 (DON) stated she was treated without regrequired assistance DON further stated cognitively impaire in their pants. The behavior and state undignified.	continent of bowel and bladder.  eport dated 2/10/14, indicated m memory deficits with action with intervention of call each. The Care Planning cated R159 was alert and with intermittent confusion to a able to let needs be known planning report indicated at of bowel and bladder, did not ce products, and required staff akness and intermittent  30 p.m. R159 was stated the nursing assistant pants that night about 3 weeks at the same story told to the po. R159 went on to state cident has happened since and able to recall the name of the r face.  30 p.m. the director of nursing was not aware R159 was ard during a night when R159 ard during a night when R159 ard they should not be told to go DON confirmed the staff's ment to R159 was very	F 2	DON and/or designee will mon actions to ensure the effective actions including:  • 4 interview audits per dignity related to toiler areas will be completed week of 3-17-14 to ensure compliance, until complete actions and then 4 quality and the englished and then 4 quality and the englished areas will make ongoing record for monitoring  Completion Date: 3-26-14	week addressing ring and other ad starting the sure ongoing pliance is uarterly will be reported be process the quarterly and	
	stated R159 has be bladder and did no	5 p.m. registered nurse (RN)-D een continent of bowel and t use any incontinent products. d she was not aware of any		· .		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245239	B. WING			02	/14/2014
	PROVIDER OR SUPPLIE	R I'H & REHAB CENTER		1500	EET ADDRESS, CITY, STATE, ZIP CODE DEAST THIRD AVENUE BING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	requiring staff as weeks ago. RN-incident constitut.  On 2/13/14, at ap the facility's Arial 1/2014, was required long call light res was not provided.  A Resident's Right rights of each respromoted and wo and respect.  R44 indicated the light in a timely mincontinent of botterrible.  On 2/11/14, at 9: and stated there answer his call light further indicated light off, tell him to the not return to days ago he put to use the toilet to When staff did now alked to the toil hell" from staff behelp. R44 stated bowel on several call light to be an "terrible."  R44's face sheet	R159 and toileting activities sistance during a night about 3 D confirmed R159's described ed undignified staff treatment.  Opproximately 2:30 p.m. a copy of Resident Call System log for lested to determine potential ponse times for R159. The log		241			
		minimum data set (MDS) dated					

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		COMPL	ETED
		245239	B. WING			02/14	/2014
•	PROVIDER OR SUPPLIER  AN ANGELS HEALTH	& REHAB CENTER		15	REET ADDRESS, CITY, STATE, ZIP CODE 500 EAST THIRD AVENUE IBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	T. I.	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 241	impairment. The Mextensive assistant ransfers, and was bowel (one episodocare plan dated 1/2 incontinent of bowed of the need to use to ileting program a request to use the directed one staff thater brunch, befor before and after diand at bedtime.  The comprehensive assessment dated occasionally incontinents (at least one 2/13/14, at 12: (NA)-E was intervited use the toilet, at been incontinent beight. NA-E stated couple times a wear he first wakes up.  On 2/13/14, at 12: (RN)-B was intervited incontinent of bowed on 2/13/14, at appeted to 2/13/14, at appeted incontinent of bowed on 2/13/14, at appeted incontinent of bowed incontinent of bowed on 2/13/14, at appeted incontinent of bowed incontinent incontinent of bowed incontinent of bowed incontinent incontinent incontinent incontine	age 6 I moderate cognitive IDS indicated R44 required ce of two staff for mobility and occasionally incontinent of e in the past seven days). The 14/14, indicated R44 was el with loose stools, was aware the toilet, was on a scheduled and could use the call light to toilet. R44's care guide sheet to assist to toilet upon rising, e and after siesta snack, nner, before night cap snack re bowel and bladder 12/20/13, indicated R44 was tinent of bowel, was not on a gram, and had regular bowel ast one every three days).  40 p.m. nursing assistant ewed and stated R44 is toileted and when he requests. NA-E will use his call light to request and there are times when he has before they can answer his call he is incontinent of bowel a ek usually in the morning when  59 p.m. registered nurse iewed and stated R44 was rel several times a week.  proximately 2:30 p.m. a copy of Resident Call System log for uary 2014, was requested but		241			

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 03/03/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILC	ING_		COMP	LETED
		245239	B. WING			02/1	4/2014
1	PROVIDER OR SUPPLIER  AN ANGELS HEALTH	& REHAB CENTER	•	15	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST THIRD AVENUE BBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	Continued From pa	ige 7	F:	241			
F 246 SS=D	(DON) was intervie should be answere 483.15(e)(1) REAS	25 a.m. the director of nursing ewed and stated call lights d in 8 minutes or less.  SONABLE ACCOMMODATION ERENCES	F	246			
	services in the facil accommodations o preferences, excep	right to reside and receive lity with reasonable of individual needs and ot when the health or safety of ther residents would be					
	by: Based on interview facility failed to ensifice frequency of bathir	NT is not met as evidenced w and document review, the sure resident choice for a mass consistently honored for 26) who were reviewed for					
	Findings include:	stently provided a shower/bath					
	On 2/11/14 at 10:1 get a shower twice that. I would have they're too busy. T took a shower at lestated she was su	2 a.m. R26 stated, "I should a a week. I don't always get one three times a week, but they don't ask you. At home I east three times a week." R26 pposed to receive a shower on					
		eurdays, and indicated she had ber that morning (Tuesday).					

(X2) MULTIPLE CONSTRUCTION

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245239	B. WING			02/	14/2014
		R TH & REHAB CENTER TATEMENT OF DEFICIENCIES	ID	15	REET ADDRESS, CITY, STATE, ZIP CODE 500 EAST THIRD AVENUE IBBING, MN 55746 PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLÉTION DATE
F 246	A Progress Note of required physical bathing. The quardated 1/31/14, indincluded anemia a MDS identified R2 and required phys of the bathing care plan preferred showers staff to transfer or directed R26 shown Tuesdays and The Bennett Parkindicated R26 was bath/shower on TOn 2/13/14, at 2:3 manager (RN)-B were informed showers per wee wouldn't have soft stated R26 was sfrom the regular rextra one on Satuschedule was not had requested to week it would have A Progress Note had requested to Review of the nur December 2013, indicated R26 was and indicated R26 was and indicated R26 was and indicated R26 was and indicated R26 was not had requested to Review of the nur December 2013, indicated R26 was and indicated R26 was a	dated 5/30/13, indicated R26 assistance from staff with terly Minimum Data Set (MDS) dicated R26's diagnoses and hypertension (HTN). The 26 had no cognitive impairment sical assistance from staff in part ivity with set-up help only. The printed 2/14/14, indicated R26 s; required assistance of two n and off the shower chair; and uld receive two showers a week Saturdays.  Bathing Schedule (no date), s only scheduled for a uesday Mornings.  39 a.m. the registered nurse stated upon admission residents owers/baths are once a week specified. RN-B stated R26, to tell us she wanted two k because otherwise we neduled her for two." RN-B incheduled a Tuesday shower nursing assistants (NA's), and an urdays from the bath aide (the toprovided). RN-B added, if R26 have a shower three times a we been done.  dated 11/29/13, indicated R26 have a shower twice a week raing assistant (NA) charting for and January/February 2014, its provided only one shower of 12/22/13, 12/29/13, 1/19/14,	F 2	246	F246: DON and/or designee will imple corrective action for resident (R26) at this practice by:  Resident (R26) will continue two baths per week per residence  DON and/or designee will assess residential to be affected by practice including:  All other residents have potential affected by this practice  DON and/or designee will implement to ensure that this practice does not including:  Nursing staff will be re-educated resident choice in bathing of frequency beginning the week 14	to receive dent idents by this ential to be at measures recur ated on ptions and	

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245239	B. WING			02/	14/2014
	PROVIDER OR SUPPLIER  AN ANGELS HEALTH	& REHAB CENTER		150	REET ADDRESS, CITY, STATE, ZIP CODE O EAST THIRD AVENUE BBING, MN 55746	1 02	1772017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(X5) COMPLETION DATE
F 246  F 253 SS=D	On 2/13/14, at 3:15 documentation was had received two shad received two shated she was unswere not document was provided the shad 15(h)(2) HOUS MAINTENANCE SET The facility must promaintenance services anitary, orderly, and This REQUIREMENT by:  Based on observation failed to provide contemperatures for 2 corooms where water Findings include:  R94 was interviewed 12:40 p.m. and state wash up in the bath informed facility stated that set (MDS) date alert, orientated and The water temperatures was turned or after running for 10 temperature was 97	p.m. RN-B confirmed the inconsistent to indicate R26 nowers/baths a week. RN-B ure why the showers/baths ed, and could not say if R26 nowers or not. EKEEPING & RVICES  Divide housekeeping and es necessary to maintain a d comfortable interior.  IT is not met as evidenced ion and interview the facility infortable bathroom sink water of 10 residents (R94, R16) temperatures were checked.  Id on 2/12/14, at approximately ed he can not get hot water to room. R94 stated that he had if. R94's annual minimum ed 12/5/13, indicated he was had no cognitive impairment. The was measured with the enance staff (MS)-A. The hot in R94's bathroom sink and minutes the water  5 degrees Fahrenheit (F), r 25 minutes the water	F2		DON and/or designee will monitor coractions to ensure the effectiveness of actions including:  • 4 resident interview audits per addressing preference and free bathing will be completed star week of 3-17-14 to ensure one compliance, until compliance achieved and then 4 quarterly thereafter  • The monitoring results will be to the Quality Assurance Proceed Improvement Committee qual will make ongoing recomment for monitoring  Completion Date: 3-26-14  F253: Environmental Services Director adesignee will implement corrective actives active in the service by:  • An additional circulating pump installed on the hot water lines service the area of Brooklyn and Woodland. Temperatures through those areas are now reaching 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 potential affected by this practice.	these er week equency of rting the going is reported ess rterly and dations  and/or fon for nis was that d Wells ugh t a	1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		E SURVEY PLETED
		245239	B. WING _		02/	14/2014
	PROVIDER OR SUPPLIER  AN ANGELS HEALTH	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 253	R16 was interviewed 1:10 p.m. stated the a long time before in hot water in the bat water temperature	ed on 2/12/14, at approximately at they had to run the water for it gets warm. After running the chroom sink for 5 minutes the was 101.8 degrees F. R16 ed 1/2/14, indicated moderate	F 29	Environmental Services Director an designee will implement measures that this practice does not recur inc  Domestic Water temps will monitored on a weekly bas temperatures are maintain 105 to 115 degrees as per r	to ensure cluding: be is to ensure ed between	
F 279 SS=D	afternoon of 2/12/ water most of the ti to the public bath re get hot water.  MS-A was interview and stated a reche temperature that m after running 10 mi  The administrator v 8:30 a.m. and state regarding water ter but didn't think ther keep the resident r between 105 degre 483.20(d), 483.20(l COMPREHENSIVI  A facility must use to develop, review comprehensive pla  The facility must de plan for each resid objectives and time medical, nursing, a	was interviewed on 2/13/14, at ed they would look for a policy imperatures in resident rooms in was one. The facility tries to soom hot water temperatures ees and 115 degrees F.  k)(1) DEVELOP E CARE PLANS  the results of the assessment and revise the resident's	F 2	Environmental Services Director and designee will monitor corrective accensure the effectiveness of these accinctuding:  Temperatures at all five number facility will be checked to the temperature range of 1 being maintained.  The monitoring results will to the Quality Assurance Conquarterly. The Quality Assurance Conquarterly. The Quality Assurance of the composing monitoring.  Completion Date: 03-24-2014	tions to ctions  rsing units in to ensure .05 to 115 is  be reported ommittee irance	

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245239	B. WING		02/14/2014
	PROVIDER OR SUPPLIER  AN ANGELS HEALTH	& REHAB CENTER		STREET ADDRESS, CITY, STAT 1500 EAST THIRD AVENUE HIBBING, MN 55746	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE COMPLETION DATE
F 279	to be furnished to a highest practicable psychosocial well-b §483.25; and any so be required under §483.10, including under §483.10 (b) (4)  This REQUIREMED by: Based on observareview the facility faddress non-compof 1 residents (R69 dialysis services.  Findings include: The physician's orce R69 was on a renafluid restriction. The had diagnoses of e (ESRD) and hypert Minimum Data Set indicated R69 had impairment; was in drinking; was on a dialysis services.  The renal care plar received dialysis services.  The renal care plar received dialysis services.	t describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment all.  NT is not met as evidenced tion, interview and document alled to develop a care plan to liance with fluid restriction for 1 b) who was reviewed for the right at 1200 milliliter (ml) are orders further identified R69 and stage renal disease tension (HTN). The quarterly (MDS) dated 12/13/13,	F 2	Corrective action for rethis practice by:      A Physician's of Resident (R69 restrictions was provided in the practice including:      All other resides and fluid restrictions be affected by a Care plans of the on a food and been reviewed by the provided including:      DON and/or designee to ensure that this pradiction including:      Nursing staff with this pradiction including:	esident (R69) affected by  order to discontinue ) food and fluid as obtained on 2-18-14  will assess residents o be affected by this  ents who are on a food iction have potential to or this practice those who are currently fluid restriction have d to assure compliance  will implement measures

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED	
		245239	B. WING			02/	14/2014
•	PROVIDER OR SUPPLIER	H & REHAB CENTER		150	EET ADDRESS, CITY, STATE, ZIP COI 0 EAST THIRD AVENUE BBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	fluid restriction ordincluded (but were diet compliance. T diet with a 1200ml Nepro supplement On 2/12/14, at 8:0 room with a 1/2 fu a large thermal pit bedside stand. R6 any fluid restriction and drinks his wat confirmed staff ga of ice water every the room that R69 stated in the morn all I want." No sign were noted.  On 2/13/14, at 8:5 room with a large water and a 3/4 futhe bedside stand whenever he can the unit. R69 state any fluid restrictionice water daily. R6 like the nice cold with the supplement I February 2014, in Nepro supplement days. The Oral Int February 2014, with documentation for shift fluid intakes.  On 2/13/14, at 3:2	lered by the physician. Goals anot limited to) to have good the care plan directed a renal fluid restriction; and one can of twice a day (BID).  4 a.m. R69 was observed in the II mug of tea (total 240 cc) and cher 3/4 full of ice water on the 9 stated he was unaware of 1s. R69 stated he drinks tea, er throughout the day. R69 ve him the large thermal pitcher day. There was no indication in was on a fluid restriction. R69 ing "I get tea and toast. That's 1s or symptoms of fluid overload 4 a.m. R69 was observed in his pink thermal pitcher full of ice II 591 ml bottle of root beer on 1. R69 stated he buys root beer (almost daily) in the machine on 1s and stated he received the 1s stated he drinks most of it, "I water with ice to drink."  Intake records for January and dicated R69 drank 100% of the 1s twice a day (480 ml) on most 1s ake records for January and 1s ere incomplete and lacked 1s several day shift and afternoon 1s of p.m. the registered nurse 1s was not on any special fluid 1s was not on any special	4	279	DON and/or designee will monitactions to ensure the effectivent actions including:  • 2 care plan audits regard fluid restrictions will be weekly starting the wee ensure ongoing compliance is achieved quarterly thereafter  • The monitoring results to the Quality Assurance Improvement Committed will make ongoing record for monitoring  Completion Date: 3-26-14	rding food and completed ek of 3-17-14 to ance, until and then 2 will be reported e Process ee quarterly and	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ′		E CONSTRUCTION	COMF	PLETED
	•	245239	B. WING	·		02/1	4/2014
	PROVIDER OR SUPPLIER	& REHAB CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST THIRD AVENUE HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279 F 282 SS=D	thing."  On 2/13/14, at 3:31 stated R69 was on unsure as to how m NA-H stated R69 ke "He does his own the We don't always kn On 2/13/14, at 4:00 (DM) stated dietary the trays of residen nursing assistants (and keep track.  On 2/13/14, at 3:45 monitoring of R69's consistent. RN-A state found that R69 whis fluid intake and confirmed R69's canon-compliance with 483.20(k)(3)(ii) SEPERSONS/PER CATHE Services provious be provided by accordance with eacare.  This REQUIREMENT by:  Based on observatives followed regards.	p.m. nursing assistant (NA)-H a fluid restriction, but was nuch fluid R69 could drink. eeps track of it on his own. ning and drinks what he wants. low."  a.m. the dietary manager staff doesn't put any fluids on ts with fluid restrictions. The (NA's) pass all the beverages  p.m. RN-A confirmed affuid intake had not been atted after talking with the staff was not always compliant with drinks what he wants. RN-A are plan did not address the the fluid restriction.  RVICES BY QUALIFIED		279 282	F282: DON and/or designee will implem corrective action for resident (R97, R69 affected by this practice by:  • (R97) was shaved on 2-14-14 acto plan of care and staff continufollow the plan of care for shave.  • Resident (R69) was provided wishave (R69) continues to refuse staff to shave on a regular basis plan for (R69) was updated to refusal of shaving	ccording ue to ing ith pre- to allow s, care	
	` '	•	1			1	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245239	B. WING _		02/14/20	14
	PROVIDER OR SUPPLIER	I & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 55746	, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMP	X5) PLETION ATE
F 282	daily living.  On 2/11/14, at 8.4 unshaven, with factors.  R97's diagnosis list without behavioral minimum data set R97 was severely required extensive grooming. R97's c staff to shave R97  On 2/14/14, at 10:: (DON) was intervice expect staff to follow shaving.  R69 had several downwas interviewed.  The February 13, staff were to set R hygiene, assist with and brush resident face.  The care plan date facial hair removal daily. The care plan times.	It a.m. R97 was observed stall hair approximately 1/4 inch stall hair when assistance of one staff for are plan dated 11/1/13, directed is face every morning.  23 a.m. the director of nursing ewed and stated she would ow the care plan regarding and says growth of facial hair when don 2/12/14, at 8:00 a.m  Care Guide for grooming noted 69 up at the bed side for daily h perineum care, staff to comb it's hair and shave resident's are defended on weekly bath days as well as noted R69 refused shaving at an noted staff should set him	F 28	DON and/or designee will assess re having the potential to be affected practice including:  Other residents who require with shaving have potential affected by this practice All plans of care related to reviewed for accuracy  DON and/or designee will implement to ensure that this practice does not including:  All nursing staff will be resproviding ADL's including spolicy and procedure the world and procedure the world actions to ensure the effectiveness actions including:  Ageneral observation aud residents will be completed starting the week of 3-17-1 ongoing compliance, until a achieved and then 4 quarted thereafter  The monitoring results will to the Quality Assurance P Improvement Committee of will make ongoing recomment for monitoring  Completion Date: 3-26-14	e assistance al to be shaving were  Int measures of recur  Inducated on having per week of 3-10-  corrective of these  Its of d weekly 4 to ensure compliance is erly  be reported rocess quarterly and	
	of the "To Do List"	(nursing assistant plan of care) ded to shave "continuously"				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '		CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED		
		245239	B. WING			02/1	14/2014
	PROVIDER OR SUPPLIER  AN ANGELS HEALTH	& REHAB CENTER		150	EET ADDRESS, CITY, STATE, ZIP CODE 0 EAST THIRD AVENUE BBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 312 SS=D	meaning daily. 483.25(a)(3) ADL ODEPENDENT RES A resident who is u daily living receives maintain good nutri and oral hygiene.  This REQUIREMED by: Based on observareview, the facility cassistance in accorassessed needs for reviewed for activity. Findings include: R69 was observed several days growth R69 had several days growth R69 had several days growth R69 had several days growth was interviewed stated the nursing shave him. Stated pulls his beard and their razors don't was a razor in the facility and it would be even that "Pre Shave" the could shave him ar face would be like use it every day.	CARE PROVIDED FOR IDENTS  nable to carry out activities of a the necessary services to a tion, grooming, and personal of the necessary services to a tion, grooming, and personal of the necessary services to a tion, interview and document and and provide shaving and ance with the resident's and a resident's are 2 of 3 residents (R69, R97) are of daily living.  on 2/11/14, at 10:56 a.m. with the of facial hair.  anys growth of facial hair when are no 2/12/14, at 8:00 a.m R69 assistants didn't know how to that when they shave him it it hurts like "h" because fork. R69 stated he didn't have been the could shave himself and better if they would just use at the used at home, then they are baby's bottom and he would		812	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 act to plan of care and staff continufollow the plan of care for shaving.  • Resident (R69) was provided with shave (R69) continues to refuse staff to shave on a regular basis plan for (R69) was updated to refusal of shaving.  DON and/or designee will assess resident having the potential to be affected by the practice including:  • Other residents who require assemite with shaving have potential to affected by this practice.  • All plans of care related to shaving reviewed for accuracy.  DON and/or designee will implement meto ensure that this practice does not recincluding:  • All nursing staff will be re-educated providing ADL's including shaving policy and procedure the week to 14	cording le to lng th pre- to allow , care eflect hts his sistance be ling were easures cur eted on lng per	
	R69's significant ch	nange minimum data set					

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION		E SURVEY PLETED
		245239	B. WING			02/	14/2014
	PROVIDER OR SUPPLIER  AN ANGELS HEALTH			15	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST THIRD AVENUE BBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	(MDS) dated 6/25/data set (MDS) da was able to talk ar moderate cognitive or mood issues. The extensive assistant grooming and persidentified diagnose renal failure, depresent the factor of the shaved because the razor doesn't with the February 13, staff were to set Resident face.  The February 13, staff were to set Resident hair removal daily. The care plan date facial hair removal daily. The care plan times. The care plan times. The care plan date facial hair removal daily.	13, and the quarterly minimum ted 12/11/13, indicated R69 and understands others. R69 had a impairment and no behaviors he MDS indicated R69 needed ce of one staff for bathing, sonal hygiene. The MDS as of congestive heart failure, assion, and dementia.  (NA)-F, interviewed on 2/12/14, it hat R69 sometimes refuses use the razor pulls hard on his he lets it go too long and then work right.  Care Guide for grooming noted 69 up at the bed side for daily h perineum care, staff to comb this hair and shave resident's an noted R69 refused shaving at an noted staff should set him		312	DON and/or designee will monitor coractions to ensure the effectiveness of actions including:  • 4 general observation audits residents will be completed we starting the week of 3-17-14 tongoing compliance, until conachieved and then 4 quarterly thereafter  • The monitoring results will be to the Quality Assurance Proclimprovement Committee qual will make ongoing recomment for monitoring  Completion Date: 3-26-14	of eekly o ensure npliance is reported ess rterly and	

PRINTED: 03/03/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
		245239	B. WING			02/	14/2014
	PROVIDER OR SUPPLIER AN ANGELS HEALTH	& REHAB CENTER		150	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST THIRD AVENUE BBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 312	The Electric Razor that resident would shaver to be used indicated if a reside should update Sociask the family to posituation one specinursing supervision the medication root sanitized after use	Policy dated 12/95, indicated provide their own electric for daily grooming. The policy ent did not have a razor they ial Services and they would rovide one. In an emergency fied electric razor under n would be used and stored in m and thoroughly cleaned and	F	312			
	unshaven with factorial long.  R97's diagnosis list without behavioral minimum data set R97 was severely required extensive grooming. R97's continuational assess directed R97 to ha	a a.m. R97 was observed all hair approximately 1/4 inch sting sheet included dementia disturbances. The quarterly (MDS) dated 1/28/14, indicated cognitively impaired, and assistance of one staff for are plan dated 11/1/13, directed dent's face every morning. The ment completed 10/28/13, ave extensive assistance of 1-2 of daily living (ADLs).				·	
F 329 SS=0	(DON) was intervience expect staff to sha directed in the care 483.25(I) DRUG FUNNECESSARY  Each resident's drunnecessary drug drug when used in	REGIMEN IS FREE FROM		329			

Event ID:7JBJ11

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMI	SURVEY PLETED
		245239	B. WING			02/1	14/2014
	PROVIDER OR SUPPLIER	H & REHAB CENTER	1	150	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST THIRD AVENUE BBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	indications for its used adverse conseque should be reduced combinations of the Based on a compresident, the facilit who have not used given these drugs therapy is necessas diagnosed and record; and reside drugs receive grad behavioral interventages.	use; or in the presence of ences which indicate the dose or discontinued; or any	F	329	F329: DON and/or designee will imple corrective action for resident (R151) a this practice by:  Resident (R151) primary care was updated on insulin admin regimen 2-18-14  DON and/or designee will assess resid having the potential to be affected by practice including:  All other residents have the probe affected by this practice  DON and/or designee will implement to ensure that this practice does not rincluding:	physician istration ents this otential to	
	by: Based on observareview, the facility administered per propertion of 5 residents were reviewed.  Findings include: A computer-gener 2/13/14, indicated diabetes mellitus to the admission Min 12/23/13, indicated	ENT is not met as evidenced ation, interview, and document failed to ensure insulin was obysicians ordered parameters is (R151) whose medications rated diagnosis list dated R151's diagnoses included type 2.  nimum Data Set (MDS) dated d R151 was cognitively intact.  Report dated 12/23/13, indicated	d		<ul> <li>All nursing staff will be re-edu Medication administration, re medications, and Physician no beginning the week of 3-17-14</li> </ul>	fusal of otification	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245239	B. WING			02/14/2014		
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1500 EAST THIRD AVENUE  HIBBING, MN 55746					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 329	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			329	DON and/or designee will monitor coractions to ensure the effectiveness of actions including:  • 4 Medication Administration will be completed weekly star week of 3-17-14 to ensure on compliance, until compliance achieved and then 4 quarterly thereafter  • The monitoring results will be to the Quality Assurance Proclimprovement Committee quawill make ongoing recomment for monitoring  Completion Date: 3-26-14	audits ting the going is reported tess audits		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245239	B. WING			02/14/2014			
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGELS HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  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 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION CROSS-R			BE	(X5) COMPLETION DATE		
F 329	indicated R151 did of insulin. LPN-B sto be held if R151's below 120 and corwas not below 120 Novolog insulin wastated she was aw some doses of ins going too low. LPI policy on resident holding of medicat refusal or the held why the medication verified R151's medocumentation of On 2/13/14, at 3:3 (DON) stated all remedications and in physicians's order MAR, and/or progheld or refused, ar sent. The DON velacked documentation of the company of the compan	sted initials on the MAR in ot receive the ordered dose stated the Novolog insulin was a blood glucose reading was firmed R151's blood glucose on the dates and times the s not given. LPN-B further are R151 had been refusing ulin due to concern with the BG N-B confirmed the facility's refusal of medications or staff ions was to document the medication and the reason in was refused or held. LPN-B dical record did not contain why the insulin was not given.  O p.m. the director of nursing esidents' refusals of nedications held according to a should be documented in the ress notes, and with the insulin in update to physician should be rified R151's medical record tion of follow up regarding insulin not administered as	F	329					
F 431 SS=E	responsible to folk recommendations administering trea residents. 483.60(b), (d), (e) LABEL/STORE D	2/2011, directed the nurse was		431					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245239	B. WING		02/14/2014
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGELS HEALTH & REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			1	TREET ADDRESS, CITY, STATE, ZIP CODE  500 EAST THIRD AVENUE  IIBBING, MN 55746  PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPENDEFICIENCY)	ULD BE COMPLETION
F 431	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		F 431	F431: DON and/or designee will in corrective action for the destruction Patches by:  • A policy and procedure was the destruction of Fentany.  DON and/or designee will assess in having the potential to be affected practice including:  • Few residents and all staff potential to be affected by DON and/or designee will implement to ensure that this practice does including:  • Nursing staff will be educed Destruction of Fentanyl Parand Procedure starting the 10-14  DON and/or designee will monito actions to ensure the effectiveness actions including:  • 2 audits per week will be starting the week of 3-17-ongoing compliance, until achieved and then 2 quarthereafter  • The monitoring results with the starting results	as written for yl patches esidents d by this f have the y this practice ent measures not recur  ated on the atches Policy e week of 3- r corrective ss of these completed -14 to ensure I compliance is terly
	by: Based on intervie facility failed to en used for pain) wer	ew and document review, the sure Fentanyl patches (narcotic disposed of in accordance Drug Enforcement Agency)		to the Quality Assurance Improvement Committee will make ongoing recom for monitoring Completion Date: 3-26-14	quarterly and

PRINTED: 03/03/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245239	B. WING			02/14/2014	
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  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 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIED TO THE A			DBE	(X5) COMPLETION DATE
F 431	regulations for 5 of R42, R97) who we patches.  Findings include:  Used Fentanyl patraccording to currer decrease the risk of the Brooklyn unit of stated the used Ferof in a small sharps the medication car were not cut in halmont witnessed by a sharps container who maintenance for R25 was administed Brooklyn unit medication cart.  On 2/12/14, at 9:44 Fentanyl patches where the patches is medication cart.  On 2/12/14, at 1:36 not had to dispose time as disposal whought the patches is series.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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		431			

PRINTED: 03/03/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245239	B. WING			02/1	4/2014
	PROVIDER OR SUPPLIER  AN ANGELS HEALTH			18	TREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST THIRD AVENUE IBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 431	Fentanyl patches is sharps container of were flushed down stated the patches disposal was not very LPN-E confirmed administered Fent View unit medicated.  On 2/12/14, at 1:3 (DON) stated the used Fentanyl patches. The DON was unswitnessed. The DON tracking of the diswitness. The DON tracking of the diswitness. The DON tracking of the diswitness of the patch patch in the sewer disposal should be staff and signed of disposed. CP confeducated the facility of practice for disposal should be staff and signed of disposed. CP confeducated the facility of practice for disposal should be staff and signed of disposed. CP confeducated the facility of practice for disposal should be staff and signed of disposed. CP confeducated the facility of practice for disposal should be down and would be down and would be down and would be down and would be down as a witness. Designed the controlled substant would be down and would be down as a witness.	O P.M. LPN-E stated used were disposed of either in the on top of the medication cart or in the septic system. LPN-E were not cut or folded, and witnessed by another staff. R42 and R97 were anyl patches from the Merry		431			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY PLETED
		245239	B. WING _		02/	14/2014
	PROVIDER OR SUPPLIER  AN ANGELS HEALTH	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIECT OF THE APPROPRIE	ULD BE	(X5) COMPLETION DATE
F 441 SS=D	SPREAD, LINENS The facility must es Infection Control Property and to help prevent the of disease and infection Control The facility must esprogram under whice (1) Investigates, coin the facility; (2) Decides what poshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spreadisolate the resident (2) The facility must communicable diseron direct contact direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicable diseron direct contact will to (3) The facility must communicate direct contact will to (4) The facility must communicate direct contact will be communicated to the facility must communicate direct contact will be communicated to the facility must communicate direct contact will be communicated to the facility must communicate direct contact will be communicated to the facility must communicate direct contact will be communicated to the facility must communicated to the	of Program stablish an Infection Control ich it - introls, and prevents infections rocedures, such as isolation, to an individual resident; and ord of incidents and corrective infections.  Bead of Infection it ion Control Program esident needs isolation to of infection, the facility must in its prohibit employees with a lease or infected skin lesions with residents or their food, if ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 44	• The razor used by (R69) we per policy and procedure phis use on 2-13-14  DON and/or designee will assess rehaving the potential to be affected practice including:  • Other residents who do not personal razor are potential by this practice  DON and/or designee will implement to ensure that this practice does not including:  • All nursing staff will be educal electric razor use policy are starting 3-17-14  DON and/or designee will monitor actions to ensure the effectiveness actions including:  • 2 observational audits will completed per week starting 3-17-14 to ensure ongo compliance, until compliance, until compliance, until compliance, until compliance, until compliance achieved and then 2 quart thereafter  • The monitoring results will to the Quality Assurance Plent in the Public	as cleaned previous to esidents by this at have a cally affected ent measures of recur acated on disprocedure corrective of these all be ng the weeking ace is early all be reported rocess quarterly and	

PRINTED: 03/03/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245239	B. WING			02/	14/2014
	PROVIDER OR SUPPLIER	H & REHAB CENTER		150	REET ADDRESS, CITY, STATE, ZIP CODE 10 EAST THIRD AVENUE BBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	by: Based on observ documentation retheir infection corand sanitized razer reviewed for activ Findings include:  R69 had several the was interviewed stated the nursing shave him. Stated pulls his beard and their razors don't a razor of his own facility.  Interview on 2/12 assistant (NA)-Fibasis stated that shaved because beard. Stated that shaved because beard. Stated that stored in the main was what she use When NA-F's raz gray and black had Interview on 2/12 was assisting R6 on his shower datelectric shaver that he uses brust retained in the rathat retained in	ation, interview, and view, the facility did not follow atrol policy to provide a clean or for 1 of 2 residents (R69) ities of daily living.  days growth of facial hair when ed on 2/12/14, at 8:00 a.m R69 grassistants didn't know how to did that when they shave him it and it hurts like "h" because work. R69 stated he didn't have a rand used one provided by the 1/14, at 8:10 a.m. with the nursing who works with R69 on a regular sometimes he refuses to be of the razor pulls hard on his at she has her own razor that she in bath/shower room and that es when she shaves residents. For was observed, it was full of		441			

Facility ID: 00858

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245239	B. WING			02/1	4/2014
	PROVIDER OR SUPPLIE	TH & REHAB CENTER		18	TREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST THIRD AVENUE IBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	2/12/14, at 8:40 a razors. RN-A fou of the Medication and had fine hair brush.  On 2/12/14, at 9: (LPN)-E stated s facility policy direrazor. LPN-E stated states and to be dirty fuzz. LPN-E state on residents in hoclean it after it haknow if there was community razor with alcohol.  Interview on 2/12 director of nursir what the policy with the policy with the tolean it after it haknow if there was community shave.  Review of the Elindicated that reselectric shaver to policy indicated they should upday would ask the fall emergency situation.	e (RN)-A was interviewed on a.m. about the use of community a.m. about the use of community and a white razor on the counter a room. The razor was opened as as if it was cleaned out with a so as if it was cleaned out with a so as if it was cleaned out with a so as if it was cleaned out with a so as if it was cleaned out with a so as if it was cleaned out with a so as if it was cleaned out with a so and it was being charged in the and or that was being charged in the and or that was being charged in the and or that was being charged in the and overy full of hair and gray so and that someone didn't ad been used. LPN-E did not a procedure for cleaning the as but she sometimes cleaned it so but she sometimes cleaned it as a procedure for cleaning the as but she sometimes cleaned it so stated that she did not know was for cleaning razors. Stated a knew there should not be a		1441			
	stored in the me cleaned and sar use nursing staf	dication room and thoroughly litized after each use. After each f would ensure the razor heads apart and cleaned with					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		245239	B. WING			02/1	4/2014
	PROVIDER OR SUPPLIER  AN ANGELS HEALTH			15	TREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST THIRD AVENUE IBBING, MN 55746		1,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) . COMPLETION DATE
F 441 F 465 SS=E	super Sani Cloths.  Interview on 2/13/1 of nursing/infection razors should not be directed each resid Staff should not ro razor and the razor by policy. 483.70(h) SAFE/FUNCTION E ENVIRON  The facility must p	ctant which was noted to be  14 at 9:58 a.m. with the director of control nurse indicated the period put away dirty. Facility policy dent to have their own razor. Utinely use the emergency of should be cleaned as directed at AL/SANITARY/COMFORTABL rovide a safe, functional,		441			
	residents, staff and This REQUIREME by: Based on observa failed to maintain a comfortable enviro the public. Findings include: On 2/12/14 at 12: environmental tou supervisor (MS)-A noted: R130's room was vent deflector mac ceiling with pealin said the vent was	fortable environment for d the public.  ENT is not met as evidenced ations and interview the facility a safe, functional, and onment for residents, staff and and on the following concerns were observed to have a make-shift de of card board held on to the g black and clear tape. R130 above her bed blew cold air on that when she has visitors they					

	OF DEFICIENCIES OF CORRECTION			COMPLETED			
		245239	B. WING	·		02/1	4/2014
	PROVIDER OR SUPPLIER	H & REHAB CENTER	<u> </u>	15	TREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST THIRD AVENUE IBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	always ask about a nurse put up the months ago and it heating company problem but did not company had not of communication requested but not R160's door jams scrapped with sha scrapped 1 and or and the other door inches off of the flewall had two areas off. The area near by 9 inches. The selow the light.  R94's room also he the wall by the clofloor tile had black tiles in a 8 by 5 for p.m. that staff wou floor on a regular asked the contract response to help wall paper missing foot by 7 inches be R31 had two area off the wall behind was 1/4 inch by 1/2 inches by 1/4 inch by 1/2 inches by 1/2 inche	the vent deflector. R130 stated cardboard deflector about 4 looks ugly. MS-A stated the had been called to fix the of know the date. The heating responded to date. Verification with the heating company was provided.  on both sides of the door were up edges. One side was ne half feet up from the floor riam was scraped and sharp 6 por. The painted burnt orange is with primer and paint scraped of the clock measured 1.5 inches second area was on the wall and missing paint and primer on the clock measured at 1.30 and scrape this black glue off the bases. State that they had to about this, but had got no with this issue.  8 small scrapes of paint and dry grom the wall in an area one yethe bed.  s with paint and primer scraped I their chair in the room, one 5 inches and the second one the wide.		465	F465: ESD and/or designee will implem corrective action by:  • The temporary air stop in resid (R130) was taken down on 2-1: after our HVAC contractor comthe repairs to the air unit.  • The door jams and paint chips resident rooms of (R160), (R94 and (R31) were repaired the w17-14.  • The floor in the resident room was stripped and waxed on 3-3.  ESD and/or designee will assess reside having the potential to be affected by practice including:  • All resident and common areas potentially affected.  ESD and/or designee will implement m to ensure that this practice does not reincluding:  • All staff were re-educated on timportance of noting issues the require maintenance attention the work order procedure. The acomplete inspection of the rooms and common areas, and developed a plan for the repair others areas/items noted in his inspection.	lent room 2-14, ipleted in the ), (R110) eek of 2- of (R94) 11-14.  Ints this s can be neasures ecur  the nusing ne ESD did esident d has ir of	
		14, at 2:30 p.m. with MS-A ove issues and had stated that					

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245239	B. WING			02/	14/2014
	PROVIDER OR SUPPLIER  AN ANGELS HEALTH	& REHAB CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST THIRD AVENUE HIBBING, MN 55746	, <u>, , , , , , , , , , , , , , , , , , </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	the system to inform	nge 29 m maintenance of these types was for staff to use the	F4	165	ESD and/or designee will monitor corn actions to ensure the effectiveness of actions including:  • ESD will complete two building inspections per week, to look items that may need repair, to painting and ensure air vents a clear. This will continue until compliance is maintained, the thereafter.	hese or other uch up re kept	
					Completion Date: 3-24-2014		
			d.				

Printed: 02/14/2014 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING 01 - MAIN BUILDING 01 COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245239 B. WING 02/11/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1500 EAST THIRD AVENUE GUARDIAN ANGELS HEALTH & REHAB CENT** HIBBING, MN 55746 (X5) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

has a capacity of 96 beds and had a census of 85

The requirement at 42 CFR, Subpart 483.70(a) is

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.

at the time of the survey.

met.

Printed: 02/14/2014 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING 02 - 2006 ADDITION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** 245239 B. WING 02/11/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **GUARDIAN ANGELS HEALTH & REHAB CENT** 1500 EAST THIRD AVENUE HIBBING, MN 55746 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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.

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.



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 <u>only a suggestion</u> 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.

Guardian Angels Health & Rehab Center March 3, 2014 Page 2

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 Weeth

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

5239s14lic.rtf

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00858	B. WING		02/14/2014
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
GUARDIA	N ANGELS HEALTH & R	EHAB CENTER HIBBING,		<del>-</del>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart Determination of whe corrected requires correquirements of the results.	ther a violation has been mpliance with all ule provided at the tag			
	When a rule contains comply with any of the lack of compliance. L re-inspection with any result in the assessm	number indicated below. several items, failure to e items will be considered ack of compliance upon vitem of multi-part rule will ent of a fine even if the item ng the initial inspection was			
	that may result from rorders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.			
	Department's staff, vi the following correction corrections are completed make a copy of these original to the Minnes	2/14/14, surveyors of this sited the above provider and on orders are issued. When leted, please sign and date, orders and return the ota Department of Health, see Monitoring, Licensing and		Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers have been assigned to Minnesota state statutes/for nursing homes. The assigned tag number appears in the far left column	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00858	B. WING		02/14/2014
	ROVIDER OR SUPPLIER N ANGELS HEALTH & F	1500 EA	ADDRESS, CITY, ST. ST THIRD AVEN 3, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
2 000		n; 11 East Superior Street;	2 000	entitled "ID Prefix Tag." The state statute/rule number and the corresp text of the state statute/rule out of compliance is listed in the "Summar Statement of Deficiencies" column a replaces the "To Comply" portion of correction order. This column also includes the findings which are in vio of the state statute after the stateme "This Rule is not met as evidenced be Following the surveyors findings are Suggested Method of Correction and Time Period for Correction.  PLEASE DISREGARD THE HEADIT THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. TWILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STATUTES/RULES.	y ind the blation ent, by." the d the NG OF
2 555	Subpart 1. Develor must develop a compeach resident within completion of the colassessment as defin comprehensive plan by an interdisciplinar attending physician, responsibility for the	opment. A nursing home prehensive plan of care for seven days after the mprehensive resident ed in part 4658.0400. The of care must be developed y team that includes the a registered nurse with resident, and other isciplines as determined by	2 555		

Minnesota Department of Health

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLI	
VIAD LEVIA	O CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	<del></del>	COWIPLI	-120
		00858	B. WING		02/1	4/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GUARDIA	N ANGELS HEALTH & R	EHAB CENTER	T THIRD AVENU	JE		
		HIBBING,	MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 555	Continued From page	2	2 555			
		participation of the resident,				
	by: Based on observation review the facility faile	t is not met as evidenced  n, interview and document ed to develop a care plan to nce with fluid restriction for 1 who was reviewed for				
	Findings include:					
	R69 was on a renal d fluid restriction. The c had diagnoses of end (ESRD) and hyperten Minimum Data Set (M indicated R69 had mo impairment; was inde	sion (HTN). The quarterly IDS) dated 12/13/13,				
	received dialysis serv record intake and out 1200 ml per day fluid care plan revised 12/9 dialysis, and required fluid restriction ordere included (but were no diet compliance. The	ated 11/7/13, identified R69 ices and directed staff to put (I & O) totals due to a restriction. The nutrition 5/13, identified R69 received a therapeutic diet with a ed by the physician. Goals of limited to) to have good care plan directed a renal id restriction; and one can of ice a day (BID).				
	room with a 1/2 full m	.m. R69 was observed in the ug of tea (total 240 cc) and er 3/4 full of ice water on the				

Minnesota Department of Health

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Minnesota Department of Health

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00858	B. WING		02/14	1/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GUARDIA	N ANGELS HEALTH & R	EHAB CENTER HIBBING, N	THIRD AVENU IN 55746	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 555	any fluid restrictions. and drinks his water to confirmed staff gave I of ice water every day the room that R69 was stated in the morning all I want." No signs of were noted.  On 2/13/14, at 8:54 a room with a large pinl water and a 3/4 full 50 the bedside stand. R60 whenever he can (alnothe unit. R69 stated hany fluid restrictions a ice water daily. R69 slike the nice cold water the cold water than the unit. R69 stated hany fluid restrictions a ice water daily. R69 slike the nice cold water than the unit. R69 stated hany fluid restrictions a cold water than the unit. R69 stated hany fluid restrictions are cold water than the supplement Intal February 2014, indicated Nepro supplement two days. The Oral Intake February 2014, were documentation for sets shift fluid intakes.  On 2/13/14, at 3:27 p (RN)-E stated R69 was east restrictions and, "Prefit thing."  On 2/13/14, at 3:31 p stated R69 was on a unsure as to how much NA-H stated R69 keept stat	tated he was unaware of R69 stated he drinks tea, hroughout the day. R69 nim the large thermal pitcher y. There was no indication in its on a fluid restriction. R69 "I get tea and toast. That's or symptoms of fluid overload m. R69 was observed in his key thermal pitcher full of ice in most daily) in the machine on the was not aware he was on and stated he received the stated he drinks most of it, "I with ice to drink."  The records for January and incomplete and lacked weral day shift and afternoon incomplete incomplete and lacked weral day shift and afternoon incomplete incomplete and lacked weral day shift and afternoon incomplete incomp	2 555			

Minnesota Department of Health STATE FORM

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00858	B. WING		02/14/2014	
	ROVIDER OR SUPPLIER  N ANGELS HEALTH & R	1500 EAS	DRESS, CITY, STAT T THIRD AVENU MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
2 555	(DM) stated dietary state trays of residents nursing assistants (Na and keep track.  On 2/13/14, at 3:45 p monitoring of R69's fluconsistent. RN-A state he found that R69 was his fluid intake and dr confirmed R69's care non-compliance with SUGGESTED METHOM The director of nursin development and imp procedures for the de The director of nursin then monitor the appreto the policies and procedures are not residually as the confirmed R69's care non-compliance with the director of nursin development and important procedures for the derector of nursin then monitor the appreto the policies and procedures are not residually as the confirmed R69's care non-compliance with the director of nursin the director of nursin then monitor the appreto the policies and procedures for the director of nursin the policies and procedures for the director of nursin the policies and procedures for the director of nursin the policies and procedures for the director of nursin the policies and procedures for the director of nursin the policies and procedures for the director of nursin the policies and procedures for the director of nursin the policies and procedures for the policies and procedures for the director of nursin the policies and procedures for the policies and procedures for the director of nursin the policies and procedures for the poli	.m. the dietary manager raff doesn't put any fluids on with fluid restrictions. The A's) pass all the beverages  .m. RN-A confirmed uid intake had not been ed after talking with the staff is not always compliant with inks what he wants. RN-A plan did not address the fluid restriction.  OD OF CORRECTION: g or her designee could lement policies and velopment of care plans. g or her designee could opriate staff for adherence	2 555			
2 565	Plan of Care; Use Subp. 3. Use. A commust be used by all p care of the resident.  This MN Requirement by: Based on observation	Subp. 3 Comprehensive  Apprehensive plan of care ersonnel involved in the  t is not met as evidenced and interview and document ed to ensure the care plan	2 565			

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		SURVEY PLETED
		00858	B. WING		02	/14/2014
	ROVIDER OR SUPPLIER  N ANGELS HEALTH & R	EHAB CENTER 1500 EA	DDRESS, CITY, STA ST THIRD AVENI I, MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
2 565	was followed regardir residents (R97) review living.  On 2/11/14, at 8:41 a unshaven, with facial long.  R97's diagnosis listing without behavioral disminimum data set (MI R97 was severely cogrequired extensive as grooming. R97's care staff to shave R97's factor of no 2/14/14, at 10:23 (DON) was interviewed expect staff to follow is shaving.  SUGGESTED METH The director of nursin development and imporcedures to inform plan. The director of recould then monitor the adherence to the policy.	ing shaving needs for 1 of 3 wed for activities of daily  I.m. R97 was observed hair approximately 1/4 inch  I.g. sheet included dementia sturbances. The quarterly DS) dated 1/28/14 indicated gnitively impaired, and sistance of one staff for plan dated 11/1/13, directed acce every morning.  I.m. the director of nursing a.m. the director of nursing a.m. the director of nursing a.m. the care plan regarding  OD OF CORRECTION: g or her designee could blement policies and staff on following the care nursing or her designee e appropriate staff for	2 565			
2 835	MN Rule 4658.0520 \$ Proper Nursing Care;	determining adequate and teria for determining care include:	2 835			

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Minnesota Department of Health

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
	00858	B. WING		02	/14/2014
VIDER OR SUPPLIER	EHAB CENTER 1500 EAS	ST THIRD AVENUE			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
considerate treatmer be respected and safe.  This MN Requirement by: Based on observation eview, the facility fail reated in a dignified concerns for 2 of 2 revere reviewed for dignifications.  Findings include:  On 2/10/14, at 5:17 p	nt at all times. Privacy must eguarded.  It is not met as evidenced in, interview, and document ed to honor the right to be manner regarding toileting sidents (R44, R159) who inity.	2 835			
occurred about 3 week or the call light to be minutes. R159 stated bathroom and ended the needed to use the interview R159's stated the incident esponded to the call getting up without help ust "go in your pants R159 was not able to R159 stated they were pladder and did not word and would need to the call upsetting and very unstated they both could vould tell a resident to R159's admission Minuted 2/11/14, indicated the status (BIMS)	eks prior when R159 waited answered for over 30 d she needed to use the up getting up on her own as the toilet very badly. During spouse was present and st. R159 that when the staff light they scolded her for p, then the staff told R159 to and we will change you. The recall who said that to her the continent of bowel and the staff comment was adignified. R159's spouse d not believe some one of that.  The prior when R159 waited answer is the staff comment was adignified. R159's spouse do not believe some one of that.  The prior when R159 waited has been supported by the staff comment was adignified. R159's spouse do not believe some one of that.				
	VIDER OR SUPPLIER  ANGELS HEALTH & R  SUMMARY ST.  (EACH DEFICIENC REGULATORY OR I  Continued From page considerate treatmer be respected and safe.  This MN Requirement of the respected and safe.  Considerate treatmer be respected and safe.  This MN Requirement of the respected and safe.  Substitute of the respected and safe.	O0858  VIDER OR SUPPLIER  ANGELS HEALTH & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 eview, the facility failed to honor the right to be reated in a dignified manner regarding toileting concerns for 2 of 2 residents (R44, R159) who were reviewed for dignity.	A BUILDING:    00858	WIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1500 EAST THIRD AVENUE HIBBING, MN 55746  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC DENTIFYING INFORMATION)  Continued From page 6  Onsiderate treatment at all times. Privacy must re respected and safeguarded.  This MIN Requirement is not met as evidenced by: lassed on observation, interview, and document eview, the facility failed to honor the right to be reated in a dignified manner regarding toileting oncerns for 2 of 2 residents (R44, R159) who lever reviewed for dignity.  Findings include:  On 2/10/14, at 5:17 p.m. during an initial resident therview, R159 seported an incident which courred about 3 weeks prior when R159 waited or the call light to be answered for over 30 ninutes. R159 stated she needed to use the althorour and ended up getting up on her own as he needed to use the toilet very badly. During he interview R159's spouse was present and onfirmed the incident. R159 that when the staff esponded to the call light they scolded her for etting up without help, then the staff fold R159 to sit "go in your pants" and we will change you.  159 was not able to recall who said that to her. 159 stated they were continent of bowel and ladder and did not wear any type of incontinent roduct and would never just go in the bed or lothing. R159 stated the staff comment was postiting and very undignified. R159's spouse tated they both could not believe some one would tell a resident to do that.  2159's admission Minimum Data Set (MDS) lated 2/11/14, indicated R159's brief interview for herntal status (BIMS) scorred 7, indicating severe ognitive impairment. The MDS further indicated	DIDENTIFICATION NUMBER:    OBS88

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00858	B. WING		02/1	4/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GUARDIA	N ANGELS HEALTH & R	EHAB CENTER	T THIRD AVENU MN 55746	JE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICED TO THE APPROFICED TO THE APPROFICENCY)	D BE	(X5) COMPLETE DATE
2 835	Continued From page	e 7	2 835			
	activities and was cor	ntinent of bowel and bladder.				
	R159 had short-term variable mental function bell placed within real Report further indicate oriented to person with time/place, and was a verbally. The Care placed R159 was continent of the care placed R159 was continent with the care placed	on with intervention of call ch. The Care Planning ed R159 was alert and th intermittent confusion to able to let needs be known lanning report indicated of bowel and bladder, did not products, and required staff				
	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.					
	(DON) stated she wa treated without regard required assistance to DON further stated ex cognitively impaired t	hey should not be told to go ON confirmed the staff's				
	stated R159 has been bladder and did not u RN-D further stated s incident involving R15	.m. registered nurse (RN)-D n continent of bowel and se any incontinent products. he was not aware of any 59 and toileting activities nce during a night about 3				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING: COMPLETEI				
		00050	B. WING			V/4.4/2004.4
		00858			02	/14/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STATE	ZIP CODE		
GUARDIA	N ANGELS HEALTH & R		ST THIRD AVENUE			
OOAINDIA	TANGEEG HEAEIN G N	HIBBING	, MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 835	Continued From page	e 8	2 835			
	weeks ago. RN-D co incident constituted u	nfirmed R159's described ndignified staff treatment.				
	the facility's Arial Res 1/2014, was requeste	kimately 2:30 p.m. a copy of ident Call System log for ed to determine potential se times for R159. The log				
	rights of each residen	nt's Right policy dated 5/2005, indicated each resident would be protected and and would include the right to privacy ect.				
	R44 indicated that stallight in a timely mann incontinent of bowel verrible.					
	and stated there was answer his call light in further indicated staff light off, tell him they then not return to his days ago he put his couse the toilet to haw When staff did not an walked to the toilet all hell" from staff becau help. R44 stated he howel on several occ	.m. R44 was interviewed not enough staff available to a timely manner. R44 would come in, shut his call would be right back, and room. R44 stated a few all light on because he had we a bowel movement (bm). swer his call light, he one, then stated he "caught se he is supposed to ask for as been incontinent of asions while waiting for his red, and this makes him feel				
	dementia, muscle we	cates diagnoses that include akness and abnormal gait. mum data set (MDS) dated loderate cognitive				

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	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00858	B. WING		02	2/14/2014	
	ROVIDER OR SUPPLIER  N ANGELS HEALTH & R	1500 EAS	DRESS, CITY, STA T THIRD AVENU MN 55746				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
2 835	extensive assistance transfers, and was ochowel (one episode in care plan dated 1/14/incontinent of bowel vor the need to use the toileting program and request to use the toil directed one staff to a after brunch, before a before and after dinner and at bedtime.  The comprehensive beassessment dated 12 occasionally incontine bowel toileting program overments (at least of the comprehensive werened to the toilet, and the couple times a week of the first wakes up.  On 2/13/14, at 12:59 (RN)-B was interview incontinent of bowel so the facility's Arial Res January and February not provided.	s indicated R44 required of two staff for mobility and casionally incontinent of the past seven days). The 14, indicated R44 was with loose stools, was aware to toilet, was on a scheduled could use the call light to et. R44's care guide sheet ssist to toilet upon rising, and after siesta snack, er, before night cap snack owel and bladder /20/13, indicated R44 was ent of bowel, was not on a m, and had regular bowel one every three days).  p.m. nursing assistant ed and stated R44 is toileted when he requests. NA-E I use his call light to request here are times when he has re they can answer his call is incontinent of bowel a usually in the morning when p.m. registered nurse ed and stated R44 was	2 835				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		00858	B. WING		02/14/2014
	ROVIDER OR SUPPLIER  N ANGELS HEALTH & R	1500 EAS	DRESS, CITY, STA T THIRD AVENU MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 835	should be answered i	ed and stated call lights	2 835		
	The director of nursin development and imp procedures to ensure dignity. The director occuld then monitor the adherence to the police.	g or her designee could lement policies and residents are treated with of nursing or her designee e appropriate staff for			
2 850	Proper Nursing Care; Subp. 2. Criteria for oproper care. The crit adequate and proper D. Assistance with	determining adequate and eria for determining	2 850		
	by: Based on observation review, the facility did assistance in accorda assessed needs for 2 reviewed for activities	of 3 residents (R69, R97)			
	Findings include: R69 was observed or several days growth of	n 2/11/14, at 10:56 a.m. with of facial hair.			

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00858	B. WING		02	/14/2014
	ROVIDER OR SUPPLIER	EHAB CENTER 1500 EAS	DRESS, CITY, STATE T THIRD AVENUE MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 850	he was interviewed of stated the nursing assistant (MDS) dated was able to talk and umoderate cognitive in or mood issues. The extensive assistante grooming and person identified diagnoses or renal failure, depressional failure, depressional failure, designed to the razor doesn't world.	s growth of facial hair when a 2/12/14, at 8:00 a.m R69 sistants didn't know how to at when they shave him it hurts like "h" because k. R69 stated he didn't have or he could shave himself better if they would just use he used at home, then they it wouldn't pull at all. His paby's bottom and he would and the quarterly minimum 12/11/13, indicated R69 anderstands others. R69 had apairment and no behaviors MDS indicated R69 needed of one staff for bathing, all hygiene. The MDS of congestive heart failure, fon, and dementia.	2 850			
	facial hair removal on	February 13, 2014, directed weekly bath days as well as oted R69 refused shaving at				

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	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		E SURVEY PLETED
		00858	B. WING		02	/14/2014
	ROVIDER OR SUPPLIER  N ANGELS HEALTH & R	EHAB CENTER 1500 EAS	DDRESS, CITY, STAT ST THIRD AVENU , MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 850	up at the bed side for Interview with NA-D of indicated R69 was shof the "To Do List" (nu indicated R69 needed meaning daily.  Interview on 2/13/14, director of nursing (Do policy for every one to that resident would proposed that resident would proposed for indicated if a resident should update Social ask the family to provious ituation one specified nursing supervision with emedication room sanitized after use.  On 2/11/14, at 8:41 a unshaven with facial I long.  R97's diagnosis listing without behavioral disminimum data set (MI R97 was severely cogrequired extensive as grooming. R97's care staff to shave resident functional assessment directed R97 to have staff for activities of displacements.	noted staff should set him daily hygiene.  In 2/12/14, at 8:30 a.m. aved on bath days. Review ursing assistant plan of care) if to shave "continuously"  at 9:58 a.m. with the ON) stated it was facility have their own razor.  Olicy dated 12/95, indicated rovide their own electric daily grooming. The policy did not have a razor they Services and they would ide one. In an emergency delectric razor under rould be used and stored in and thoroughly cleaned and  Im. R97 was observed hair approximately 1/4 inch  g sheet included dementia sturbances. The quarterly DS) dated 1/28/14, indicated gnitively impaired, and sistance of one staff for plan dated 11/1/13, directed the formulation of the completed 10/28/13, extensive assistance of 1-2	2 850			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		00858	B. WING		02	2/14/2014
	ROVIDER OR SUPPLIER  N ANGELS HEALTH & R	EHAB CENTER 1500 EA	ADDRESS, CITY, STATE ST THIRD AVENUE 3, MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 850	expect staff to shave directed in the care p	ed and stated she would R97 every morning as lan.	2 850			
	The director of nursin development and imp procedures to ensure their preference. The designee could then a	OD OF CORRECTION: g or her designee could plement policies and all residents are shaved per director of nursing or her monitor the appropriate staff policies and procedures.				
	TIME PERIOD FOR (21) days	CORRECTION: Twenty one				
21375	MN Rule 4658.0800 S Program	Subp. 1 Infection Control;	21375			
	home must establish	control program. A nursing and maintain an infection gned to provide a safe and				
	by: Based on observation documentation review their infection control	v, the facility did not follow I policy to provide a clean or 1 of 2 residents (R69)				
	Findings include:					
	he was interviewed o	s growth of facial hair when n 2/12/14, at 8:00 a.m R69 sistants didn't know how to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		, , ,	E SURVEY PLETED	
		00858	B. WING		02	2/14/2014
	ROVIDER OR SUPPLIER	REHAB CENTER 1500 EAS	DDRESS, CITY, STATE ST THIRD AVENUE , MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21375	pulls his beard and it their razors don't wor a razor of his own an facility.  Interview on 2/12/14, assistant (NA)-F who basis stated that son shaved because of the beard. Stated that shat stored in the main bawas what she uses with When NA-F's razor with gray and black hairs.  Interview on 2/12/14, was assisting R69 saon his shower days, electric shaver that he asked how the razor that he uses brushes	at when they shave him it hurts like "h" because rk. R69 stated he didn't have rid used one provided by the at 8:10 a.m. with the nursing of works with R69 on a regular netimes he refuses to be the razor pulls hard on his re has her own razor that she reth/shower room and that when she shaves residents.	21375			
	2/12/14, at 8:40 a.m. razors. RN-A found a of the Medication roo	N)-A was interviewed on about the use of community white razor on the counter om. The razor was opened if it was cleaned out with a				
	(LPN)-E stated she of facility policy directing razor. LPN-E stated black electric razor the medication room. The found to be dirty and	a.m. licensed practical nurse didn't know if there was g cleaning of a community the staff uses the blue and nat was being charged in the e razor was opened and very full of hair and gray nat they only used this razor				

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00858	B. WING		02	:/14/2014	
	ROVIDER OR SUPPLIER  N ANGELS HEALTH & R	1500 EAS	DRESS, CITY, STATE T THIRD AVENUE MN 55746				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21375	clean it after it had be know if there was a prommunity razors but with alcohol.  Interview on 2/12/14, director of nursing stawhat the policy was for that as far as she knew community shaver.  Review of the Electric indicated that resident electric shaver to be upolicy indicated if a resthey should update Swould ask the family the emergency situation of under nursing supervistored in the medicatic cleaned and sanitized use nursing staff wou would be taken apart appropriate disinfectate super Sani Cloths.  Interview on 2/13/14 and for nursing/infection contains a should not be a directed each resident Staff should not routing razor and the razor should not routing supervision.  SUGGESTED METHOLDER STATED ST	oup and that someone didn't en used. LPN-E did not rocedure for cleaning the she sometimes cleaned it at 12:30 p.m. the assistant at ted that she did not know or cleaning razors. Stated withere should not be a Razor Policy dated 12/95, to would provide their own used for daily grooming. The esident did not have a razor ocial Services and they so provide one. In an one specified electric razor ision would be used and on room and thoroughly after each use. After each and cleaned with ant which was noted to be set 9:58 a.m. with the director portrol nurse indicated the pout away dirty. Facility policy at to have their own razor. The ly use the emergency mould be cleaned as directed on the country of the pout away dirty. Facility policy are to have their own razor.	21375				
	development and imp	g or her designee could lement policies and on control measures and the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
		00858	B. WING		02/14/2014
	ROVIDER OR SUPPLIER	EHAB CENTER 1500 EAS	DDRESS, CITY, STATE ST THIRD AVENUE I, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETE
21375	nursing or her design appropriate staff for a procedures.	e 16 ee could then monitor the adherence to the policies and CORRECTION: Twenty one	21375		
21426	Prevention And Control  (a) A nursing home imaintain a comprehe infection control progicurrent tuberculosis it issued by the United Control and Prevention Tuberculosis Eliminat Morbidity and Mortalion This program must in infection control plan unpaid employees, coresidents, and volunted Health shall provide to the control implementation of the control plan unpaid employees.	provider must establish and nsive tuberculosis ram according to the most infection control guidelines. States Centers for Disease on (CDC), Division of tion, as published in CDC's ty Weekly Report (MMWR). clude a tuberculosis that covers all paid and contractors, students, eers. The Department of echnical assistance ation of the guidelines.	21426		
	by: Based on interview a facility failed to ensur	nd document review, the e baseline screening for aptoms for 2 of 5 residents for immunizations.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLETED
		00858	B. WING		02/14/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
GUARDIA	N ANGELS HEALTH & R	EHAB CENTER 1500 EAST HIBBING,	THIRD AVENU MN 55746	JE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
21426	Continued From page Findings include:  R55 was readmitted to		21426		
	November, 2013. Me indicated R55 had re solution used to test intradermally on 11/2 11/27/13, with 0 mm result). A second tub administered on 12/8 intradermally, and warm of induration. Re	ceived Tubersol (a medical for exposure to TB) 5/13, with the result read on of induration (negative terculin skin test (TST) was 1/13, using Tubersol test read on 12/10/13, with 0 eview of R55's electronic led no documentation of			
	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.				
	nurse (RN)-A stated I the facility during the received only the first	priately 2:00 p.m. registered R96 had been admitted to TB solution shortage so R96 is step TST. RN-A further nould have been completed			
	nursing (ADON) prov for R96 dated 11/17/2				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION		SURVEY PLETED
		00858	B. WING		02	/14/2014
	ROVIDER OR SUPPLIER N ANGELS HEALTH & F	1500 EAS	ODRESS, CITY, STA ST THIRD AVENU , MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21426	On 2/13/14, at 1:30 p (DON) stated the dat would be the residen date entered is the d into the computer to form. The DON conf to the facility would h completed and a 2-s tuberculin serum was	o.m. the director of nursing e on the TB Screening form t's admission date and the ate the information was put complete the TB screening firmed all residents admitted ave a TB Screening form tep Mantoux test given if the s available.  Ts Tuberculosis policy, dated of direction related to the	21426			
	The director of nursir development and improcedures for tubers. Center for Disease Content of nursir then monitor the app to the policies and present the content of nursir then monitor the app to the policies and present of th	culosis screening per the control recommendations. on the designee could ropriate staff for adherence				
21540	Subp. 2. Monitoring monitor each resider unnecessary drug us home's policies and pharmacist must represident's attending physician does not contact.	age, based on the nursing	21540			

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00858	B. WING		02/14/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GUARDIA	N ANGELS HEALTH & R	EHAB CENTER 1500 EAST HIBBING, I	THIRD AVENU VIN 55746	JE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21540	adversely affected, the matter to the medical medical director is not the medical director of physician does not have the order and if the attending the order, the review to the Quality (QAA) committee require attending physicial the consulting pharma directly to the QAA.  This MN Requirement by: Based on observation	, and the pharmacist s quality of life is being the pharmacist must refer the director for review if the to the attending physician. If the letermines that the attending the adequate justification for the tending physician does not a matter must be referred for the Assurance and Assessment to uired by part 4658.0070. If an is the medical director, acist shall refer the matter the is not met as evidenced to, interview, and document	21540		
	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-generate 2/13/14, indicated R1 diabetes mellitus type	51's diagnoses included			
	12/23/13, indicated R	um Data Set (MDS) dated 151 was cognitively intact.			
	A Care Planning Report R151 was to receive monitoring q.i.d. [four				
	Novolog insulin 17 un	rders dated 1/3/14, directed its subcutaneous t.i.d [three eakfast, lunch and dinner,			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00858	B. WING		02	/14/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE			
GUARDIA	N ANGELS HEALTH & R	EHAB CENTER	T THIRD AVENU MN 55746	E			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
21540	dated 2/1/14, to 2/28/ receiving Accu-check [hour of sleep]. The M monitoring values writimes daily, with three 2/7/14 at 0800 the BG the BG was 118; and 115. All other BG rea through 2/13/14 at 10  The MAR directed No subcutaneous t.i.d wit NOON, and 1600. Th AM through 2/13/14, I with the nurses' initial was not administered MAR, a lined page for [as needed], Refusals contain 3 entries: 2/10 Novolog d/t [due to] lo "refused Novolog d/t I dose, "Held Novolog R151's electronic pro- indicated 1 entry date refusal of another type documentation to add Novolog insulin that w	stration Record (MAR) 14, indicated R151 was s before meals and at hs MAR contained BG tten with nurses' initials, four readings less than 120: 6 was 117; 2/10/14 at 1600 2/13/14 at 0800 the BG was dings for 2/1/14, 0800 00 were greater than 120.  evolog 17 units th the times noted as AM, ne MAR dated from 2/1/14, NOON, contained 18 entries s circled to indicate the dose . On the reverse side of the r documentation of PRN's s, Holds, etc was noted to 0/14 at 1630 "refused by BG; 2/11/14 at 1630 ow BG"; and 2/13/14 the AM d/t BG 115."  gress notes for 2/2014, dd 2/4/14, addressing R151's e of insulin. There was no liress the remaining doses of vere not administered.	21540				
	(LPN)-B stated circled indicated R151 did not of insulin. LPN-B state to be held if R151's bloelow 120 and confirm was not below 120 or	a.m. licensed practical nurse d initials on the MAR ot receive the ordered dose ted the Novolog insulin was lood glucose reading was med R151's blood glucose of the dates and times the					

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	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLIAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLIAN OF CORRECTION (X3) DATE S COMPLIAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) DATE S COMPLIAN OF CORRECTION (X6) DATE S CORRECTION (X6) DAT		E SURVEY PLETED			
		00858	B. WING		02	2/14/2014
	ROVIDER OR SUPPLIER  N ANGELS HEALTH & R	1500 EA	DDRESS, CITY, STATE ST THIRD AVENUE 6, MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21540	some doses of insuling going too low. LPN-E policy on resident ref holding of medication refusal or the held mowhy the medication of whom the medication of whom the medication of whom the medications and medication and ministering treatmer residents.  SUGGESTED METH The director of nursing development and improcedures to ensure the physician's parannursing or her design appropriate staff for a procedures.	e R151 had been refusing in due to concern with the BG is confirmed the facility's usal of medications or staff ins was to document the edication and the reason was refused or held. LPN-B cal record did not contain by the insulin was not given.  In the director of nursing dents' refusals of dications held according to thould be documented in the sentes, and with the insulin podate to physician should be ded R151's medical record in of follow up regarding ulin not administered as it's orders.  Stration policy  O11, directed the nurse was medication in did physician orders in ents/medications to the insulin potential medications to the insulin policy or her designee could	21540			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		00858	B. WING		02/1	14/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE. ZIP CODE		
			T THIRD AVEN			
GUARDIA	N ANGELS HEALTH & R	EHAB CENTER	MN 55746	_		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO	ULD BE	COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE	DATE
21565	Continued From page	e 22	21565			
21565	MN Rule 4658 1325	Subp. 4 Administration of	21565			
21000	Medications Self Adm		2.000			
	Subp. 4. Self-admin	istration. A resident may				
		cations if the comprehensive				
		and comprehensive plan of				
	care as required in pa					
	4658.0405 indicate this practice is safe and there is a written order from the attending physician.					
	is a written order non	Title attending physician.				
	This MN Requiremen	t is not met as evidenced				
	by:					
	Based on observation	n, interview, and document				
		led to ensure safe self				
		dications for 1 of 3 residents				
	(R31) observed to se	elf-administer medications.				
	Findings include:					
	On 2/10/14, at 6:06 p	m during the initial				
		small, white paper cup with				
		medications was observed				
	on R31's chair-side ta	able. R31 was observed				
	sitting in a recliner ch	air in the room. Next to the				
		e medications, several				
		ng clear and red liquids were				
	observed. During the					
		eral of the medications out ce them into the mouth, and				
		ar liquid. R31 was then				
		one round, white tablet out of				
		ght hand, and place the				
	tablet into a garbage	can on the right side of				
	R31's recliner chair.	•				
		pty white medication cup				
	was observed on R3	1's chair-side table.				
	Licensed practical pu	rea (LDN) A interviewed on				
		rse (LPN)-A, interviewed on stated she left the cup of				

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	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE SU COMPLE			
		00858	B. WING		02	2/14/2014
	ROVIDER OR SUPPLIER  N ANGELS HEALTH & R	1500 EAS	DRESS, CITY, STA T THIRD AVENU MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21565	while she went to get with the medications. R31's room the door stated R31 often refusivhen she was in the R31's annual Minimulation of the state of	room the previous night R31 something else to drink When LPN-A returned to was closed. LPN-A further sed to take the medications room.  m Data Set (MDS) dated 31 had moderate cognitive  ment (CAA) for medications dated 11/12/13, have an order and did not or medications or treatments. cated R31 had a BIMS [brief atus] of 10 which indicated orgitive impairment and a hand decreasing R31's e CAA further indicated R31 andidate for self censed staff were directed to administer all medications hysician order daily.  ort dated 12/31/12, indicated elf administer medications, staff to administer, store and ions and treatments. R31 er to self-administer  stration Record (MAR) dated dicated R31 received 5 oral designated for PM on: Zoloft 50 mg, Vitamin C mg, Lipitor 20 mg, and	21565			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00858	B. WING		02/1	4/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GUARDIA	N ANGELS HEALTH & R	EHAB CENTER 1500 EAST HIBBING,	THIRD AVENU MN 55746	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETE DATE
21565	(DON) stated medical bedside, unless the reas able to self-adminishad been obtained. The not have an order to self-administration policy revised 11/201 interdisciplinary team self-administration would be responsible medications are safe administer. The policy would not be permitted medication in their roothe attending physicial interdisciplinary team SUGGESTED METH. The director of nursing development and improcedures to ensure monitored to safely self-administer of nursing the monitor the apprent to the policies and prent to the policies and prent and incomplete to the policies and prent to the policies and prent to the policies and prent and incomplete to the policies and prent to the prent to th	tions should not be left at esident had been assessed ister and a physician's order The DON confirmed R31 did self-administer medications.  of Medication by Residents 1, directed the would define what bull be for the resident and to determine what for the resident to self by further directed residents and approved by the company of the designee could be residents are assessed and elf-administer medications.  g or her designee could copriate staff for adherence	21565			
21630	Medications; Destruction Subp. 2. Destruction A. Unused portio remaining in the nurs		21630			
	prescribed, or any co	ntrolled substance ently must be destroyed in a				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		00858	B. WING		02	2/14/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE	·		
GUARDIA	N ANGELS HEALTH & R	EHAB CENTER	T THIRD AVENUE MN 55746				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21630	or the consultant phan pharmacist must furning instructions and forms kept on file in the nurse. B. Unused portion drugs remaining in the death or discharge of were prescribed or an discontinued permane according to part 680 be returned to the phane 6800.2700, subpart 2 destruction listing the medication, prescripting person destroying the	d by the Board of Pharmacy macist. The board or the sh the necessary s, a copy of which must be sing home for two years. In so of other prescription e nursing home after the the resident for whom they by prescriptions ently, must be destroyed 10.6500, subpart 3, or must armacy according to part	21630				
	by: Based on interview ar facility failed to ensure used for pain) were diwith federal DEA (Dru regulations for 5 of 5 R42, R97) who were patches. Findings include: Used Fentanyl patche according to current sedecrease the risk of divining a medication at the Brooklyn unit on 2	es were not disposed of tandards of practice to					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	E CONSTRUCTION (X3) DATE SUR COMPLETE		
		00858	B. WING		02	2/14/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
GUARDIA	AN ANGELS HEALTH &	REHAB CENTER	AST THIRD AVENUE G, MN 55746	İ		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21630	of in a small sharps the medication cart. were not cut in half not witnessed by an sharps container wato maintenance for or R25 was administer Brooklyn unit medic.  On 2/12/14, at 9:49 Fentanyl patches we container on top of the folded or cut, and diwitness. LPN-C confentanyl patches from medication cart.  On 2/12/14, at 1:30 not had to dispose of time as disposal was but thought the patches discarded in the gar was administered Febennett Park unit modication cart.  On 2/12/14, at 1:30 Fentanyl patches we sharps container on were flushed down the stated the patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E confirmed Radministered Fentanyl patches we disposal was not with LPN-E con	container located on top of LPN-B stated the patches or folded, and disposal was other staff. LPN-B stated the is closed when full and given disposal. LPN-B confirmed ed Fentanyl patches from the ation cart.  a.m. LPN-C stated the used ere discarded in the sharps the medication cart; were not sposal did not require a firmed R56 was administered om the Home Acres  p.m. LPN-D stated she had of a Fentanyl patch in a long is done on the afternoon shift, thes were just folded over and bage. LPN-D confirmed R87 entanyl patches from the edication cart.  P.M. LPN-E stated used ere disposed of either in the top of the medication cart or the septic system. LPN-E were not cut or folded, and thessed by another staff. 42 and R97 were nyl patches from the Merry	21630			

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
	00858	B. WING		02/14/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GUARDIAN ANGELS HEALTH & REH	1500 EAST HAB CENTER HIBBING, I	THIRD AVENU VIN 55746	JE	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
witness. The DON confil tracking of the disposed and verified security of trisk.  On 2/12/14, at 2:58 p.m. pharmacist (CP) stated to practice for disposal of Fremove the patch from the patch in the sewer systed disposal should be witnest aff and signed off in the disposed. CP confirmed educated the facility regrof practice for disposal copatches.  The Destruction of medicindicated all controlled security destroyed by the DON of as a witness. Destruction the controlled substance and would be document destruction form provided Pharmacy.  SUGGESTED METHOD The director of nursing of development and impler procedures to destroy us the director of nursing of the policies and procedures and procedures and procedures to the policies and procedures and pr	d of by her and a qualified irmed there would be no d used Fentanyl patches, the disposal could be at the current standard of Fentanyl patches was to the resident and flush the em. CP stated the essed by two qualified he narcotic book as d he had not formally garding the new standard of the used Fentanyl ication policy revised 9/11, substances would be or CP and a second nurse on would occur by flushing es into the sewer system, ted on the medical ed by the MN Board of the designee could ment policies and ised/unused medications. Or her designee could oriate staff for adherence	21630		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00858	B. WING		02/1	4/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GUARDIA	N ANGELS HEALTH & R	EHAB CENTER 1500 EAST HIBBING, N	THIRD AVENU IN 55746	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21685	Continued From page	28	21685			
21685	MN Rule 4658.1415 S Housekeeping, Opera	•	21685			
	including walls, floors systems, and equipm continuous state of go with regard to the hea	ood repair and operation llth, comfort, safety, and dents according to a written				
	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 environmental tour wi supervisor (MS)-A the noted:					
	vent deflector made of ceiling with pealing blue said the vent was about the result of the call ways ask about the anurse put up the call months ago and it look heating company had problem but did not known and the company had not result of the ceiling ceiling the ceiling ceiling the c	now the date. The heating ponded to date. Verification In the heating company was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			A. BOILDING.					
		00858	B. WING		02/1	4/2014		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE				
GUARDIA	GUARDIAN ANGELS HEALTH & REHAB CENTER  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 SHOULI CROSS-REFERENCED TO THE APPROFICIENCY)	CTION SHOULD BE COMPLETE O THE APPROPRIATE DATE			
21685	Sommer Fage 25		21685					
	scrapped with sharp scrapped 1 and one I and the other door ja inches off of the floor wall had two areas w off. The area near the	both sides of the door were edges. One side was half feet up from the floor m was scraped and sharp 6. The painted burnt orange ith primer and paint scraped e clock measured 1.5 inches and area was on the wall						
	the wall by the clock floor tile had black glu tiles in a 8 by 5 foot a p.m. that staff would floor on a regular bas	missing paint and primer on The 12 by 12 inch square ue seeping up between the area. MS-A stated at 1:30 scrape this black glue off the aes. State that they had about this, but had got no a this issue.						
		mall scrapes of paint and dry om the wall in an area one le bed.						
	off the wall behind the	with paint and primer scraped eir chair in the room, one nches and the second one wide.						
	confirmed the above	at 2:30 p.m. with MS-A issues and had stated that maintenance of these types s for staff to use the						
	The environmental di development and imp procedures to mainta comfortable environn	OD OF CORRECTION: rector or his designee could blement policies and in a clean, orderly and nent . The environmental ee could then monitor the						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDIEAN	or doring of the state of the s	IDENTIFICATION NOMBER.	A. BUILDING: _		OOM! LETE	-0
		00858	B. WING		02/14/2	2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GUARDIA	N ANGELS HEALTH & R	EHAB CENTER	T THIRD AVEN	JE		
		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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	OULD BE COMPLETE	
21685	Continued From page	e 30	21685			
	appropriate environment for adherence to the policies and procedures.					
	TIME PERIOD FOR ( (21) days	CORRECTION: Twenty one				
21710	MN Rule 4658.1415 S Housekeeping, Opera		21710			
	Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to 115 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:					
	12:40 p.m. and stated wash up in the bathro informed facility staff. data set (MDS) dated alert, orientated and has temperatur assistance of mainter water was turned on after running for 10 m	5 degrees Fahrenheit (F), 25 minutes the water				
	R16 was interviewed	on 2/12/14, at approximately				

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		00858		B. WING		02/14/2014	
		00000				1 02/14/2014	
NAME OF F	PROVIDER OR SUPPLIER			RESS, CITY, STA			
GUARDIA	AN ANGELS HEALTH & R	EHAB CENTER	1500 EAST HIBBING, N	THIRD AVENU IN 55746	JE		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET	
21710	1:10 p.m. stated that a long time before it ghot water in the bathr water temperature was quarterly MDS dated cognitive impairment.  Nursing assistant (NA afternoon of 2/12/14, water most of the time to the public bath roon get hot water.  MS-A was interviewed and stated a recheck temperature that morn after running 10 minu.  The administrator was 8:30 a.m. and stated regarding water temp but didn't think there were the resident roon between 105 degrees.  SUGGESTED METH The environmental did development and imperocedures to ensure between 105 degrees degrees Fahrenheit. To rhis designee could appropriate hot water adherence to the policities.	they had to run the water pets warm. After running oom sink for 5 minutes that 101.8 degrees F. R1 1/2/14, indicated moder 1/2/14, indicated 1/2/14, at 4:00 p.r. of R94's bath room water in indicated 98 degrees 1/2/14, at 4:00 p.r. of R94's bath room water in resident room water in resident room was one. The facility tries in hot water temperatures and 115 degrees F. OD OF CORRECTION: rector or his designee confident policies and 1/2/14, hot water temperatures in Fahrenheit and 115. The environmental direct then monitor the temperatures for	the the 6 cate thot o go to m. er es F 4, at es to es ould s are ctor	21710	DEFICIENCY)		

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