| DEPARTMENT OF HEALT | TH AND HUMAN | SERVICES | | | CENTERS FOR ME | CDICARE & MEDICAID SERVICES |
|---|-------------------------------|---|---|-------------------------------|--|--|
| | MEDIC | CARE/MEDICA | ID CERTIFIC | CATION A | AND TRANSMITTAL | ID: 8H24 |
| | PART I | - TO BE COMP | LETED BY 1 | THE STAT | TE SURVEY AGENCY | Facility ID: 00611 |
| MEDICARE/MEDICAID PROVIDE (L1) 245012 2.STATE VENDOR OR MEDICAID N (L2) 205240000 | | 3. NAME AND AL (L3) GUARDIAN (L4) 400 EVANS | ANGELS CAN AVENUE | | | TYPE OF ACTION: <u>7</u> (L8) Initial Recertification Termination CHOW |
| (L2) 395040900 | | (L5) ELK RIVER | R, MN | | (L6) 55330 | 5. Validation 6. Complaint 7. On-Site Visit 9. Other |
| EFFECTIVE DATE CHANGE OF ((L9) | | 7. PROVIDER/SU 01 Hospital | 05 HHA | 09 ESRD | <u>02</u> (L7) 13 PTIP 22 CLIA | 8. Full Survey After Complaint |
| DATE OF SURVEY 05/. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | 18/2017 (L34) (L10) | 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF | 06 PRTF 07 X-Ray 08 OPT/SP | 10 NF 11 ICF/IID 12 RHC | 14 CORF 15 ASC 16 HOSPICE | FISCAL YEAR ENDING DATE: (L35) 09/30 |
| 11LTC PERIOD OF CERTIFICATIO | N | 10.THE FACILITY | IS CERTIFIED A | S: | | |
| From (a): To (b): | | Complian | Requirements ce Based On: | | And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN | 6. Scope of Services Limit 7. Medical Director |
| 12.Total Facility Beds | 120 (L18) | | Acceptable POC | | 4. 7-Day RN (Rural SNF) 5. Life Safety Code | 8. Patient Room Size 9. Beds/Room |
| 13.Total Certified Beds | 120 (L17) | | mpliance with Prog and/or Applied Wa | - | * Code: A | (L12) |
| 14. LTC CERTIFIED BED BREAKDO | OWN | | | | 15. FACILITY MEETS | |
| 18 SNF 18/19 SNF 120 | 5 19 SNF | ICF | IID | | 1861 (e) (1) or 1861 (j) (1): | (L15) |
| (L37) (L38) | (L39) | (L42) | (L43) | | | |
| 16. STATE SURVEY AGENCY REM | ARKS (IF APPLICABL | E SHOW LTC CANC | ELLATION DATE | 3): | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY A | PPROVAL Date: |
| Bruce Melchert, HFE, NE | E | | 06/19/2017 | (L19) | Anne Peterson, Enforceme | ent Specialist 08/01/2017 (L20) |
| | PART II - TO BI | E COMPLETED | BY HCFA R | EGIONAI | L OFFICE OR SINGLE STA | ATE AGENCY |
| 19. DETERMINATION OF ELIGIBIL 1. Facility is Eligible to 2. Facility is not Eligit | Participate | | MPLIANCE WITH GHTS ACT: | CIVIL | Statement of Finan Ownership/Control Both of the Above | Interest Disclosure Stmt (HCFA-1513) |
| 2. Tubinty is not Engle | (L21) | | | | | |
| 22. ORIGINAL DATE | 23. LTC AGREEN | IENT 2 | 4. LTC AGREEN | MENT | 26. TERMINATION ACTION: | (L30) |
| OF PARTICIPATION 01/01/1967 | BEGINNING | DATE | ENDING DAT | ГЕ | VOLUNTARY 00 01-Merger, Closure | 05-Fail to Meet Health/Safety |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ Reimbursemen | nt 06-Fail to Meet Agreement |
| 25. LTC EXTENSION DATE: | 27. ALTERNATI | VE SANCTIONS | | | 03-Risk of Involuntary Termination | OTHER |
| | A. Suspension | n of Admissions: | (L44) | | 04-Other Reason for Withdrawal | 07-Provider Status Change 00-Active |
| (L27) | B. Rescind Sus | spension Date: | (L45) | | | |
| 28. TERMINATION DATE: | 29 |). INTERMEDIARY/ | | | 30. REMARKS | |
| | | 03001 | | | | |
| | (L28) | 03001 | | (L31) | | |
| 31. RO RECEIPT OF CMS-1539 | 32 | 2. DETERMINATION | OF APPROVAL D | DATE | Posted 08/07/2017 Co. | |
| | (L32) | 05/23/2017 | | (L33) | DETERMINATION APPRO | OVAL |



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.

Guardian Angels Care Center June 19, 2017 Page 2

Sincerely,

de Comston X

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



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: 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,

ate Comston

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

| | MULTIPLE CONSTRUCTION A. Building | | DATE OF REVISIT | | | |
|---------------------------|--------------------------------------|---------------------------------------|-----------------|----|--|--|
| | B. Wing | Y2 | 5/18/2017 | Y3 | | |
| NAME OF FACILITY | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| GUARDIAN ANGELS CARE CENT | ER | 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).

| ITE | N | DATE | ITEM | | DATE | ITEM | | DATE | |
|--|----------------------------|---------------------------|--|------------------------------|------------|-----------|------------------------------|------------|----|
| Y4 | | Y5 | Y4 | | Y5 | Y4 | | Y5 | |
| ID Prefix | 20560 | Correction | ID Prefix 2056 | 55 | Correction | ID Prefix | 20830 | Correctio | n |
| Reg. # | MN Rule 4658.04 Subp. 2 | 05 Completed | Reg. # MN F Subp | Rule 4658.0405 9. 3 | Completed | Reg. # | MN Rule 4658.0520 Subp. 1 | Complete | ∍d |
| LSC | | 05/03/2017 | LSC | | 05/03/2017 | LSC | | 05/03/201 | 7 |
| ID Prefix | 20900 | Correction | ID Prefix 2199 | 95 | Correction | ID Prefix | | Correctio | n |
| Reg. # | MN Rule 4658.05 Subp. 3 | 25 Completed | Reg. # MN S | 6t. Statute 626.557 I. 4a | Completed | Reg. # | | Complete | ∍d |
| LSC | | 05/03/2017 | LSC | | 05/03/2017 | LSC | | | |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correctio | n |
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| LSC | | | LSC | | - | LSC | | | |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correctio | n |
| Reg. # | | Completed | Reg. # | | Completed | Reg. # | | Complete | ۶d |
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| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correctio | n |
| Reg. # | _ | Completed | Reg. # | | Completed | Reg. # | _ | Complete | ٠d |
| LSC | | | LSC | | _ | LSC | | | |
| | | | | | | | | | |
| REVIEWE STATE AG | | | DATE | SIGNATURE OF S | | | | DATE | |
| | | BF/KJ | 06/19/2017 | | 32 | 2613 | | 05/18/2017 | , |
| REVIEWE 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? | | | | |) | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| | MEDICARE/MEDICAID CERTIFICATIO PART I - TO BE COMPLETED BY THE ST | | | | | | | | |
|---|--|--|---|-------------------------------|---|---|--|--|--|
| MEDICARE/MEDICAID PROVIDER NO (L1) 245012 STATE VENDOR OR MEDICAID NO. (L2) 395040900 S. EFFECTIVE DATE CHANGE OF OWN |). | 3. NAME AND ADDRESS OF FACILITY (L3) GUARDIAN ANGELS CARE CENTER (L4) 400 EVANS AVENUE (L5) ELK RIVER, MN 7. PROVIDER/SUPPLIER CATEGORY | | | (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 | | | |
| (L9) | EKSIII | 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP 22 CLIA | 8. Full Survey After Complaint | | | |
| 6. DATE OF SURVEY 03/24/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | 2017 (L34) (L10) | 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF | 06 PRTF 07 X-Ray 08 OPT/SP | 10 NF 11 ICF/IID 12 RHC | 14 CORF 15 ASC 16 HOSPICE | FISCAL YEAR ENDING DATE: (L35) 09/30 | | | |
| 11. LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 120 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS | 120 (L18) 120 (L17) 19 SNF (L39) S (IF APPLICABLE S | X B. Not in Comp Requirements a ICF (L42) | cce With juirements Based On: cceptable POC bliance with Program ind/or Applied Waiv IID (L43) | n | And/Or Approved Waivers Of Th2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code * Code: B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): | e Following Requirements: 6. Scope of Services Limit 7. Medical Director)8. Patient Room Size 9. Beds/Room (L12) (L15) | | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY A | PPROVAL Date: | | | |
| Michelle Thompso | on, HFE NE | | 05/08/2017 | (L19) | Kate JohnsTon, Pr | ogram Specialist 05/22/2017 (L20) | | | |
| | PART II - TO | BE COMPLETEI | D BY HCFA RI | EGIONAL | OFFICE OR SINGLE STAT | FE AGENCY | | | |
| DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Parti 2. Facility is not Eligible | cipate (L21) | | PLIANCE WITH C ITS ACT: | TVIL | Statement of Finan Ownership/Control Both of the Above | Interest Disclosure Stmt (HCFA-1513) | | | |
| 22. ORIGINAL DATE | 23. LTC AGREEMI | ENT 24 | 4. LTC AGREEM | ENT | 26. TERMINATION ACTION: | (L30) | | | |
| OF PARTICIPATION 01/01/1967 | BEGINNING | DATE | ENDING DAT | E | VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem | 0 INVOLUNTARY 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement | | | |
| (L24) 25. LTC EXTENSION DATE: (L27) | (L41) 27. ALTERNATIVI A. Suspension o B. Rescind Sus | of Admissions: | (L25) (L44) | | 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal | OTHER 07-Provider Status Change 00-Active | | | |
| | D. Reseniu Sus | pension Date. | (L45) | | | | | | |
| 28. TERMINATION DATE: | 29 | . INTERMEDIARY/C | ARRIER NO. | | 30. REMARKS | | | | |
| | (1.20) (1.20) | 03001 | | (1.21) | | | | | |
| 31. RO RECEIPT OF CMS-1539 | (L28) 32 | . DETERMINATION O | DF APPROVAL DA | (L31) TE | Posted 05/23/2017 Co. | | | | |
| | (L32) | | | (L33) | DETERMINATION APPRO | WAI | | | |



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumala Fiske Downing

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: <u>Kamala.Fiske-Downing@state.mn.us</u>

| | - | | | | | | APPROVED |
|--------------------------|--|--|--------------------|-----|---|------|----------------------------|
| | | & MEDICAID SERVICES | | | | | . 0938-0391 |
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | | E SURVEY IPLETED |
| | | 245012 | B. WING | | | 03/ | 24/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 4 | 00 EVANS AVENUE | | |
| GUARDI | AN ANGELS CARE CI | ENTER | | E | ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENT | S | F(| 000 | | | |
| | signature is not req | | | | | | |
| F 225 SS=D | revisit of your facilit validate that substa regulations has bee your verification. | acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with)-(4) INVESTIGATE/REPORT DIVIDUALS | F2 | 225 | | | 5/3/17 |
| | 483.12(a) The facili | ty must- | | | | | |
| | (3) Not employ or o who- | therwise engage individuals | | | | | |
| | | l guilty of abuse, neglect, propriation of property, or court of law; | | | | | |
| | nurse aide registry | ng entered into the State concerning abuse, neglect, atment of residents or their property; or | | | | | |
| | or her professional body as a result of a | ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property. | | | | | |
| | licensing authorities | ate nurse aide registry or any knowledge it has of f law against an employee, | | | | | |
| LABORATORY | / DIRECTOR'S OR PROVID | ER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | | TITLE | | (X6) DATE |
| Electron | ically 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.

PRINTED: 05/17/2017

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | : 05/17/2017 APPROVED : 0938-0391 |
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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | | E SURVEY IPLETED |
| | | 245012 | B. WING | | 03/ | 24/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE CI | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 225 | nurse aide or other (c) In response to a exploitation, or mist (1) Ensure that all a abuse, neglect, explicitly injuries of misappropriation of reported immediate after the allegation cause the allegation cause the allegation serious bodily injury the events that cause abuse and do not rethe administrator of officials (including to adult protective serior for jurisdiction in lor accordance with Staprocedures. (2) Have evidence the thoroughly investigation is in protective and with State law, including the administrator or his representative and with State law, including the administrator or his representative and with State law, including the alleged violation or misting the alleged violation or the administrator or his representative and with State law, including the alleged violation or misting the alleged vi | e unfitness for service as a facility staff. Illegations of abuse, neglect, reatment, the facility must: Illeged violations involving ploitation or mistreatment, unknown source and resident property, are ely, but not later than 2 hours is made, if the events that n involve abuse or result in <i>v</i> , or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established that all alleged violations are ated. potential abuse, neglect, creatment while the rogress. Its of all investigations to the or her designated to other officials in accordance using to the State Survey orking days of the incident, and on is verified appropriate ust be taken. | F 225 | | | |
| | This REQUIREMEN | NT is not met as evidenced | | | | |

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| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | FORM APPROVE OMB NO. 0938-039 |
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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 245012 | B. WING | | 03/24/2017 |
| | PROVIDER OR SUPPLIER | ENTER | | STREET ADDRESS, CITY, STATE, ZIP 400 EVANS AVENUE ELK RIVER, MN 55330 | CODE |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE COMPLÉTION E APPROPRIATE DATE |
| F 225 | facility failed to imm agency (SA) injurie residents (R218) ref Findings include: R218's quarterly Mi 10/25/16, identified Alzheimer's demen identified R218 had required limited ass daily living (ADLs) e corridor and persor identified R218 had R218's care plan, p had Alzheimer dem wandered. R218's d interventions which alone in her room in use her call light for bed was in the low night. Review of the Resin 12/23/16, indicated after she attempted 9:46 a.m. and was after she was heard 4 cm laceration to t right hand and paln had a 1 cm x 1 cm a 5 cm x 1 cm abra cm x 4 cm reddene report identified R2 head laceration was | Age 2 W, and document review, the hediately report to the State is of unknown origin for 1 of 3 eviewed for abuse prohibition. A severe cognitive impairment, sistance with all activities of except for walking in her room, hal hygiene. The MDS further d one fall without injury. A severe cognitive impairment, sistance with all activities of except for walking in her room, hal hygiene. The MDS further d one fall without injury. A severe cognitive impairment, sistance with all activities of except for walking in her room, hal hygiene. The MDS further d one fall without injury. A severe cognitive impulsivity and care plan listed various included to not leave R218 in her wheelchair, remind to r assistance with transfers and position for napping and at dent Incident Report dated R218 had an unwitnessed fall d to self-transfer on 12/23/16 at found on the floor in her room d screaming. R218 sustained a he right side of her head, her in was painful and swollen, she abrasion to her right cheek and a 4 ed area to her right elbow. The 18's vital signs were taken, her s cleansed and closed with oplied around her head and ice | | Guardian Angels Care Ce every attempt to investigate vulnerable adult concerns the state authorities where state and federal regulation As noted on 2567, resident attempting to self-transfer floor sustaining injury. The noted changes in level of co or mentation. As noted, Guardian Angels policy states an incident wa an injury of unknown origin the following conditions we source of the injury was no any person or the source the the injury could not be explice resident and the injury is subecause of the extent of the locations of the injury or the injuries observed at one patime or the incidence of injiin The policy further identified would report immediately the Health Facility Complaints injuries of unknown origin. Mandatory training will be of all facility staff regarding Wi Reporting. Training will inc our Vulnerable Adult policy emphasis on requirements resident injuries. The Nurse Unit Manager of Nurse (on-call nurse) will be falls with injury at the time | e all potential and report to required by n. t #218 was and fell to the ere were no consciousness a Care Center as considered of when both of ere met: the ot observed by he location of lained by the uspicious ne injury or e number of articular point in uries over time. d the facility o the Office of incidents of conducted for ulnerable Adult lude all areas of c, with particular s for reporting |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00611

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| STATEMEN | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION IG | (X3) DAT | 0938-039 E SURVEY PLETED |
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| | | 245012 | B. WING | G | 02/ | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | | 24/2017 |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETIO DATE |
| F 225 | physician and famil the report lacked dinotified. Review of R218's 12/23/16 revealed sustained a fall. R2 her scalp in the righ The area was clear She had pain at rig and a laceration. A wrist was ordered. Review R218's righ after the fall finding radius fracture with Review of R218's F Investigation Works revealed the nurse however, lacked do notified of the incid On 3/22/17 at 2:25 (DON) confirmed th the SA for R218 sir 3/23/17 at 4:36 p.m with the DON and a confirmed the curre On 3/23/17 at 2:42 stated R218 sustai head laceration wh closed with skin glu of her right wrist an Review of the facili | The report listed the ly had been notified. However, ocumentation the SA had been nurse practitioner note dated R218 was seen after she the had a 2 inch laceration of nt side of the front of her head. nsed, and derma bond applied. ht wrist and right facial pain t that time a x-ray of the right at wrist X-ray done on 12/23/16 is was a concern for a distal out significant displacement. Post Fall/Incident Huddle sheet, dated 12/26/16, practitioner had been notified; ocumentation the SA had been ent. p.m. the director of nursing here had been no reports to nee the last survey on 5/16. At n., during a follow up interview administrator, the administrator ent facility policy. p.m. clinical manager (CM)-A ned, after the 12/23/16 fall, a ich the nurse practitioner ue and R218 had x-rays done | F 22 | occurrence. A determination at that time of the need to su to the state authority based federal regulation and facility. Nurse Unit Managers will retheir respective units during worked. A review of all falls will be conthe interdisciplinary team an each week to ensure complination and Vulnerable A Results of these reviews will to the QAPI meeting which i other month. Ongoing monitoring for Vuln Reporting will be the respondirector of Nursing | ubmit a report on state and y policy. view falls for all shifts onducted with minimum of ance with fall dult reporting. be reported s held every erable Adult | |

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| | | AND HUMAN SERVICES | | | | FORM | 05/17/2017 APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245012 | B. WING | | | 03/: | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE CI | ENTER | | | 00 EVANS AVENUE LK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 F 226 SS=D | injury of unknown of following conditions injury was not obse source the location explained by the resulation of the injurice of the injurice of the injurice of the injurice of the office of the atthe of injuries of unknow 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES 483.12 (b) The facility must written policies and (1) Prohibit and pre exploitation of resid resident property, (2) Establish policie investigate any succional (3) Include training §483.95 (c) Abuse, neglect, the freedom from a requirements in § 4 provide training to t educates staff on- | t develop and implement procedures to solutions and misappropriation of | | 225 | | | 5/3/17 |

| | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUI | TIPLE CONSTRUCTION | | <u>0938-039</u> E SURVEY |
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| | OF CORRECTION | IDENTIFICATION NUMBER: | | NG | | PLETED |
| | | 245012 | B. WING | | | 24/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZI | PCODE | |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETIO DATE |
| F 226 | Continued From pa | ige 5 | F 2 | 26 | | |
| | exploitation, and mi property as set forth | isappropriation of resident h at § 483.12. | | | | |
| | | or reporting incidents of abuse, n, or the misappropriation of | | | | |
| | prevention. | anagement and resident abuse | | | | |
| | Based on interview facility failed to implimmediate reporting injuries of unknown | w, and document review, the lement their abuse policy for g to the State agency (SA) origin for 1 of 3 residents r abuse prohibition. | | Guardian Angels Care C every attempt to investiga vulnerable adult concerns the state authorities wher state and federal regulation | te all potential and report to e required by | |
| | Plan identified an ir injury of unknown o | ty undated Abuse Prevention ncident was considered an prigin when both of the | | As noted on 2567, reside attempting to self-transfe floor sustaining injury. Th noted changes in level of or mentation. | r and fell to the here were no | |
| | injury was not obse source the location explained by the re- suspicious because locations of the inju observed at one pa incidence of injuries identified the facility the Office of Health of injuries of unknow | C | | As noted, Guardian Ange policy states an incident w an injury of unknown orig the following conditions w source of the injury was r any person or the source the injury could not be ex resident and the injury is because of the extent of t locations of the injury or t injuries observed at one p | vas considered in when both of vere met: the not observed by the location of plained by the suspicious he injury or he number of particular point in | |
| | 10/25/16, identified Alzheimer's demen identified R218 had | nimum Data Set (MDS) dated R218 had diagnoses of tia, anxiety. The MDS I severe cognitive impairment, sistance with all activities of | | time or the incidence of in The policy further identifie would report immediately Health Facility Complaints injuries of unknown origin | ijuries over time. ed the facility to the Office of s incidents of | |

Facility ID: 00611

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| | | & MEDICAID SERVICES | | | | <u>MB NO.</u> | |
|--------------------------|--|--|---------------------|----|--|--|---------------------------|
| | OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | · · · | E SURVEY PLETED |
| | | 245012 | B. WING | | | 03/2 | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | | | 00 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIZ TAG | × | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETIO DATE |
| F 226 | daily living (ADLs) of corridor and persor- identified R218 had R218's care plan, p had Alzheimer dem wandered. R218's interventions which alone in her room in use her call light fo bed was in the low night. Review of the Resi 12/23/16, indicated after she attempted 9:46 a.m. and was after she was heard 4 cm laceration to the right hand and path had a 1 cm x 1 cm a 5 cm x 1 cm abraic cm x 4 cm reddene report identified R2 head laceration was skin glue, kerlex ap applied to her wrist physician and famil the report lacked do notified. Review of R218's 12/23/16 revealed sustained a fall. R2 her scalp in the right The area was cleare She had pain at right | age 6 except for walking in her room, hal hygiene. The MDS further d one fall without injury. Derinted 3/23/17, identified R218 mentia, anxiety, impulsivity and care plan listed various included to not leave R218 in her wheelchair, remind to r assistance with transfers and position for napping and at dent Incident Report dated R218 had an unwitnessed fall d to self-transfer on 12/23/16 at found on the floor in her room d screaming. R218 sustained a the right side of her head, her in was painful and swollen, she abrasion to her right knee and asion to her right cheek and a 4 ed area to her right elbow. The 18's vital signs were taken, her s cleansed and closed with oplied around her head and ice . The report listed the by had been notified. However, ocumentation the SA had been nurse practitioner note dated R218 was seen after she 18 had a 2 inch laceration of it side of the front of her head. nsed, and derma bond applied. ht wrist and right facial pain t that time a x-ray of the right | F 2 | 26 | Mandatory training will be conducte all facility staff regarding Vulnerable Reporting. Training will include all a our Vulnerable Adult policy, with pa emphasis on requirements for repo- resident injuries. The Nurse Unit Manager or Resou Nurse (on-call nurse) will be notifie falls with injury at the time of their occurrence. A determination will be at that time of the need to submit a to the state authority based on stat federal regulation and facility policy Nurse Unit Managers will review fa their respective units during all shif worked. A review of all falls will be conducte the interdisciplinary team a minimu each week to ensure compliance w notification and Vulnerable Adult re Results of these reviews will be rep to the QAPI meeting which is held other month. Ongoing monitoring for Vulnerable Reporting will be the responsibility Director of Nursing | e Adult areas of rticular orting rce d of all e made report e and r. Ils for ts ed with m of <i>v</i> ith fall porting. ported every Adult | |

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| | - | AND HUMAN SERVICES | | | FORM | APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | (X3) DATE | E SURVEY PLETED |
| | | 245012 | B. WING | | 03/: | 24/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE CI | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | Continued From pa | ge 7 | F 22 | 6 | | |
| | after the fall finding | t wrist X-ray done on 12/23/16 s was a concern for a distal out significant displacement. | | | | |
| | Investigation Works revealed the nurse | Post Fall/Incident Huddle sheet, dated 12/26/16, practitioner had been notified; ocumentation the SA had been ent. | | | | |
| | (DON) confirmed th to the SA for R218 s At 3/23/17 at 4:36 p interview with the D | p.m. the director of nursing here had been no reports sent since the last survey on 5/16. o.m., during a follow up ON and administrator, the med the current facility policy. | | | | |
| F 279 SS=D | stated R218 sustain head laceration whi |)(1) DEVELOP | F 27 | 9 | | 5/3/17 |
| | assessments comp months in the resideresults of the asses | nust maintain all resident deted within the previous 15 ent's active record and use the asments to develop, review dent's comprehensive care | | | | |
| | 483.21 (b) Comprehensive | Care Plans | | | | |

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| | | AND HUMAN SERVICES | | | FORM | 05/17/2017 APPROVED 0938-0391 |
|--------------------------|--|--|---------------------|---|-----------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE | E SURVEY PLETED |
| | | 245012 | B. WING | | 03/2 | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | | 100 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 279 | (1) The facility musicomprehensive pereach resident, consist forth at §483.10 includes measurable to meet a resident's and psychosocial n comprehensive assist care plan must des (i) The services that or maintain the resiphysical, mental, arrequired under §483.24, §48 provided due to the under §483.10, incluter at ment under §483.10, incluter at the service provide as a result recommendations. findings of the PAS, rationale in the resigned outcomes. (B) The resident's pfuture discharge. Faw hether the resident | t develop and implement a son-centered care plan for sistent with the resident rights 0(c)(2) and §483.10(c)(3), that le objectives and timeframes a medical, nursing, and mental eeds that are identified in the sessment. The comprehensive cribe the following - t are to be furnished to attain ident's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. | F 279 | | | |

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| | OF DEFICIENCIES | | | | | 0938-039 | |
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| | F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | E SURVEY PLETED | |
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| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CC | DDE | | |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | | |
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| F 279 | Continued From pa | ae 9 | F 27 | 79 | | | |
| | | ies and/or other appropriate | | | | | |
| | plan, as appropriate requirements set for section. | s in the comprehensive care e, in accordance with the orth in paragraph (c) of this NT is not met as evidenced | | | | | |
| | by: Based on interview facility failed to dev | v and document review, the elop a comprehensive care ileting program for 1 of 2 | | Guardian Angels Care Cent to develop and maintain a co plan of care that reflects the needs of each resident. | mprehensive | | |
| | Findings include: R241's admission M dated 11/29/16, ide intact, had a diagno one side of the bod incontinent of urine | Minimum Data Set (MDS) ntified R241 was cognitively osis of hemiplegia (paralysis to y), was occasionally (less than seven episodes of required extensive assistance olete toileting. | | Resident #241's plan of care updated to reflect her level o incontinence and necessary interventions to minimize inc A 100% audit will be conduct current residents to determin accuracy of the care plans for including measures to reduc urinary incontinence. | her level of urinary necessary staff inimize incontinence. be conducted of all to determine the are plans for toileting, es to reduce episodes of | | |
| | identified a three da was completed on 11/25/16, and R241 retrained and incom 51-75% (percent). indicated staff to, " Asks for bedpan." | ta Summary dated 11/30/16, ay bladder/toileting collection was able to be partially tinence episodes decreased The comment section Toilet Q (every) 2 hrs (hours). | | Education and training will be all licensed nurses regarding and maintaining the accurac of care, including the need to timely updates. A review schedule has been unit nurses that will include s monitoring of each resident's twice weekly for transitional of | developing y of the plan provide developed for pecific s care plan | | |
| | R241's Care Area Assessment (CAA) Summary dated 12/2/16, identified urinary incontinence as a triggered area and indicated, "New Care Plan Started." | | | residents, weekly for long-ter residents. | | | |

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| | RS FOR MEDICARE | & MEDICAID SERVICES | (X2) MUUTI | PLE CONSTRUCTION | | 0938-039 SURVEY |
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| | OF CORRECTION | IDENTIFICATION NUMBER: | | | | PLETED |
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| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C | ODE | |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETIO DATE |
| F 279 | R241's quarterly M R241 was frequent episodes of urinary episode of continer program had been since urinary incont facility. However, t response to the tria also indicated R24' program or trial to r incontinence. R241's Transitional lacked any identifie interventions to add incontinence despit urinary incontinence When interviewed of nursing assistant (N continent of bladde program. During interview on registered nurse (R a care plan for elim should be an elimin RN-A stated it was manager's respons were completed an When interviewed of registered nurse m "Does not" have an there, "Should be" also stated the nurs portion of the care screened and revie | DS dated 2/16/17, identified ly incontinent (seven or more incontinence, but at least one it voiding) and a trial toileting attempted on admission or tinence was noted in the he MDS did not identify R241's at toileting program. The MDS 1 was not on a toileting manage R241's urinary I Unit Care Plan, undated, ed problem, goals, or dress R241's urinary te her having documented | F 27 | the plan of care during each reference period. Identified be reported to the Director of A 5% audit of care plan acc conducted each week by th Manager or designee. Res audits will be reviewed by th Nursing and reported at the every other month. Ongoing monitoring for care development and accuracy responsibility of the Nurse L and the Director of Nursing. | concerns will of Nursing. uracy will be e Nurse Unit ults of these he Director of QAPI meeting e plan will be the Jnit Managers | |

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| | - | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | 05/17/2017 APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | (X3) DAT | E SURVEY IPLETED |
| | | 245012 | B. WING | | 03/ | 24/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE CE | INTER | | ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 279 F 282 SS=D | plan. During interview on director of nursing (have a care plan for R241 should have a stated a urinary care R241. A Resident Assesser Discharge Planning identified all care pla and in compliance w care. The policy als would include reside history, and needs. 483.21 (b) (3) (ii) SEF PERSONS/PER CA (b) (3) Comprehensi The services provid as outlined by the c must- (ii) Be provided by c accordance with ea care. This REQUIREMEN by: Based on observat review, the facility fa plan to ensure the r services were provid development of pre- | tion was not on R241's care 3/23/17, at 3:10 p.m. the DON) stated R241 did not r urinary incontinence, but a urinary care plan. DON e plan would be initiated for nent, Care Planning, policy dated 3/22/17, ans would be person centered with professional standards of so identified the plan of care ent strengths, goals, life RVICES BY QUALIFIED ARE PLAN ve Care Plans ed or arranged by the facility, omprehensive care plan, ualified persons in ch resident's written plan of IT is not met as evidenced ion, interview, and document ailed to implement the care necessary treatment and | F 279 | | tate The | 5/3/17 |
| | | | | | | |

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| | - | AND HUMAN SERVICES | | | O | | APPROVE 0938-039 |
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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | · · / | SURVEY PLETED |
| | | 245012 | B. WING _ | | | 03/2 | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EL | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETIO DATE |
| F 282 | Continued From pa | age 12 | F 28 | | maintained through use of a low air | loss | |
| | 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 incontinen of bowel and not on toileting program and had a suprapubic catheter. | | | | lateral rotation mattress. The mattress allows for repositioning of the resident or 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. | | |
| | 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 suppor 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. | | | Staff have been retrained regarding need to reposition resident #1 man directed by the plan of care. Staff will be retrained regarding the to manually reposition all residents air loss mattresses in accordance w plan of care. | need on low with the | | |
| | 7:03 a.m. to 9:30 a R1 was lying in her the left. At 7:13 a.r with her head turne nurse entered her r bed, checked her b supplement and low room. At 7:30 a.m. entered her room a the bathroom and e At 7:51 a.m. R1 wa turned to the left in a.m. R1 was still lyi staff had entered h brought R1's break eating, with the door | | | | A 10% audit of turning and reposition residents on low air loss mattresses be conducted each week. Results of these audits will be reviet Nurse Unit Managers and Director Nursing. Results will be reported a QAPI meeting every other month. Ongoing monitoring for compliance turning and repositioning schedules the responsibility of the Nurse Unit Managers. | s will ewed by of t each e with | |

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| | | AND HUMAN SERVICES | | | | FORM | 05/17/2017 APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | (X3) DAT | E SURVEY PLETED |
| | | 245012 | B. WING | | | 03/2 | 24/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | TREET ADDRESS, CITY, STATE, ZI | P CODE | | |
| GUARDI | AN ANGELS CARE CI | ENTER | | 00 EVANS AVENUE LK RIVER, MN 55330 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ION SHOULD | BE | (X5) COMPLETION DATE |
| F 282 F 314 SS=D | bed watching televis still remained in the entering the room to stool incontinence. During interview 3/2 stated she was R1's changed by the nigh hours and 50 minut has a special mattro be repositioned ever way to check R1's r During interview 3/2 nurse (RN)-D stated and had a history of skin. She (R1) need repositioned every to turns her, but they shours and check her R1 should not have out checking or rep- identifies. 483.25(b)(1) TREAT PREVENT/HEAL P (b) Skin Integrity - (1) Pressure ulcers comprehensive ass facility must ensure (i) A resident receive professional standa pressure ulcers and ulcers unless the in | sion. At 9:15 a.m. the resident e same position, with no staff o reposition R1 or check for 22/17, at 9:30 a.m. NA-E s NA and she was last ht shift around 6:50 a.m., 2 tes earlier. NA-E stated R1 ess so she doesn't need to to ery two hours and was on her reposition now. 22/17, at 9:32 a.m. registered d R1 was incontinent of bowel f pressure ulcers with fragile ded to be turned and two hours and the mattress still should go in every two er for stooling. RN-D stated e been left over two hours with ositioning, which her care plan TMENT/SVCS TO RESSURE SORES | F 282 | | | | 5/3/17 |

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| | | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPI | | | 0938-039 |
|--------------------------|---|--|--------------------|------|---|---|----------------------------|
| | F CORRECTION | IDENTIFICATION NUMBER: | | | | | PLETED |
| | | 245012 | B. WING | | | 03/2 | 24/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE CI | ENTER | | | 00 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 314 | necessary treatmer professional standa healing, prevent info from developing. This REQUIREMEN by: Based on observat review the facility fa assistance for toilet reduce the risk of p 1 of 1 residents (R1 ulcers. Findings include: R1's quarterly Minin 12/7/16, included di paraplegia (paralysi and a neurological o indicated she had s no mood problems needed total assista toileting, was alway was not on a toiletir suprapubic catheter she was at risk for p and had a stage 3 p skin loss involving o subcutaneous tissu but had moisture re pressure device for R1's pressure ulcer (CAA) dated 6/22/1 | num Data Set (MDS) dated iagnosis of diabetes mellitus, is to the legs and lower body), disease. The MDS further evere cognitive impairment, and did not reject care, ance of two with bed mobility, s incontinent of bowel and mg program and had a r. Further the MDS indicated pressure ulcer development is on the legs and lower body), disease. The MDS further evere cognitive impairment, and contreject care, ance of two with bed mobility, s incontinent of bowel and mg program and had a r. Further the MDS indicated pressure ulcer (full thickness damage to, or necrosis of, e) which was currently healed, dated skin damage with a | F 3 | 314 | Guardian Angels Care Center strive maintain the integrity of all resident skin, promote healing of all pressure ulcers. Resident #1 has very fragile skin. T integrity of her skin was restored an maintained through use of a low air lateral rotation mattress. The mattre allows for repositioning of the reside a frequent basis (up to every 5 minu reducing pressure on any portion of body. Staff have been retrained regarding need to reposition resident #1 manu directed by the plan of care. Staff will be retrained regarding the to manually reposition all residents of air loss mattresses in accordance w plan of care. Education and training will be held for facility nurses and nursing assistant regarding prevention of pressure ulco including necessity of turning and repositioning. | s The d loss ess ent on ites), her the ially as need on low rith the or all s | |
| | needed special mat | ttress, seat cushion to reduce only able to mover her right | | | A review of any residents with press ulcers will be conducted each week. Focus will include any newly acquire | | |

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| | <u>RS FOR MEDICARE</u> OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | PLE CONSTRUCTION | | 0938-039 SURVEY |
|--------------------------|---|---|---------------------|--|---|----------------------------|
| AND PLAN C | FCORRECTION | IDENTIFICATION NUMBER: | | G | | PLETED |
| | | 245012 | | | 03/2 | 24/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE | | |
| GUARDI | AN ANGELS CARE CI | ENTER | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 314 | Continued From pa | ge 15 | F 314 | 4 | | |
| | R1's care plan date required physical as transfers and assis side to side or side alignment using pill and had air mattres The care plan direct incontinence, check product every two h care plan further ind skin integrity due to incontinence and put thigh wound related with dental appointr unavoidable due to indicated she had a pressure ulcer on h 2/10/17. The care p a history of being re laying back in bed a repositioning sched A Tissue Tolerance indicated she was a and she had fragile posterior thighs whi directed the staff to two hours and air m areas. Care plan wa A additional Tissue indicated she was a breakdown and and | d 2/10/17, indicated she ssist with bed mobility, at of two to turn resident from to back, position in functional ows for body extremity support as for her to reduce pressure. ted staff to monitor and change incontinence nours and as needed. The dicated she had alteration in e edema, obesity, bowel rogression of left buttock and to increased time in chair ment and was clinically fragility of skin. The care plan a history of a stage two er coccyx that healed on plan further indicated she had esistive to treatment by not after two hours and following | | pressure ulcers/residents admitted pressure ulcers, current treatment utilized and improvement/deterior all pressure ulcers/injuries. A 10% audit of all residents with pressure ulcers will be conducted weekly be nurses to monitor turning and repositioning is occurring as spect the plan of care. Results of these will be reviewed by nurse unit materia and the director of nursing. Result reported at the QAPI meetings even months. A report of all pressure ulcers will made at QAPI meetings every oth month. Ongoing monitoring of all pressure will be conducted by Nurse Unit Material Director of Nursing. | ts ration of pressure by unit sified by audits nagers its will be very two be her | |
| | assist in predicting | essment Report (a tool used to pressure risk assessment) tted R1 responded to verbal | | | | |

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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | (X3) DA | 0. 0938-039 TE SURVEY MPLETED |
|--------------------------|---|--|---------------------|--|-------------|-------------------------------------|
| | | 245012 | B. WING | | 03 | /24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C | ODE | |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETIC DATE |
| F 314 | discomfort or need assessment further skin, confined to be problem with friction moderate to maxim frequently slides do required frequent re assistance. A Wound Assessme indicated that on 2/ was identified on he 2/10/17. She currer During continuous of 7:03 a.m. to 9:30 a. R1 was lying in her the left. At 7:13 a.m with her head turne nurse entered her r bed, checked her b supplement and low room. At 7:30 a.m. entered her room a the bathroom and e At 7:51 a.m. R1 wa turned to the left in a.m. R1 was still lyi staff had entered her brought R1's break eating, with the do a.m. NA-E left her r At 9:04 a.m. R1 rer bed watching televi still remained in the | n not always communicate to be turned. The indicated she has very moist ed, completely immobile, has a n and shear. Requires turn assistance in moving, own in bed or chair and epositioning with maximum ent Report dated 3/22/17, 2/17, a stage 3 pressure ulcer er sacrum which resolved on htly has no pressure ulcers. observation on 3/22/17, from .m.(2 hours and 27 minutes) bed with her head turned to n. she was still lying in bed id to the left. At 7:20 a.m. a room raised the head of the | F3 | | | |

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| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | FORM | 05/17/2017 APPROVED 0938-0391 |
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| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE | E SURVEY PLETED |
| | | 245012 | B. WING | | 03/: | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 314 | During interview 3/2 stated she was R1' changed by the nig "around 6:50 a.m.," earlier. NA-E state so she doesn't nee hours. She was on reposition her now. During interview 3/2 nurse (RN)-D state and had a history o skin. She needs to the mattress turns f every two hours an RN-D stated R1 sh two hours with out I RN-D provided a br entitled, Invacare R and stated the matt every five minutes. During observation 9:40 a.m. NA-E and providing personal changed, she had r product, and no op stated it always tak reposition her. Review of the Invac Therapy brochure, rotational low air los of turning the patier and used a lateral r turning, moving and by the mattress. Th the mattress has se | 22/17, at 9:30 a.m. NA-E 's NA and that she was last that shift and thought it was " 2 hours and 50 minutes ed she has a special mattress d to be reposition every two her way to check R1 and 22/17, at 9:32 a.m. registered ed R1 was incontinent of bowel of pressure ulcers with fragile be turned every two hours and her, but they still should go in id check her for stooling. would not have been left over being checked or repositioned. rochure on R1's mattress Rotating Low Air Loss Therapy, tress is set to change positions | F 314 | | | |

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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | (X3) DAT | . 0938-039 E SURVEY IPLETED |
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| | | | A. BUILDIN | G | 001 | |
| | | 245012 | B. WING | | 03/ | 24/2017 |
| | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE | | |
| GUARDI | AN ANGELS CARE C | ENTER | | ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETIO DATE |
| F 314 | pressure ulcers. Th that manually turnir be needed to fully o patient. | ige 18 used for treating and healing the brochure does not indicate ing and repositioning would not off load pressure from the view 3/30/17, at 3:35 p.m. a | F 31 | 4 | | |
| | they do not have ar Rotating Low Air Lo manually turning ar pressure. A facility Policy And | service representative stated hything in writing to indicate the bass Therapy device substitutes and repositioning to off load d Procedure For The atment Of Skin Breakdown | | | | |
| F 323 SS=D | properly identify, ar clinical conditions in skin integrity, and p preventative measu treatment modalitie industry standards | 1)-(3) FREE OF ACCIDENT | F 32 | 3 | | 5/3/17 |
| | (d) Accidents. The facility must er | sure that - | | | | |
| | | vironment remains as free rds as is possible; and | | | | |
| | | eceives adequate supervision ices to prevent accidents. | | | | |
| | appropriate alterna bed rail. If a bed or | e facility must attempt to use tives prior to installing a side or side rail is used, the facility t installation, use, and | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | F | FORM / | 05/17/2017 APPROVED 0938-0391 |
|--------------------------|---|---|---------------------|----|---|--|-------------------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION (X | | E SURVEY PLETED |
| | | 245012 | B. WING _ | | | 03/2 | 24/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE CI | ENTER | | | 0 EVANS AVENUE ∟K RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 323 | to the following eler (1) Assess the resid from bed rails prior (2) Review the risks the resident or resid informed consent p (3) Ensure that the appropriate for the This REQUIREMEN by: Based on observat review, the facility fa assess, and implem minimize the risk of (R218) who had fall Findings include: R218's quarterly MI R218 had severe co extensive assistance personal hygiene at included Alzheimer' further identified R2 injury, which was a MDS of 10/25/16. T did not have a curret trial toileting progra documented R218's program within the R218's quarterly Mi 10/25/16, identified impairment, require | d rails, including but not limited nents. dent for risk of entrapment to installation. s and benefits of bed rails with dent representative and obtain rior to installation. bed's dimensions are resident's size and weight. NT is not met as evidenced ion, interview, and document ailed to comprehensively nent effective interventions to falls for 1 of 3 residents s. DS dated 1/23/17, identified ognitive impairment, required are with all ADLs except for nd had diagnoses which s and anxiety. The MDS 218 had sustained 2 falls with change from her previous he MDS also indicated R218 ent toileting program, was on a m but the facility had not s response to her toileting | F 3 | 23 | Guardian Angels strives to minimize for all residents. A comprehensive assessment for fall been performed for resident #218. Ongoing monitoring of interventions continues. Education and training on fall prevent and assessment will be conducted fo licensed nurses. The Nurse Unit Manager or Resource Nurse (on-call nurse) will be notified of falls with injury at the time of their occurrence. A determination will be r at that time of the need to submit a re to the state authority based on state a federal regulation. Nurse Unit Managers will review falls their respective units during all shifts worked. A review of all falls will be conducted | Is has tion or all e of all made eport and s for | |

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| CENTE | RS FOR MEDICARE | AND HUMAN SERVICES | | | | OMB | NO. 0938-039 | | |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245012 | | | | IPLE CONSTRUC | | | DATE SURVEY COMPLETED | | |
| | | B. WING | | | | 03/24/2017 | | | |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | ODE | | | |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EVANS AN ELK RIVER, | - | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EAC | ROVIDER'S PLAN OF CON H CORRECTIVE ACTION S-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETIO DATE | | |
| F 323 | in her room, corrido MDS further identifi injury, was on a toil frequently incontine R218's care area a identified R218 had wandered and had understand others a understood. The Ca decreased visual pr balance, had a dec disruption of her ab and increased depe CAA further identifie for falls related to re balance, gait and p pain, contractures, medication and was Review of R218's F identified the follow -On 7/28/16, the too risk for falls related taking a high risk m risk factors and had The document furth factors which includ around, unsafe and and impulsive trans to environment in a and dining and repo with urgency, noctu and accidents. Als repeated falls at the the facility and the factors | or and personal hygiene. The ied R218 had one fall with no eting program and was ent of bowel and bladder. ssessment (CAA) dated 8/6/16 d severe cognitive impairment, a decreased ability to and making herself AA indicated R218 had roblems which affected her line in cognitive status, a bility to speak, mood problem endence on staff for ADLs. The ed R218 had an increased risk ecent falls, disturbances of ositioning ability, infection, received anti-anxiety s incontinent. | F 3 | the interce each wee notification Results of to the QA other mo Ongoing reporting | disciplinary team a ek to ensure compl on and Vulnerable / of these reviews wil API meeting which onth. monitoring for Vulr will be the respons of Nursing | liance with f Adult report Il be reporte is held ever nerable Adu | all ing. id y It | | |

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| | | AND HUMAN SERVICES | | | | FORM | 05/17/2017 APPROVED 0938-0391 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
| 245012 | | B. WING | | | 03/24/2017 | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| GUARDIAN ANGELS CARE CENTER | | | | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 323 | therapy (OT), use of socks or sturdy sho -On 10/20/16, the torisk for falls related taking 2 high risk model in the cognitive impairment following instruction tool further identifie which included diffic was unsafe, impuls for mobility, was un reached during tran- orientation to environe bathroom and dinin- incontinence with u- incontinence), and falls and action plan plan were left blank -On 1/18/17, the too risk for falls related had severe cognitiv- identified R218 was disoriented, difficult risk taking behavior mobility, was unsafe transfers and over n- orientation to environe bathroom and dinin- incontinence with u- incontinence), and falls and action plar plan were left blank R218's care plan da had anxiety, was im- frequent falls. Staff | all light and wear gripper ness. Dol identified R218 was at high to history of recent falls, was nedications and had severe nt, and R218 had difficulty ns or was non-complaint. The d R218 had fall risk factors culty finding her way around, ive and forgot her walking aid safe, impulsive and over nsfers, had difficulty with onment in areas between bed, g and reported or known rgency, nocturia (night time accidents. R218's history of n for interventions and care the impairment. The tool further is agitated, confused and y finding her way around, had rs, forgot her walking aid for e, impulsive in her mobility and reached, had difficulty with onment in areas between bed, g and reported or known rgency, nocturia (night time accidents. R218's history of n for interventions and care | F | 323 | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 05/17/2017 APPROVED 0938-0391 |
|---|--|---|--|-----|--|--|-------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | PLE CONSTRUCTION | OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED | |
| | | 245012 | B. WING | ì | | 03/ | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| GUARDI | AN ANGELS CARE C | ENTER | | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | MUST BE PRECEDED BY FULL | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 323 | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 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. | | F | 323 | | | |

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| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | FORM | 05/17/2017 APPROVED 0938-0391 |
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| STATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245012 | B. WING | | 03/2 | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | TREET ADDRESS, CITY, STATE, ZIP CODE | <u>.</u> | |
| GUARDI | AN ANGELS CARE C | ENTER | | 00 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 323 | R218 complained the bleeding from the bleeding from the bleeding from the bleeding from the bleeding from the bleedin low position and conduct frequeeding bleed in low position and conduct frequeeding bleeding for the facility interverse to be completed which the facility interverse to be completed Review of the clinic identified on 9/29/1 ordered physical the On 03/23/17, at 103 (CM-A) stated the funwitnessed and the fell from bed and survive to be completed the form bed and survive to be stated R218's arefused toileting five on the floor. The best when she's napping had dementia and the time of the fall with | hat her head hurt and was back of her head. The r identified staff applied head laceration and her vital The report indicated there was er care plan to keep R218's when napping and at night ent checks as R218 was t identify what the frequency in tervention of "frequent checks" ted. c referral progress notes 6 R218 the provider had erapy. :40 a.m. clinical manager fall on 8/6/16, at 7:55 p.m. was nought R218 self-transferred ustained a head laceration isfer to the emergency aples to close the laceration. was toileted after dinner and e minutes prior to finding her ed was to be in the low position g and at night because R218 was impulsive. Incontinence at was not noted, and R218 was | | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 05/17/2017 APPROVED 0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245012 | B. WING | | | 03/; | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | | | 00 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 323 | R218 fell after she a was found in the ha investigation identif sustained an abras indication of any ne R218 had last been incontinent. On 03/23/17, at 10: on 8/15/16, at 1:30 she thought R218 s into the hallway and laceration to her elk at the time of the fa interventions were a 3.) Resident Incider indicated R218 fell she attempted to se the floor in her room R218 was found pro- with her incontinent hips and R218 had of the incontinent b Review of R218's P Investigation Works R218 fell on 8/20/10 self-transfer and wa room between her I investigation further what she was doing The investigation in wandering earlier, r rounds. She was fo the dining room, wa toileted and put bac noted R218 needed | attempted to self-transfer and allway outside of her room. The ied R218 was confused, and ion from the fall. There was no ew fall interventions or when a toileted, or if she was 40 a.m. CM-A stated the fall a.m. was unwitnessed and self-transferred from her room d sustained a 2 cm x 2 cm bow. She stated incontinence ill was not noted, and no new added. Int Report dated 8/20/16, on 8/20/16, at 1:25 a.m. after elf-transfer and was found on m. The report further indicated opped up on her right elbow ce pad pulled down off her both legs in the same opening | F3 | 323 | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 05/17/2017 APPROVED 0938-0391 |
|--------------------------|--|---|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245012 | B. WING | i | | 03/: | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | | | 100 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 323 | of these checks. On 03/23/17, at 10: on 8/20/16, at 1:25 thought R218 self-t the floor between h R218 was incontine down and both legs was instructed on h 4.) Resident Incider indicated R218 fell self-transfer on 9/8/ found on the floor of indicated R218 was voided and had no Review of R218's F Investigation Works R218 fell on 9/8/16 self-transfer and wa room. The investiga water was starting t the bathroom at 8:0 identified R218 free frequent checks an interventions. There identified to check of On 03/23/17, at 10: on 9/8/16, at 11:46 she thought R218 s on the floor in her ro The resident had st come out at the tim toileting was an issi go to the bathroom | 40 a.m. CM-A stated the fall a.m. was unwitnessed but ransferred and was found on er bed and her bathroom. ent with her pull-up pulled in the same opening. R218 how to call for help. Int Report dated 9/8/16, after she attempted to (16 at 11:46 p.m. and was of her room. The report is taken to the bathroom, apparent injuries. Post Fall/Incident Huddle sheet dated 9/9/16, identified after she attempted to as found on the floor in her ation identified R218 stated the to come out, and had last used 05 p.m. The investigation quently wandered at night, had d to continue current e was no specific frequency | F | 323 | | | |

Facility ID: 00611

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| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | FORM | 05/17/2017 APPROVED 0938-0391 |
|--------------------------|--|---|---------------------|---|-----------|-------------------------------------|
| STATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245012 | B. WING | | 03/: | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | TREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| GUARDI | AN ANGELS CARE C | ENTER | | 00 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 323 | checked for incontii dry. There were no interventions for fal 5.) Resident Incider indicated R218 fell self-transfer on 12/ on the floor outside head against the chi identified R218 sus abrasion to her left Review of R218's F Investigation Works identified R218 fell attempted to self-tra floor in her room. T R218 stated she was she fell, and R218 m The investigation no more frequent mon On 03/23/17, at 10: on 12/13/16, at 2:19 self-transferred tryin hit her head on the sustained a small a knee and was last t completed the invest form R218 needed every 2 hours and e She did not think sh sheet for the NA's. area they needed to bed in low position. 6.) Resident Incider | nence at 11:35 p.m. and was new or changes to the lls. nt Report dated 12/13/16, after she attempted to 13/16 at 2:15 p.m., was found of her bathroom with her osed door. The report stained a 1.5 cm X 1.2 cm knee. Post Fall/Incident Huddle sheet dated 12/13/16, on 12/13/16 after she ansfer and was found on the The investigation identified as going to the bathroom when was last toileted at 12:45 p.m. oted there was a need for itoring and toileting. :40 a.m. CM-A stated the fall 5 p.m. was from the resident ng to go to the bathroom and door. She stated R218 abrasion on her scalp and left toileted at 12:45 p.m. She stigation and indicated on the more frequent monitoring than every 1.5 hours for toileting. he added it to R218's care task If R218 wasn't in the common o look for her and keep her | F 323 | | | |

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| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | FORM | : 05/17/2017 APPROVED : 0938-0391 |
|--------------------------|--|--|---------------------|--|-----------|---|
| STATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE | E SURVEY IPLETED |
| | | 245012 | B. WING | | 03/: | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 323 | self-transfer on 12/2 found on the floor in heard screaming. F laceration to the rig hand and palm was a 1 cm x 1 cm abrasion x 4 cm reddened an nurse practitioner w saw the resident aff Review of R218's n 12/23/16 identified of her scalp. The an bond applied. She f facial pain and a lac the right wrist was of Review R218's righ 12/23/16 identified fracture without sig Review of R218's F Investigation Works identified R218 fell to self-transfer, goin found on the floor in bathroom. The invest last toileted at 9:15 fall. The investigation more difficulty to re tried to keep her at on her. The investig self-transferred free program 4-6 times investigation noted interventions plus m | 23/16 at 9:46 a.m. and was n her room after she was R218 sustained a 4 cm sht side of her head, her right s painful and swollen, she had asion to her right knee and a 5 n to her right cheek and a 4 cm rea to her right elbow. The was present in the facility and ter the fall. nurse practitioner note dated R218 had a 2 inch laceration rea was cleansed, and derma had pain at right wrist, right ceration. At that time a x-ray of | F 323 | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 05/17/2017 APPROVED 0938-0391 |
|--------------------------|---|---|---------------------|----|--|-----------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE | E SURVEY PLETED |
| | | 245012 | B. WING | | | 03/: | 24/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | | | 00 EVANS AVENUE LK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 323 | on 12/23/16, at 9:46 self-transferring, we head. She stated R her room and no or resident was last to primary NA left on b with family (F)-A in she may have been shoes", so they wer shoes", so they wer shoes. 7.) Resident Incider indicated R218 fell self-transfer on 2/14 found on the floor ir identified R218 had signs were taken. Review of R218's P Investigation Works R218 fell on 2/14/1' self-transfer and wa room next to her ro investigation indicat was doing when sh there. The resident a.m. was incontiner they were unsure h night wandering hav no falls on the day s shoes. On 03/23/17, at 10: on 2/14/16, at 5:30 self-transferring, an resident didn't know last checked on R2 they found her. She | age 28 6 a.m. was from the resident ent to the bathroom and hit her 1218 likely wandered back into he saw or looked for her. The bileted at 9:15 a.m. before her break. She states she spoke January and discussed that in falling because of her "loafer re replaced with black tie nt Report dated 2/14/17, after she attempted to 4/17 at 5:30 a.m. and was in her room. The report I no apparent injuries and vital Post Fall/Incident Huddle sheet dated 2/14/17, identified 7 after attempted to as found on the floor in her ommate's wheelchair. The ted R218 didn't know what she e fell, and was trying to sleep was last checked on at 3:35 int. The investigation indicated ow to prevent this fall, her d decreased and there were shift since they changed her 440 a.m. CM-A stated the fall a.m. from the resident ind was found in her room. The v why she was there. They had c18 at 3:35 a.m. and at 5:30 e wasn't sure how the fall could ed. R218's wandering at night | F 3 | 23 | | | |

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| | | AND HUMAN SERVICES | | | FORM | 05/17/2017 APPROVED 0938-0391 |
|--------------------------|---|--|---------------------|---|-----------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245012 | B. WING | | 03/: | 24/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 323 | had decreased and since they changed toilet her every 2 ho hours at night. She checks up during th trial toileting plan of work because she bathroom and woul stated they were av up until after 11:00 During observation was seated in her w nurse's station. R27 right side of her wh and a clear plastic of continually fidgeting sweater and the co shirt. She repeated napkins. She had b her glasses on, and ankle. On 3/23/17, at 10:3 beauty shop and Na the hallway and use walker. R218 wore had her glasses on very confused and she tried to turn the resident's room. R2 assistance and tool quickly with her hea up on the mechanic walker. NA-A had to directed her toward On 3/23/17, at 9:29 | I she has not fallen on day shift I her shoes. They continue to burs and check on her every 2 e thought about "bumping" her he day and they completed a f every 1.5 hours, but it did not was fixated on going to the d have to go again. CM-A vare the resident liked to stay | F 323 | 3 | | |

| | | AND HUMAN SERVICES | | | | FORM | 05/17/2017 APPROVED 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245012 | B. WING | | | 03/; | 24/2017 |
| NAME OF | PROVIDER OR SUPPLIER | <u> </u> | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE CI | ENTER | | | 00 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 323 | She stated R218 dc as she used to and out of her chair to p floor. The last time was about a month out of her bed every bed. R218 liked to s keep her occupied wander off. On 3/23/17, at 9:46 stated R218 was or for falls and needed not like to leave her was no set schedul On 3/23/17, at 9:56 confused, at risk for stand or walk on he NA-C stated R218 I 10:30-11:15 p.m. ar time she would stay On 3/23/17, at 10:2 confused, could wa walk on her own. Th and she has becom month. On 3/23/17, at 10:4 stated fall risk asse quarterly and with a condition. She conf quarterly on 7/28/16 did not think they w they had recurrent f felt the residents fal | besn't stand up as much now stated R218 would still leap bick up something from the she saw R218 try to stand up ago but R218 tries to wiggle y time when she awaken in stay up late and they try to but this was difficult, would 6 a.m. registered nurse (RN-C) riented to person, was at risk d to be checked on. They did r alone in her room but there le for checking on her. 6 a.m. NA-C stated R218 was r falling because R218 tried to er own especially at bedtime. liked to stay up until nd if she went to bed at that | F 3 | 123 | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | 05/17/2017 APPROVED 0938-0391 |
|--------------------------|---|---|---------------------|--|-------------------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 245012 | B. WING | | 03/; | 24/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 323 | stated they only cor assessments quart expected the staff t look at what was go to complete their as would expect a root every fall, and felt a was included in the stated after the pos the UM-A reviewed together to determine would manage the However, the facility care that R218 liked and to keep her up facility add a specific checking on R218, help decrease pote Review of falls polic facility would decrease major injury for resi identified the facility to residents who had determine patterns would consult with to interdisciplinary tea | a.m. director of nurses (DON) mplete a comprehensive erly. After a fall with injury she o look at the whole event and bing on surrounding the event sessment. DON stated she t cause analysis done with all of the necessary information ir post fall huddle form. She t fall huddle was completed it and pulled everything ne interventions and how they situation. y did not identify in the plan of d to stay up after 11:00 p.m., until that time, nor did the ic increased frequency for besides every two hours to ntial falls. cy dated 2/19/17, identified the ase the risk of further falls or dents. The policy further y would pay particular attention two sustained multiple falls to and etiology of falls and they | F 323 | | | |

Facility ID: 00611

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| | | AND HUMAN SERVICES | , | Floring | FORM | 05/01/2017 APPROVED 0938-0391 |
|---------------|--|--|--------------|---|----------|-------------------------------------|
| STATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01 | (X3) DAT | E SURVEY IPLETED |
| | | 245012 | B. WING | | 03/ | 21/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 | |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | X (EACH CORRECTIVE ACTION SHOUL | D BE | COMPLETION DATE |
| K 000 | INITIAL COMMENT | ſS | КC | 000 | | |
| | FIRE SAFETY | | | | | |
| | ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT C CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA ACCORDANCE WI A Life Safety Code Minnesota Departm Marshal Division. A Guardian Angels Ca compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 19 Existing PLEASE RETURN | MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. Survey was conducted by the nent of Public Safety, Fire t the time of this survey, are Center was found not in e requirements for participation nid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care. THE PLAN OF R THE FIRE SAFETY TAGS) TO: RE INSPECTIONS SHAL DIVISION | | EPOC | | |
| ABORATOR | | ER/SUPPLIER REPRESENTATIVE'S SIGN | | TITLE | | (X6) DATE |
| | ically Signed | | | | | 04/28/201 |

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.

| | | AND HUMAN SERVICES | | | | FORM | 05/01/2017 APPROVED 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|-------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ´ | | LE CONSTRUCTION 01 - MAIN BUILDING 01 | | E SURVEY PLETED |
| | | 245012 | B, WING | | | 03/; | 21/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | | | 100 EVANS AVENUE ELK RIVER, MN 55330 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| K 000 | By e-mail to: Marian.Whitney@s and Angela.Kappenmar THE PLAN OF COD DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pro- 3. The name and/or responsible for com- prevent a reoccurre Guardian Angels C with a partial baser constructed at 4 diff building was constru- determined to be or 1974 a single story the East Wing and (111) construction. constructed to the I be of Type II (111). constructed in 2007 determined to be T separation. As of November 1, one building, existing as the least fire res NFPA 101 section 8 | tate.mn.us n@state.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. are Center is a 1-story building nent. The building was ferent times. The original fucted in 1965 and was f Type II (111) construction. In addition was constructed to determined to be of Type II Also, in 1995 an addition was East Wing and determined to Another addition was 7 to the Northeast Wing and ype V (111) with a 2 hour 2016 this was surveyed as ng, with the construction type istive construction type per 3.2.1.3 (3) | K | 000 | | | |
| | The building is fully | sprinkler protected | | | | | |

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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIF | PLE CONSTRUCTION | (X3) DATE SURVEY |
|-----------------------------------|--|--|---------------------|--|--|
| ID PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | G 01 - MAIN BUILDING 01 | COMPLETED |
| | | 245012 | B. WING | | 03/21/2017 |
| AME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| GUARDI | AN ANGELS CARE C | ENTER | | 400 EVANS AVENUE ELK RIVER, MN 55330 | |
| (X4) ID PREFIX T A G | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLE |
| K 000 | with smoke detect open to the corrido automatic fire depa has a capacity of 1 | cility has a fire alarm system on in the corridors and spaces ors that is monitored for artment notification. The facility 20 beds and had a census of | K 00 | D | |
| | NOT MET as evide | t 42 CFR, Subpart 483.70(a) is | K 91 | 6 | 5/3/17 |
| | Alarm Annunciator A remote annuncia powered is provide generating room in operating personn hard-wired to indic emergency power system (e.g., build to be substituted fo 6.4.1.1.17, 6.4.1.1 This STANDARD Essential Electric remote annunciator powered is provide generating room in operating personn hard-wired to indic emergency power system (e.g., build | ator that is storage battery ed to operate outside of the a location readily observed by el. The annunciator is ate alarm conditions of the source. A centralized computer ing information system) is not or the alarm annunciator. .17.5 (NFPA 99) is not met as evidenced by: System Alarm Annunciator A or that is storage battery ed to operate outside of the n a location readily observed by el. The annunciator is ate alarm conditions of the source. A centralized computer ing information system) is not or the alarm annunciator. | | The remote annunciator failure or related to equipment upgrades. The replacement had been ordered the week in March, 2017 and is curred installed and operating effectively We will monitor the operation of the by completing monthly preventation maintenance checks. | The new e first ntly ne panel |
| | Findings include: | | | The Maintenance Director will be responsible for ongoing complian | ce. |

Facility ID: 00611

If continuation sheet Page 3 of 4

| | | AND HUMAN SERVICES | | | | FORM | 05/01/2017 APPROVED 0938-0391 |
|--------------------------|--|--|-------------------|------|---|-------------------|-------------------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | E CONSTRUCTION 11 - Main Building 01 | (X3) DATE COMI | E SURVEY PLETED |
| | | 245012 | B. WING | | | 03/2 | 21/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | I | 4 | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| GHARDI | AN ANGELS CARE C | ENTER | | 40 | 0 EVANS AVENUE | | |
| OUANDI | | | | EL | LK RIVER, MN 55330 | | |
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| K 916 | revealed the remot | age 3 ations and staff interview e annunciator located on the rork at the time of the survey. | K | 916 | 6 | | |
| | This deficient cond Director of Mainten | ition was verified by the ance. | | | | | |
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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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Guardian Angels Care Center April 20, 2017 Page 2

"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,

Kumala Piske Downing

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: <u>Kamala.Fiske-Downing@state.mn.us</u>

| Minneso | ota Department of He | alth | | | | |
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| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess | hether a violation has been | | | | |
| | that may result fron orders provided tha the Department wit | hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance. | | | | |
| | receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a | participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are | | | | |
| ABORATOR | epartment of Health Y DIRECTOR'S OR PROVIE ically Signed | DER/SUPPLIER REPRESENTATIVE'S SIG | NATURE | TITLE | | (X6) DATE 04/28/17 |

Electronically Signed

If continuation sheet 1 of 29

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| 2 000 | Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On March 20-24, 24 Department's staff, the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follor are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE | Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 017 surveyors of this visited the above provider and ction orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed. Nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for number appears in the far left of Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection. ARD THE HEADING OF THE | | | | | |

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| | PLAN OF CORREC | QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES. | : | | | |
| 2 560 | MN Rule 4658.0409 Plan of Care; Conte | 5 Subp. 2 Comprehensive ents | 2 560 | | 5/3/17 | |
| | comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc | of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557 agraph (b). | n | | | |
| | by: Based on interview facility failed to dev | ent is not met as evidenced and document review, the elop a comprehensive care ileting program for 1 of 2 eviewed for urinary | | Corrected | | |
| | Findings include: | | | | | |
| | dated 11/29/16, ide intact, had a diagno one side of the bod incontinent of urine | Minimum Data Set (MDS) ntified R241 was cognitively osis of hemiplegia (paralysis to y), was occasionally (less than seven episodes of required extensive assistance objecte toileting. | | | | |
| | | ta Summary dated 11/30/16, ay bladder/toileting collection | | | | |

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| | retrained and incor 51-75% (percent). indicated staff to, " Asks for bedpan." | 1 was able to be partially ntinence episodes decreased The comment section Toilet Q (every) 2 hrs (hours). | | | | |
| | dated 12/2/16, ider | Assessment (CAA) Summary ntified urinary incontinence as a indicated, "New Care Plan | a | | | |
| | R241 was frequent episodes of urinary episode of continer program had been since urinary incon facility. However, t response to the tria also indicated R24 | IDS dated 2/16/17, identified tly incontinent (seven or more r incontinence, but at least one nt voiding) and a trial toileting attempted on admission or tinence was noted in the the MDS did not identify R241's al toileting program. The MDS 1 was not on a toileting manage R241's urinary | 3 | | | |
| | lacked any identifie interventions to ad | I Unit Care Plan, undated, ed problem, goals, or dress R241's urinary te her having documented e. | | | | |
| | nursing assistant (| on 3/22/17, at 12:03 p.m. NA)-B stated R241 was er and was not on a toileting | | | | |
| | registered nurse (F a care plan for elim should be an elimin RN-A stated it was | n 3/23/17, at 11:29 a.m. RN)-A stated R241 did not have nination adding, "I agree" there nation care plan for R241. the nurses and the nurse sibility to make sure care plans | | | | |

Minnesota Department of Health STATE FORM

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If continuation sheet 4 of 29

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| | 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. | | | | | |
| | director of nursing have a care plan for R241 should have | n 3/23/17, at 3:10 p.m. the (DON) stated R241 did not or urinary incontinence, but a urinary care plan. DON re plan would be initiated for | | | | |
| | Discharge Planning identified all care p and in compliance care. The policy a | ment, Care Planning, g policy dated 3/22/17, plans would be person centered with professional standards of lso identified the plan of care dent strengths, goals, life | | | | |
| | The director of nur develop and implein related to the care could provide train to the development assessment. The I | THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures plan. The DON or designee, ing for all nursing staff related t of the care plan based on the DON or designee could g systems to ensure ongoing | | | | |
| | TIME PERIOD FO (21) days. epartment of Health | R CORRECTION: Twenty-one | | | | |

STATE FORM

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| | MN Rule 4658.0408 Plan of Care; Use Subp. 3. Use. A comust be used by all care of the resident This MN Requirement by: Based on observati review, the facility fa plan to ensure the r services were providevelopment of pre residents (R1) idem Findings include: R1's quarterly Miniman 12/7/16, included di paraplegia (paralys and neurological disi indicated R1 needer bed mobility, toiletir of bowel and not or suprapubic cathete R1's care plan date required physical as side to side or side alignment using pill and had air mattres | 5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the ent is not met as evidenced on, interview, and document ailed to implement the care necessary treatment and ded to minimize the ssure ulcers for 1 of 1 tified at risk for pressure ulcer. num Data Set (MDS) dated agnosis of diabetes mellitus, is to the legs and lower body), sease. In addition the MDS d total assistance of two with ng and was always incontinent to toileting program and had a | 2 565 | | PRIATE | 5/3/17 |
| | incontinence, check | and change incontinence nours and as needed. | | | | |

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| 2 565 | During continuous 7:03 a.m. to 9:30 a R1 was lying in her the left. At 7:13 a.r with her head turne nurse entered her r bed, checked her b supplement and low room. At 7:30 a.m. entered her room a the bathroom and e At 7:51 a.m. R1 wa turned to the left in a.m. R1 was still lyi staff had entered h brought R1's break eating, with the doc a.m. NA-E left her At 9:04 a.m. R1 rer bed watching televi still remained in the entering the room t stool incontinence. During interview 3/3 stated she was R1' changed by the nig hours and 50 minur has a special mattr be repositioned every skin. She (R1) need repositioned every | observation on 3/22/17, from .m.(2 hours and 27 minutes) bed with her head turned to n. she was still lying in bed ed to the left. At 7:20 a.m. a room raised the head of the blood sugar, gave a wered her bed and left the . nursing assistant (NA)- E and assisted her roommate in exited the room at 7:49 a.m. is lying in bed with her head the same position. At 8:07 ing in the same position, no er room. At 8:34 a.m. NA-E fast tray and assisted her with or and curtain opened. At 8:48 room with R1's breakfast tray. mained in the same position, in ision. At 9:15 a.m. the resident e same position, with no staff to reposition R1 or check for 22/17, at 9:30 a.m. NA-E 's NA and she was last ht shift around 6:50 a.m., 2 tes earlier. NA-E stated R1 ress so she doesn't need to to ery two hours and was on her reposition now. | | | | |

| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED | |
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| | out checking or rep identifies. | ositioning, which her care plar | ו | | | |
| | The director of nurs review and revise p to ensuring the car resident is followed designee could dev and develop a mon | THOD OF CORRECTION: sing (DON) or designee could policies and procedures related e plan for each individual I. The director of nursing or velop a system to educate staff itoring system to ensure staff as directed by the written plan | | | | |
| | (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 830 | Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as | 0 Subp. 1 Adequate and re; General general. A resident must re and treatment, personal and supervision based on id preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the | t | | | 5/3/17 |
| | resident must rema prefers to remain in This MN Requirem by: Based on observat review, the facility f | ain in bed or the resident | | Corrected | | |

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| | | 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 impairment, require activities of daily liv in her room, corrido MDS further identif | R218 had severe cognitive ed limited assistance with all ing (ADLs) except for walking or and personal hygiene. The ied R218 had one fall with no | | | | |
| | | eting program and was ent of bowel and bladder. | | | | |
| | identified R218 had wandered and had understand others understood. The C | ssessment (CAA) dated 8/6/16 I severe cognitive impairment, a decreased ability to and making herself AA indicated R218 had | 5 | | | |
| | balance, had a dec disruption of her ab and increased depe | roblems which affected her line in cognitive status, a bility to speak, mood problem endence on staff for ADLs. The | | | | |
| | for falls related to rebalance, gait and p | ed R218 had an increased risk ecent falls, disturbances of ositioning ability, infection, received anti-anxiety | | | | |

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| | 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 ris 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. | | | | | |
| | risk for falls related taking 2 high risk m cognitive impairme following instruction tool further identifie which included diffi was unsafe, impuls for mobility, was un | ool identified R218 was at high to history of recent falls, was nedications and had severe nt, and R218 had difficulty ns or was non-complaint. The ed R218 had fall risk factors culty finding her way around, sive and forgot her walking aid nsafe, impulsive and over | | | | |
| | orientation to enviro bathroom and dinin incontinence with u incontinence), and | nsfers, had difficulty with onment in areas between bed, ng and reported or known irgency, nocturia (night time accidents. R218's history of n for interventions and care K. | | | | |

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| 2 830 | Continued From pa | ige 10 | 2 830 | | | | |
| | risk for falls related had severe cognitivi identified R218 was disoriented, difficult risk taking behaviou mobility, was unsaft transfers and over to orientation to envire bathroom and dinin incontinence with u incontinence), and falls and action plan plan were left blank R218's care plan da had anxiety, was im frequent falls. Staff use call light for ass required assistance Alzheimer's demen incontinence, and h bathroom. The care required the physic transfer belt for trar walker to ambulate meals and in the ha awake with black to leave R218 in her v room, Staff were to environment and di needed. R218 had had an impaired sle dementia with want R218's bed was to | ol identified R218 was at high to history of recent falls and re impairment. The tool further s agitated, confused and cy finding her way around, had rs, forgot her walking aid for e, impulsive in her mobility and reached, had difficulty with onment in areas between bed, og and reported or known rgency, nocturia (night time accidents. R218's history of n for interventions and care the example of the resident to sistance with transfers. She e with toileting related to tia, urinary and bowel her inability to find the e plan further identified R218 al assistance of 1 staff and a nsfers and a rear wheeled R218 to the bathroom, to allways every 2 hours while e shoes on. Staff were not to vheelchair alone when in her monitor, provide a safe rect/cue the resident as a history of fractured ribs and eep pattern related to pain and dering. The care plan identified be in low position when related to frequent falls. Staff | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | |
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| | | 00611 | B. WING | | 03/ | 03/24/2017 | |
| IAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| GUARDI | AN ANGELS CARE C | ENTER | NS AVENUE ER, MN 55330 |) | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE | (X5) COMPLET DATE | |
| 2 830 | Continued From pa | age 11 | 2 830 | | | | |
| | | t reports and post fall huddle s identified the following falls: | | | | | |
| | on 8/6/16 at 7:55 a self-transfer and we room. The report in on door, 911 was c transferred to emen identified R218's co incident included fa understand direction and incontinency. T | nt Report indicated R218 fell .m. after she attempted to as found on the floor in her ndicated R218 had hit her head alled and R218 was rgency department. The report ondition at the time of the all history, inability to ons, confusion/disorientation, There was no indication of st toileted, or if she was me of the fall. | | | | | |
| | Investigation Works R218 complained t bleeding from the b investigation furthe pressure to R218's signs were taken. T a need to update h bed in low position and conduct freque impulsive. It did not | Post Fall/Incident Huddle sheet dated 8/8/16, identified hat her head hurt and was back of her head. The r identified staff applied head laceration and her vital The report indicated there was er care plan to keep R218's when napping and at night ent checks as R218 was t identify what the frequency in tervention of "frequent checks" ted. | | | | | |
| | | c referral progress notes 6 R218 the provider had erapy. | | | | | |
| | (CM-A) stated the f unwitnessed and th fell from bed and s | :40 a.m. clinical manager fall on 8/6/16, at 7:55 p.m. was nought R218 self-transferred ustained a head laceration usfer to the emergency | | | | | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | CONSTRUCTION | | E SURVEY PLETED | |
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| AME OF F | PROVIDER OR SUPPLIER | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | | | |
| UARDI | AN ANGELS CARE C | ENTER | NS AVENUE ER, MN 55330 |) | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE | (X5) COMPLET DATE | |
| 2 830 | Continued From pa | age 12 | 2 830 | | | | |
| | She stated R218's refused toileting fiv on the floor. The be when she's nappin had dementia and | aples to close the laceration. was toileted after dinner and re minutes prior to finding her ed was to be in the low positio g and at night because R218 was impulsive. Incontinence a was not noted, and R218 was om alone. | | | | | |
| | on 8/15/16 at 1:30 self-transfer and w hallway next to her R218 complained of | ent Report indicated R218 fell a.m. after she attempted to as found on the floor in the room. The report identified of pain in her ribs and had a 2 r 2 cm left elbow abrasion. | | | | | |
| | Investigation Work R218 fell after she was found in the ha investigation identi sustained an abras indication of any ne | Post Fall/Incident Huddle sheet dated 8/15/16, identified attempted to self-transfer and allway outside of her room. Th fied R218 was confused, and sion from the fall. There was ne ew fall interventions or when n toileted, or if she was | e | | | | |
| | on 8/15/16, at 1:30 she thought R218 s into the hallway an laceration to her el | :40 a.m. CM-A stated the fall a.m. was unwitnessed and self-transferred from her room d sustained a 2 cm x 2 cm bow. She stated incontinence all was not noted, and no new added. | | | | | |
| | indicated R218 fell she attempted to s the floor in her root R218 was found pr | ent Report dated 8/20/16, on 8/20/16, at 1:25 a.m. after elf-transfer and was found on m. The report further indicated ropped up on her right elbow ice pad pulled down off her | | | | | |

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | |
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| NAME OF I | PROVIDER OR SUPPLIER | | ADDRESS, CITY, STATE, ZIP CODE | | | | |
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| 2 830 | Continued From pa | age 13 | 2 830 | | | | |
| | hips and R218 had of the incontinent b | l both legs in the same opening prief. | | | | | |
| | Investigation Work R218 fell on 8/20/1 self-transfer and w room between her investigation furthe what she was doing The investigation ir wandering earlier, rounds. She was for the dining room, wa toileted and put bar noted R218 needed impulsive, unable t position. There was of these checks. | Post Fall/Incident Huddle sheet dated 8/20/16, identified 6 after she attempted to as found on the floor in her bed and her bathroom. The rr identified R218 didn't know g or trying to do when she fell. ndicated R218 was found not in her room at 11:00 p.m. bund on the opposite wing in as brought back to her room, ck in bed. The investigation d frequent checks and was o redirect, and bed kept in low s no indication of the frequency | | | | | |
| | on 8/20/16, at 1:25 thought R218 self-t the floor between h R218 was incontine | :40 a.m. CM-A stated the fall a.m. was unwitnessed but transferred and was found on her bed and her bathroom. ent with her pull-up pulled s in the same opening. R218 how to call for help. | | | | | |
| | indicated R218 fell self-transfer on 9/8 found on the floor of | nt Report dated 9/8/16, after she attempted to /16 at 11:46 p.m. and was of her room. The report s taken to the bathroom, apparent injuries. | | | | | |
| | Investigation Work R218 fell on 9/8/16 self-transfer and w | Post Fall/Incident Huddle sheet dated 9/9/16, identified after she attempted to as found on the floor in her ation identified R218 stated the | | | | | |

| STATEMEN | ta Department of He T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED | |
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| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | | |
| GUARDI | AN ANGELS CARE C | ENTER | IS AVENUE R, MN 55330 |) | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 830 | the bathroom at 8:0 identified R218 free frequent checks an interventions. There identified to check On 03/23/17, at 10 on 9/8/16, at 11:46 she thought R218 s on the floor in her r The resident had s come out at the tim toileting was an iss go to the bathroom to be toileted freque checked for inconti dry. There were no interventions for fall 5.) Resident Incide indicated R218 fell self-transfer on 12/ on the floor outside head against the cli identified R218 sus abrasion to her left Review of R218's F Investigation Work | to come out, and had last used 05 p.m. The investigation quently wandered at night, had hd to continue current e was no specific frequency on R218. :40 a.m. CM-A stated the fall p.m. was unwitnessed and self-transferred and was found room with no apparent injuries. tated us water was trying to he of the fall. CM-A stated ue and R218 constantly had to h, was fixated on it, and needed ently. The resident had been inence at 11:35 p.m. and was new or changes to the lls. nt Report dated 12/13/16, after she attempted to 13/16 at 2:15 p.m., was found e of her bathroom with her losed door. The report stained a 1.5 cm X 1.2 cm | 2 830 | DEFICIENC | Υ) | | |
| | floor in her room. T R218 stated she w she fell, and R218 The investigation n | ansfer and was found on the The investigation identified as going to the bathroom when was last toileted at 12:45 p.m. oted there was a need for hitoring and toileting. | | | | | |
| | On 03/23/17, at 10 | :40 a.m. CM-A stated the fall | | | | | |

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| GUARDI | AN ANGELS CARE C | ENTER | NS AVENUE ER, MN 55330 |) | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 830 | Continued From pa | age 15 | 2 830 | | | | |
| | self-transferred tryi hit her head on the sustained a small a knee and was last completed the inve form R218 needed every 2 hours and She did not think s sheet for the NA's. area they needed t bed in low position 6.) Resident Incide indicated R218 fell self-transfer on 12/ found on the floor i heard screaming. F laceration to the rig hand and palm was a 1 cm x 1 cm abrasion x 4 cm reddened a nurse practitioner w saw the resident af | Int Report dated 12/23/16, after she attempted to (23/16 at 9:46 a.m. and was n her room after she was R218 sustained a 4 cm ght side of her head, her right s painful and swollen, she had asion to her right knee and a 5 n to her right cheek and a 4 cn rea to her right elbow. The was present in the facility and iter the fall. | < | | | | |
| | 12/23/16 identified of her scalp. The a bond applied. She facial pain and a la the right wrist was | | f | | | | |
| | 12/23/16 identified | nt wrist X-ray completed on a concern with a distal radius Inificant displacement. | | | | | |
| | Investigation Work | Post Fall/Incident Huddle sheet dated 12/23/16, on 12/23/16 after attempting | | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED | |
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| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| GUARDI | AN ANGELS CARE C | ENTER | NS AVENUE ER, MN 55330 | I | | | |
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| 2 830 | Continued From pa | age 16 | 2 830 | | | | |
| | bathroom. The invelast toileted at 9:15 fall. The investigati more difficulty to re- tried to keep her at on her. The investi self-transferred fre program 4-6 times investigation noted interventions plus r On 03/23/17, at 10 on 12/23/16, at 9:4 self-transferring, w head. She stated F her room and no o resident was last to primary NA left on with family (F)-A in she may have bee shoes", so they we shoes. | n her room outside the estigation indicated R218 was a.m., 36 minutes before her on further identified R218 had edirect with her wandering and the main desk to keep an eye gation identified R218 quently and was on a walking per day in the hallways. The they would continue current more short, frequent walks. :40 a.m. CM-A stated the fall 6 a.m. was from the resident ent to the bathroom and hit he R218 likely wandered back into ne saw or looked for her. The bileted at 9:15 a.m. before her break. She states she spoke January and discussed that n falling because of her "loafer are replaced with black tie | r | | | | |
| | indicated R218 fell self-transfer on 2/1 found on the floor i | ont Report dated 2/14/17, after she attempted to 4/17 at 5:30 a.m. and was n her room. The report d no apparent injuries and vital | | | | | |
| | Investigation Work R218 fell on 2/14/1 self-transfer and w room next to her ro investigation indica was doing when sh | Post Fall/Incident Huddle sheet dated 2/14/17, identified 7 after attempted to as found on the floor in her commate's wheelchair. The ated R218 didn't know what sho he fell, and was trying to sleep t was last checked on at 3:35 | | | | | |

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| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| GUARDI | AN ANGELS CARE C | ENTER | NS AVENUE ER, MN 55330 |) | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG | | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 830 | Continued From pa | age 17 | 2 830 | | | | |
| | they were unsure h night wandering ha | nt. The investigation indicated now to prevent this fall, her ad decreased and there were shift since they changed her | | | | | |
| | on 2/14/16, at 5:30 self-transferring, ar resident didn't know last checked on R2 they found her. Sh have been prevent had decreased and since they changed toilet her every 2 h hours at night. Sh checks up during t trial toileting plan o work because she bathroom and wou | :40 a.m. CM-A stated the fall a.m. from the resident nd was found in her room. The w why she was there. They had 218 at 3:35 a.m. and at 5:30 e wasn't sure how the fall could ed. R218's wandering at night d she has not fallen on day shif d her shoes. They continue to ours and check on her every 2 e thought about "bumping" her he day and they completed a f every 1.5 hours, but it did not was fixated on going to the ld have to go again. CM-A ware the resident liked to stay p.m | E E | | | | |
| | was seated in her nurse's station. R2 right side of her wh and a clear plastic continually fidgetin sweater and the co shirt. She repeated napkins. She had b | on 3/22/17, at 7:03 a.m. R218 wheelchair in the hall facing the 18 had a half tray affixed to the neelchair with white napkins cup with water. R218 was g with her green cardigan ollar of her plaid blue/green dly wiped her nose with black rubber sole tie shoes on, d a wander guard on her right | 9 | | | | |
| | beauty shop and N the hallway and us | 31 a.m. R218 returned from the IA-A walked with R218 down ed a gait belt and wheeled black rubber sole shoes and | 9 | | | | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| 2 830 | had her glasses or very confused and she tried to turn the resident's room. Ra assistance and too quickly with her her up on the mechani walker. NA-A had t directed her toward On 3/23/17, at 9:29 stated R218 was c She stated R218 d as she used to and out of her chair to p floor. The last time was about a month out of her bed ever bed. R218 liked to keep her occupied wander off. On 3/23/17, at 9:46 | a. R218 was hunched over and needed to be redirected as walker to go into another 218 continued to walk with k small steps but walked ad down. R218 became hung cal lift in the hallway with her o untangle her walker and ds the middle of the hallway. A a.m. nursing assistant (NA-A) onfused and at risk for falls. oesn't stand up as much now I stated R218 would still leap bick up something from the she saw R218 try to stand up a go but R218 tries to wiggle by time when she awaken in stay up late and they try to but this was difficult, would a.m. registered nurse (RN-C) | | | | |
| | stated R218 was o for falls and neede not like to leave he | riented to person, was at risk d to be checked on. They did r alone in her room but there le for checking on her. | | | | |
| | confused, at risk for stand or walk on he NA-C stated R218 | a.m. NA-C stated R218 was or falling because R218 tried to er own especially at bedtime. liked to stay up until nd if she went to bed at that y asleep. | | | | |
| | confused, could wa walk on her own. T | 26 a.m. NA-D stated R218 was alk but it was unsafe for her to hey toilet her every 2 hours ne more incontinent this past | | | | |

| - | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | | E SURVEY PLETED |
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| GUARDI | AN ANGELS CARE C | ENTER | NS AVENUE ER, MN 55330 | I | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 2 830 | Continued From pa | age 19 | 2 830 | | | |
| | stated fall risk asse quarterly and with a condition. She com quarterly on 7/28/1 did not think they w they had recurrent felt the residents fa and there was no p On 3/24/17, at 9:21 stated they only co assessments quart expected the staff look at what was g to complete their a would expect a roo every fall, and felt a was included in the stated after the pos the UM-A reviewed together to determ would manage the However, the facilit care that R218 like and to keep her up facility add a specifi checking on R218, help decrease pote | ty did not identify in the plan of d to stay up after 11:00 p.m., until that time, nor did the fic increased frequency for besides every two hours to |) n | | | |
| | facility would decre major injury for res identified the facilit to residents who ha | ease the risk of further falls or idents. The policy further y would pay particular attentior ave sustained multiple falls to and etiology of falls and they | | | | |

STATE FORM

8H2411

If continuation sheet 20 of 29

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | E SURVEY PLETED | |
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| IAME OF I | PROVIDER OR SUPPLIER | STREET / | ADDRESS, CITY, S | DDRESS, CITY, STATE, ZIP CODE | | | |
| JUARDI | AN ANGELS CARE C | ENTER | ANS AVENUE | | | | |
| | | | VER, MN 55330 | PROVIDER'S PLAN OF | CORRECTION | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 830 | Continued From pa | age 20 | 2 830 | | | | |
| | and suggestions to | decrease risk of falls. | | | | | |
| | Director of Nursing provide education t importance of ensu and plans of care for receive care and su related to falls. The | THOD OF CORRECTION: Th (DON) or designee, could to nursing staff about the uring assessment is conducted ollowed to ensure residents upervision in a safe manner to DON or designee, could the sure the proper nursing car dents. | d | | | | |
| | (21) days. | R CORRECTION: Twenty-one | | | | | |
| 2 900 | MN Rule 4658.052 Ulcers | 5 Subp. 3 Rehab - Pressure | 2 900 | | | 5/3/17 | |
| | comprehensive res of nursing services | sores. Based on the ident assessment, the directo must coordinate the iursing care plan which | pr | | | | |
| | without pressure s pressure sores unle condition demonstr | o enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and | | | | | |
| | receives necessar | who has pressure sores y treatment and services to revent infection, and prevent veloping. | | | | | |
| | by: | ent is not met as evidenced | | Corrected | | | |
| | Daseu on observat | ion, interview and document | | Corrected | | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | E SURVEY PLETED | |
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| GUARDI | AN ANGELS CARE C | ENTER | NS AVENUE ER, MN 55330 |) | | | |
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| 2 900 | Continued From pa | Continued From page 21 | | | | | |
| | assistance for toile reduce the risk of p | ailed to provide timely ting and repositioning to pressure ulcer development for 1) identified at risk of pressure | | | | | |
| | Findings include: | | | | | | |
| | 12/7/16, included of paraplegia (paralys and a neurological indicated she had s no mood problems needed total assist toileting, was alway was not on a toileti suprapubic cathete she was at risk for and had a stage 3 skin loss involving subcutaneous tissu but had moisture re pressure device for | | | | | | |
| | (CAA) dated 6/22/1 to bed, required re- needed special ma | r Care Area Assessment 16, indicated she was confined gular schedule of turning, ttress, seat cushion to reduce only able to mover her right | | | | | |
| | required physical a transfers and assist side to side or side alignment using pil and had air mattree The care plan direct | ed 2/10/17, indicated she ssist with bed mobility, st of two to turn resident from to back, position in functional lows for body extremity suppo ss for her to reduce pressure. cted staff to monitor k and change incontinence | | | | | |

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| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | | | | |
| GUARD | IAN ANGELS CARE C | ENTER | NS AVENUE ER, MN 55330 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE | (X5) COMPLET DATE | |
| 2 900 | product every two h care plan further ing skin integrity due to incontinence and p thigh wound related with dental appoint unavoidable due to indicated she had a pressure ulcer on h 2/10/17. The care a history of being re laying back in bed a repositioning scheo A Tissue Tolerance indicated she was a and she had fragile posterior thighs wh directed the staff to two hours and air m areas. Care plan w A additional Tissue indicated she was a breakdown and and redness and reside every two hours. A Braden Risk Asse assist in predicting dated 3/2/17, indica commands, but car discomfort or need assessment further skin, confined to be problem with friction moderate to maxim frequently slides do | nours and as needed. The dicated she had alteration in o edema, obesity, bowel rogression of left buttock and d to increased time in chair ment and was clinically fragility of skin. The care plan a history of a stage two her coccyx that healed on plan further indicated she had esistive to treatment by not after two hours and following dule. Testing Review dated 1/30/17, at high risk for skin breakdown e skin on buttocks and ich were currently intact. It o continue to reposition every nattress to reduce pressure to as reviewed with no changes. Testing Review dated 3/5/17, still at high risk for skin d had no open areas or ent was to be repositioned essment Report (a tool used to pressure risk assessment) ated R1 responded to verbal n not always communicate | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---------------------------|--|----------------------------------|-------------------------|
| | 00611 | | B. WING | | 03/ | 24/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | NS AVENUE ER, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 900 | Continued From pa | age 23 | 2 900 | | | |
| | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | | | |
| | reposition her now During interview 3/ | her way to check R1 and 22/17, at 9:32 a.m. registered ed R1 was incontinent of bowel | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | E SURVEY PLETED | |
|--|--|---|---|--|--------------------|-------------------------|
| | 00611 | | B. WING | | 03/ | 24/2017 |
| IAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | AN ANGELS CARE C | 400 EVA | NS AVENUE | | | |
| | | ELK RIV | ER, MN 55330 |) | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE | (X5) COMPLET DATE |
| 2 900 | Continued From pa | age 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. | | | | | |
| | 9:40 a.m. NA-E an providing personal changed, she had product, and no op | and interview 03/22/17, at d NA-L were observed care in R1's room. R1 was no stooling in her incontinent en areas were noted. NA-E at two staff to change and | | | | |
| | Therapy brochure, rotational low air lo of turning the patie and used a lateral turning, moving an by the mattress. Th the mattress has s perform the rotatio mattress could be pressure ulcers. Th that manually turning | care Rotating Low Air Loss undated, identified it was a ss mattress, that was capable nt up to a 40 degree angle, rotational mattress system for d shifting of the patient is done be brochure further indicated ettings so the mattress can n at set timed intervals and the used for treating and healing he brochure does not indicate ng and repositioning would not off load pressure from the | • | | | |
| | Invacare customer they do not have a Rotating Low Air Lo | view 3/30/17, at 3:35 p.m. a service representative stated nything in writing to indicate the oss Therapy device substitutes nd repositioning to off load | | | | |

STATE FORM

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | | E SURVEY PLETED | |
|---|---|--|---|---|--------------------------------|-------------------------|
| | | B. WING | | | 24/2017 | |
| IAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S ⁻ | TATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | NS AVENUE ER, MN 55330 |) | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 2 900 | Continued From pa | age 25 | 2 900 | | | |
| | Prevention And Tre dated 3/13/12, indi properly identify, and clinical conditions i skin integrity, and p preventative meas | d Procedure For The eatment Of Skin Breakdown cated "It is the policy to nd assess residents whose ncrease the risk for impaired pressure ulcers, to implement ures and to provide appropriate es for wounds according to of care." | Ð | | | |
| | director of nursing inservice staff rega plan to ensure app ulcers, and then au | THOD OF CORRECTION: The (DON) or designee could arding implementation of a care ropriate treatment of pressure udit to ensure compliance. | • | | | |
| | (21) days. | R CORRECTION: Twenty-one | | | | |
| 21995 | MN St. Statute 626 Maltreatment of Vu | 6.557 Subd. 4a Reporting - Inerable Adults | 21995 | | | 5/3/17 |
| | (a) Each facility sh ongoing written pr applicable licensing of suspected maltr facility has an inter mandated reporter requirements of the internally. However responsible for cor | al reporting of maltreatment. hall establish and enforce an ocedure in compliance with g rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting is section by reporting er, the facility remains nplying with the immediate ents of this section. | | | | |
| | This MN Requirem by: | ent is not met as evidenced | | | | |
| | | w, and document review, the | | Corrected | | |

| Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | E SURVEY PLETED | |
|--|---|---|---------------------|--|---|---------|
| | 00611 | | B. WING | | 03/ | 24/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AI | DRESS, CITY, S | TATE, ZIP CODE | · | |
| | | 400 EVA | NS AVENUE | | | |
| GUARDI | AN ANGELS CARE C | ENTER ELK RIV | ER, MN 55330 |) | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE COMPL THE APPROPRIATE DAT | |
| 21995 | Continued From pa | age 26 | 21995 | | | |
| | agency (SA) injurie | nediately report to the State s of unknown origin for 1 of 3 eviewed for abuse prohibition. | | | | |
| | Findings include: | | | | | |
| | 10/25/16, identified Alzheimer's demen identified R218 hac required limited ass daily living (ADLs) e corridor and persor | inimum Data Set (MDS) dated R218 had diagnoses of tia, anxiety. The MDS severe cognitive impairment, sistance with all activities of except for walking in her room, hal hygiene. The MDS further d one fall without injury. | | | | |
| | had Alzheimer dem wandered. R218's o interventions which alone in her room in use her call light fo | printed 3/23/17, identified R218 pentia, anxiety, impulsivity and care plan listed various included to not leave R218 in her wheelchair, remind to r assistance with transfers and position for napping and at | | | | |
| | 12/23/16, indicated after she attempted 9:46 a.m. and was after she was heard 4 cm laceration to t right hand and palm had a 1 cm x 1 cm a 5 cm x 1 cm abra cm x 4 cm reddene report identified R2 head laceration wa skin glue, kerlex ap | dent Incident Report dated R218 had an unwitnessed fall to self-transfer on 12/23/16 at found on the floor in her room d screaming. R218 sustained a the right side of her head, her n was painful and swollen, she abrasion to her right knee and asion to her right cheek and a 4 ed area to her right elbow. The 18's vital signs were taken, her s cleansed and closed with oplied around her head and ice . The report listed the | t L F | | | |

| | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|---------------------------|--|-----------------------------------|-------------------------|
| | 00611 | | B. WING | | 03/ | 24/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| GUARDI | AN ANGELS CARE C | ENTER | IS AVENUE ER, MN 55330 |) | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21995 | Continued From page 27 | | 21995 | | | |
| | the report lacked d notified. | ocumentation the SA had been | | | | |
| | 12/23/16 revealed sustained a fall. R2 her scalp in the right The area was clean She had pain at right | nurse practitioner note dated R218 was seen after she 218 had a 2 inch laceration of ht side of the front of her head. nsed, and derma bond applied. ht wrist and right facial pain t that time a x-ray of the right | | | | |
| | after the fall finding | nt wrist X-ray done on 12/23/16 Is was a concern for a distal Iout significant displacement. | | | | |
| | Investigation Work revealed the nurse | Post Fall/Incident Huddle sheet, dated 12/26/16, practitioner had been notified; ocumentation the SA had been ent. | | | | |
| | (DON) confirmed the SA for R218 sir 3/23/17 at 4:36 p.m | p.m. the director of nursing here had been no reports to nee the last survey on 5/16. At n., during a follow up interview administrator, the administrator ent facility policy. | | | | |
| | stated R218 sustai head laceration wh | p.m. clinical manager (CM)-A ned, after the 12/23/16 fall, a ich the nurse practitioner ue and R218 had x-rays done nd chest. | | | | |
| | Plan identified an in injury of unknown of following conditions | ty undated Abuse Prevention ncident was considered an origin when both of the s were met: the source of the erved by any person or the | | | | |

| Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) DENTIFICATION NUMBER: 00611 | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---|--|---|
| | | A. BOILDING. | | | |
| | | B. WING | | 03/24/2017 | |
| ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| N ANGELS CARE C | ENTER | |) | | |
| SUMMARY STATEMENT OF DEFICIENCIES | | | | | |
| | | PREFIX TAG | CROSS-REFERENCED TO TI | HE APPROPRIATE | COMPLET DATE |
| Continued From pa | age 28 | 21995 | | | |
| explained by the re suspicious because locations of the inju- observed at one pa incidence of injuries identified the facility the Office of Health of injuries of unknown SUGGESTED MET The administrator of policies and proceed injuries of unknown could develop a mo ongoing complianc | sident and the injury is e of the extent of the injury or iry or the number of injuries articular point in time or the s over time. The policy further y would report immediately to a Facility Complaints incidents wn origin. THOD OF CORRECTION: could educate all staff on dures regarding reports of a origin. The administrator ponitoring system to ensure e. | | | | |
| | ROVIDER OR SUPPLIER N ANGELS CARE C SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L Continued From particular Source the location explained by the re- suspicious because locations of the inju- observed at one particular incidence of injurie dentified the facility the Office of Health of injuries of unknown SUGGESTED MET The administrator of policies and proceed injuries of unknown could develop a mo- ongoing compliance TIME PERIOD FOL | OUDER OR SUPPLIER STREET AL NANGELS CARE CENTER 400 EVAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 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. | A BUILDING: NANGELS CARE CENTER STREET ADDRESS, CITY, S MANGELS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 28 source the location of the injury could not be explained by the resident and 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. 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WING NANGELS CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330 SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CI (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDERS PLAN OF CI (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDERS PLAN OF CI (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDERS PLAN OF CI (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDERS PLAN OF CI (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDERS PLAN OF CO (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDERS PLAN OF CO (EACH DEFICIENCY MUST BO OF INJURY OF ID DEFICIENCY Continued From page 28 source the location of the injury or the number of injuries souspicious 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. 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WING 03/ NANGELS CARE CENTER 200 EVANS AVENUE ELK RIVER, MIN 55330 PROVIDERS PLAN OF CORRECTION (EACH DEPICIONC MUST BE RECEDED BY FULL RECOLLATORY OR LISE IDENTIFYING INFORMATION) PB PROVIDERS PLAN OF CORRECTION (EACH DEPICIONC MUST BE RECEDED BY FULL RECOLLATORY OR LISE IDENTIFYING INFORMATION) PB PROVIDERS PLAN OF CORRECTION (EACH DEPICIONC MUST BE RECEDED BY FULL RECOLLATORY OR LISE IDENTIFYING INFORMATION) PB PROVIDERS PLAN OF CORRECTION (EACH DEPICIONC MUST BE RECEDED BY FULL RECOLLATORY OR LISE IDENTIFYING INFORMATION) PB PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY WIST BE RECEDED BY FULL RECOLLATORY OR LISE IDENTIFYING INFORMATION) PB PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY WIST BE RECEDED BY FULL PAGE PROVIDERS PLAN OF CORRECTION (EACH DEPICE ACH PROPERTIES) Continued From page 28 21995 21995 PROVIDERS PLAN OF CORRECTION (EACH DEPICE) PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY) Continued From page 28 21995 21995 PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY) PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY) SUGGESTED METHOD OF CORRECTION: The administrator could educate all staff on policies and procedures regarding reports of injuries of unknown origin. 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