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

ID: 8H24
Facility ID: 00611

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245012**
2. STATE VENDOR OR MEDICAID NO. (L2) **395040900**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **05/18/2017** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **120** (L18)
13. Total Certified Beds **120** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE: Bruce Melchert, HFE, NE II — Date: 06/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL: Anne Peterson, Enforcement Specialist — Date: 08/01/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **01/01/1967** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 08/07/2017 Co.

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE **05/23/2017** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245012
June 19, 2017

Ms. Julie Spiers, Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

Dear Ms. Spiers:

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 May 3, 2017 the above facility is certified for or recommended for:

120 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 19, 2017

Ms. Julie Spiers, Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

RE: Project Number S5012028

Dear Ms. Spiers:

On April 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 24, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 6, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 24, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 3, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 24, 2017, effective May 3, 2017 and therefore remedies outlined in our letter to you dated April 20, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Electronically delivered
June 19, 2017

Ms. Julie Spiers, Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

Re: Reinspection Results - Project Number S5012028

Dear Ms. Spiers:

On May 18, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 18, 2017, with orders received by you on May 19, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00611 (Y1)	A. Building B. Wing (Y2)	5/18/2017 (Y3)

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

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. 2 LSC	Correction Completed 05/03/2017	ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 05/03/2017	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 05/03/2017
ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	Correction Completed 05/03/2017	ID Prefix 21995 Reg. # MN St. Statute 626.557 Subd. 4a LSC	Correction Completed 05/03/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 06/19/2017	SIGNATURE OF SURVEYOR 32613	DATE 05/18/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/24/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

 EVENT ID: 8H2412

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

ID: 8H24
Facility ID: 00611

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245012**
2. STATE VENDOR OR MEDICAID NO. (L2) **395040900**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **03/24/2017** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12. Total Facility Beds **120** (L18)
13. Total Certified Beds **120** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Michelle Thompson, HFE NE II 05/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/22/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **01/01/1967** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

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

25. LTC EXTENSION DATE: (L27)

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

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)
30. REMARKS

Posted 05/23/2017 Co.

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 20, 2017

Ms. Julie Spiers, Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

RE: Project Number S5012028

Dear Ms. Spiers:

On March 24, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<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:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Brenda.fischer@state.mn.us
Phone: (320) 223-7338 Fax: (320) 223-7348

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 May 3, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 3, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 24, 2017 (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 September 24, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee,	F 225		5/3/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/28/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

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

F 225

Continued From page 2

Based on interview, and document review, the facility failed to immediately report to the State agency (SA) injuries of unknown origin for 1 of 3 residents (R218) reviewed for abuse prohibition.

Findings include:

R218's quarterly Minimum Data Set (MDS) dated 10/25/16, identified R218 had diagnoses of Alzheimer's dementia, anxiety. The MDS identified R218 had severe cognitive impairment, required limited assistance with all activities of daily living (ADLs) except for walking in her room, corridor and personal hygiene. The MDS further identified R218 had one fall without injury.

R218's care plan, printed 3/23/17, identified R218 had Alzheimer dementia, anxiety, impulsivity and wandered. R218's care plan listed various interventions which included to not leave R218 alone in her room in her wheelchair, remind to use her call light for assistance with transfers and bed was in the low position for napping and at night.

Review of the Resident Incident Report dated 12/23/16, indicated R218 had an unwitnessed fall after she attempted to self-transfer on 12/23/16 at 9:46 a.m. and was found on the floor in her room after she was heard screaming. R218 sustained a 4 cm laceration to the right side of her head, her right hand and palm was painful and swollen, she had a 1 cm x 1 cm abrasion to her right knee and a 5 cm x 1 cm abrasion to her right cheek and a 4 cm x 4 cm reddened area to her right elbow. The report identified R218's vital signs were taken, her head laceration was cleansed and closed with skin glue, kerlex applied around her head and ice

F 225

Guardian Angels Care Center makes every attempt to investigate all potential vulnerable adult concerns and report to the state authorities where required by state and federal regulation.

As noted on 2567, resident #218 was attempting to self-transfer and fell to the floor sustaining injury. There were no noted changes in level of consciousness or mentation.

As noted, Guardian Angels Care Center policy states an incident was considered an injury of unknown origin when both of the following conditions were met: the source of the injury was not observed by any person or the source the location of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or locations of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy further identified the facility would report immediately to the Office of Health Facility Complaints incidents of injuries of unknown origin.

Mandatory training will be conducted for all facility staff regarding Vulnerable Adult Reporting. Training will include all areas of our Vulnerable Adult policy, with particular emphasis on requirements for reporting resident injuries.

The Nurse Unit Manager or Resource Nurse (on-call nurse) will be notified of all falls with injury at the time of their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 applied to her wrist. The report listed the physician and family had been notified. However, the report lacked documentation the SA had been notified. Review of R218's nurse practitioner note dated 12/23/16 revealed R218 was seen after she sustained a fall. R218 had a 2 inch laceration of her scalp in the right side of the front of her head. The area was cleansed, and derma bond applied. She had pain at right wrist and right facial pain and a laceration. At that time a x-ray of the right wrist was ordered. Review R218's right wrist X-ray done on 12/23/16 after the fall findings was a concern for a distal radius fracture without significant displacement. Review of R218's Post Fall/Incident Huddle Investigation Worksheet, dated 12/26/16, revealed the nurse practitioner had been notified; however, lacked documentation the SA had been notified of the incident. On 3/22/17 at 2:25 p.m. the director of nursing (DON) confirmed there had been no reports to the SA for R218 since the last survey on 5/16. At 3/23/17 at 4:36 p.m., during a follow up interview with the DON and administrator, the administrator confirmed the current facility policy. On 3/23/17 at 2:42 p.m. clinical manager (CM)-A stated R218 sustained, after the 12/23/16 fall, a head laceration which the nurse practitioner closed with skin glue and R218 had x-rays done of her right wrist and chest. Review of the facility undated Abuse Prevention Plan identified an incident was considered an	F 225	occurrence. A determination will be made at that time of the need to submit a report to the state authority based on state and federal regulation and facility policy. Nurse Unit Managers will review falls for their respective units during all shifts worked. A review of all falls will be conducted with the interdisciplinary team a minimum of each week to ensure compliance with fall notification and Vulnerable Adult reporting. Results of these reviews will be reported to the QAPI meeting which is held every other month. Ongoing monitoring for Vulnerable Adult Reporting will be the responsibility of the Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 injury of unknown origin when both of the following conditions were met: the source of the injury was not observed by any person or the source the location of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or locations of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy further identified the facility would report immediately to the Office of Health Facility Complaints incidents of injuries of unknown origin.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect,	F 226		5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 5	F 226		

exploitation, and misappropriation of resident property as set forth at § 483.12.

(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property

(c)(3) Dementia management and resident abuse prevention.
This REQUIREMENT is not met as evidenced by:
Based on interview, and document review, the facility failed to implement their abuse policy for immediate reporting to the State agency (SA) injuries of unknown origin for 1 of 3 residents (R218) reviewed for abuse prohibition.

Findings include:

Review of the facility undated Abuse Prevention Plan identified an incident was considered an injury of unknown origin when both of the following conditions were met: the source of the injury was not observed by any person or the source the location of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or locations of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy further identified the facility would report immediately to the Office of Health Facility Complaints incidents of injuries of unknown origin.

R218's quarterly Minimum Data Set (MDS) dated 10/25/16, identified R218 had diagnoses of Alzheimer's dementia, anxiety. The MDS identified R218 had severe cognitive impairment, required limited assistance with all activities of

Guardian Angels Care Center makes every attempt to investigate all potential vulnerable adult concerns and report to the state authorities where required by state and federal regulation.

As noted on 2567, resident #218 was attempting to self-transfer and fell to the floor sustaining injury. There were no noted changes in level of consciousness or mentation.

As noted, Guardian Angels Care Center policy states an incident was considered an injury of unknown origin when both of the following conditions were met: the source of the injury was not observed by any person or the source the location of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or locations of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy further identified the facility would report immediately to the Office of Health Facility Complaints incidents of injuries of unknown origin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 6 daily living (ADLs) except for walking in her room, corridor and personal hygiene. The MDS further identified R218 had one fall without injury. R218's care plan, printed 3/23/17, identified R218 had Alzheimer dementia, anxiety, impulsivity and wandered. R218's care plan listed various interventions which included to not leave R218 alone in her room in her wheelchair, remind to use her call light for assistance with transfers and bed was in the low position for napping and at night. Review of the Resident Incident Report dated 12/23/16, indicated R218 had an unwitnessed fall after she attempted to self-transfer on 12/23/16 at 9:46 a.m. and was found on the floor in her room after she was heard screaming. R218 sustained a 4 cm laceration to the right side of her head, her right hand and palm was painful and swollen, she had a 1 cm x 1 cm abrasion to her right knee and a 5 cm x 1 cm abrasion to her right cheek and a 4 cm x 4 cm reddened area to her right elbow. The report identified R218's vital signs were taken, her head laceration was cleansed and closed with skin glue, kerlex applied around her head and ice applied to her wrist. The report listed the physician and family had been notified. However, the report lacked documentation the SA had been notified. Review of R218's nurse practitioner note dated 12/23/16 revealed R218 was seen after she sustained a fall. R218 had a 2 inch laceration of her scalp in the right side of the front of her head. The area was cleansed, and derma bond applied. She had pain at right wrist and right facial pain and a laceration. At that time a x-ray of the right wrist was ordered.	F 226	Mandatory training will be conducted for all facility staff regarding Vulnerable Adult Reporting. Training will include all areas of our Vulnerable Adult policy, with particular emphasis on requirements for reporting resident injuries. The Nurse Unit Manager or Resource Nurse (on-call nurse) will be notified of all falls with injury at the time of their occurrence. A determination will be made at that time of the need to submit a report to the state authority based on state and federal regulation and facility policy. Nurse Unit Managers will review falls for their respective units during all shifts worked. A review of all falls will be conducted with the interdisciplinary team a minimum of each week to ensure compliance with fall notification and Vulnerable Adult reporting. Results of these reviews will be reported to the QAPI meeting which is held every other month. Ongoing monitoring for Vulnerable Adult Reporting will be the responsibility of the Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 7 Review R218's right wrist X-ray done on 12/23/16 after the fall findings was a concern for a distal radius fracture without significant displacement. Review of R218's Post Fall/Incident Huddle Investigation Worksheet, dated 12/26/16, revealed the nurse practitioner had been notified; however, lacked documentation the SA had been notified of the incident. On 3/22/17 at 2:25 p.m. the director of nursing (DON) confirmed there had been no reports sent to the SA for R218 since the last survey on 5/16. At 3/23/17 at 4:36 p.m., during a follow up interview with the DON and administrator, the administrator confirmed the current facility policy. On 3/23/17 at 2:42 p.m. clinical manager (CM)-A stated R218 sustained, after the 12/23/16 fall, a head laceration which the nurse practitioner closed with skin glue and R218 had x-rays done of her right wrist and chest.	F 226		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans	F 279		5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8	F 279		

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 9 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan to include a toileting program for 1 of 2 residents (R241) reviewed for urinary incontinence. Findings include: R241's admission Minimum Data Set (MDS) dated 11/29/16, identified R241 was cognitively intact, had a diagnosis of hemiplegia (paralysis to one side of the body), was occasionally incontinent of urine (less than seven episodes of incontinence), and required extensive assistance of two staff to complete toileting. R241's Bladder Data Summary dated 11/30/16, identified a three day bladder/toileting collection was completed on 11/25/16, and R241 was able to be partially retrained and incontinence episodes decreased 51-75% (percent). The comment section indicated staff to, "Toilet Q (every) 2 hrs (hours). Asks for bedpan." R241's Care Area Assessment (CAA) Summary dated 12/2/16, identified urinary incontinence as a triggered area and indicated, "New Care Plan Started."	F 279	Guardian Angels Care Center endeavors to develop and maintain a comprehensive plan of care that reflects the up-to-date needs of each resident. Resident #241's plan of care has been updated to reflect her level of urinary incontinence and necessary staff interventions to minimize incontinence. A 100% audit will be conducted of all current residents to determine the accuracy of the care plans for toileting, including measures to reduce episodes of urinary incontinence. Education and training will be provided for all licensed nurses regarding developing and maintaining the accuracy of the plan of care, including the need to provide timely updates. A review schedule has been developed for unit nurses that will include specific monitoring of each resident's care plan twice weekly for transitional care unit residents, weekly for long-term care residents. MDS nurses will review the accuracy of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

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

F 279 — Continued From page 10

R241's quarterly MDS dated 2/16/17, identified R241 was frequently incontinent (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) and a trial toileting program had been attempted on admission or since urinary incontinence was noted in the facility. However, the MDS did not identify R241's response to the trial toileting program. The MDS also indicated R241 was not on a toileting program or trial to manage R241's urinary incontinence.

R241's Transitional Unit Care Plan, undated, lacked any identified problem, goals, or interventions to address R241's urinary incontinence despite her having documented urinary incontinence.

When interviewed on 3/22/17, at 12:03 p.m. nursing assistant (NA)-B stated R241 was continent of bladder and was not on a toileting program.

During interview on 3/23/17, at 11:29 a.m. registered nurse (RN)-A stated R241 did not have a care plan for elimination adding, "I agree" there should be an elimination care plan for R241. RN-A stated it was the nurses and the nurse manager's responsibility to make sure care plans were completed and updated as needed.

When interviewed on 3/23/17, at 11:40 a.m. registered nurse manager, RN-B stated R241, "Does not" have an incontinence care plan, but there, "Should be" an elimination care plan. He also stated the nurses completed the elimination portion of the care plan and the nurse managers screened and reviewed the care plans as time permitted. RN-B stated it should have been

F 279 — Provider's plan of correction:

the plan of care during each assessment reference period. Identified concerns will be reported to the Director of Nursing.

A 5% audit of care plan accuracy will be conducted each week by the Nurse Unit Manager or designee. Results of these audits will be reviewed by the Director of Nursing and reported at the QAPI meeting every other month.

Ongoing monitoring for care plan development and accuracy will be the responsibility of the Nurse Unit Managers and the Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 noticed that elimination was not on R241's care plan. During interview on 3/23/17, at 3:10 p.m. the director of nursing (DON) stated R241 did not have a care plan for urinary incontinence, but R241 should have a urinary care plan. DON stated a urinary care plan would be initiated for R241. A Resident Assessment, Care Planning, Discharge Planning policy dated 3/22/17, identified all care plans would be person centered and in compliance with professional standards of care. The policy also identified the plan of care would include resident strengths, goals, life history, and needs.	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the care plan to ensure the necessary treatment and services were provided to minimize the development of pressure ulcers for 1 of 1 residents (R1) identified at risk for pressure ulcer. Findings include:	F 282	Guardian Angels Care Center strives to adhere to all resident care plans; providing care in accordance with state and federal regulations and current standard of practice. Resident #1 has very fragile skin. The integrity of her skin was restored and	5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

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

F 282

Continued From page 12

R1's quarterly Minimum Data Set (MDS) dated 12/7/16, included diagnosis of diabetes mellitus, paraplegia (paralysis to the legs and lower body), and neurological disease. In addition the MDS indicated R1 needed total assistance of two with bed mobility, toileting and was always incontinent of bowel and not on toileting program and had a suprapubic catheter.

R1's care plan dated 2/10/17, indicated she required physical assist with bed mobility, transfers and assist of two to turn resident from side to side or side to back, position in functional alignment using pillows for body extremity support and had air mattress for her to reduce pressure. The care plan directed staff to monitor for incontinence, check and change incontinence product every two hours and as needed.

During continuous observation on 3/22/17, from 7:03 a.m. to 9:30 a.m.(2 hours and 27 minutes) R1 was lying in her bed with her head turned to the left. At 7:13 a.m. she was still lying in bed with her head turned to the left. At 7:20 a.m. a nurse entered her room raised the head of the bed, checked her blood sugar, gave a supplement and lowered her bed and left the room. At 7:30 a.m. nursing assistant (NA)- E entered her room and assisted her roommate in the bathroom and exited the room at 7:49 a.m. At 7:51 a.m. R1 was lying in bed with her head turned to the left in the same position. At 8:07 a.m. R1 was still lying in the same position, no staff had entered her room. At 8:34 a.m. NA-E brought R1's breakfast tray and assisted her with eating, with the door and curtain opened. At 8:48 a.m. NA-E left her room with R1's breakfast tray. At 9:04 a.m. R1 remained in the same position, in

F 282

maintained through use of a low air loss lateral rotation mattress. The mattress allows for repositioning of the resident on a frequent basis (up to every 5 minutes), reducing pressure on any portion of her body. Resident #1's pressure ulcers were healed as the result of facility interventions.

Staff have been retrained regarding the need to reposition resident #1 manually as directed by the plan of care.

Staff will be retrained regarding the need to manually reposition all residents on low air loss mattresses in accordance with the plan of care.

A 10% audit of turning and reposition of all residents on low air loss mattresses will be conducted each week.

Results of these audits will be reviewed by Nurse Unit Managers and Director of Nursing. Results will be reported at each QAPI meeting every other month.

Ongoing monitoring for compliance with turning and repositioning schedules will be the responsibility of the Nurse Unit Managers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 13 bed watching television. At 9:15 a.m. the resident still remained in the same position, with no staff entering the room to reposition R1 or check for stool incontinence. During interview 3/22/17, at 9:30 a.m. NA-E stated she was R1's NA and she was last changed by the night shift around 6:50 a.m., 2 hours and 50 minutes earlier. NA-E stated R1 has a special mattress so she doesn't need to to be repositioned every two hours and was on her way to check R1's reposition now. During interview 3/22/17, at 9:32 a.m. registered nurse (RN)-D stated R1 was incontinent of bowel and had a history of pressure ulcers with fragile skin. She (R1) needed to be turned and repositioned every two hours and the mattress turns her, but they still should go in every two hours and check her for stooling. RN-D stated R1 should not have been left over two hours with out checking or repositioning, which her care plan identifies.	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 314		5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 14 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely assistance for toileting and repositioning to reduce the risk of pressure ulcer development for 1 of 1 residents (R1) identified at risk of pressure ulcers. Findings include: R1's quarterly Minimum Data Set (MDS) dated 12/7/16, included diagnosis of diabetes mellitus, paraplegia (paralysis to the legs and lower body), and a neurological disease. The MDS further indicated she had severe cognitive impairment, no mood problems and did not reject care, needed total assistance of two with bed mobility, toileting, was always incontinent of bowel and was not on a toileting program and had a suprapubic catheter. Further the MDS indicated she was at risk for pressure ulcer development and had a stage 3 pressure ulcer (full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue) which was currently healed, but had moisture related skin damage with a pressure device for bed and chair. R1's pressure ulcer Care Area Assessment (CAA) dated 6/22/16, indicated she was confined to bed, required regular schedule of turning, needed special mattress, seat cushion to reduce pressure and was only able to mover her right arm and hand.	F 314	Guardian Angels Care Center strives to maintain the integrity of all resident s skin, promote healing of all pressure ulcers. Resident #1 has very fragile skin. The integrity of her skin was restored and maintained through use of a low air loss lateral rotation mattress. The mattress allows for repositioning of the resident on a frequent basis (up to every 5 minutes), reducing pressure on any portion of her body. Staff have been retrained regarding the need to reposition resident #1 manually as directed by the plan of care. Staff will be retrained regarding the need to manually reposition all residents on low air loss mattresses in accordance with the plan of care. Education and training will be held for all facility nurses and nursing assistants regarding prevention of pressure ulcers, including necessity of turning and repositioning. A review of any residents with pressure ulcers will be conducted each week. Focus will include any newly acquired	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 15 R1's care plan dated 2/10/17, indicated she required physical assist with bed mobility, transfers and assist of two to turn resident from side to side or side to back, position in functional alignment using pillows for body extremity support and had air mattress for her to reduce pressure. The care plan directed staff to monitor incontinence, check and change incontinence product every two hours and as needed. The care plan further indicated she had alteration in skin integrity due to edema, obesity, bowel incontinence and progression of left buttock and thigh wound related to increased time in chair with dental appointment and was clinically unavoidable due to fragility of skin. The care plan indicated she had a history of a stage two pressure ulcer on her coccyx that healed on 2/10/17. The care plan further indicated she had a history of being resistive to treatment by not laying back in bed after two hours and following repositioning schedule. A Tissue Tolerance Testing Review dated 1/30/17, indicated she was at high risk for skin breakdown and she had fragile skin on buttocks and posterior thighs which were currently intact. It directed the staff to continue to reposition every two hours and air mattress to reduce pressure to areas. Care plan was reviewed with no changes. A additional Tissue Testing Review dated 3/5/17, indicated she was still at high risk for skin breakdown and and had no open areas or redness and resident was to be repositioned every two hours. A Braden Risk Assessment Report (a tool used to assist in predicting pressure risk assessment) dated 3/2/17, indicated R1 responded to verbal	F 314	pressure ulcers/residents admitted with pressure ulcers, current treatments utilized and improvement/deterioration of all pressure ulcers/injuries. A 10% audit of all residents with pressure ulcers will be conducted weekly by unit nurses to monitor turning and repositioning is occurring as specified by the plan of care. Results of these audits will be reviewed by nurse unit managers and the director of nursing. Results will be reported at the QAPI meetings every two months. A report of all pressure ulcers will be made at QAPI meetings every other month. Ongoing monitoring of all pressure ulcers will be conducted by Nurse Unit Managers and Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 16	F 314		

commands, but can not always communicate discomfort or need to be turned. The assessment further indicated she has very moist skin, confined to bed, completely immobile, has a problem with friction and shear. Requires moderate to maximum assistance in moving, frequently slides down in bed or chair and required frequent repositioning with maximum assistance.

A Wound Assessment Report dated 3/22/17, indicated that on 2/2/17, a stage 3 pressure ulcer was identified on her sacrum which resolved on 2/10/17. She currently has no pressure ulcers.

During continuous observation on 3/22/17, from 7:03 a.m. to 9:30 a.m.(2 hours and 27 minutes) R1 was lying in her bed with her head turned to the left. At 7:13 a.m. she was still lying in bed with her head turned to the left. At 7:20 a.m. a nurse entered her room raised the head of the bed, checked her blood sugar, gave a supplement and lowered her bed and left the room. At 7:30 a.m. nursing assistant (NA)- E entered her room and assisted her roommate in the bathroom and exited the room at 7:49 a.m. At 7:51 a.m. R1 was lying in bed with her head turned to the left in the same position. At 8:07 a.m. R1 was still lying in the same position, no staff had entered her room. At 8:34 a.m. NA-E brought R1's breakfast tray and assisted her with eating, with the door and curtain opened. At 8:48 a.m. NA-E left her room with R1's breakfast tray. At 9:04 a.m. R1 remained in the same position, in bed watching television. At 9:15 a.m. the resident still remained in the same position, with no staff entering the room to reposition R1 or check for stool incontinence.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 17	F 314		

During interview 3/22/17, at 9:30 a.m. NA-E stated she was R1's NA and that she was last changed by the night shift and thought it was "around 6:50 a.m.," 2 hours and 50 minutes earlier. NA-E stated she has a special mattress so she doesn't need to be reposition every two hours. She was on her way to check R1 and reposition her now.

During interview 3/22/17, at 9:32 a.m. registered nurse (RN)-D stated R1 was incontinent of bowel and had a history of pressure ulcers with fragile skin. She needs to be turned every two hours and the mattress turns her, but they still should go in every two hours and check her for stooling. RN-D stated R1 should not have been left over two hours with out being checked or repositioned. RN-D provided a brochure on R1's mattress entitled, Invacare Rotating Low Air Loss Therapy, and stated the mattress is set to change positions every five minutes.

During observation and interview 03/22/17, at 9:40 a.m. NA-E and NA-L were observed providing personal care in R1's room. R1 was changed, she had no stooling in her incontinent product, and no open areas were noted. NA-E stated it always take two staff to change and reposition her.

Review of the Invacare Rotating Low Air Loss Therapy brochure, undated, identified it was a rotational low air loss mattress, that was capable of turning the patient up to a 40 degree angle, and used a lateral rotational mattress system for turning, moving and shifting of the patient is done by the mattress. The brochure further indicated the mattress has settings so the mattress can perform the rotation at set timed intervals and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 18 mattress could be used for treating and healing pressure ulcers. The brochure does not indicate that manually turning and repositioning would not be needed to fully off load pressure from the patient. During phone interview 3/30/17, at 3:35 p.m. a Invacare customer service representative stated they do not have anything in writing to indicate the Rotating Low Air Loss Therapy device substitutes manually turning and repositioning to off load pressure. A facility Policy And Procedure For The Prevention And Treatment Of Skin Breakdown dated 3/13/12, indicated "It is the policy to properly identify, and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers, to implement preventative measures and to provide appropriate treatment modalities for wounds according to industry standards of care."	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and	F 323		5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

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

F 323

Continued From page 19

maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to comprehensively assess, and implement effective interventions to minimize the risk of falls for 1 of 3 residents (R218) who had falls.

Findings include:

R218's quarterly MDS dated 1/23/17, identified R218 had severe cognitive impairment, required extensive assistance with all ADLs except for personal hygiene and had diagnoses which included Alzheimer's and anxiety. The MDS further identified R218 had sustained 2 falls with injury, which was a change from her previous MDS of 10/25/16. The MDS also indicated R218 did not have a current toileting program, was on a trial toileting program but the facility had not documented R218's response to her toileting program within the MDS assessment.

R218's quarterly Minimum Data Set (MDS) dated 10/25/16, identified R218 had severe cognitive impairment, required limited assistance with all activities of daily living (ADLs) except for walking

F 323

Guardian Angels strives to minimize falls for all residents.

A comprehensive assessment for falls has been performed for resident #218. Ongoing monitoring of interventions continues.

Education and training on fall prevention and assessment will be conducted for all licensed nurses.

The Nurse Unit Manager or Resource Nurse (on-call nurse) will be notified of all falls with injury at the time of their occurrence. A determination will be made at that time of the need to submit a report to the state authority based on state and federal regulation.

Nurse Unit Managers will review falls for their respective units during all shifts worked.

A review of all falls will be conducted with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20	F 323		

in her room, corridor and personal hygiene. The MDS further identified R218 had one fall with no injury, was on a toileting program and was frequently incontinent of bowel and bladder.

R218's care area assessment (CAA) dated 8/6/16 identified R218 had severe cognitive impairment, wandered and had a decreased ability to understand others and making herself understood. The CAA indicated R218 had decreased visual problems which affected her balance, had a decline in cognitive status, a disruption of her ability to speak, mood problem and increased dependence on staff for ADLs. The CAA further identified R218 had an increased risk for falls related to recent falls, disturbances of balance, gait and positioning ability, infection, pain, contractures, received anti-anxiety medication and was incontinent.

Review of R218's Fall Risk Assessment Tools identified the following:

-On 7/28/16, the tool identified R218 was at high risk for falls related to history of recent falls, was taking a high risk medication, had psychological risk factors and had severe cognitive impairment. The document further identified R218 had fall risk factors which included difficulty finding her way around, unsafe and impulsive mobility, unsafe and impulsive transfers, difficulty with orientation to environment in areas between bed, bathroom and dining and reported or known incontinence with urgency, nocturia (night time incontinence), and accidents. Also noted that R218 had repeated falls at the hospital prior to admission to the facility and the fall management strategies included physical therapy (PT), occupational

the interdisciplinary team a minimum of each week to ensure compliance with fall notification and Vulnerable Adult reporting. Results of these reviews will be reported to the QAPI meeting which is held every other month.

Ongoing monitoring for Vulnerable Adult reporting will be the responsibility of the Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21	F 323		

therapy (OT), use call light and wear gripper socks or sturdy shoes.

-On 10/20/16, the tool identified R218 was at high risk for falls related to history of recent falls, was taking 2 high risk medications and had severe cognitive impairment, and R218 had difficulty following instructions or was non-complaint. The tool further identified R218 had fall risk factors which included difficulty finding her way around, was unsafe, impulsive and forgot her walking aid for mobility, was unsafe, impulsive and over reached during transfers, had difficulty with orientation to environment in areas between bed, bathroom and dining and reported or known incontinence with urgency, nocturia (night time incontinence), and accidents. R218's history of falls and action plan for interventions and care plan were left blank.

-On 1/18/17, the tool identified R218 was at high risk for falls related to history of recent falls and had severe cognitive impairment. The tool further identified R218 was agitated, confused and disoriented, difficulty finding her way around, had risk taking behaviors, forgot her walking aid for mobility, was unsafe, impulsive in her mobility and transfers and over reached, had difficulty with orientation to environment in areas between bed, bathroom and dining and reported or known incontinence with urgency, nocturia (night time incontinence), and accidents. R218's history of falls and action plan for interventions and care plan were left blank.

R218's care plan dated 2/14/17, identified R218 had anxiety, was impulsive, wandered and had frequent falls. Staff were to remind the resident to use call light for assistance with transfers. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22	F 323		

required assistance with toileting related to Alzheimer's dementia, urinary and bowel incontinence, and her inability to find the bathroom. The care plan further identified R218 required the physical assistance of 1 staff and a transfer belt for transfers and a rear wheeled walker to ambulate R218 to the bathroom, to meals and in the hallways every 2 hours while awake with black tie shoes on. Staff were not to leave R218 in her wheelchair alone when in her room, Staff were to monitor, provide a safe environment and direct/cue the resident as needed. R218 had a history of fractured ribs and had an impaired sleep pattern related to pain and dementia with wandering. The care plan identified R218's bed was to be in low position when napping or at night related to frequent falls. Staff were to reposition her, toilet her and monitor her every 2 hours.

The facility incident reports and post fall huddle investigation sheets identified the following falls:

1.) Resident Incident Report indicated R218 fell on 8/6/16 at 7:55 a.m. after she attempted to self-transfer and was found on the floor in her room. The report indicated R218 had hit her head on door, 911 was called and R218 was transferred to emergency department. The report identified R218's condition at the time of the incident included fall history, inability to understand directions, confusion/disorientation, and incontinency. There was no indication of when R218 was last toileted, or if she was incontinent at the time of the fall.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 8/8/16, identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23	F 323		

R218 complained that her head hurt and was bleeding from the back of her head. The investigation further identified staff applied pressure to R218's head laceration and her vital signs were taken. The report indicated there was a need to update her care plan to keep R218's bed in low position when napping and at night and conduct frequent checks as R218 was impulsive. It did not identify what the frequency in which the facility intervention of "frequent checks" were to be completed.

Review of the clinic referral progress notes identified on 9/29/16 R218 the provider had ordered physical therapy.

On 03/23/17, at 10:40 a.m. clinical manager (CM-A) stated the fall on 8/6/16, at 7:55 p.m. was unwitnessed and thought R218 self-transferred fell from bed and sustained a head laceration which required transfer to the emergency department and staples to close the laceration. She stated R218's was toileted after dinner and refused toileting five minutes prior to finding her on the floor. The bed was to be in the low position when she's napping and at night because R218 had dementia and was impulsive. Incontinence at the time of the fall was not noted, and R218 was not to be in her room alone.

2.) Resident Incident Report indicated R218 fell on 8/15/16 at 1:30 a.m. after she attempted to self-transfer and was found on the floor in the hallway next to her room. The report identified R218 complained of pain in her ribs and had a 2 (centimeter) cm by 2 cm left elbow abrasion.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 8/15/16, identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 R218 fell after she attempted to self-transfer and was found in the hallway outside of her room. The investigation identified R218 was confused, and sustained an abrasion from the fall. There was no indication of any new fall interventions or when R218 had last been toileted, or if she was incontinent. On 03/23/17, at 10:40 a.m. CM-A stated the fall on 8/15/16, at 1:30 a.m. was unwitnessed and she thought R218 self-transferred from her room into the hallway and sustained a 2 cm x 2 cm laceration to her elbow. She stated incontinence at the time of the fall was not noted, and no new interventions were added. 3.) Resident Incident Report dated 8/20/16, indicated R218 fell on 8/20/16, at 1:25 a.m. after she attempted to self-transfer and was found on the floor in her room. The report further indicated R218 was found propped up on her right elbow with her incontinence pad pulled down off her hips and R218 had both legs in the same opening of the incontinent brief. Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 8/20/16, identified R218 fell on 8/20/16 after she attempted to self-transfer and was found on the floor in her room between her bed and her bathroom. The investigation further identified R218 didn't know what she was doing or trying to do when she fell. The investigation indicated R218 was found wandering earlier, not in her room at 11:00 p.m. rounds. She was found on the opposite wing in the dining room, was brought back to her room, toileted and put back in bed. The investigation noted R218 needed frequent checks and was impulsive, unable to redirect, and bed kept in low	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25	F 323		

position. There was no indication of the frequency of these checks.

On 03/23/17, at 10:40 a.m. CM-A stated the fall on 8/20/16, at 1:25 a.m. was unwitnessed but thought R218 self-transferred and was found on the floor between her bed and her bathroom. R218 was incontinent with her pull-up pulled down and both legs in the same opening. R218 was instructed on how to call for help.

4.) Resident Incident Report dated 9/8/16, indicated R218 fell after she attempted to self-transfer on 9/8/16 at 11:46 p.m. and was found on the floor of her room. The report indicated R218 was taken to the bathroom, voided and had no apparent injuries.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 9/9/16, identified R218 fell on 9/8/16 after she attempted to self-transfer and was found on the floor in her room. The investigation identified R218 stated the water was starting to come out, and had last used the bathroom at 8:05 p.m. The investigation identified R218 frequently wandered at night, had frequent checks and to continue current interventions. There was no specific frequency identified to check on R218.

On 03/23/17, at 10:40 a.m. CM-A stated the fall on 9/8/16, at 11:46 p.m. was unwitnessed and she thought R218 self-transferred and was found on the floor in her room with no apparent injuries. The resident had stated us water was trying to come out at the time of the fall. CM-A stated toileting was an issue and R218 constantly had to go to the bathroom, was fixated on it, and needed to be toileted frequently. The resident had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 26	F 323		

checked for incontinence at 11:35 p.m. and was dry. There were no new or changes to the interventions for falls.

5.) Resident Incident Report dated 12/13/16, indicated R218 fell after she attempted to self-transfer on 12/13/16 at 2:15 p.m., was found on the floor outside of her bathroom with her head against the closed door. The report identified R218 sustained a 1.5 cm X 1.2 cm abrasion to her left knee.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 12/13/16, identified R218 fell on 12/13/16 after she attempted to self-transfer and was found on the floor in her room. The investigation identified R218 stated she was going to the bathroom when she fell, and R218 was last toileted at 12:45 p.m. The investigation noted there was a need for more frequent monitoring and toileting.

On 03/23/17, at 10:40 a.m. CM-A stated the fall on 12/13/16, at 2:15 p.m. was from the resident self-transferred trying to go to the bathroom and hit her head on the door. She stated R218 sustained a small abrasion on her scalp and left knee and was last toileted at 12:45 p.m. She completed the investigation and indicated on the form R218 needed more frequent monitoring than every 2 hours and every 1.5 hours for toileting. She did not think she added it to R218's care task sheet for the NA's. If R218 wasn't in the common area they needed to look for her and keep her bed in low position.

6.) Resident Incident Report dated 12/23/16, indicated R218 fell after she attempted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 27	F 323		

self-transfer on 12/23/16 at 9:46 a.m. and was found on the floor in her room after she was heard screaming. R218 sustained a 4 cm laceration to the right side of her head, her right hand and palm was painful and swollen, she had a 1 cm x 1 cm abrasion to her right knee and a 5 cm x 1 cm abrasion to her right cheek and a 4 cm x 4 cm reddened area to her right elbow. The nurse practitioner was present in the facility and saw the resident after the fall.

Review of R218's nurse practitioner note dated 12/23/16 identified R218 had a 2 inch laceration of her scalp. The area was cleansed, and derma bond applied. She had pain at right wrist, right facial pain and a laceration. At that time a x-ray of the right wrist was ordered.

Review R218's right wrist X-ray completed on 12/23/16 identified a concern with a distal radius fracture without significant displacement.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 12/23/16, identified R218 fell on 12/23/16 after attempting to self-transfer, going to the bathroom and was found on the floor in her room outside the bathroom. The investigation indicated R218 was last toileted at 9:15 a.m., 36 minutes before her fall. The investigation further identified R218 had more difficulty to redirect with her wandering and tried to keep her at the main desk to keep an eye on her. The investigation identified R218 self-transferred frequently and was on a walking program 4-6 times per day in the hallways. The investigation noted they would continue current interventions plus more short, frequent walks.

On 03/23/17, at 10:40 a.m. CM-A stated the fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 28	F 323		

on 12/23/16, at 9:46 a.m. was from the resident self-transferring, went to the bathroom and hit her head. She stated R218 likely wandered back into her room and no one saw or looked for her. The resident was last toileted at 9:15 a.m. before her primary NA left on break. She states she spoke with family (F)-A in January and discussed that she may have been falling because of her "loafer shoes", so they were replaced with black tie shoes.

7.) Resident Incident Report dated 2/14/17, indicated R218 fell after she attempted to self-transfer on 2/14/17 at 5:30 a.m. and was found on the floor in her room. The report identified R218 had no apparent injuries and vital signs were taken.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 2/14/17, identified R218 fell on 2/14/17 after attempted to self-transfer and was found on the floor in her room next to her roommate's wheelchair. The investigation indicated R218 didn't know what she was doing when she fell, and was trying to sleep there. The resident was last checked on at 3:35 a.m. was incontinent. The investigation indicated they were unsure how to prevent this fall, her night wandering had decreased and there were no falls on the day shift since they changed her shoes.

On 03/23/17, at 10:40 a.m. CM-A stated the fall on 2/14/16, at 5:30 a.m. from the resident self-transferring, and was found in her room. The resident didn't know why she was there. They had last checked on R218 at 3:35 a.m. and at 5:30 they found her. She wasn't sure how the fall could have been prevented. R218's wandering at night

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 29	F 323		

had decreased and she has not fallen on day shift since they changed her shoes. They continue to toilet her every 2 hours and check on her every 2 hours at night. She thought about "bumping" her checks up during the day and they completed a trial toileting plan of every 1.5 hours, but it did not work because she was fixated on going to the bathroom and would have to go again. CM-A stated they were aware the resident liked to stay up until after 11:00 p.m..

During observation on 3/22/17, at 7:03 a.m. R218 was seated in her wheelchair in the hall facing the nurse's station. R218 had a half tray affixed to the right side of her wheelchair with white napkins and a clear plastic cup with water. R218 was continually fidgeting with her green cardigan sweater and the collar of her plaid blue/green shirt. She repeatedly wiped her nose with napkins. She had black rubber sole tie shoes on, her glasses on, and a wander guard on her right ankle.

On 3/23/17, at 10:31 a.m. R218 returned from the beauty shop and NA-A walked with R218 down the hallway and used a gait belt and wheeled walker. R218 wore black rubber sole shoes and had her glasses on. R218 was hunched over and very confused and needed to be redirected as she tried to turn the walker to go into another resident's room. R218 continued to walk with assistance and took small steps but walked quickly with her head down. R218 became hung up on the mechanical lift in the hallway with her walker. NA-A had to untangle her walker and directed her towards the middle of the hallway.

On 3/23/17, at 9:29 a.m. nursing assistant (NA-A) stated R218 was confused and at risk for falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 30	F 323		

She stated R218 doesn't stand up as much now as she used to and stated R218 would still leap out of her chair to pick up something from the floor. The last time she saw R218 try to stand up was about a month ago but R218 tries to wiggle out of her bed every time when she awaken in bed. R218 liked to stay up late and they try to keep her occupied but this was difficult, would wander off.

On 3/23/17, at 9:46 a.m. registered nurse (RN-C) stated R218 was oriented to person, was at risk for falls and needed to be checked on. They did not like to leave her alone in her room but there was no set schedule for checking on her.

On 3/23/17, at 9:56 a.m. NA-C stated R218 was confused, at risk for falling because R218 tried to stand or walk on her own especially at bedtime. NA-C stated R218 liked to stay up until 10:30-11:15 p.m. and if she went to bed at that time she would stay asleep.

On 3/23/17, at 10:26 a.m. NA-D stated R218 was confused, could walk but it was unsafe for her to walk on her own. They toilet her every 2 hours and she has become more incontinent this past month.

On 3/23/17, at 10:40 a.m. unit manager (UM)-A stated fall risk assessments were completed quarterly and with a significant change in condition. She confirmed R218 was assessed quarterly on 7/28/16, 10/20/16 and 1/18/16 and did not think they would re-assess a resident after they had recurrent falls or falls with injuries. She felt the residents falls were not related to toileting and there was no pattern of R218's falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 31 On 3/24/17, at 9:21 a.m. director of nurses (DON) stated they only complete a comprehensive assessments quarterly. After a fall with injury she expected the staff to look at the whole event and look at what was going on surrounding the event to complete their assessment. DON stated she would expect a root cause analysis done with every fall, and felt all of the necessary information was included in their post fall huddle form. She stated after the post fall huddle was completed the UM-A reviewed it and pulled everything together to determine interventions and how they would manage the situation. However, the facility did not identify in the plan of care that R218 liked to stay up after 11:00 p.m., and to keep her up until that time, nor did the facility add a specific increased frequency for checking on R218, besides every two hours to help decrease potential falls. Review of falls policy dated 2/19/17, identified the facility would decrease the risk of further falls or major injury for residents. The policy further identified the facility would pay particular attention to residents who have sustained multiple falls to determine patterns and etiology of falls and they would consult with members of the interdisciplinary team for additional interventions and suggestions to decrease risk of falls.	F 323		

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

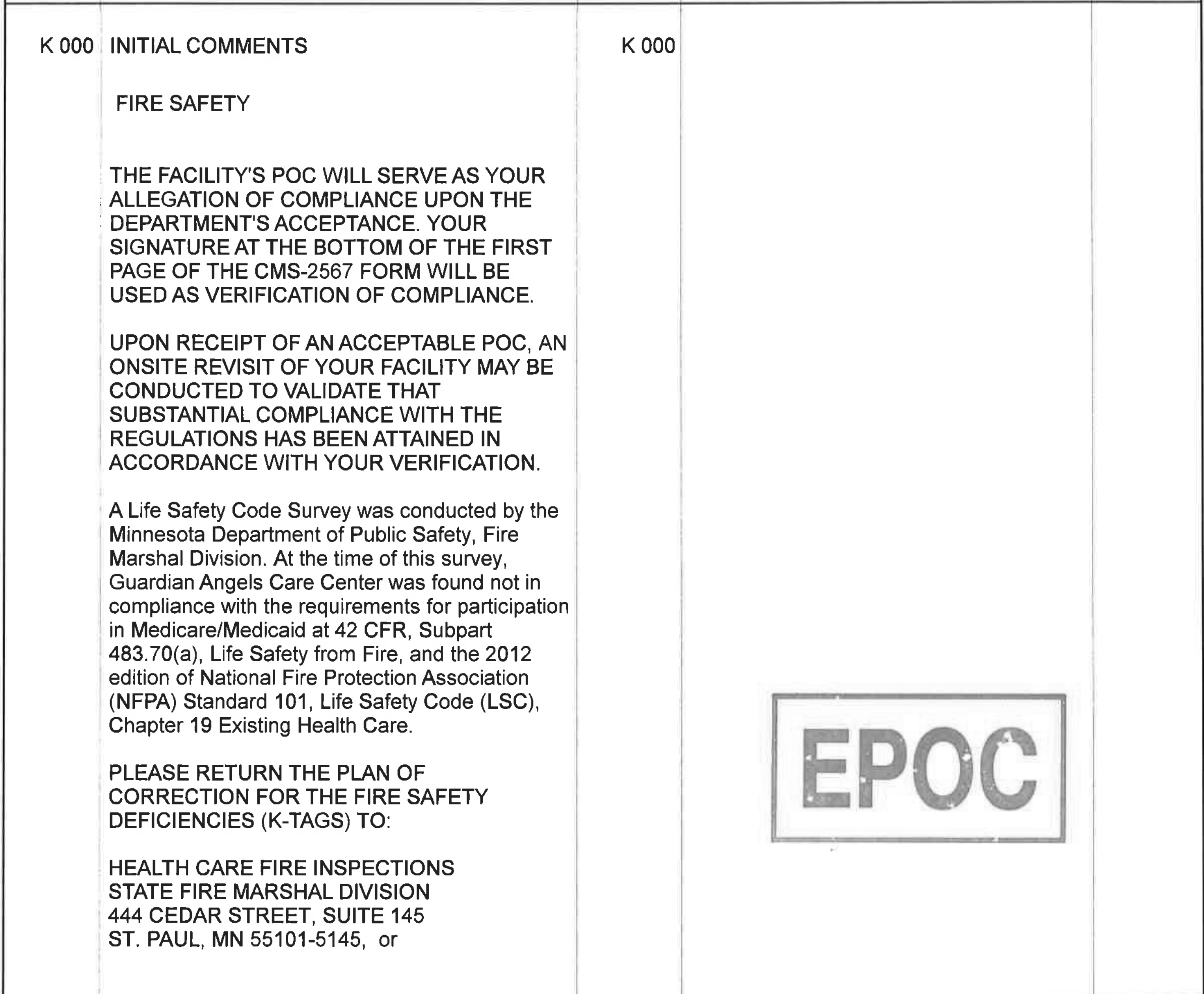
F5012026

PRINTED: 05/01/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**03/21/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		



FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Guardian Angels Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/28/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/21/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

By e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Guardian Angels Care Center is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1965 and was determined to be of Type II (111) construction. In 1974 a single story addition was constructed to the East Wing and determined to be of Type II (111) construction. Also, in 1995 an addition was constructed to the East Wing and determined to be of Type II (111). Another addition was constructed in 2007 to the Northeast Wing and determined to be Type V (111) with a 2 hour separation.

As of November 1, 2016 this was surveyed as one building, existing, with the construction type as the least fire resistive construction type per NFPA 101 section 8.2.1.3 (3)

The building is fully sprinkler protected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**03/21/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 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. The facility has a capacity of 120 beds and had a census of 118 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 916 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This STANDARD is not met as evidenced by: Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Findings include: On the facility tour between 9 am to 2:00 pm on	K 916	The remote annunciator failure occurred related to equipment upgrades. The new replacement had been ordered the first week in March, 2017 and is currently installed and operating effectively. We will monitor the operation of the panel by completing monthly preventative maintenance checks. The Maintenance Director will be responsible for ongoing compliance.	5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/21/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 916	Continued From page 3 03/21/2017 observations and staff interview revealed the remote annunciator located on the 100 Wing did not work at the time of the survey. This deficient condition was verified by the Director of Maintenance.	K 916		

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted

April 20, 2017

Ms. Julie Spiers, Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5012028

Dear Ms. Spiers:

The above facility was surveyed on March 20, 2017 through March 24, 2017 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, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 contact Brenda Fischer, Unit Supervisor at (320) 223-7338.

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.

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 04/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On March 20-24, 2017 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ____ B. WING ____	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan to include a toileting program for 1 of 2 residents (R241) reviewed for urinary incontinence. Findings include: R241's admission Minimum Data Set (MDS) dated 11/29/16, identified R241 was cognitively intact, had a diagnosis of hemiplegia (paralysis to one side of the body), was occasionally incontinent of urine (less than seven episodes of incontinence), and required extensive assistance of two staff to complete toileting. R241's Bladder Data Summary dated 11/30/16, identified a three day bladder/toileting collection was completed on	2 560	Corrected	5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 3 11/25/16, and R241 was able to be partially retrained and incontinence episodes decreased 51-75% (percent). The comment section indicated staff to, "Toilet Q (every) 2 hrs (hours). Asks for bedpan." R241's Care Area Assessment (CAA) Summary dated 12/2/16, identified urinary incontinence as a triggered area and indicated, "New Care Plan Started." R241's quarterly MDS dated 2/16/17, identified R241 was frequently incontinent (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) and a trial toileting program had been attempted on admission or since urinary incontinence was noted in the facility. However, the MDS did not identify R241's response to the trial toileting program. The MDS also indicated R241 was not on a toileting program or trial to manage R241's urinary incontinence. R241's Transitional Unit Care Plan, undated, lacked any identified problem, goals, or interventions to address R241's urinary incontinence despite her having documented urinary incontinence. When interviewed on 3/22/17, at 12:03 p.m. nursing assistant (NA)-B stated R241 was continent of bladder and was not on a toileting program. During interview on 3/23/17, at 11:29 a.m. registered nurse (RN)-A stated R241 did not have a care plan for elimination adding, "I agree" there should be an elimination care plan for R241. RN-A stated it was the nurses and the nurse manager's responsibility to make sure care plans	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 4	2 560		

were completed and updated as needed.

When interviewed on 3/23/17, at 11:40 a.m. registered nurse manager, RN-B stated R241, "Does not" have an incontinence care plan, but there, "Should be" an elimination care plan. He also stated the nurses completed the elimination portion of the care plan and the nurse managers screened and reviewed the care plans as time permitted. RN-B stated it should have been noticed that elimination was not on R241's care plan.

During interview on 3/23/17, at 3:10 p.m. the director of nursing (DON) stated R241 did not have a care plan for urinary incontinence, but R241 should have a urinary care plan. DON stated a urinary care plan would be initiated for R241.

A Resident Assessment, Care Planning, Discharge Planning policy dated 3/22/17, identified all care plans would be person centered and in compliance with professional standards of care. The policy also identified the plan of care would include resident strengths, goals, life history, and needs.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could develop and implement policies and procedures related to the care plan. The DON or designee, could provide training for all nursing staff related to the development of the care plan based on the assessment. The DON or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the care plan to ensure the necessary treatment and services were provided to minimize the development of pressure ulcers for 1 of 1 residents (R1) identified at risk for pressure ulcer. Findings include: R1's quarterly Minimum Data Set (MDS) dated 12/7/16, included diagnosis of diabetes mellitus, paraplegia (paralysis to the legs and lower body), and neurological disease. In addition the MDS indicated R1 needed total assistance of two with bed mobility, toileting and was always incontinent of bowel and not on toileting program and had a suprapubic catheter. R1's care plan dated 2/10/17, indicated she required physical assist with bed mobility, transfers and assist of two to turn resident from side to side or side to back, position in functional alignment using pillows for body extremity support and had air mattress for her to reduce pressure. The care plan directed staff to monitor for incontinence, check and change incontinence product every two hours and as needed.	2 565	Corrected	5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 6	2 565		

During continuous observation on 3/22/17, from 7:03 a.m. to 9:30 a.m.(2 hours and 27 minutes) R1 was lying in her bed with her head turned to the left. At 7:13 a.m. she was still lying in bed with her head turned to the left. At 7:20 a.m. a nurse entered her room raised the head of the bed, checked her blood sugar, gave a supplement and lowered her bed and left the room. At 7:30 a.m. nursing assistant (NA)- E entered her room and assisted her roommate in the bathroom and exited the room at 7:49 a.m. At 7:51 a.m. R1 was lying in bed with her head turned to the left in the same position. At 8:07 a.m. R1 was still lying in the same position, no staff had entered her room. At 8:34 a.m. NA-E brought R1's breakfast tray and assisted her with eating, with the door and curtain opened. At 8:48 a.m. NA-E left her room with R1's breakfast tray. At 9:04 a.m. R1 remained in the same position, in bed watching television. At 9:15 a.m. the resident still remained in the same position, with no staff entering the room to reposition R1 or check for stool incontinence.

During interview 3/22/17, at 9:30 a.m. NA-E stated she was R1's NA and she was last changed by the night shift around 6:50 a.m., 2 hours and 50 minutes earlier. NA-E stated R1 has a special mattress so she doesn't need to to be repositioned every two hours and was on her way to check R1's reposition now.

During interview 3/22/17, at 9:32 a.m. registered nurse (RN)-D stated R1 was incontinent of bowel and had a history of pressure ulcers with fragile skin. She (R1) needed to be turned and repositioned every two hours and the mattress turns her, but they still should go in every two hours and check her for stooling. RN-D stated R1 should not have been left over two hours with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 7 out checking or repositioning, which her care plan identifies. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, and implement effective interventions to	2 830	Corrected	5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8	2 830		

minimize the risk of falls for 1 of 3 residents (R218) who had falls.

Findings include:

R218's quarterly MDS dated 1/23/17, identified R218 had severe cognitive impairment, required extensive assistance with all ADLs except for personal hygiene and had diagnoses which included Alzheimer's and anxiety. The MDS further identified R218 had sustained 2 falls with injury, which was a change from her previous MDS of 10/25/16. The MDS also indicated R218 did not have a current toileting program, was on a trial toileting program but the facility had not documented R218's response to her toileting program within the MDS assessment.

R218's quarterly Minimum Data Set (MDS) dated 10/25/16, identified R218 had severe cognitive impairment, required limited assistance with all activities of daily living (ADLs) except for walking in her room, corridor and personal hygiene. The MDS further identified R218 had one fall with no injury, was on a toileting program and was frequently incontinent of bowel and bladder.

R218's care area assessment (CAA) dated 8/6/16 identified R218 had severe cognitive impairment, wandered and had a decreased ability to understand others and making herself understood. The CAA indicated R218 had decreased visual problems which affected her balance, had a decline in cognitive status, a disruption of her ability to speak, mood problem and increased dependence on staff for ADLs. The CAA further identified R218 had an increased risk for falls related to recent falls, disturbances of balance, gait and positioning ability, infection, pain, contractures, received anti-anxiety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9	2 830		

medication and was incontinent.

Review of R218's Fall Risk Assessment Tools identified the following:

-On 7/28/16, the tool identified R218 was at high risk for falls related to history of recent falls, was taking a high risk medication, had psychological risk factors and had severe cognitive impairment. The document further identified R218 had fall risk factors which included difficulty finding her way around, unsafe and impulsive mobility, unsafe and impulsive transfers, difficulty with orientation to environment in areas between bed, bathroom and dining and reported or known incontinence with urgency, nocturia (night time incontinence), and accidents. Also noted that R218 had repeated falls at the hospital prior to admission to the facility and the fall management strategies included physical therapy (PT), occupational therapy (OT), use call light and wear gripper socks or sturdy shoes.

-On 10/20/16, the tool identified R218 was at high risk for falls related to history of recent falls, was taking 2 high risk medications and had severe cognitive impairment, and R218 had difficulty following instructions or was non-complaint. The tool further identified R218 had fall risk factors which included difficulty finding her way around, was unsafe, impulsive and forgot her walking aid for mobility, was unsafe, impulsive and over reached during transfers, had difficulty with orientation to environment in areas between bed, bathroom and dining and reported or known incontinence with urgency, nocturia (night time incontinence), and accidents. R218's history of falls and action plan for interventions and care plan were left blank.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10	2 830		

-On 1/18/17, the tool identified R218 was at high risk for falls related to history of recent falls and had severe cognitive impairment. The tool further identified R218 was agitated, confused and disoriented, difficulty finding her way around, had risk taking behaviors, forgot her walking aid for mobility, was unsafe, impulsive in her mobility and transfers and over reached, had difficulty with orientation to environment in areas between bed, bathroom and dining and reported or known incontinence with urgency, nocturia (night time incontinence), and accidents. R218's history of falls and action plan for interventions and care plan were left blank.

R218's care plan dated 2/14/17, identified R218 had anxiety, was impulsive, wandered and had frequent falls. Staff were to remind the resident to use call light for assistance with transfers. She required assistance with toileting related to Alzheimer's dementia, urinary and bowel incontinence, and her inability to find the bathroom. The care plan further identified R218 required the physical assistance of 1 staff and a transfer belt for transfers and a rear wheeled walker to ambulate R218 to the bathroom, to meals and in the hallways every 2 hours while awake with black tie shoes on. Staff were not to leave R218 in her wheelchair alone when in her room, Staff were to monitor, provide a safe environment and direct/cue the resident as needed. R218 had a history of fractured ribs and had an impaired sleep pattern related to pain and dementia with wandering. The care plan identified R218's bed was to be in low position when napping or at night related to frequent falls. Staff were to reposition her, toilet her and monitor her every 2 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ___ B. WING ___	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11	2 830		

The facility incident reports and post fall huddle investigation sheets identified the following falls:

1.) Resident Incident Report indicated R218 fell on 8/6/16 at 7:55 a.m. after she attempted to self-transfer and was found on the floor in her room. The report indicated R218 had hit her head on door, 911 was called and R218 was transferred to emergency department. The report identified R218's condition at the time of the incident included fall history, inability to understand directions, confusion/disorientation, and incontinency. There was no indication of when R218 was last toileted, or if she was incontinent at the time of the fall.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 8/8/16, identified R218 complained that her head hurt and was bleeding from the back of her head. The investigation further identified staff applied pressure to R218's head laceration and her vital signs were taken. The report indicated there was a need to update her care plan to keep R218's bed in low position when napping and at night and conduct frequent checks as R218 was impulsive. It did not identify what the frequency in which the facility intervention of "frequent checks" were to be completed.

Review of the clinic referral progress notes identified on 9/29/16 R218 the provider had ordered physical therapy.

On 03/23/17, at 10:40 a.m. clinical manager (CM-A) stated the fall on 8/6/16, at 7:55 p.m. was unwitnessed and thought R218 self-transferred fell from bed and sustained a head laceration which required transfer to the emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 12	2 830		

department and staples to close the laceration. She stated R218's was toileted after dinner and refused toileting five minutes prior to finding her on the floor. The bed was to be in the low position when she's napping and at night because R218 had dementia and was impulsive. Incontinence at the time of the fall was not noted, and R218 was not to be in her room alone.

2.) Resident Incident Report indicated R218 fell on 8/15/16 at 1:30 a.m. after she attempted to self-transfer and was found on the floor in the hallway next to her room. The report identified R218 complained of pain in her ribs and had a 2 (centimeter) cm by 2 cm left elbow abrasion.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 8/15/16, identified R218 fell after she attempted to self-transfer and was found in the hallway outside of her room. The investigation identified R218 was confused, and sustained an abrasion from the fall. There was no indication of any new fall interventions or when R218 had last been toileted, or if she was incontinent.

On 03/23/17, at 10:40 a.m. CM-A stated the fall on 8/15/16, at 1:30 a.m. was unwitnessed and she thought R218 self-transferred from her room into the hallway and sustained a 2 cm x 2 cm laceration to her elbow. She stated incontinence at the time of the fall was not noted, and no new interventions were added.

3.) Resident Incident Report dated 8/20/16, indicated R218 fell on 8/20/16, at 1:25 a.m. after she attempted to self-transfer and was found on the floor in her room. The report further indicated R218 was found propped up on her right elbow with her incontinence pad pulled down off her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 13	2 830		

hips and R218 had both legs in the same opening of the incontinent brief.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 8/20/16, identified R218 fell on 8/20/16 after she attempted to self-transfer and was found on the floor in her room between her bed and her bathroom. The investigation further identified R218 didn't know what she was doing or trying to do when she fell. The investigation indicated R218 was found wandering earlier, not in her room at 11:00 p.m. rounds. She was found on the opposite wing in the dining room, was brought back to her room, toileted and put back in bed. The investigation noted R218 needed frequent checks and was impulsive, unable to redirect, and bed kept in low position. There was no indication of the frequency of these checks.

On 03/23/17, at 10:40 a.m. CM-A stated the fall on 8/20/16, at 1:25 a.m. was unwitnessed but thought R218 self-transferred and was found on the floor between her bed and her bathroom. R218 was incontinent with her pull-up pulled down and both legs in the same opening. R218 was instructed on how to call for help.

4.) Resident Incident Report dated 9/8/16, indicated R218 fell after she attempted to self-transfer on 9/8/16 at 11:46 p.m. and was found on the floor of her room. The report indicated R218 was taken to the bathroom, voided and had no apparent injuries.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 9/9/16, identified R218 fell on 9/8/16 after she attempted to self-transfer and was found on the floor in her room. The investigation identified R218 stated the

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 14	2 830		

water was starting to come out, and had last used the bathroom at 8:05 p.m. The investigation identified R218 frequently wandered at night, had frequent checks and to continue current interventions. There was no specific frequency identified to check on R218.

On 03/23/17, at 10:40 a.m. CM-A stated the fall on 9/8/16, at 11:46 p.m. was unwitnessed and she thought R218 self-transferred and was found on the floor in her room with no apparent injuries. The resident had stated us water was trying to come out at the time of the fall. CM-A stated toileting was an issue and R218 constantly had to go to the bathroom, was fixated on it, and needed to be toileted frequently. The resident had been checked for incontinence at 11:35 p.m. and was dry. There were no new or changes to the interventions for falls.

5.) Resident Incident Report dated 12/13/16, indicated R218 fell after she attempted to self-transfer on 12/13/16 at 2:15 p.m., was found on the floor outside of her bathroom with her head against the closed door. The report identified R218 sustained a 1.5 cm X 1.2 cm abrasion to her left knee.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 12/13/16, identified R218 fell on 12/13/16 after she attempted to self-transfer and was found on the floor in her room. The investigation identified R218 stated she was going to the bathroom when she fell, and R218 was last toileted at 12:45 p.m. The investigation noted there was a need for more frequent monitoring and toileting.

On 03/23/17, at 10:40 a.m. CM-A stated the fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 15	2 830		

Continued From page 15

on 12/13/16, at 2:15 p.m. was from the resident self-transferred trying to go to the bathroom and hit her head on the door. She stated R218 sustained a small abrasion on her scalp and left knee and was last toileted at 12:45 p.m. She completed the investigation and indicated on the form R218 needed more frequent monitoring than every 2 hours and every 1.5 hours for toileting. She did not think she added it to R218's care task sheet for the NA's. If R218 wasn't in the common area they needed to look for her and keep her bed in low position.

6.) Resident Incident Report dated 12/23/16, indicated R218 fell after she attempted to self-transfer on 12/23/16 at 9:46 a.m. and was found on the floor in her room after she was heard screaming. R218 sustained a 4 cm laceration to the right side of her head, her right hand and palm was painful and swollen, she had a 1 cm x 1 cm abrasion to her right knee and a 5 cm x 1 cm abrasion to her right cheek and a 4 cm x 4 cm reddened area to her right elbow. The nurse practitioner was present in the facility and saw the resident after the fall.

Review of R218's nurse practitioner note dated 12/23/16 identified R218 had a 2 inch laceration of her scalp. The area was cleansed, and derma bond applied. She had pain at right wrist, right facial pain and a laceration. At that time a x-ray of the right wrist was ordered.

Review R218's right wrist X-ray completed on 12/23/16 identified a concern with a distal radius fracture without significant displacement.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 12/23/16, identified R218 fell on 12/23/16 after attempting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ____ B. WING ____	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 16	2 830		

to self-transfer, going to the bathroom and was found on the floor in her room outside the bathroom. The investigation indicated R218 was last toileted at 9:15 a.m., 36 minutes before her fall. The investigation further identified R218 had more difficulty to redirect with her wandering and tried to keep her at the main desk to keep an eye on her. The investigation identified R218 self-transferred frequently and was on a walking program 4-6 times per day in the hallways. The investigation noted they would continue current interventions plus more short, frequent walks.

On 03/23/17, at 10:40 a.m. CM-A stated the fall on 12/23/16, at 9:46 a.m. was from the resident self-transferring, went to the bathroom and hit her head. She stated R218 likely wandered back into her room and no one saw or looked for her. The resident was last toileted at 9:15 a.m. before her primary NA left on break. She states she spoke with family (F)-A in January and discussed that she may have been falling because of her "loafer shoes", so they were replaced with black tie shoes.

7.) Resident Incident Report dated 2/14/17, indicated R218 fell after she attempted to self-transfer on 2/14/17 at 5:30 a.m. and was found on the floor in her room. The report identified R218 had no apparent injuries and vital signs were taken.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet dated 2/14/17, identified R218 fell on 2/14/17 after attempted to self-transfer and was found on the floor in her room next to her roommate's wheelchair. The investigation indicated R218 didn't know what she was doing when she fell, and was trying to sleep there. The resident was last checked on at 3:35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 17	2 830		

a.m. was incontinent. The investigation indicated they were unsure how to prevent this fall, her night wandering had decreased and there were no falls on the day shift since they changed her shoes.

On 03/23/17, at 10:40 a.m. CM-A stated the fall on 2/14/16, at 5:30 a.m. from the resident self-transferring, and was found in her room. The resident didn't know why she was there. They had last checked on R218 at 3:35 a.m. and at 5:30 they found her. She wasn't sure how the fall could have been prevented. R218's wandering at night had decreased and she has not fallen on day shift since they changed her shoes. They continue to toilet her every 2 hours and check on her every 2 hours at night. She thought about "bumping" her checks up during the day and they completed a trial toileting plan of every 1.5 hours, but it did not work because she was fixated on going to the bathroom and would have to go again. CM-A stated they were aware the resident liked to stay up until after 11:00 p.m..

During observation on 3/22/17, at 7:03 a.m. R218 was seated in her wheelchair in the hall facing the nurse's station. R218 had a half tray affixed to the right side of her wheelchair with white napkins and a clear plastic cup with water. R218 was continually fidgeting with her green cardigan sweater and the collar of her plaid blue/green shirt. She repeatedly wiped her nose with napkins. She had black rubber sole tie shoes on, her glasses on, and a wander guard on her right ankle.

On 3/23/17, at 10:31 a.m. R218 returned from the beauty shop and NA-A walked with R218 down the hallway and used a gait belt and wheeled walker. R218 wore black rubber sole shoes and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 18 had her glasses on. R218 was hunched over and very confused and needed to be redirected as she tried to turn the walker to go into another resident's room. R218 continued to walk with assistance and took small steps but walked quickly with her head down. R218 became hung up on the mechanical lift in the hallway with her walker. NA-A had to untangle her walker and directed her towards the middle of the hallway. On 3/23/17, at 9:29 a.m. nursing assistant (NA-A) stated R218 was confused and at risk for falls. She stated R218 doesn't stand up as much now as she used to and stated R218 would still leap out of her chair to pick up something from the floor. The last time she saw R218 try to stand up was about a month ago but R218 tries to wiggle out of her bed every time when she awaken in bed. R218 liked to stay up late and they try to keep her occupied but this was difficult, would wander off. On 3/23/17, at 9:46 a.m. registered nurse (RN-C) stated R218 was oriented to person, was at risk for falls and needed to be checked on. They did not like to leave her alone in her room but there was no set schedule for checking on her. On 3/23/17, at 9:56 a.m. NA-C stated R218 was confused, at risk for falling because R218 tried to stand or walk on her own especially at bedtime. NA-C stated R218 liked to stay up until 10:30-11:15 p.m. and if she went to bed at that time she would stay asleep. On 3/23/17, at 10:26 a.m. NA-D stated R218 was confused, could walk but it was unsafe for her to walk on her own. They toilet her every 2 hours and she has become more incontinent this past month.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 19 On 3/23/17, at 10:40 a.m. unit manager (UM)-A stated fall risk assessments were completed quarterly and with a significant change in condition. She confirmed R218 was assessed quarterly on 7/28/16, 10/20/16 and 1/18/16 and did not think they would re-assess a resident after they had recurrent falls or falls with injuries. She felt the residents falls were not related to toileting and there was no pattern of R218's falls. On 3/24/17, at 9:21 a.m. director of nurses (DON) stated they only complete a comprehensive assessments quarterly. After a fall with injury she expected the staff to look at the whole event and look at what was going on surrounding the event to complete their assessment. DON stated she would expect a root cause analysis done with every fall, and felt all of the necessary information was included in their post fall huddle form. She stated after the post fall huddle was completed the UM-A reviewed it and pulled everything together to determine interventions and how they would manage the situation. However, the facility did not identify in the plan of care that R218 liked to stay up after 11:00 p.m., and to keep her up until that time, nor did the facility add a specific increased frequency for checking on R218, besides every two hours to help decrease potential falls. Review of falls policy dated 2/19/17, identified the facility would decrease the risk of further falls or major injury for residents. The policy further identified the facility would pay particular attention to residents who have sustained multiple falls to determine patterns and etiology of falls and they would consult with members of the interdisciplinary team for additional interventions	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 20 and suggestions to decrease risk of falls. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, could provide education to nursing staff about the importance of ensuring assessment is conducted and plans of care followed to ensure residents receive care and supervision in a safe manner related to falls. The DON or designee, could randomly audit to be sure the proper nursing care is provided the residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 900	Corrected	5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 21	2 900		

review the facility failed to provide timely assistance for toileting and repositioning to reduce the risk of pressure ulcer development for 1 of 1 residents (R1) identified at risk of pressure ulcers.

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 12/7/16, included diagnosis of diabetes mellitus, paraplegia (paralysis to the legs and lower body), and a neurological disease. The MDS further indicated she had severe cognitive impairment, no mood problems and did not reject care, needed total assistance of two with bed mobility, toileting, was always incontinent of bowel and was not on a toileting program and had a suprapubic catheter. Further the MDS indicated she was at risk for pressure ulcer development and had a stage 3 pressure ulcer (full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue) which was currently healed, but had moisture related skin damage with a pressure device for bed and chair.

R1's pressure ulcer Care Area Assessment (CAA) dated 6/22/16, indicated she was confined to bed, required regular schedule of turning, needed special mattress, seat cushion to reduce pressure and was only able to mover her right arm and hand.

R1's care plan dated 2/10/17, indicated she required physical assist with bed mobility, transfers and assist of two to turn resident from side to side or side to back, position in functional alignment using pillows for body extremity support and had air mattress for her to reduce pressure. The care plan directed staff to monitor incontinence, check and change incontinence

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 22	2 900		

product every two hours and as needed. The care plan further indicated she had alteration in skin integrity due to edema, obesity, bowel incontinence and progression of left buttock and thigh wound related to increased time in chair with dental appointment and was clinically unavoidable due to fragility of skin. The care plan indicated she had a history of a stage two pressure ulcer on her coccyx that healed on 2/10/17. The care plan further indicated she had a history of being resistive to treatment by not laying back in bed after two hours and following repositioning schedule.

A Tissue Tolerance Testing Review dated 1/30/17, indicated she was at high risk for skin breakdown and she had fragile skin on buttocks and posterior thighs which were currently intact. It directed the staff to continue to reposition every two hours and air mattress to reduce pressure to areas. Care plan was reviewed with no changes. A additional Tissue Testing Review dated 3/5/17, indicated she was still at high risk for skin breakdown and and had no open areas or redness and resident was to be repositioned every two hours.

A Braden Risk Assessment Report (a tool used to assist in predicting pressure risk assessment) dated 3/2/17, indicated R1 responded to verbal commands, but can not always communicate discomfort or need to be turned. The assessment further indicated she has very moist skin, confined to bed, completely immobile, has a problem with friction and shear. Requires moderate to maximum assistance in moving, frequently slides down in bed or chair and required frequent repositioning with maximum assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 23	2 900		

A Wound Assessment Report dated 3/22/17, indicated that on 2/2/17, a stage 3 pressure ulcer was identified on her sacrum which resolved on 2/10/17. She currently has no pressure ulcers.

During continuous observation on 3/22/17, from 7:03 a.m. to 9:30 a.m.(2 hours and 27 minutes) R1 was lying in her bed with her head turned to the left. At 7:13 a.m. she was still lying in bed with her head turned to the left. At 7:20 a.m. a nurse entered her room raised the head of the bed, checked her blood sugar, gave a supplement and lowered her bed and left the room. At 7:30 a.m. nursing assistant (NA)- E entered her room and assisted her roommate in the bathroom and exited the room at 7:49 a.m. At 7:51 a.m. R1 was lying in bed with her head turned to the left in the same position. At 8:07 a.m. R1 was still lying in the same position, no staff had entered her room. At 8:34 a.m. NA-E brought R1's breakfast tray and assisted her with eating, with the door and curtain opened. At 8:48 a.m. NA-E left her room with R1's breakfast tray. At 9:04 a.m. R1 remained in the same position, in bed watching television. At 9:15 a.m. the resident still remained in the same position, with no staff entering the room to reposition R1 or check for stool incontinence.

During interview 3/22/17, at 9:30 a.m. NA-E stated she was R1's NA and that she was last changed by the night shift and thought it was "around 6:50 a.m.," 2 hours and 50 minutes earlier. NA-E stated she has a special mattress so she doesn't need to be reposition every two hours. She was on her way to check R1 and reposition her now.

During interview 3/22/17, at 9:32 a.m. registered nurse (RN)-D stated R1 was incontinent of bowel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 24	2 900		

and had a history of pressure ulcers with fragile skin. She needs to be turned every two hours and the mattress turns her, but they still should go in every two hours and check her for stooling.
RN-D stated R1 should not have been left over two hours with out being checked or repositioned.
RN-D provided a brochure on R1's mattress entitled, Invacare Rotating Low Air Loss Therapy, and stated the mattress is set to change positions every five minutes.

During observation and interview 03/22/17, at 9:40 a.m. NA-E and NA-L were observed providing personal care in R1's room. R1 was changed, she had no stooling in her incontinent product, and no open areas were noted. NA-E stated it always take two staff to change and reposition her.

Review of the Invacare Rotating Low Air Loss Therapy brochure, undated, identified it was a rotational low air loss mattress, that was capable of turning the patient up to a 40 degree angle, and used a lateral rotational mattress system for turning, moving and shifting of the patient is done by the mattress. The brochure further indicated the mattress has settings so the mattress can perform the rotation at set timed intervals and the mattress could be used for treating and healing pressure ulcers. The brochure does not indicate that manually turning and repositioning would not be needed to fully off load pressure from the patient.

During phone interview 3/30/17, at 3:35 p.m. a Invacare customer service representative stated they do not have anything in writing to indicate the Rotating Low Air Loss Therapy device substitutes manually turning and repositioning to off load pressure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 25 A facility Policy And Procedure For The Prevention And Treatment Of Skin Breakdown dated 3/13/12, indicated "It is the policy to properly identify, and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers, to implement preventative measures and to provide appropriate treatment modalities for wounds according to industry standards of care." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding implementation of a care plan to ensure appropriate treatment of pressure ulcers, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview, and document review, the	21995	Corrected	5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 26	21995		

facility failed to immediately report to the State agency (SA) injuries of unknown origin for 1 of 3 residents (R218) reviewed for abuse prohibition.

Findings include:

R218's quarterly Minimum Data Set (MDS) dated 10/25/16, identified R218 had diagnoses of Alzheimer's dementia, anxiety. The MDS identified R218 had severe cognitive impairment, required limited assistance with all activities of daily living (ADLs) except for walking in her room, corridor and personal hygiene. The MDS further identified R218 had one fall without injury.

R218's care plan, printed 3/23/17, identified R218 had Alzheimer dementia, anxiety, impulsivity and wandered. R218's care plan listed various interventions which included to not leave R218 alone in her room in her wheelchair, remind to use her call light for assistance with transfers and bed was in the low position for napping and at night.

Review of the Resident Incident Report dated 12/23/16, indicated R218 had an unwitnessed fall after she attempted to self-transfer on 12/23/16 at 9:46 a.m. and was found on the floor in her room after she was heard screaming. R218 sustained a 4 cm laceration to the right side of her head, her right hand and palm was painful and swollen, she had a 1 cm x 1 cm abrasion to her right knee and a 5 cm x 1 cm abrasion to her right cheek and a 4 cm x 4 cm reddened area to her right elbow. The report identified R218's vital signs were taken, her head laceration was cleansed and closed with skin glue, kerlex applied around her head and ice applied to her wrist. The report listed the physician and family had been notified. However,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 27	21995		

the report lacked documentation the SA had been notified.

Review of R218's nurse practitioner note dated 12/23/16 revealed R218 was seen after she sustained a fall. R218 had a 2 inch laceration of her scalp in the right side of the front of her head. The area was cleansed, and derma bond applied. She had pain at right wrist and right facial pain and a laceration. At that time a x-ray of the right wrist was ordered.

Review R218's right wrist X-ray done on 12/23/16 after the fall findings was a concern for a distal radius fracture without significant displacement.

Review of R218's Post Fall/Incident Huddle Investigation Worksheet, dated 12/26/16, revealed the nurse practitioner had been notified; however, lacked documentation the SA had been notified of the incident.

On 3/22/17 at 2:25 p.m. the director of nursing (DON) confirmed there had been no reports to the SA for R218 since the last survey on 5/16. At 3/23/17 at 4:36 p.m., during a follow up interview with the DON and administrator, the administrator confirmed the current facility policy.

On 3/23/17 at 2:42 p.m. clinical manager (CM)-A stated R218 sustained, after the 12/23/16 fall, a head laceration which the nurse practitioner closed with skin glue and R218 had x-rays done of her right wrist and chest.

Review of the facility undated Abuse Prevention Plan identified an incident was considered an injury of unknown origin when both of the following conditions were met: the source of the injury was not observed by any person or the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: ______ B. WING ______	03/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 28	21995		

source the location of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or locations of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy further identified the facility would report immediately to the Office of Health Facility Complaints incidents of injuries of unknown origin.

SUGGESTED METHOD OF CORRECTION:
The administrator could educate all staff on policies and procedures regarding reports of injuries of unknown origin. The administrator could develop a monitoring system to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.