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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DK7N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00858

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245239**
2.STATE VENDOR OR MEDICAID NO.
(L2) **863278200**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/17/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **85** (L18)
13.Total Certified Beds **85** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Chris Campbell, HFE NEII 03/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 05/03/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00130
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/24/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245239

May 3, 2016

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

Dear Mr. Kessler:

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

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

Effective March 15, 2016 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 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.

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 25, 2016

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

RE: Project Number S5239030

Dear Mr. Kessler:

On February 25, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 4, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), widespread deficiencies that constituted actual harm that was not immediate jeopardy (Level I) whereby corrections were required.

On March 17, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 22, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 4, 2016, effective March 15, 2016 and therefore remedies outlined in our letter to you dated February 25, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245239 Y1	A. Building B. Wing Y2	3/17/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0249	Correction	ID Prefix F0323	Correction	ID Prefix F0329	Correction
Reg. # 483.15(f)(2)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(l)	Completed
LSC	03/15/2016	LSC	03/15/2016	LSC	03/15/2016
ID Prefix F0371	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.35(i)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/15/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	03/25/2016	27200	03/17/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/4/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245239 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/22/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	03/15/2016	LSC K0025	03/15/2016	LSC K0046	03/15/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	03/15/2016	LSC K0067	03/15/2016	LSC K0147	03/15/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	03/25/2016	27200	03/22/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/3/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245239 Y1	A. Building 02 - 2006 ADDITION B. Wing Y2	3/22/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0046	03/15/2016	LSC K0050	03/15/2016	LSC K0052	03/15/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0067	03/15/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	CC/mm	03/25/2016	13922	03/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/3/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DK7N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00858

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245239**
2.STATE VENDOR OR MEDICAID NO.
(L2) **863278200**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/04/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **85** (L18)
13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE
Susan Frericks, HPR SWS
Date : 03/18/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 03/06/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00130
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 25, 2016

Mr. Scott Kessler, Administrator
Guardian Angels Health & RehabilitationCenter
1500 East Third Avenue
Hibbing, Minnesota 55746

RE: Project Number S5239030

Dear Mr. Kessler:

On February 4, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: chris.campbell@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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 May 4, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 4, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 249 SS=C	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the activity director had the	F 249	F249: The Activity Director at Guardian Angels Health and Rehabilitation Center	3/15/16

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

Electronically Signed | 03/03/2016

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

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F 249	Continued From page 1 proper qualifications. This had the potential to affect all residents residing in the facility. Findings include: In an interview on 2/3/16, at 2:59 p.m., the Activity Director (AD)-A stated she was enrolled in classes for activity professionals at Ridgewater College in Alexandria, MN. AD-A stated she was not a Certified Occupational Therapy Assistant (COTA) and did not have 2 years of full time activity experience in the last five years. AD-A stated she has worked in long term care for many years, but started as the AD at the facility about three months ago. Previous to this position, AD-A had no activity experience. AD-A stated enrollment in the courses meant she was "provisionally certified". In an interview on 2/4/16, at 8:27 a.m., the Administrator stated AD-A started in her position on 9/21/16 and started classes at Ridgewater in January. The Administrator stated the AD-A was provisionally certified by taking the Ridgewater course work. The Administrator stated the social worker is overseeing the activity Minimum Data Set (MDS) and care plan development, but acknowledged that the facility social worker does not have activity professional qualifications. The Administrator stated he has been a qualified activity professional, and was certified through a national organization, but acknowledged he is the administrator, not the activity director. In addition, the activity professional certification provided by the administer expired on 12/1/12, which does not meet the 2 years, full time activity work within the last five years. In addition, the Administrator's resume was reviewed and only one year of full	F 249	was hired on 9/21/15. She is currently enrolled in courses at the Ridgewater Community College in Hutchinson, MN. Her expected certification date to become Provisionally Certified will be in July 2016. In the interim, the Administrator will get his certification renewed through the National Certification Council of Activity Professionals (NCCAP) and will oversee the functions of the Activity Director and the activity department. The Administrator will continue to monitor the duties of the Activity Director while she is becoming Provisionally Certified. Completion Date: 3-15-16	

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F 249	Continued From page 2 time activities work is documented in the last five years (2/11 to 2/12). The facility's 2/23/03, therapeutic recreation director position job description listed the following qualifications: Must be a qualified therapeutic recreation specialist or an activities professional who is licensed by this state and is eligible for certification as a recreation specialist or as an activities professional; or Must have, as a minimum, two (2) years of experience in a social or recreation program within the last five (5) years, one (1) of which was full time in a patient activities program in a health care setting; or Must be a qualified occupational therapy assistant; or Must have completed a training course approved by this state.	F 249		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure care and services were assessed and provided to minimize the risk of accidents for 1 of 3 residents (R12)	F 323	F323: DON and/or designee will implement corrective action for resident (R12) affected by this practice by:	3/15/16

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F 323	Continued From page 3 reviewed for accidents. Findings include: R12's face sheet printed 2/3/16, indicated R12's diagnoses included dementia without behavioral disturbances, generalized muscle weakness, generalized osteoarthritis, and difficulty in walking. R12's quarterly Minimum Data Set (MDS) assessment dated 12/7/15, indicated R12 had a severe cognitive impairment, no behaviors, and required extensive assist of 1 staff for bed mobility and transfers. R12 ambulated with extensive assist of 2 staff. The MDS further indicated R12 had a balance impairment and required assistance to stabilize when standing, used a wheelchair and walker, and had no falls in the previous 90 days. In addition, the MDS indicated no restraints were used for R12. R12's care plan initiated 9/11/14, indicated R12 was at risk for falls. The approach included directives for the staff to put the bed in low position when R12 was in bed, and for R12 to wear non skid foot wear at night. The care plan further identified R12 required assistance for position changes, and directed staff to turn and reposition R12 every 2 hours to help prevent skin breakdown. The care plan was silent regarding repositioning with pillows and placement of pillows. R12's care guide located in R12's closet dated 2/3/16, indicated R12's safety approaches and bed mobility directives included repositioning every 2 hours, bed in low position, and to recheck resident 10-15 minutes after repositioning. The	F 323	•Resident R12 will have pillows for positioning on top of sheets to prevent safety risk. •Resident R12 had a Safety/Potential Restraint Assessment completed for the bed pillows, including the resident's ability to sit on the edge of the bed and get in and out of bed. Resident R12's care plan was revised as needed. DON and/or designee will assess residents having the potential to be affected by this practice including: •All residents that use pillows as positioning devices. DON and/or designee will implement measures to ensure that this practice does not recur including: •The policy for Positioning Devices-Pillows was created. •All direct care staff will be educated on the Positioning Devices-Pillows. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: •3 positioning device audits, with use of pillows, will be performed weekly at various times to ensure ongoing compliance beginning the week 3-7-16, until compliance is achieved, then quarterly thereafter. •The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations	

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F 323	Continued From page 4 care guide was silent regarding positioning with pillows and placement of pillows. An Incident Detail report for a fall on 8/22/15, indicated R12 had slid out of bed onto the mat beside the bed. The report indicated the interdisciplinary team (IDT) reviewed the fall on 8/26/15, and initiated an intervention to recheck R12 10-15 minutes after putting to bed. A progress note dated 8/26/15, indicated a perimeter mattress (a mattress with raised side edges on the upper third and lower third with a cut out area in the middle third of the mattress) was used to set boundaries for R12. The progress note indicated R12 had slid out of bed and this was not considered to be a restraint. The documentation lacked an assessment of the perimeter mattress at the time it was initiated. An Incident Detail report for a fall on 10/12/15, indicated R12 fell while getting out of bed or rolled out of bed. The IDT reviewed the fall on 10/12/15, and completed a root cause analysis of the incident. The IDT report indicated R12 had interventions in place for rolling out of bed, including a perimeter mattress. An Incident Detail report for a fall on 1/19/16, indicated R12 slid out of bed. The IDT fall review dated 1/20/16, indicated R12 had needed to use the bathroom. A Fall Risk Assessment (FRA) dated 1/1/16, indicated R12's risk score was 20, and a score over 9 indicated the resident was at risk for falls. R12's medical record lacked an assessment of the perimeter mattress until 2/3/16, which	F 323	for ongoing monitoring. Completion Date: 3-15-16	

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F 323	Continued From page 5	F 323		

indicated the perimeter mattress was not a restraint as it did not restrict R12's movement in bed or movement of extremities in bed. The documentation lacked assessment of R12's ability to sit up on the edge of the bed or to get in and out of bed. The progress note indicated the perimeter mattress was a safety intervention to prevent R12 from rolling out of bed.

During an observation on 2/2/16, at 8:37 a.m. R12 was lying in bed, facing the wall. The left side of R12's bed was against the wall. R12's bed had a perimeter mattress and there were pillows stuffed under the fitted sheet along the right side of the bed, approximately three and a half feet in length, covering the cutout area of the mattress. The pillows consisted of one bed pillow, one small pillow, and one square decorator pillow. R12 was positioned on the left side and had no contact with the pillows.

During an interview on 2/2/16, at 8:37 a.m. nursing assistant (NA)-B verified R12 had pillows on the side of the bed, placed under the sheets. NA-B stated the pillows were placed under the sheets to prevent R12 from rolling out of bed. NA-B stated it was a safety intervention, rather than a restraint. NA-B stated she had seen R12 sitting on the edge of the bed, so is able to get out of bed if desired. NA-B stated the pillows were the same as a positioning device.

During an observation on 2/3/16, at 7:44 a.m. R12 was lying in bed on the left side, facing the wall. A bed pillow and square decorator pillow were placed under the fitted sheet along the right side of the bed. The total length of the pillows was approximately three and a half feet and covered the cut out portion of the mattress

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F 323	Continued From page 6 perimeter. During an observation on 2/3/16, at 8:07 a.m. NA-C entered R12's room and repositioned R12. When NA-B left the room, R12 was lying on the left side, but was positioned back, against the pillows, which remained under the fitted sheet on the right side of the bed. During an observation on 2/3/16, at 8:58 a.m. NA-C entered R12's room to take her to the bathroom. NA-C removed the pillows from under the sheet, assisted her to sit on the edge of the bed, put her shoes on, assisted to stand up and walk to the bathroom, using a gait belt and walker. R12 was very unsteady while walking and required NA-C to support her and steady her. During an interview on 2/3/16, at 9:18 a.m. NA-C stated R12 always has pillows under the fitted sheet so they don't slide off the bed. NA-C stated the pillows are in place for positioning. During an interview, on 2/3/16, at 2:20 p.m. registered nurse (RN)-D stated R12 has rolled out of bed, so had a perimeter mattress placed. RN-D stated R12 was able to get out of bed with the mattress on. RN-D stated the pillows were for positioning in bed and were not a falls intervention to keep her in bed. RN-D verified the pillows should be on top of the sheet and that the pillows had not been assessed as a potential safety intervention or restraint. During an interview on 2/4/16, at 1:50 p.m. the director of nursing (DON) stated pillows were used for positioning and not a restraint or fall intervention. The DON verified the pillows had not been assessed, as they were to be used for	F 323		

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F 323	Continued From page 7 positioning. The DON verified if a new device is put into place there should be an assessment and re-evaluation of the device. The facility policy and procedure for restraints, dated 7/10/11, prior to placing a resident in a restraint, there shall be a pre-restraining assessment and review to determine the need for restraints. The policy further indicated the facility staff would be responsible for care planning and implementation of appropriate and safe application of restraints and monitoring. The policy indicated the purpose was to "ensure each person attains and maintains his/hr (sic) highest practicable well-being in an environment that limits the use of protective devices, positioning aides, and restraints to only when medically necessary and in accordance with state and federal regulations and with facility policies."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		3/15/16

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F 329	Continued From page 8 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain proper consent for antipsychotic medications for 2 of 5 residents (R14, R61) reviewed for unnecessary medications. Findings include: R14's diagnosis list dated 2/3/16, indicated R14's diagnoses included dementia without behavioral disturbance, delirium, delusional disorders, anxiety disorder, insomnia and seizures. R14's comprehensive annual Minimum Data Set (MDS) assessment dated 12/14/15, indicated R14 had a severe cognitive impairment, symptoms of mild depression, including trouble sleeping, no delirium or rejection of cares, and displayed physical aggression toward others 1-3 days during the 14-day assessment period. The MDS further indicated R14 received antipsychotic and antidepressant medications. R14's signed physician orders dated 2/3/16, included orders for Seroquel (antipsychotic medication) 25 milligrams (mg) by mouth (po) twice daily (BID) for delusional disorder. The order indicated R14 had received this dose of	F 329	F329: DON and/or designee will implement corrective action for residents, R14 and R61, affected by this practice by: •A new Psychotropic Medication Informed Consent Form was created, that includes the significant side-effects and black box warnings for antipsychotic medications, which includes 'increased risk of death'. •Resident R14 will have a new Psychotropic Medication Informed Consent Form completed. •Resident R61 will have a new Psychotropic Medication Informed Consent Form completed. DON and/or designee will assess residents having the potential to be affected by this practice including: •All residents that use antipsychotic drugs. DON and/or designee will implement measures to ensure that this practice does not recur including: •The Psychotropic Medication policy was	

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F 329	Continued From page 9 Seroquel since 4/26/14. R14's Informed Consent Form for Use of Psychotropic Medications signed 9/17/13, indicated Seroquel was ordered to be used to reduce anxiety, refusal of cares, and physical behaviors. A list of potential side effects was attached to the consent form. The consent form and list of side effects lacked information regarding significant warnings for Seroquel, which includes the increased risk of death. On 2/3/16, at 2:29 p.m. registered nurse (RN)-D stated R14's agitated behaviors included physically aggressive behaviors. RN-D verified R14's behaviors were related to dementia. RN-D stated R14's dementia has progressed and the behaviors have somewhat improved. On 2/4/16, at 1:50 p.m. the director of nursing (DON) verified the consents did not contain the significant warnings for antipsychotics. The Package insert and Label Information for Seroquel, indicated there was an increased mortality in elderly patients with dementia-related psychosis. The facility policy and procedure for Psychotropic Medication revised 11/15, directed the licensed nurse would notify the resident or the responsible party of the indication for medication usage and the potential side effects. The policy and procedure directed an Informed Consent would be obtained for the use of the medication. R61 or her power of attorney (POA) were not informed of the side effects regarding the significant risks for an antipsychotic medication, which included the increased risk of death. R61's Face Sheet diagnosis list dated 2/4/16,	F 329	reviewed. •All residents on antipsychotic drugs will have a new Psychotropic Medication Informed Consent Form completed. •All licensed nurses will be educated on the new Psychotropic Medication Informed Consent Form and Psychotropic Medication Policy. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: •Audit will be completed with any new order for antipsychotic drug that the Psychotropic Medication Informed Consent Form was used, until compliance is achieved, then quarterly thereafter. •The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 3-15-16	

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F 329	Continued From page 10 indicated R61's diagnoses included anxiety, dementia with behavioral disturbances and paranoid personality disorder. The significant change MDS assessment dated 12/23/15, indicated R61 had moderately impaired cognition, displayed verbal behaviors, received antipsychotic and antidepressant medications and was under Hospice care. R61's signed physician orders dated 2/3/16, included orders for Risperidone (antipsychotic medication) 0.5 mg po BID for paranoid personality disorder. The order indicated R61 had received this dose of Seroquel since 2/15/15. R61's Informed Consent Form for Use of Psychotropic Medications indicated verbal consent was given by R61's POA on 11/5/15. The form did not identify indications for use, specific target behaviors or non-pharmacological interventions. A list of potential side effects was attached to the consent form. The consent form and list of side effects lacked information regarding the significant warnings for Risperidone, which included an increased risk of death. On 2/4/16, at 2:05 p.m. registered nurse (RN)-E verified the significant warning of increased risk of fatality was not included. RN-E stated she was not aware the information should be included on the form. The RN further stated she did not discuss the warning or side effects including the risk of death with the POA on 11/5/15. RN-E stated POA stated the behavioral health facility discussed R61's medications with him/her. On 2/4/16, at 2:12 p.m. RN-A stated she had informed the POA that if R61 did not drink enough there was the chance of it building up in her	F 329		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 11 system and becoming toxic which could lead to death. The RN further stated R61 was aware of her medications and had refused medications in the past. The RN stated the consent and side effects were also mailed to the POA.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure freezer temperatures were at the proper temperature in 1 of 3 unit refrigerator/freezers. This had the potential to affect 22 of 76 residents residing in the facility, who received food out of this freezer. Findings include: During an observation with the dietary manager (DM) on 2/4/16, at 8:47 a.m. the thermometer in the Bennett Park freezer read 9 degrees Fahrenheit (F). The DM verified the thermometer reading and turned down the temperature and said she would re-check it. The freezer contained 8 individual cups of ice cream in the freezer door shelf, 3 individual cups of ice cream on the	F 371	F371: . All dietary staff will be in-serviced on how to report the temperatures of the nursing station and kitchenette refrigerators/freezers that are out of the correct range to the Dietary Manager. . The dietary staff will be in- serviced that the correct ranges are 34 to 40 degrees for the refrigerators and 0 to -10 degrees for the freezers. . The dietary manager or designee will check the temperatures daily for 4 weeks to see that the temperatures are within range and then will check weekly, thereafter. . Dietary staff and the Dietary Manager will initial the temperatures after they are	3/15/16

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F 371	Continued From page 12 middle shelf and a partial 1 quart container of ice cream on the same middle shelf. None of the ice cream cups/containers were frozen. They were soft and easily compressed. DM lifted the cover of one of the cups from the door shelf. The ice cream was soft. DM verified the ice cream was soft. In addition, the Unit Refrigerator Temperature log found on the side of the Bennett Park refrigerator/freezer indicated the temperature had been 10 degrees F on 2/2/16, and 9 degrees F on 2/3/16. DM verified the freezer temperature had been too high since 2/2/16, and stated the staff were expected to report high temperature readings above 0 degrees F, immediately to her or to maintenance. DM stated the temperatures are read daily, usually in the evening. The Unit Refrigerator Temperature log indicated the freezer temperatures were to be between 0 degrees F and minus 10 degrees F. The temperature log directed staff to notify maintenance and the dietary manager immediately if the temperature was outside of the parameter. During an interview on 2/4/16, at 12:00 p.m. DM stated she had replaced all the ice cream in the refrigerator and the freezer temperature was now -2 degrees F. The facility policy and procedure for Nursing Station Refrigerators, revised 9/3/07, indicated the freezers would be maintained at a temperature of 0 degrees F to -10 degrees F, the temperature were to be recorded daily, and unacceptable temperature were to be reported to maintenance personnel or the dietary manager.	F 371	taken on temperature log. . Signs will be posted on the refrigerators to remind staff to report any temperatures that are out of range to the Dietary Manager, Completion date: 3-15-16	

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	245239	A. BUILDING 02 B. WING _____	02/03/2016

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K 000	INITIAL COMMENTS FIRE SAFETY Building 02: 2006 and 2011 Additions THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Guardian Angels Care Center Building 2 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/03/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Facility was inspected as 2 buildings: Guardian Angels Care Center Building 2 is a 1-story building with a partial basement, Type II(111), constructed in 2006. In 2011 another wing was constructed to "New", that is one story, with a small partial mechanical basement Type II(000). The building is fully sprinkled protected throughout. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 85 beds and had a census of 78 at the time of the survey.	K 000		

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	245239	A. BUILDING **02** B. WING _____	**02/03/2016**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 18.2.9.1. This deficient practice could affect 78 of 78 residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 10:30 AM to 2:30 PM on 02/03/2016, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor revealed the that the facility did not annotate the annual 90 minute testing for 7 of 21 battery back-up emergency lights. This deficient condition was verified by a Maintenance Supervisor.	K 046	K046: •Emergency battery backup exit lighting will be tested in accordance with NFPA LSC Section 7.9.3 and 19.2.9.1. •The annual 90 minute testing on the 7 of 21 battery backup emergency lights was completed, recorded and verified by the ESD. •ESD will monitor and verify testing and recording of batter backup emergency lights to ensure compliance. Completion date: 3-15-16	3/15/16
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050		3/15/16

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K 050	Continued From page 3 The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 18.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of 78 of 78 residents. Findings include: On facility tour between 10:30 AM to 2:30 PM on 02/03/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility had he following deficient conditions were found affecting the facility's fire drills: 1. the facility could not provide documentation for a evening shift fire drill in the 1st calendar quarter. 2. the facility did not vary the time of all 4 of the overnight fire drill. All of the overnight fire drills were held in the 5 AM hour. . This deficient condition was verified by a	K 050	K050: •In order to comply with NFPA LSC (101) (00) 19.7.1.2 the policy for fire drills was reviewed. •ESD and /or designee will conduct fire drills monthly and on varying shifts. •The ESD will continue to record the date and time of the fire drills and will ensure times of the drills vary throughout all shifts to ensure compliance. •Completion date: 3-15-16	

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K 050	Continued From page 4 Maintenance Supervisor.	K 050		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 20 of 78 residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 02/03/2016, observation revealed, that the smoke detector that is located in Bennett Park outside of the serving kitchen has been installed within 36 inches of a heating, ventilation, and air conditioning diffuser. This deficient condition was verified by a	K 052	K052: •In accordance with the 2000 NFPA 101, Sections 18.3.4.1 and 9.6 as well 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1 •The smoke detector located in Bennett Park outside of the serving kitchen was relocated more than 36 inches from a heating, ventilation and air conditioning diffuser. •ESD inspected entire facility for similar problems. •ESD will monitor future changes to ensure compliance. Completion date: 3-15-16	3/15/16

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K 052	Continued From page 5 Maintenance Supervisor.	K 052		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect 78 of 78 residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 10:30 AM to 2:30 PM on 02/03/2016, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and interview with the Maintenance Supervisor, that the facility could not provide any documentation for the smoke and fire damper testing at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 067	K067: •In order to comply with the NFPA 90A the smoke damper tests will be conducted by 3-15-16. •Entire facility was inspected to ensure all smoke dampers are tested. •ESD will track and record timing of future testing. Completion date: 3-15-16	3/15/16

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	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/03/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY Building 01 - Main Building: THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Guardian Angels Health & Rehab Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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K 000	Continued From page 1 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Facility was inspected as 2 buildings: Guardian Angels Health and Rehab Center, is a 1-story building with a small partial basement. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1968, 73, & 91 additions were constructed to the building that was determined to be of Type II(111) construction. In 1990 a Type V (111) administrative wing (non resident use area) was constructed. It is properly separated from the rest of the building. Because the original building and its additions meet the construction type allowed for existing buildings. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke	K 000		

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K 000	Continued From page 2 detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 85 beds and had a census of 78 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is met.	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 fire separations was found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect the 12 of 78 residents, visitors, and staff members of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on	K 011	K011: •In order to comply with NFPA 101and LSC 2000 Guardian Angels H&R will complete the following. •The penetrations around communication wires and conduit that are passing through the two hour fire wall will be filled and sealed with appropriate fire and smoke barrier sealant. •All fire separations will be inspected and all penetrations will be filled and sealed with the appropriate fire and smoke barrier sealant.	3/15/16

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K 011	Continued From page 3 02/03/2016, observations revealed that there were penetrations around communication wires and conduit located above the fire doors that are passing through the Mary View North 2 hour fire wall. This deficient condition was verified by a Maintenance Supervisor.	K 011	•ESD will verify completion and monitor future changes to ensure compliance. Completion date: 3-15-16	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect 11 of 78 residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 10:30 AM to 2:30 PM on 02/03/2016, observation revealed that there were	K 025	K025: •In order to comply with NFPA 101-2000 Guardian Angels H&R will complete the following. •The penetrations around the conduit that is passing through the 1 hour smoke barrier on the dining room side of room 201 and northeast of the smoke barrier door will be filled and sealed with appropriate fire and smoke barrier sealant. •All smoke separations will be inspected and all penetrations will be filled and	3/15/16

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

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K 025	Continued From page 4 penetrations found around the conduit that is passing through the 1 hour smoke barrier on the dinning room side opposite of room 201 and northeast of the smoke barrier doors. This deficient condition was verified by a Maintenance Supervisor.	K 025	sealed with appropriate fire and smoke barrier sealant. •ESD will verify completion and monitor future changes to ensure compliance. Completion date: 3-15-16	
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could affect 78 of 78 residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 10:30 AM to 2:30 PM on 02/03/2016, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor revealed the that the facility did not annotate the annual 90 minute testing for 7 of 21 battery back-up emergency lights. This deficient condition was verified by a Maintenance Supervisor.	K 046	K046: •Emergency battery backup exit lighting will be tested in accordance with NFPA LSC Section 7.9.3 and 19.2.9.1. •The annual 90 minute testing on the 7 of 21 battery backup emergency lights was completed, recorded and verified by the ESD. •ESD will monitor and verify testing and recording of batter backup emergency lights to ensure compliance. Completion date: 3-15-16	3/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/03/2016**

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

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K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of 78 of 78 residents. Findings include: On facility tour between 10:30 AM to 2:30 PM on 02/03/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility had he following deficient conditions were found affecting the facility's fire drills: 1. the facility could not provide documentation for a evening shift fire drill in the 1st calendar quarter. 2. the facility did not vary the time of all 4 of the overnight fire drill. All of the overnight fire drills were held in the 5 AM hour. .	K 050	K050: •In order to comply with NFPA LSC (101) (00) 19.7.1.2 the policy for fire drills was reviewed. •ESD and /or designee will conduct fire drills monthly and on varying shifts. •The ESD will continue to record the date and time of the fire drills and will ensure times of the drills vary throughout all shifts to ensure compliance. •Completion date: 3-15-16	3/15/16

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	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/03/2016**

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K 050	Continued From page 6 This deficient condition was verified by a Maintenance Supervisor.	K 050		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect 78 of 78 residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 10:30 AM to 2:30 PM on 02/03/2016, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and interview with the Maintenance Supervisor, that the facility could not provide any documentation for the smoke and fire damper testing at the time of the inspection. This deficient condition was verified by a	K 067	K067: •In order to comply with the NFPA 90A the smoke damper tests will be conducted by 3-15-16. •Entire facility was inspected to ensure all smoke dampers are tested. •ESD will track and record timing of future testing. Completion date: 3-15-16	3/15/16

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K 067	Continued From page 7 Maintenance Supervisor.	K 067		
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility had as electrical junction box found not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect 12 of 78 residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 02/03/2016, it was observed that there is a open electrical junction box located above the ceiling tile to the northeast of the North Mary View 2 hour fire doors. This deficient condition was verified by a Maintenance Supervisor.	K 147	K147: •In accordance with NFPA 70 (99) the electrical junction box located above the ceiling tile to the northeast of the north Merryview 2 hour fire doors was enclosed. •The entire facility was inspected for similar problems. •ESD will monitor all future contractor work to ensure compliance. Completion date: 3-15-16	3/15/16

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 25, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5239030

Dear Mr. Kessler:

The above facility was surveyed on February 1, 2016 through February 4, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact one of the following:**

Lyla Burkman, Unit Supervisor
Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

Chris Campbell, Unit Supervisor
Email: chris.campbell@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	02/04/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/1/16, through 2/4/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000		

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2 000	Continued From page 1 Certification Program; 11 East Superior Street; Suite 290, Duluth, MN 55802. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure freezer temperatures were at the proper temperature in 1 of 3 unit refrigerator/freezers. This had the potential to affect 22 of 76 residents residing in the facility, who received food out of this freezer. Findings include: During an observation with the dietary manager (DM) on 2/4/16, at 8:47 a.m. the thermometer in the Bennett Park freezer read 9 degrees Fahrenheit (F). The DM verified the thermometer reading and turned down the temperature and said she would re-check it. The freezer contained 8 individual cups of ice cream in the freezer door shelf, 3 individual cups of ice cream on the middle shelf and a partial 1 quart container of ice cream on the same middle shelf. None of the ice	21100	Corrected	3/15/16

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21100	Continued From page 3	21100		

cream cups/containers were frozen. They were soft and easily compressed. DM lifted the cover of one of the cups from the door shelf. The ice cream was soft. DM verified the ice cream was soft. In addition, the Unit Refrigerator Temperature log found on the side of the Bennett Park refrigerator/freezer indicated the temperature had been 10 degrees F on 2/2/16, and 9 degrees F on 2/3/16. DM verified the freezer temperature had been too high since 2/2/16, and stated the staff were expected to report high temperature readings above 0 degrees F, immediately to her or to maintenance. DM stated the temperatures are read daily, usually in the evening.

The Unit Refrigerator Temperature log indicated the freezer temperatures were to be between 0 degrees F and minus 10 degrees F. The temperature log directed staff to notify maintenance and the dietary manager immediately if the temperature was outside of the parameter.

During an interview on 2/4/16, at 12:00 p.m. DM stated she had replaced all the ice cream in the refrigerator and the freezer temperature was now -2 degrees F.

The facility policy and procedure for Nursing Station Refrigerators, revised 9/3/07, indicated the freezers would be maintained at a temperature of 0 degrees F to -10 degrees F, the temperature were to be recorded daily, and unacceptable temperature were to be reported to maintenance personnel or the dietary manager.

SUGGESTED METHOD OF CORRECTION:
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The director of culinary services could review and

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21100	Continued From page 4 revise policies related to storage of food in areas of potential contamination. The director of culinary services could provide education to all culinary and homemaking staff and monitor for continued compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21100		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a facility tuberculosis (TB)	21426	Corrected	3/15/16

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21426	Continued From page 5 skin testing was appropriately documented in millimeters (mm) of induration (a firm lump formed by the reaction to the injected TB testing solution) for 4 of 5 residents (R9, R13, R31, R93) reviewed for TB screening. Findings include: R9 was admitted to the facility 10/29/15. The results of the second-step Mantoux (TB skin test) was documented on 11/15/15, as negative. R13 was admitted to the facility 11/9/15. The results of the second-step Mantoux was documented on 11/26/15, as negative. R31 was admitted to the facility 8/26/15. The results of the second-step Mantoux was documented on 9/13/15, as negative. R93 was admitted to the facility 10/2/15. The results of the first-step Mantoux was documented on 11/11/15, as negative. On 2/3/16, at 2:05 p.m. registered nurse (RN)-B verified Mantoux skin tests should be documented in mm of induration. The facility policy and procedure on Tuberculosis dated 6/13, lacked direction on documentation of Mantoux skin tests. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents and staff have appropriate documentation of Mantoux results according to the CDC guidelines. The director of nursing or designee could educate all appropriate staff on these policies and procedures. The director of nursing or designee	21426		

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21426	Continued From page 6 could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21445	MN Rule 4658.0900 Subp. 3 Activity and Recreation Program; Director Subp. 3. Activity and recreation program director. The activity and recreation program director must be a person who is trained or experienced to direct the activity and recreation staff and program at that nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the activity director had the proper qualifications. This had the potential to affect all residents residing in the facility. Findings include: In an interview on 2/3/16, at 2:59 p.m., the Activity Director (AD)-A stated she was enrolled in classes for activity professionals at Ridgewater College in Alexandria, MN. AD-A stated she was not a Certified Occupational Therapy Assistant (COTA) and did not have 2 years of full time activity experience in the last five years. AD-A stated she has worked in long term care for many years, but started as the AD at the facility about three months ago. Previous to this position, AD-A had no activity experience. AD-A stated enrollment in the courses meant she was "provisionally certified". In an interview on 2/4/16, at 8:27 a.m., the	21445	Corrected	3/15/16

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21445	Continued From page 7 Administrator stated AD-A started in her position on 9/21/16 and started classes at Ridgewater in January. The Administrator stated the AD-A was provisionally certified by taking the Ridgewater course work. The Administrator stated the social worker is overseeing the activity Minimum Data Set (MDS) and care plan development, but acknowledged that the facility social worker does not have activity professional qualifications. The Administrator stated he has been a qualified activity professional, and was certified through a national organization, but acknowledged he is the administrator, not the activity director. In addition, the activity professional certification provided by the administer expired on 12/1/12, which does not meet the 2 years, full time activity work within the last five years. In addition, the Administrator's resume was reviewed and only one year of full time activities work is documented in the last five years (2/11 to 2/12). The facility's 2/23/03, therapeutic recreation director position job description listed the following qualifications: Must be a qualified therapeutic recreation specialist or an activities professional who is licensed by this state and is eligible for certification as a recreation specialist or as an activities professional; or Must have, as a minimum, two (2) years of experience in a social or recreation program within the last five (5) years, one (1) of which was full time in a patient activities program in a health care setting; or Must be a qualified occupational therapy assistant; or Must have completed a training course approved by this state.	21445		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21445	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The administrator or designee, could ensure a qualified Activity Director is provided to direct organized activities and recreation in a health care setting. The administrator or designee could monitor to ensure this requirement is met. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21445		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced	21540		3/15/16

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21540	Continued From page 9 by: Based on interview and document review, the facility failed to obtain proper consent for antipsychotic medications for 2 of 5 residents (R14, R61) reviewed for unnecessary medications. Findings include: R14's diagnosis list dated 2/3/16, indicated R14's diagnoses included dementia without behavioral disturbance, delirium, delusional disorders, anxiety disorder, insomnia and seizures. R14's comprehensive annual Minimum Data Set (MDS) assessment dated 12/14/15, indicated R14 had a severe cognitive impairment, symptoms of mild depression, including trouble sleeping, no delirium or rejection of cares, and displayed physical aggression toward others 1-3 days during the 14-day assessment period. The MDS further indicated R14 received antipsychotic and antidepressant medications. R14's signed physician orders dated 2/3/16, included orders for Seroquel (antipsychotic medication) 25 milligrams (mg) by mouth (po) twice daily (BID) for delusional disorder. The order indicated R14 had received this dose of Seroquel since 4/26/14. R14's Informed Consent Form for Use of Psychotropic Medications signed 9/17/13, indicated Seroquel was ordered to be used to reduce anxiety, refusal of cares, and physical behaviors. A list of potential side effects was attached to the consent form. The consent form and list of side effects lacked information regarding significant warnings for Seroquel, which includes the increased risk of death. On 2/3/16, at 2:29 p.m. registered nurse (RN)-D stated R14's agitated behaviors included	21540	Corrected	

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21540	Continued From page 10 physically aggressive behaviors. RN-D verified R14's behaviors were related to dementia. RN-D stated R14's dementia has progressed and the behaviors have somewhat improved. On 2/4/16, at 1:50 p.m. the director of nursing (DON) verified the consents did not contain the significant warnings for antipsychotics. The Package insert and Label Information for Seroquel, indicated there was an increased mortality in elderly patients with dementia-related psychosis. The facility policy and procedure for Psychotropic Medication revised 11/15, directed the licensed nurse would notify the resident or the responsible party of the indication for medication usage and the potential side effects. The policy and procedure directed an Informed Consent would be obtained for the use of the medication. R61 or her power of attorney (POA) were not informed of the side effects regarding the significant risks for an antipsychotic medication, which included the increased risk of death. R61's Face Sheet diagnosis list dated 2/4/16, indicated R61's diagnoses included anxiety, dementia with behavioral disturbances and paranoid personality disorder. The significant change MDS assessment dated 12/23/15, indicated R61 had moderately impaired cognition, displayed verbal behaviors, received antipsychotic and antidepressant medications and was under Hospice care. R61's signed physician orders dated 2/3/16, included orders for Risperidone (antipsychotic medication) 0.5 mg po BID for paranoid	21540		

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21540	Continued From page 11	21540		

personality disorder. The order indicated R61 had received this dose of Seroquel since 2/15/15. R61's Informed Consent Form for Use of Psychotropic Medications indicated verbal consent was given by R61's POA on 11/5/15. The form did not identify indications for use, specific target behaviors or non-pharmacological interventions. A list of potential side effects was attached to the consent form. The consent form and list of side effects lacked information regarding the significant warnings for Risperidone, which included an increased risk of death.

On 2/4/16, at 2:05 p.m. registered nurse (RN)-E verified the significant warning of increased risk of fatality was not included. RN-E stated she was not aware the information should be included on the form. The RN further stated she did not discuss the warning or side effects including the risk of death with the POA on 11/5/15. RN-E stated POA stated the behavioral health facility discussed R61's medications with him/her.

On 2/4/16, at 2:12 p.m. RN-A stated she had informed the POA that if R61 did not drink enough there was the chance of it building up in her system and becoming toxic which could lead to death. The RN further stated R61 was aware of her medications and had refused medications in the past. The RN stated the consent and side effects were also mailed to the POA.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or her designee could development and implement policies and procedures to ensure consents were provided and risks explained for medications. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and

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21540	Continued From page 12 procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21540		