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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HRTU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00611

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245012**

2.STATE VENDOR OR MEDICAID NO.
(L2) **395040900**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial	2. Recertification
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/10/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:
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
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susie Haben, Unit Supervisor 06/21/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 06/21/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/24/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 21, 2021

CMS Certification Number (CCN): 245012

Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

Dear Administrator:

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 June 9, 2021 the above facility is certified for:

120 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

An equal opportunity employer.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 21, 2021

Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

RE: CCN: 245012
Cycle Start Date: April 8, 2021

Dear Administrator:

On June 10, 2021, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HRTU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00611

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/08/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Tina Hieserich, HFE NE II 05/18/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 05/21/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
April 27, 2021

Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

RE: CCN: 245012
Cycle Start Date: April 8, 2021

Dear Administrator:

On April 8, 2021, a 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 July 8, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by October 8, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/5/21 to 4/8/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was found in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	E 000		
F 000	INITIAL COMMENTS On 4/5/21 to 4/8/21, a standard recertification survey was conducted at your facility along with multiple complaint investigations. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5012051C (MN00070896), with a deficiency cited at F677 H5012052C (MN00047996), with no deficiencies issued H5012053C (MN00048935), with a deficiency cited at F677 H5012054C (MN00058907), with no deficiencies issued H5012055C (MN00068542), with no deficiencies issued due to actions implemented by the facility prior to survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 05/06/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine personal hygiene care and grooming for 3 of 4 residents (R80, R79, R4) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R80's annual Minimum Data Set (MDS), dated 3/14/21, identified R80 had long and short-term memory impairment, demonstrated no rejection of care behavior(s) and was totally dependent on staff for her personal hygiene needs and care. R80's care plan, dated 4/5/21, identified R80 was dependent on staff to meet her physical and social needs. R80 had a listed ADL self-care deficit and listed a goal which read, "[R80] will be	F 677	The facility strives for all residents to be clean and well groomed. Facial hair has been removed on all 3 residents identified (R4, R79, and R80). All residents potential could have been impacted by this tag, therefore a 100% audit will be performed on all residents by 5/27/21 to ensure facial hair has been removed. If the resident declines having facial hair removed, Nurse Unit Managers will document resident refusal/care preference on the plan of care. All residents will be provided shaving weekly and prn. The care plan will be updated to indicate those female residents who prefer to not have facial	5/27/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 2 clean and well groomed through the review date." The care plan then listed several interventions to help R80 meet this goal which included, "PERSONAL HYGIENE: The resident requires assist of one staff with personal hygiene. Resident prefers to have face shaved." On 4/5/21, at 2:22 p.m. R80 was observed lying in bed in her room. R80 had numerous, visible white and gray colored hairs on the right side of her chin which stated to extend down her neck line. R80 did not answer if she would like them removed or not when questioned. During subsequent observations, on 4/6/21 at 7:03 p.m. and 4/8/21 at approximately 10:00 a.m., R8 continued to have the same long, visible white and gray colored hairs on her right chin which had been observed on 4/5/21. R80's POC (Point of Care) Response History flowsheet, dated 3/26/21 to 4/8/21, identified R8 was recorded by staff as being totally dependent for her personal hygiene on all days. R80's medical record was reviewed and lacked evidence R80 had shaved, or been offered and/or refused shaving these facial hairs. There was no evidence the facility had attempted to shave R8 despite her care plan outlining this as her preference. When interviewed on 4/8/21, at 10:25 a.m. nursing assistant (NA)-C stated R80 required total assistance to complete her cares and "for the most part" allowed care to be done. NA-C observed R80 and verified the presence of facial hair which she expressed was not R80's	F 677	hair removed, resident□s preference will be respected. Education will be provided to all Nursing Assistants to provide shaving services to all residents on bath day unless resident preference indicates otherwise. This education will be provided through electronic format using Relias, and to be completed by 5/27/21. The facility will complete random audits weekly on 10% of residents for 12 weeks and then 5% monthly for 40 weeks. Oversight by DON to collect/review audits and Report to QA committee. Correction date 5/27/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 3	F 677		

preference to her knowledge. At 10:29 a.m. licensed practical nurse (LPN)-B joined the interview and verified R80 should be shaved using her personal shaver. LPN-B stated it was the nursing home staff' responsibility to ensure it was completed to help promote cleanliness and "self worth."

On 4/8/21, at 12:26 p.m. registered nurse manager (RN)-B stated R80 required "total care" and expressed shaving should be completed on a resident's bath day and as needed. RN-B expressed R80 should have been shaved as unshaven hair could cause skin issues like ingrown hairs and infections. RN-B added, "That's a dignity thing, too."

R79's annual MDS dated 12/9/20, indicated R79 received extensive assistance of 1-2 with all ADLs and was moderately cognitively impaired.

During observation and resident interview on 4/5/21, at 11:31 a.m. R79 was noted to have multiple chin and facial hairs (on and under chin, the corner of left side of mouth and in the smile crease between the right side of mouth and nose), that were approximately 1/2 - 3/4 inches in length. R79 stated she was unaware of these, and would have taken care of them "but they took away her mirror and tweezers."

In subsequent observations of R79, the following was noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 4	F 677		

On 4/6/21, at 7:05 p.m. R79 was in her room sitting in her wheelchair (wc) watching TV. R79 still had the long facial hairs present on her face. Again, R79 stated she would have plucked them but did not have her mirror and tweezers.

On 4/7/21, 9:54 p.m. R79 was again sitting in wc with her breakfast tray in front of her. R79's chin appeared to still have the hairs present.

During further observation and interview on 4/7/21, at 10:07 a.m. nursing assistant (NA)-A verified R79's long chin and facial hair. NA-A indicated she had not seen R79's facial hair and would need to check R79's Kardex and care plan for how and when this needed to be done. R79 again stated that if she had her mirror and tweezers, she could remove the hairs. NA-A indicated she had never seen R79 with a mirror or tweezers.

On 4/8/21, at 9:20 a.m. R79 was noted to be cleanly shaven.

In a review of R79's care plan (last revised 6/20/20) indicated:
"The resident has and ADL self-care performance deficit impaired mobility [related to] impaired mobility, weakness, intraventricular hemorrhage, neuropathy, chronic pain, [chronic kidney disease] and cognitive impairment." However, in regards to groom needs, the care plan only addressed oral and nail care. The care plan did document personal hygiene, but did not indicated what this included.

A review of the nursing assistant care sheets / Kardex (accessed by a hand held device by all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 5	F 677		

nursing assistants) documented the same information as noted above in R79's ADL section of her care plan.

During interview on 4/8/21, at 9:31 a.m. unit manager (RN)-C stated she was unaware of R79's facial hair. RN-C stated the direct care staff should be monitoring all residents on their assigned group for care needs such as this. RN-C was unaware if R79 ever had a hand mirror or tweezers, and they would not of have taken them from a resident if a resident would be able to use them safely. Finally, RN-C stated she only documents on a residents care plan if they do not wish to be shaved or not have facial hair removed.

Surveyor: Hieserich, Christina

R4's quarterly MDS, dated 3/22/21, indicated R4 required extensive physical assistance to complete ADLs and had severe cognitive impairments with diagnosis of senile (disease of old age) degeneration of the brain and dementia.

R4's care plan, revised on 12/15/19, identified R4 had "an ADL self-care performance deficit related to dementia with cognitive impairments... generalized weakness, physical deconditioning, decreased mobility, and functional limitations," which directed R4 required assistance from staff to complete personal hygiene. Further, the care plan indicated, "The resident prefers to have face shaved."

R4's Skin Evaluation, dated 4/4/21, identified R4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 6	F 677		

had "dignified grooming care" provided to her that day which included "finger and toe nails have been trimmed, scalp is clean, facial hair has been shaved unless resident desires to grow a mustache or beard..."

During observation and resident interview on 4/5/21, at 10:22 a.m. R4 had numerous, visible white colored hairs present on her chin region, along with her upper lip and lip corners. Many of these hairs were approximately one centimeter (cm) in length. R4 stated the presence of the hair had bothered her and asked the surveyor if she could remove the hair; however, R4 verbalized, "My razor does not work." R4 explained, "Those things that are supposed to twirl do not twirl...and it [the razor] makes a humming noise but does not work." In addition, R4 stated she had used a tweezers after the razor had quit working "but got tired of that" and "had to give that up as my magnifying glass pooped out on me." R4 obtained a woman's battery operated Finishing Touch Flawless face shaver from a dresser drawer which did not function when she had attempted to turn it on. R4 stated she felt the hairs "every morning" and wanted "to be shaved whenever they grow."

During subsequent observations, from 4/5/21 at 3:25 p.m. through 4/7/21 at 12:04 p.m. R4 continued to have the same visible facial hairs present on her chin and lip regions.

On 4/6/21, at 1:22 p.m. R4 again stated the facial hair bothered her and her razor did not work, in which she again asked the surveyor to remove the hair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 7	F 677		

A task flowsheet Personal Hygiene: Self Performance, dated 3/26/21 through 4/6/21, indicated "How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers). The flowsheet identified R4 had required assistance that ranged from independence to extensive physical assist and that R4 had not refused assistance for any of the identified areas of personal hygiene.

During interview on 4/7/21, at 1:09 p.m. nursing assistant (NA)-D explained she determined resident shaving preferences when she reviewed the Kardex, asked the resident during cares, or "the family will tell us if there is a razor in there [the resident's room]." NA-D confirmed she had assisted R4 with her grooming hygiene that morning; however, she denied she had reviewed R4's Kardex prior to assisting R4 with her morning cares. NA-D acknowledged R4 had facial hair that morning which had been present for "a couple weeks now...maybe even two months." Further, she acknowledged R4 had a non-functioning razor. NA-D denied having brought this information to management or the floor nurse that day; however, she explained she had brought this to a nurse's attention approximately two months ago. NA-D had been unsure who the nurse had been or if she had brought this to the nurse manager.

A review of the nursing assistant care sheets / Kardex (accessed by a hand held device by all nursing assistants) documented the same information as noted above in R4's ADL section of her care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 8 When interviewed on 4/7/21, at 1:18 p.m. licensed practical nurse (LPN)-A reviewed R4's Kardex and stated R4 preferred to be shaven. Due to this, he expected R4 to be clean shaven. LPN-A denied staff had reported to him R4's razor had been non-functioning. LPN-A acknowledged if R4's razor had been broken staff were to contact the family or power of attorney. LPN-A observed R4's facial hair and had asked her if she would like the hair removed. R4 explained to LPN-A that he could not help her because, "none of them [razors] work." LPN-A stated he would contact R4's family and update them on the non-functioning razor. During interview on 4/07/21, at 1:46 p.m. nursing unit manager (RN)-B denied knowledge R4 had been unshaven related to her having had a non-functioning razor. RN-B explained she expected staff to update her if resident shaving concerns were identified. RN-B identified family must provide resident razors/shavers. R4's progress notes, dated 3/17/21 through 4/8/21 were reviewed and lacked evidence R4's family had been updated on R4's non-functioning shaver. On 4/8/21, at 10:26 a.m. R4 had been observed seated in the day room with a mask over her face. She had denied being shaved that morning and stated, "I don't look good." When encouraged to explain her statement, R4 pulled down the mask to expose her lip and chin areas and explained while she rubbed the hair on her chin, "Because of this."	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 9 When interviewed on 4/08/21, at 10:41 a.m. NA-D confirmed she had assisted R4 again that morning with grooming cares. NA-D explained she and R4 had a conversation about shaving; however, R4 had mentioned the nurse had told her the day prior that he would shave her. NA-D denied any further follow up related to R4's shaving comments and had not looked for a razor in R4's room. NA-D denied morning report that day had identified any concerns related to R4's razor or of the family being updated. On 4/08/21, at 10:42 a.m. the health unit coordinator (HUC)-A was observed taking a new shaver out of a box. When interviewed, HUC-A stated it was for R4. She explained RN-B had purchased it for R4 and the facility would pay for it. HUC-A stated the facility normally does not provide shavers for residents. A policy for resident grooming was requested, however RN-C stated the facility did not have a policy for shaving / facial hair removal, while the facility considers this to be customary required care and all are nurses and or nursing assistants should have been trained from school and upon hire to meet this need of the residents.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		5/27/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure poor wheelchair positioning was assessed and acted upon to provide comfort and reduce the risk of complication for 1 of 1 resident (R8) reviewed who leaned significantly to the side while seated in her wheelchair. In addition, the facility failed to complete comprehensive, ongoing respiratory monitoring and assessments to prevent post-hospitalization complication for 1 of 1 resident (R158) reviewed who used oxygen and had complaints of a productive cough after being hospitalized with pneumonia. Findings include: WHEELCHAIR POSITIONING: R8's quarterly Minimum Data Set (MDS), dated 3/23/21, identified R8 had severe cognitive impairment and required extensive assistance with her activities of daily living (ADLs). On 4/5/21, at 1:57 p.m. R8 was observed in her room and was seated in a specialty wheelchair which had a large back and positioned R8 lower to the ground than a standard wheelchair. R8 appeared comfortable, however, leaned significantly to the right side which caused her right arm to hang over the armrest which appeared nearly even with her shoulder. The following day, on 4/6/21 at 4:46 p.m., R8 was observed and continued to have obvious, significant leaning to the right side with her head	F 684	The facility strives to ensure residents have proper seating alignment in their wheelchairs. The deficiency for R8 was corrected on 4/7/21, OT had implemented an order to eval and tx. A lateral bolster was applied to R8□s specialty chair to prevent leaning. The plan of care has been reviewed and updated. Nursing staff to utilize □'Stop and watch'□ forms when they recognize a resident leaning in their wheel chair. Additionally the Therapy department will screen all residents wheel chair position a minimum of every 90 days. Nurse unit managers to review and audit □Stop and watch□ forms for necessary interventions. Nursing staff to receive in-service training on utilizing □Stop and watch□ forms to be completed by 5/27/21 Lack of respiratory monitoring. The facility strives to provide ongoing respiratory monitoring for residents with a newly acquired respiratory disease or an exacerbation of a chronic respiratory disease. The deficiency for R158 was corrected on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 to the side and her shoulder being nearly even with the right armrest. At times, R8's head nearly came to touch the armrest. On 4/6/21, at 5:52 p.m. nursing assistant (NA)-B was interviewed and observed R8 in her wheelchair. NA-B stated she was aware R8 leaned significantly to the right side while in her wheelchair and voiced, "That's usually how she sits [in her wheelchair]." NA-B stated the staff would, at times, try to prop R8 more upright using pillows but R8 often removes them as she had "some behaviors." NA-B stated she had observed R8 to lean in her wheelchair for several months now and expressed she was unaware if therapy had ever screened R8 for her positioning adding, "I don't think so." Further, NA-B stated she had not noticed any skin breakdown or heard R8 complain of back pain due to her positioning. R8's progress note(s) were reviewed. On 2/3/21, an activity-related note was record which outlined, "[R8] was observed leaning to one side in her wheelchair, eyes closed at the session start." Further, an additional note, dated 3/18/21, again identified, "[R8] was observed in her wheelchair, head to the side, eyes closed, not sitting upright." R8's care plan, dated 12/28/20, identified R8 had limited physical mobility due to her cognitive impairment, history of multiple rib fractures, and osteoarthritis. The care plan directed R8 was non-ambulatory and required assistance for locomotion in her wheelchair. The care plan lacked any evidence R8 had a history of leaning in her wheelchair or any dictation outlining her positioning had been screened and/or evaluated	F 684	4/7/21 The facility will provide a twice daily comprehensive respiratory assessment with all newly acquired respiratory diseases until resolved, residents who are high risk for aspiration, and also for an exacerbation of a chronic respiratory disease until returning to baseline. Licensed nursing staff will receive in-service Respiratory assessment education through electronic format using Relias. To be completed by 5/27/21 A 100% audit will be performed on all residents with a respiratory diagnosis to ensure implementation of a respiratory assessment is completed. The facility will complete 100% audits on new admissions and changes of conditions to determine if an ongoing respiratory assessment is required. Audits will be received by the DON for review of this tag, and report to QAPI. Correction date 5/27/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 by occupational therapy (OT). R8's medical record was reviewed and lacked evidence R8 had been comprehensively reassessed or screened by nursing and/or OT to ensure appropriate wheelchair positioning to provide comfort and reduce the risk of skin breakdown or back pain despite multiple progress notes outlining her leaning in the wheelchair and staff voicing the leaning had been ongoing for several months. When interviewed on 4/7/21, at 12:26 p.m. registered nurse manager (RN)-B stated she had noticed R8 leaning to the right side in her wheelchair and voiced she "didn't think she looked good" while seated. RN-B stated she felt the leaning may be related to pain; however, voiced she reviewed the medical record and could not see any obvious changes which would cause R8 to lean so sharply in the wheelchair. RN-B expressed she felt R8 had always had a little bit of a lean to the right side while seated in her wheelchair, however, voiced she was "leaning more" over the past days than normal. RN-B acknowledged there was no evidence in the medical record or on R8's care plan which identified R8 had a history of leaning to the side while in her wheelchair; nor evidence such lean had been reassessed to ensure optimal positioning had been achieved and maintained. RN-B explained R8 had been placed in the specialty wheelchair she currently used in July 2020, and voiced R8 had been last screened for her wheelchair positioning in November 2020. RN-B acknowledged R8's positioning needed to be addressed and added, "I one hundred percent see your point." Further, RN-B stated she had	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 13	F 684		

just spoken to OT and they would screen her "to make sure [she's; R8] positioned properly."

On 4/7/21, at 1:37 p.m. occupational therapist (OT)-A and the physical therapist (PT)-A were interviewed about R8's wheelchair positioning. OT-A explained R8 had admitted to the transitional care unit (TCU) in a standard wheelchair, and they placed her in the specialty wheelchair she now used as it was more appropriate for her "at the time." OT-A stated she had observed R8 that morning, on 4/7/21, and expressed she felt "we do need to re-look at this [her positioning]." OT-A voiced R8 may benefit from some lateral supports or other various devices to help maintain more upright positioning which were "things I need to assess." Further, OT-A stated it was important to ensure residents have good wheelchair positioning to help them increase or maintain their functional abilities and provide comfort.

A provided Therapy Rehabilitation Referrals policy, dated 6/2017, identified residents would be referred to therapy services as "changes/fluctuations" in their physical condition or cognition warranted to help prevent avoidable declines in resident function and range of motion. A procedure was listed which directed staff to consider if a resident would benefit from therapy services should they have a change in condition and listed several examples of such changes which included, "Seating/posture/positioning in wheelchair." The policy outlined the unit' nurse manager should be notified of any changes in condition and they would then review the concerns and request any needed screenings or evaluations from therapy services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 14	F 684		

LACK OF RESPIRATORY MONITORING:

R158's Allina Health Discharge Summary, dated 4/1/21, identified R158 had been hospitalized with pneumonia related to dysphagia (swallowing difficulties) from another medical condition. The report listed a review of systems (ROS) which identified R158's lungs were, "Clear to auscultation bilaterally," upon discharge from the hospital. Further, R158 was listed as using oxygen to keep his O2 saturation (a measurement to help determine the amount of oxygen saturated hemoglobin in the blood) greater than or equal to 90% (percent).

On 4/5/21, at 9:50 a.m. R158 was interviewed and expressed he had been hospitalized for pneumonia before coming to the nursing home for therapy services. R158 stated he thought he was potentially still sick or coming down with a sinus infection as he had noticed "my sinuses are draining," and he had a productive cough. R158 then started to cough during the interview and produced a light, brown-colored phlegm in a tissue. R158 voiced he had been coughing since he admitted to the nursing home and the staff were aware as, "They [can] hear me."

R158's Nursing Admission/Readmission V3, dated 4/1/21, identified R158 was alert and oriented to person, place, and time. R158's initial vital signs were recorded which identified R158 had a temperature of 97.6 F (degrees Fahrenheit), 16 breaths per minute and had an O2 saturation of 92% while wearing oxygen. Further, a section labeled, "Respiratory," outlined

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15	F 684		

R158 used supplemental oxygen with a nasal cannula and area(s) to recorded R158's lung sounds identified R158 had, "Rales [abnormal rattling sound]," present in both the left and right lung(s) with shortness of breath on exertion. In addition, R158's corresponding NURSING: Respiratory Evaluation assessment, dated 4/2/21, identified R158 used oxygen on a continuous basis and was 96.0% saturation with a respiratory rate of 16 breaths per minute. R158 was recorded as not experiencing shortness of breath.

Neither of the completed assessments had dictation present which identified R158 as having a cough, productive or non-productive, and no interventions or directions were listed to outline how or when comprehensive, ongoing respiratory monitoring (i.e., auscultation of lung sounds, visualization of chest movement and respiratory effort, or subjective signs of dyspnea) would be assessed for R158 despite having been admitted after being hospitalized for pneumonia, using oxygen on a continuous basis, and having been identified on his admission assessment as having abnormal breath sounds.

R158's progress note, dated 4/1/21, identified R158 admitted via Allina transportation and was on 2 LPM (liters per minute) of oxygen. R158's vital signs were listed as within normal limits (WNL). A subsequent note, dated 4/5/21, identified R158 was alert and orientated. R158 continued on oxygen at 2 LPM via nasal cannula and had no complaints of shortness of breath or chest pain.

On 4/7/21, at 9:47 a.m. R158 was observed to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16	F 684		

lying in bed in his room and had visible feeding tube equipment present at his bedside. R158 had a nasal cannula in place and voiced his productive cough was "still there" and expressed he was unsure if any of the nursing staff were routinely listening to his lung sounds or monitoring his respiratory status adding, "I don't know if they are or not." R158 continued, "Nobody mentions anything about it."

R158's Weights and Vitals Summary, dated 4/1/21 to 4/7/21, identified R158's O2 saturation was being monitored and recorded on a daily basis; ranging 92-96% while using oxygen. However, the provided vital signs and R158's medical record lacked any evidence comprehensive, ongoing respiratory assessments and monitoring was being completed including auscultation of R158's lung sounds, visualization of his chest movement and respiratory effort, or subjective signs of dyspnea (i.e., feeling smothered).

On 4/7/21, at 9:52 a.m. nursing assistant (NA)-E stated she had noticed R158 to cough and "he does have phlegm." NA-E stated R158 had used oxygen since he admitted and, at times, did "get coughing pretty good still" which caused him to "get kind of winded." Further, NA-E voiced the nurses were aware R158 had a productive cough.

During interview on 4/7/21, at 10:00 a.m. registered nurse (RN)-F stated she was currently caring for R158 and verified he admitted to the nursing home after being hospitalized for pneumonia. During the hospitalization, R158 also had "a new feeding tube" placed and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17	F 684		

currently NPO (nothing by mouth), however, was able to have ice chips. RN-F explained she had noticed R158 to have a persistent, productive cough which she felt tended to "clear by mid-day" after he was more awake. RN-F explained the nurses should be completing lung sounds and respiratory assessments "each morning" which was more crucial if someone was symptomatic of potential respiratory infection or respiratory impairment. RN-F explained it "depends on the patient" with how often these assessments were completed and recorded, and expressed the physician, at times, would write specific orders for monitoring while others do not. RN-F reviewed R158's medical record and verified it lacked evidence or orders to ensure comprehensive, ongoing respiratory monitoring and assessments were completed adding those were "something maybe we could add to his care plan." RN-F expressed it was important to ensure ongoing respiratory monitoring and assessments were completed as R158 could be "having complications we don't see yet" given his new tube feeding and reduced mobility. RN-F added, "I think it's definitely a good thing you [the surveyor] pointed out."

When interviewed on 4/8/21 at 9:59 a.m., the director of nursing (DON) recalled R158 and stated he was at risk of aspiration given he had a newly placed feeding tube. The DON expressed the nurses need to be doing vital signs "and lung sounds" every shift which was important to help identify a change of condition "right away" as someone like R158 could "decompensate real quickly."

A facility's policy on respiratory care and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18 monitoring was requested but was not provided. However, a single yellow-colored, undated post-it note was given which identified, "No formal policy on respiratory assessment. Patient centered [and] individualized." The note was signed by the DON.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690		5/27/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 19 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess and develop interventions to address developed bowel incontinence for 1 of 2 residents (R89) reviewed for bowel care management. Findings include: R89's admission Minimum Data Set (MDS), dated 3/21/21, identified R89 had intact cognition and required extensive assistance for toileting. Further, the MDS identified R89's bowel continence as, "Not Rated," however, recorded R89 as not currently being on a bowel management program and being constipated. R89's care plan, dated 3/15/21, identified R89 had bowel incontinence and listed a goal which read, "[R89] will have less than two episodes of incontinence per day through the review date." A series of interventions were then listed to help R89 meet this goal including observing for changes in the frequency or characteristics of bowel movement, providing a bedside commode or bed pan, providing loose fitting clothing, and referencing the other care plans for mobility, activities of daily living and communication. However, R89's most recent NURSING: Bladder/Bowel Incontinence Assessment - V3, dated 3/18/21, identified R89 used an indwelling	F 690	The facility strives to asses all residents bowel/bladder status and develop interventions consistent with the standard of care to ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. The deficient practice was corrected on 5/3/21, the resident was reassessed and care plan was reviewed and updated. The facility policy and procedure on bowel/bladder incontinence was reviewed. Bowel and Bladder assessment is completed on admission. The facility will reassess residents with a change in bowel status (new onset fecal incontinence, restoration of fecal continence) to identify potential precipitating factors and develop an individualized toileting plan and any other necessary interventions. NA/R staff to utilize 'stop and watch' forms when they see new incontinence. Nursing will monitor for incontinence and follow through with documentation. Nurse unit Managers will report to IDT if a resident is being reassessed. Nurse unit Manager will audit the bowel	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 20 Foley catheter and had a usual bowel movement pattern listed which read, "b) Every other day." R89 was recorded as being alert and oriented to person, place and time along with needing assistance to transfer. The assessment concluded with a question which read, "16. Bowel Incontinence," which was answered as, "a) No." R89's care plan was recorded as being reviewed and needing no changes as a result of the assessment. When interviewed on 4/5/21 at 9:30 a.m. R89 expressed his bowel movements had become "a little loose" which concerned him. R89 stated he took laxative medication nearly "everyday" and described this contributed to bowel incontinence as the stool then "just oozes out" of his incontinence briefs as he can't make it to the bathroom. R89's progress note, dated 3/27/21, identified R89 had an nursing order in place which read, "MONITOR BOWEL STATUS AND OFFER SENNA every shift for CONSTIPATION." The note concluded, "Had large loose bm [bowel movement]." A subsequent note, dated 4/1/21, identified R89 was being incontinent of bowel and using a catheter. Further, the note outlined R89 had a wound on his coccyx which was being followed by the physician. In addition, another subsequent note, dated 4/2/21, identified the same nursing order text (inc. offering Senna) with dictation reading, "Indicated he did not need." R89's provided POC (Point of Care) Response History, dated 3/26/21 to 4/8/21, identified 15 recorded episodes of bowel incontinence between those dates. There were no recorded	F 690	record comparing to the latest bowel/bladder assessments for completion and develop interventions for incontinence/restored function, 10% audits weekly for 2 months than 10% audits monthly for 8 months. Nursing staff to receive in-service training on bowel/bladder assessment and interventions for appropriate residents by 5/27/2021. Information will be reported to DON whom will report to QAPI for review, and it responsible to monitor this tag. Correction date 5/27/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 21	F 690		

continent bowel movements. Further, the history identified one episode of loose stool, and six episodes of "putty like" stooling had occurred.

When interviewed on 4/7/21, at 1:20 p.m. nursing assistant (NA)-F stated he routinely worked with R89 and described him as needing "total care." NA-F voiced R89 had been having issues with bowel incontinence as "most of the time" he did not make it to the restroom beforehand so the staff then "have to clean it up."

During interview on 4/8/21, at 8:25 a.m. NA-G stated R89 required cues but could "help quite a bit" with cares when they were provided. NA-G stated R89 used a mechanical lift for transfers and did use his call light if he needed to use the restroom to have a bowel movement. NA-G expressed she would characterize R89's bowel continence (versus incontinence) as "fifty-fifty [50 / 50]" and described his stools as "like putty." NA-G stated she was unsure if R89 was taking medication or not to help with his bowels.

R89's medical record was reviewed and lacked evidence R89's bowel incontinence, including contributing factors such as medication use, had been comprehensively reassessed and interventions developed to promote more continence since he was first assessed after admission (on 3/18/21) where he was recorded as being continent of bowel. Further, the record lacked evidence R89's bowel medication regimen had been re-evaluated to determine effectiveness despite recorded notes of loose stools and him declining bowel-related medications at times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 22 On 4/8/21, at 9:04 a.m. registered nurse manager (RN)-G was interviewed and reviewed R89's medical record. RN-G explained residents were assessed for bowel continence upon admission using a 72-hour tracker and completion of the 'Nursing: Bladder/Bowel Incontinence Assessment.' RN-G verified R89's medical record lacked evidence R89 had been reassessed for his bowel incontinence since the initial assessment was completed on 3/18/21, which identified him as continent. RN-G stated R89 should have been reassessed "for a number of reasons" which included reviewing his medications for efficacy and they "want to develop a plan where he's toileted" to help reduce his incontinence especially since he had wounds on his coccyx. A facility' policy on bowel management programs and bowel incontinence was requested, however, none was received.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pressure dressing, post dialysis run, were removed for 1 of 1 residents per standards of practice (R29) who was reviewed for post dialysis care.	F 698	The facility strives to ensure dialysis services are provided consistent with the standard of practice. The pressure dressing was removed from the resident on 4/8/21 without untoward	5/27/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 23 Findings include: R29's Face Page documented the diagnoses of End Stage Renal Disease, personal history of other venous thrombosis (local coagulation or clotting of the blood in a part of the circulatory system) and embolism (obstruction of an artery, typically by a clot of blood or an air bubble), permanent atrial fibrillation, hypotension of hemodialysis and essential hypertension. R29's Annual Minimum Data Set (MDS), dated 1/14/21 indicated R29 was moderately cognitively impaired, received extensive assistance with activities of daily living (ADLs) and received hemodialysis. During observations and an interview on 4/5/21, at 2:13 p.m. R29 stated that he had gotten up that morning around 5:00 a.m. for dialysis and had returned around 9:00 a.m. R29 stated he received hemodialysis three times a week on Monday, Wednesday and Friday. During interview it was observed R29 still had his pressure dressing placed over his dialysis access sites on his lower right arm. R29 stated that the dressing usually stays on until bedtime. The following day on 4/6/21, at 5:30 p.m. R29 was observed to still have his pressure dressing his lower right arm. R29 verified that it was the same pressure dressing from his dialysis treatment the day before. In an interview on 4/6/21, at 5:36 p.m. and after review of R29's physician orders, registered nurse (RN)-D stated R29's orders directed the facility staff to remove the pressure dressing the day after R29's dialysis treatment. RN-D stated	F 698	effect. The resident□s care plan and MD order were reviewed and updated to be consistent with the standard of practice/dialysis dressing to be removed within 24hrs. Education will be provided for all licensed nursing staff and TMA□s re: post dialysis care/dressing removal. Training will be completed by 5/27/21 The facility will audit all Hemodialysis residents 3 times a week for 2 months and then weekly for 8 months. Nurse unit managers will conduct the audits and which will be reviewed by the DON and brought to QAPI for review. Correction date 5/27/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 24	F 698		

the dressing would be removed this evening when resident receives his evening medication pass.

A final observation on 4/6/21, at 6:55 p.m. noted R29's pressure dressing was still in place.

In a review of R2's physician's orders, it was documented the facility received an order on 1/10/20: "Pressure dressing applied at dialysis. Remove the day after dialysis. One time a day every [Tuesday], [Thursday], [Saturday]."

A review of R29's care plan, dated 4/5/21, only addressed the monitoring of the access site for signs and symptoms of infection such as swelling redness, warmth or drainage.

In a telephone interview on 4/7/21, at 11:55 a.m., the charge nurse (FMC/RN) (Foreseen Dialysis in Elk River) stated R29's dialysis run ended on Monday 4/05/21, at 8:18 a.m. and a pressure dressing was placed on at that time. FMC/RN stated that a pressure dressing should be removed as soon as hemostasis (the stopping of a flow of blood) has occurred, and not greater than 24 hours. FMC/RN stated the longer that a pressure dressing is left in place, a dialysis patient runs the risk of their access clotting, requiring the access to be de-clotted before dialysis could again be ran. FMC/RN stated she was unaware of any reports from the facility of extended bleeding, requiring R29's pressure dressing to be kept on so long (over 34 hours).

FMC/RN emailed a copy of R29's dialysis run sheet from 4/5/21, which verified R29's dialysis run did end at 8:18 a.m. that day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 25 R29's pressure dressing was observed to be left in place for over 34 hours after R29's last dialysis run. During an interview on 4/8/21, at 9:12 a.m. the unit manager (RN)-C stated she would look into the origins of R29's pressure dressing order. Later, at 12:36 p.m., RN-C stated that she checked with another registered nurse (RN)-E into the order who indicated RN-E had received this order from the dialysis unit. When asked for a copy of the telephone order, RN-C stated it could not be found. In a telephone interview on 4/8/21, at 1:13 p.m., RN-E stated she remembers receiving an order, but cannot remember if she had completed a telephone order, or with whom she spoke to. In a review of the facility's policy, entitled Caring for Residents with Hemodialysis (last revised 3/22/17), the policy did not address the duration of time a pressure dressing should be left in place. However, the policy directed the staff to "monitor site for bleeding following dialysis session. If excessive bleeding apply pressure to site. Call the dialysis center."	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours	F 732		5/27/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 26 worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently post the nurse staff posting and include the census when posted. This had the potential to effect all 104 residents residing in the facility and/or visitors who may wish to view the information.	F 732	The Posted Nurse staffing information policy and procedure was reviewed effective 4/29/21. RN managers, Nursing staff and staffing coordinator were educated on the requirements for posting the nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 27 Findings include: When reviewing the facility's daily nursing hour postings while on site 4/5/21 - 4/8/21, the daily postings were noted to be displayed on the wall on 4/6/21 and 4/7/21. However, on 4/5/21 and 4/8/21 there was no evidence of nurse staff posting. The nurse staff posting's were reviewed from 3/25/21, through 4/8/21. The facility census was not recorded on the following 10 days: 3/26/21, 3/29/21, 4/1/21, 4/2/21, 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/7/21, 4/8/21. When interviewed on 4/8/21, at 2:55 p.m., via phone call, scheduling coordinator (SC) stated she is responsible for posting the staff schedules. SC was unaware if staff schedules were posted today as she was not at the facility, adding she was not aware of any other responsible party to post in her absence. When interviewed on 4/8/21, at 3:27 p.m. administrator confirmed the staff schedule was not posted today, adding SC was not currently at the facility at it was her responsibility to post the staff schedule Monday through Friday and on the weekends the overnight nurse posts the staff schedule. Administrator stated there are no other staff identified as a back up for the staff posting (in the event SC is not working). Administrator stated posting the staff schedule was important for families to know the amount of staff working in the facility. Administrator added he was unsure why the census was not included on the staffing posts.	F 732	staffing hours in the absence of the availability of the staffing coordinator. Monitoring of Nursing Posting will be done daily x 2 weeks, weekly x 1 month, and monthly x11 to ensure accuracy. The correction will be monitored by the DON and Administrator to ensure compliance. Results of the posted nurse staffing information audits will be brought to QAPI meetings for review and recommendations. Correction date 5/27/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 28 The Posting of Direct Care Staff policy statement specified "our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents". Policy interpretation and implementation directed "shift staffing information shall be recorded on the Nursing Staff form for each shift. The information recorded on the form shall include: the name of the facility, the date of which the information is posted, the resident census at the beginning of the shift for which the information is posted, twenty-four hour shift schedule operated by the facility, the shift for which the information is posted, type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift, the actual time working during that shift for each category and type of nursing staff and total number of licensed and non-licensed nursing staff working for the posted shift".	F 732		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to adequately comprehensively assess and develop individualized interventions to address exhibited behaviors of dementia for 1 of 1 residents (R47) observed to repetitively yell and/or call out repetitive statements asking for help.	F 744	The facility strives to comprehensively assess and develop individualized interventions to address behaviors of dementia The deficiency was corrected on 5/5/21 for R47. An IDT care conference including the hospice team was	5/27/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 29 Findings include: R47's significant change Minimum Data Set (MDS), dated 2/2/21, identified R47 had dementia with resulting moderate cognitive impairment, demonstrated physical, verbal, and other non-identified behaviors 1 to 3 days during the review period, and required extensive physical assistance with her activities of daily living (ADLs). Further, the MDS identified R47 had hearing and vision limitations in which she could only identify objects, along with diagnosis of arthritis, insomnia, anxiety, and depression. The Care Area Assessment (CAA) for cognition and behavior had been triggered to be completed. On 4/6/21, at 1:25 p.m. R47 was observed seated in the day room with a bingo card on the table in front of her. R47 stated repeatedly, "Hello," until an activity staff member approached her. The activity staff engaged R47 in conversation and walked away to obtain a chair. R47 repeated, "Hello, hello," until the staff member returned to her side. Once the staff member sat down next to her, R47 escalated her statement intensity and frequency of, "Help me, help me." A different activity staff member approached R47 and explained the activity would start soon. R47 continued to vocalize "help" louder despite there having been a staff member who attempted to engage her at the time. R47 was heard to answer the staff member's questions; however, she also responded at times with, "Help me, help me." At 1:46 p.m. R47 was removed from the activity due to continued repeated statements of, "Help me, help me," in which staff propelled her up and down the unit	F 744	conducted and reviewed and updated the resident□s plan of care. The Medical Provider had reviewed and adjusted medications for R47 on 4/21/21 which has shown improvement in resident□s behavior. The facility will begin to conduct IDT behavior meetings bi-monthly to review resident behaviors, to better meet the emotional, intellectual, physical and social needs of the residents diagnosed with dementia. Director of Social services will record, review minutes and report to QAPI. The Director of Social Services will monitor this tag. Correction date 5/27/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 30	F 744		

100 hallways. R47 was subsequently brought to the activity room after she continued to be heard calling out for help despite activity staff interaction.

On 4/6/21 during continued observation, at 5:02 p.m. R47 propelled her wheelchair from the dining room table while she repeatedly yelled out, "Help me, help me!" After the third time she hollered help me, a staff member brought her back to her spot and explained to her that it was close to supper time. The staff member failed to ask her the reason for her yelling out, or ask R47 what she needed. At 5:06 p.m. after a staff member engaged R47 in a conversation and then had to leave to assist another resident, R47 repeatedly began to repeat, "Help me, help me" again. From 5:06 p.m. to 5:09 p.m. R47 verbalized, "Help," a minimum of 18 times which varied in vocal intensity. At 5:07 p.m. R47 begun to propel her wheelchair away from the dining room table. R47 was not approached by any of the four staff present in the dining room during that time frame. At 5:09 p.m. as R47 hollered out statements of help, a staff member walked by the nurses station without acknowledging R47's statements. Shortly after, another staff member, who had been engaged with another resident in the dining room, approached R47 and asked if she needed something and if she was planning on staying in the dining room for supper. R47 responded, "Yes," and asked to be taken back to her table. The staff member complied with her request while R47 stated, "Help," and sat down next to her and engaged her in social conversation. Once the staff member left R47's side, R47 remained quiet until 5:21 p.m. when she again started to holler, "HELP, HELP!" From

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 31 5:21 p.m. to 5:27 p.m. R47 verbalized, "Help," a minimum of 20 times which varied in vocal intensity; however, R47's vocalizations had been louder then heard previously. During this time frame, numerous staff were observed in the dining room vicinity; however, none acknowledged R47's statements. At 5:22 p.m. R47 propelled her wheelchair from the table and hollered, "Help," which increased again in intensity after a staff member walked over near R47 and removed a chair that had been right next to R47 and walked away from her without acknowledging her. At 5:27 p.m. R47 was brought back to her table with her meal tray and staff assisted her to eat supper, in which R47 continued to state, "Help." At 5:41 p.m. R47 indicated she had finished the meal and she was assisted from the dining room. At 5:43 p.m. R47 was heard to holler, "Help!," as she was propelled by staff down the hallway to the day room. On 4/6/21, at 6:11 p.m. R47 was observed seated in the day room with four other residents while the television was turned on. A staff member was seated next to another resident just to the left side of R47. When that staff member came into R47 line of sight, she yelled out, "HELP ME, HELP ME!" and, "Stay with me," along with, "Don't let her get away," Activity staff placed a tray table that held painting supplies in front of R47 and assisted R47 with the activity. R47 continued to make statements of "help" throughout the activity and the staff member was observed to distract R47 with questions about painting but never asking her if she needed or addressing why she needed help.	F 744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 32 On 4/7/21, during observations, at 7:23 a.m. R47's bedroom door was closed; however, R47 could be heard to state, "Help, Help," while staff assisted her with morning cares and engaged her in social conversation. -At 8:45 a.m. R47 was in the dining room and heard to holler out, "Help me, help me." When asked by a staff member what she needed help with, she replied she had been unsure. -At 12:07 p.m. R47 had been propelling her wheelchair and stated multiple times, "Help me, help me." When staff approached her, she requested to be "moved over that way."Staff brought her to the nurses station in which she then requested to be brought to the dining room table for lunch. She started to state, "Help me, help me," when propelled to her table and responded with, "I do not know," when staff questioned her on her need for help. Review of R47's care plan indicated the following: -psychosocial well-being care plan last revised 11/27/20, indicated R47 had potential for alteration in adjustment related to her dementia related cognitive impairments. Interventions directed staff to encourage ongoing family and friend support; medications as ordered; provide support and reassurance as needed; refer to house psychologist as needed; social services staff to provide supportive visits as needed. -activities care plan last revised 12/9/20, identified R47 was dependent on staff for meeting her emotional, intellectual, physical, and social needs related to forgetfulness, along with information R47 was on Hospice and would yell out during group activities. Interventions directed staff to assist R47 with music interventions,	F 744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 33	F 744		

channel 2 activity participation, observe for early signs of escalating frustration or restlessness, small group activities, provide acknowledgement of feelings and reassurance for validation, approach often to offer greetings and acknowledgement, family visits, television, and one on one visits.
-behavioral care plan last revised 12/15/20, identified R47 had a behavior problem that included yelling and calling out with a goal R47 would have fewer episodes of this behavior. Interventions directed staff to administer R47's medications as directed, provide her opportunities for positive interaction and attention while stopping and talking with "him/her" as passing by, explain all procedures to the resident before starting and allow her to adjust to changes.

R47's Hospice Plan of Care Report, dated 1/27/21, identified R47 experienced coping/psychosocial and grieving issues with a need for facility staff care coordination in which hospice had reviewed their plan of care with the facility that day. The report's Hospice Medical Social Work pathway, dated 1/27/21 identified an approach to initiate a referral to a mental health professional if mental illness had been identified; however the approach had been discontinued from her plan of care on 3/9/21. The report lacked evidence of a comprehensive assessment related to R47's behaviors or a referral to a mental health professional.

A review of R47's progress notes, dated 1/1/21 - 4/7/21, identified the following entries:

- 1/12/21, at 11:04 a.m. "Yells out all shift. "hello,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 34	F 744		

help" says where am I, I'm so anxious, what should I be doing." A follow-up note at 2:45 p.m. indicated staff had updated the nurse practitioner on R47's "yelling out and anxious behavior" with no new orders prescribed.

- 1/27/21, at 1:00 p.m. "Resident admitted to hospice today... new orders received to increase Lorazepam (antianxiety)...Resident continues to yell/call out "hello" and "help me." She states that she sometimes has anxiety but does not know why..."

- 2/18/21, medical provider had been contacted due to R47's "continual yelling out and anxiety" in which Ativan (antianxiety) had been prescribed on an as needed basis.

- 3/22/21, at 12:00 p.m. hospice nurse note indicated R47 had received as needed Lorazepam daily for the last five days.

- 4/2/21, at 2:25 p.m. hospice nurse note indicated R47 continued to call out "help" daily in which R47 had not liked to be alone and needed to be kept busy.

- 4/5/21, at 1:00 p.m.. hospice nurse note indicated staff nurse reported R47 had been calling out even when family or staff had sat with her.

R47's progress notes, dated 1/1/21 - 4/7/21, indicated many interdisciplinary (IDT) staff and hospice entries R47 had exhibited yelling/calling out for "help" despite interventions and medication administration; however, routine hospice nurse progress notes identified facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 35 nursing staff overall had "no concerns or needs at this time." Hospice Comprehensive Assessment and Plan of Care Update Report, dated 3/30/21, continued to report R47 had problems related to coping and grieving, impaired quality of life, and spiritual issues with the need for facility staff care coordination. The report continued to identify R47 called out even when assisted and had increased daytime naps. There had been no updates during the meeting and her plan of care remained the same. The report identified hospice staff had participated. The report lacked evidence of facility staff involvement and that R47's calling out behaviors had been comprehensively assessed. R47's Behavioral Symptoms CAA dated 2/5/21, identified computer generated check marks under the heading Analysis of Findings which were based on R47's 2/2/21 significant change MDS questioned responses related to R47's behavior symptoms, along with cognitive and medical status. The CAA's section labeled Nature of the problem/condition directed to "See cognitive caas." The heading Resident and/or Family/Representative which asked to provide their input for this CAA had been left blank. The heading Care Plan Considerations indicated R47's behavioral symptoms would not be addressed in her care plan and lacked evidence of documentation which explained the rationale for that decision. The CAA directed to see social services note. The CAA lacked evidence a comprehensive assessment had been performed of R47's behaviors at the time of the CAA process.	F 744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 36	F 744		

R47's Cognitive Loss / Dementia CAA dated 2/5/21, identified computer generated check marks under the heading Analysis of Findings which were based on R47's 2/2/21 significant change MDS questioned responses related to R47's cognitive, behavioral, and medical status. The CAA's section labeled Nature of the problem/condition had been left blank. The heading Care Plan consideration indicated R47's cognitive loss would be addressed in her care plan. The CAA directed to see social services note. The CAA lacked evidence a comprehensive assessment had been performed on R47's cognitive status at the time of the CAA process.

A plan of care (POC) Behavior Symptoms monitoring task, dated 3/25/21 - 4/6/21, identified R47 had documented "Yelling/Screaming" on all days except 4/3/21. The behavior charting indicated the yelling/screaming occurred on day and evening shifts. The monitoring lacked evidence of behavior frequency during those shifts.

R47's treatment administration record (TAR), dated 4/1/21 - 4/6/21, directed staff to document the number of times R47 exhibited episodes of having been weepy/tearful; withdrawn; had statements of having felt down/depressed; other. Further, the TAR directed staff to document in the progress notes the details of any exhibited behaviors, interventions attempted, and the outcome. The TAR documentation indicated R47 had no exhibited behaviors staff had identified during the TAR time frame. In addition, the TAR lacked documentation monitoring specific to R47's observed repetitive yelling/calling out.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 37	F 744		

R47's medical record was reviewed and lacked evidence R47 had been comprehensively assessed and new interventions developed during her stay to reduce R47's identified behaviors.

During interview on 4/7/21, at 1:30 p.m. hospice case manager/registered nurse (RN)-H acknowledged R47 had behaviors of yelling/calling (help me, help me) out which she had observed while in the facility even before R47 initiated hospice benefits. RN-H explained R47 had numerous interventions in place to help mitigate general yelling/calling out (help me, help me) that had been "hit and miss" on what has worked at the time of the experienced behavior. RN-H stated R47 appeared to not even realize she had been yelling/calling out when approached and felt R47's behavior was a "reflex." RN-H stated she was unsure if there had been an comprehensive assessment or comprehensive collaboration with the nursing IDT on R47's yelling/calling out that would determine etiology, need for new or adjusted interventions, and/or reassessment.

When interviewed on 4/8/21, at 10:32 a.m. nursing assistant (NA)-D stated R47 had been yelling and calling out (help me, help me) "about the same" since R47 admitted to the unit. She state R47 had not even known she had been calling out "most of the time" and had periods where she had been unable to explain her reasons for the behavior. NA-D explained R47 had not liked to be alone and further explained the interventions she used with R47 when she would yell out help me only worked for short

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 38	F 744		

periods of time, if they even worked at all. NA-D denied she had been involved in discussions with nursing management for input into R47's behaviors and intervention approaches.

During interview on 4/8/21, at 10:45 a.m. health unit coordinator (HUC)-A stated R47 yells out help me help me or hello, "all day long!" HUC-A added she felt her yelling had become more consistent since January and that, "It was never like this." R47 explained interventions she utilized to help mitigate R47's behaviors have worked at times; however, have not worked at others. HUC-A denied she had been involved in discussions with nursing management for input into R47's behaviors and intervention approaches.

When interviewed on 4/8/21, at 10:57 a.m. NA-H stated R47's yelling and calling out behaviors have been "going on for a while," have remained "about the same," and the yelling and calling out (help me, help me) were "just behavioral." NA-H confirmed R47 had episodes where she had not been aware that she was yelling or calling out and at times, even when staff worked with her. NA-H verbalized she had not thought there was anything that could be done to help mitigate R47's behaviors; however, NA-H denied she had been involved in discussions with nursing management for input into R47's behaviors and intervention approaches.

During interview on 4/8/21, at 11:08 a.m. NA-I stated R47 "yells out every 15 seconds probably" which had been present "the whole time" R47 has been a resident there. NA-I explained she has asked nursing why they "can get a handle on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 39	F 744		

some residents but not this particular one." She acknowledged she attempted to manage R47's behaviors "episode to episode." NA-A denied she had been involved in discussions with nursing management for input into R47's behaviors and intervention approaches.

When interviewed on 4/8/21 at 11:21 a.m. activity staff (A)-A stated R47 "yells out every day" which has occurred even when R47 has been directly engaged in activity staff interactions. A-A acknowledged "nothing really seems to help long term" and R47 needs to see staff and hold their hand; however, that is not always a guarantee R47 will have decreased yelling/calling out. A-A confirmed the activity staff have talked amongst their department members on how best to help R47 with her behaviors; however, A-A denied such conversations have occurred with nursing staff from the facility and/or hospice staff.

During interview on 4/8/21, at 11:47 a.m. hospice social worker (SW)-C stated she had been unsure as to where R47's behaviors stemmed from and explained the behaviors were "just something that she does." SW-C explained R47 had appeared more confused today versus other interactions she has had with her previously; otherwise, R47's behaviors have "been pretty much the same." SW-C confirmed she has kept up on R47's status as she has read hospice nursing progress notes, which have indicated R47 yells out; however SW-C commented her communication with the facility team had been limited. SW-C denied having collaborated with facility staff for a comprehensive assessment on R47's behaviors; however, she confirmed this would be helpful "to get everyone on the same

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 40	F 744		

page..." SW-C explained, "Someone would need to initiate a meeting between hospice and the facility," in which she further explained, "Nurses at the facility would take the lead, but that does not mean that I could not have initiated it." SW-C denied having conversations with RN-B related to R47's behaviors and commented after, "I think it would not hurt to try (to get together)...maybe I should have initiated it."

When interviewed on 4/8/21, at 2:11 p.m. RN-B stated, "At first we put it off that it was a behavior, and then we put if off as a personality thing, and then just determined she (R47) is that confused." RN-B explained staff utilize many interventions to redirect R47's behaviors; however, often these interventions only help for "short spurts of time." RN-B denied R47's behaviors had been comprehensively assessed by the facility IDT and/or in collaboration with the hospice team. RN-B acknowledged she had not thought to initiate a meeting with hospice in which she further explained she had not been sure if R47 would benefit from such a collaboration; however, RN-B voiced she "would like to say that she [R47] would [benefit] as any change in interventions may be beneficial."

Following survey entrance, a care plan intervention dated 4/5/21, indicated "resident continuously yells out "Help Me" even during the times staff are helping her."

A policy Dementia Care, dated 11/9/18, indicated the purpose of the policy had been, "To ensure that the best quality care will be given with patience, understanding, dignity and respect for all residents living with dementia, and that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 41 care for each resident be unique and individualized based on thorough knowledge of residents and their abilities and needs." The policy directed information regarding the resident's abilities and background would be obtained from interviews, record review, family input, and assessments in order to identify and understand any behavioral management needs for the resident; and to provide care and assistance that has been tailored to the resident's needs. Further, the policy directed the IDT would add resident specific non-pharmacological interventions; upon admission, routinely throughout therapy when needed (or if ineffective), and would review these at every care plan update.	F 744		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		5/27/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 42 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physician ordered medications were administered per standard of practice for 1 of 1 residents (R21) who had medications left unattended on their bedside tray table. Findings include: R21's quarterly Minimum Data Set (MDS), dated 1/4/21, identified R21 had moderate cognitive impairment with diagnosis of Alzheimer's dementia, macular degeneration (eye condition), and rheumatoid arthritis (inflammatory disease affecting the joints). On 4/5/21, at 11:24 a.m. R21 was observed in her room seated in her wheelchair next to her dresser. A bedside tray table was positioned approximately two feet (ft) inside the room with one end of the tray table touching the bedroom door. A medication administration cup sat on the tray table which held three pills (two white pills	F 755	The facility strives to provide services of administering medications to meet the needs of each resident. Medication dose was removed from the R21 room. The resident had been administered the medications by the licensed nurse, but had spit the medications out after the nurse left the room. The care plan has been updated to include ensuring the resident has swallowed all medication prior to leaving the room. All licensed nurses and TMA□s will receive education to stay with residents to ensure all medications are consumed unless the resident has a physician□s order to self-administer medications. Nurse unit Managers, or DON will audit and observe medication administration to three residents each week to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 43 both with "A325" engraved on one side and an oval maroon capsule). R21 identified the medications in the cup as Tylenol and a multivitamin: however, R21 had been unaware if they were medications she had been given that morning or the evening prior. She stated she was unsure as to when she normally took her medications as staff "come in and bring it in for me." Further, R21 voiced staff would come back and remind her to take her medications; however, she had been unable to provide specifics to when and/or how often this occurred. With a subsequent observation 35 minutes later, R21 had a small plastic cup of clear liquid in her hand and the bedside tray table was now positioned directly in front of her. A medication administration cup sat on the tray table still held the two white pills engraved with "A325." The oval maroon capsule was no longer present. On 4/5/21, at 1:12 p.m. observation of R21's room and tray table revealed the medication administration cup and the medications were no longer present. Review of R21's April 2021 Medication Administration Record directed staff to administer "Acetaminophen Tablet Give 650 mg (milligrams) by mouth three times a day for pain @ (at) 8am, 2pm, 8pm" and "PreserVision/Lutein Capsule (Multiple Vitamins-Minerals) Give 1 tablet by mouth two times a day for SUPPLEMENT." The record lacked evidence of a physician order that R21 may self administer these medications. During interview on 4/7/21, at 7:11 a.m. licensed practical nurse (LPN)-A stated R21 "usually takes	F 755	medications are swallowed by the resident prior to the nurse leaving the room for 3 months. The DON will review audits and bring to QAPI, and monitor this tag. Correction date 5/27/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 44	F 755		

everything in front of me" and explained on 4/5/21 he had handed R21 a medication cup of that mornings medications in which R21 "tipped the cup into her mouth and set it down." LPN-A verbalized that on 4/5/21 "one of the activity ladies" had informed him R21 had a medication cup in her room which held medications. LPN-A acknowledged when he followed up on the information he had found two Tylenol in the cup which he then observed R21 take. LPN-A denied observation of the oval maroon capsule at that time or knowledge if R21 had taken the multivitamin as prescribed. LPN-A confirmed he had not initially checked the medication cup for medications that morning which may have been missed and he had "took it for granted" that R21 had consumed them all. LPN-A acknowledged that per medication administration practices he is expected to stay with a resident to ensure they take all of their medications as there is a risk of other residents taking the missed medications or that R21 may have negative a impact if she does not take the medications as prescribed.

When interviewed on 4/8/21, at 2:02 p.m. nursing unit manager (RN)-B explained she expected staff to ensure R21 swallowed all of her medications and that the medication cup was empty before they left R21. RN-B acknowledged there is a risk of dropped or missed missed medications, or that another resident may take them, if staff did not ensure R21 consumed all of her medications.

A policy Administration Procedures for All Medications, dated 6/15, directed staff to "Review 5 Rights (3) times," in which staff were to "Check MAR/TAR (medication and treatment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 45 administration records) for order." The policy failed to direct staff to ensure the resident consumed the medication(s) as directed by the medication order(s).	F 755		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer	F 790		5/27/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 790	Continued From page 46 residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental recommendations were acted upon and future appointments coordinated to ensure timely service to prevent continued tooth decay for 1 of 2 residents (R8) reviewed for dental care and services. Findings include: R8's quarterly Minimum Data Set (MDS), dated 3/23/21, identified R8 had severe cognitive impairment and required extensive assistance to complete her personal hygiene (inc. brushing teeth). Further, R8's Census listing, printed 4/7/21, identified R8's payer source as, "Private Pay/MA Applicant." On 4/5/21, at 1:57 R8 was observed in her room. R8 had a visible missing tooth on her lower palate along with scant, white colored plaque buildup present on several teeth near the gum-line. R8 was unable to answer when, if ever, she had last been to the dentist or had her teeth looked at for hygiene. R8's dental hygiene Progress Note, dated 3/9/21, identified R8 was seen and a limited examination was completed. R8 was recorded as having no	F 790	The Facility strives to provide Dental services timely. The Deficiency was corrected for R8 with a follow up DDS visit on 5/6/21. The facility will review all dental referrals within 24hrs of receiving them to determine the need of coordinating any future appointments. The medical records coordinator or designee will audit DDS referrals to ensure follow up DDS services are coordinated timely, and report audits to the Director of Nursing who will monitor this tag. Frequency of audits will coincide with frequency of dental visits, currently 1x/month. The Director of Nursing will review audits and report to QAPI. Correction date 5/27/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 790	Continued From page 47	F 790		

pain during the visit with dictation reading, "Pain at its worst: Unknown." The examination outlined R8 had visible cavities (or a hole in the tooth) along with intra-oral swelling and bleeding due to a not allowing routine oral hygiene. An assessment was listed which recorded, "Findings: Caries, Deep Caries, Root Tip(s), Fractured tooth, Fractured Restoration ...,' along with a a recommended treatment plan which read, "Recommend silver diamine to stop caries progression-will contact [guardian] regarding treatment." Further, the note continued, "[R8] and health unit secretary [HUC-A] from Guardian Angels to help with behavior - will contact [guardian] regarding treatment was informed of findings above ... Discussed with staff that placing silver diamine would stop caries progression. [R8] would not tolerate other treatment options - will be in touch with [guardian] regarding treatment." The note was initialed by a nursing home staff member on the front page with dictation reading, "[checkmark] noted 3/16/21."

When interviewed on 4/6/21, at 4:32 p.m. R8's appointed guardian (G)-A explained she was under the impression R8's dental visits were done through someone who came to the facility and provided care. R8 had a recent dental appointment where recommendations were made for R8, and G-A stated she "thought they [the nursing home] were going to schedule that" and have the recommendations followed-up on.

R8's medical record was reviewed and lacked evidence the facility had proceeded to coordinate and schedule the recommended care for R8 with the outside dental provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 790	Continued From page 48 On 4/7/21, at 11:48 a.m. HUC-A was interviewed and verified she was the person responsible to coordinate appointments with dental providers. HUC-A stated Southside Dental had been visiting the campus and providing care in the past months and added they had just been there again the week prior. HUC-A stated R8 was not currently scheduled for any additional dental appointments and voiced she was unaware of the recommendations which had been made by the dental hygienist during the last visit on 3/9/21, adding the recommendations and appointment to complete the treatment had not been acted upon as of then. HUC-A explained the staff's initials on the progress note were a different HUC staff member's and the fact R8's appointment got missed served as "an eye opener" for her to review her own patients notes and ensure recommendations are acted upon and scheduled. HUC-A stated it was important to ensure dental appointments and recommendations were acted upon timely as tooth decay and oral issues could "cause serious problems." When interviewed on 4/7/21, at 12:06 p.m. registered nurse manager (RN)-B explained when a dental provider saw a patient and made recommendations for continued care, then the HUC should let her know so they can "try to follow up on them." RN-B reviewed R8's completed dental progress note and voiced she was unaware such recommendations had been made and verified she had not acted on them or followed up on them to ensure needed subsequent appointment(s) were scheduled. RN-B stated she was "not 100% sure" who was	F 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 790	Continued From page 49 responsible to ensure recommendations were acted upon, however, verified the appointment and treatment recommendations should have been scheduled adding, "Someone dropped the ball." Further, RN-B stated it was important to ensure dental concerns were acted upon timely as poor oral health can lead to "all kinds of health issues." A policy on dental appointments and coordination of care with outside dental providers was requested, however, none was received.	F 790		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842		5/27/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 50	F 842		

regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 51 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure conflicting notes and orders for emergency care (i.e., cardiopulmonary resuscitation) were clarified to ensure an accurate medical record was maintained for 1 of 1 resident (R8) whose medical record was found to have incorrect and conflicting information which could potentially delay emergency care. Findings include: R8's quarterly Minimum Data Set (MDS), dated 3/23/21, identified R8 had severe cognitive impairment and required extensive assistance with her activities of daily living (ADLs). Further, R8 had several medical conditions including heart failure, high blood pressure and renal insufficiency/renal failure. On 4/4/21, R8's hard chart was reviewed. In the front of the chart, a single untitled blue-colored piece of paper was present which identified R8's name and information along with two options reading, "DNR/DNI [Do Not Resuscitate]," and, "Full Code [Initiate CPR]." A black colored checkmark was placed next to the option of, "Full Code." The document was signed by R8's family member and a registered nurse on 6/16/20. R8's electronic medical record, a.k.a. Point Click Care, was reviewed. R8's record header (an area outlining basic information of R8) had visible	F 842	Guardian Angels Care Center seek to provide clear and accurate documentation of Code Status. R8 will have an updated POLST placed in the medical record. Physician orders currently include full code. Facility nursing staff are aware of and would respond to physician order. In R8 case, the SW inadvertently documented resident was not a full code, however this would not have resulted in resuscitation efforts being withheld. A 100% audit of charts will be conducted to ensure accurate POLST forms are present in the resident□s medical record, or document that a request has been made with responsible party. Training will be conducted for all licensed staff and Social Workers to verify resuscitation status prior to any documentation entries being made. Director of Social Services will monitor this tag. Correction date 5/27/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 52	F 842		

dictation which read, "Code Status: See POLST [Physician Orders for Life Sustaining Treatment]: FULL CODE."

However, multiple progress note(s) in R8's record, dated 1/8/21 and 3/31/21, identified R8 as " ... is DNR/DNI with comfort care and pain management." These notes were signed by social worker (SW)-A.

When interviewed on 4/6/21, at 4:32 p.m. R8's appointed guardian (G)-A voiced she believed R8 was a full code and would want full measures taken if she suffered cardiac or respiratory arrest. G-A could not recall ever being told or asked about changing R8 to a DNR/DNI.

R8's entire medical record, including hard chart and electronic record, were reviewed and lacked any other completed POLST(s), nor evidence these conflicting entries and orders were clarified to ensure R8's medical record was corrected and that appropriate action would be taken in the event R8 suffered sudden cardiac and/or respiratory arrest and required emergency care. Further, R8's care plan, dated 12/28/20, lacked any information or guidance on R8's code status or wishes for care in the event of sudden cardiac and/or respiratory arrest.

When interviewed on 4/6/21, at 4:55 p.m. registered nurse (RN)-A stated if R8 was found unresponsive or suffered cardiac arrest, she would check the hard chart and follow the directive which outlined R8 as a full code (i.e., she would begin CPR and call Emergency Medical Services [EMS]). RN-A stated most residents had a yellow-colored POLST present in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 53	F 842		

their chart; however, R8's record lacked one and she was not sure why. RN-A reviewed R8's medical record, including the completed progress notes from 1/8/21 and 3/31/21 which outlined R8 as a DNR/DNI, and stated they were conflicting and "this needs to be clarified." RN-A voiced they had been discussing changing R8 to a DNR/DNI, however, she was not sure if that had happened or not yet. RN-A voiced, either way, it was "very essential" all records were accurate and match for a resident's code status and wishes to ensure the correct actions would be implemented in an emergency situation. During subsequent interview, at 5:05 p.m., RN-A voiced she contacted the social worker and affirmed R8 was a full code. The multiple entries had been completed in error and the social worker needed to clarify the record immediately.

On 4/7/21, at 12:58 p.m. SW-A was interviewed and verified the multiple progress notes which identified R8 as a DNR/DNI were in error likely due to multi-tasking and she "didn't pay attention." SW-A stated it was important to ensure all records and entries in the record be accurate and outline the correct healthcare wishes of a resident otherwise the staff "don't know what's true or not true" in an emergency situation.

When interviewed on 4/7/21, at 1:09 p.m. registered nurse unit manager (RN)-B verified R8 should have been recorded in the medical record as a full code as the appointed guardian did not want to change her code status. RN-B expressed it was important to ensure all code status medical record entries and orders match to ensure R8's desired wishes would be implemented in an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 54 emergency situation and not create confusion which is what had happened since they were told of these conflicting notes. A policy on medical record(s) was not provided.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **02 - GUARDIAN ANGELS CARE CENTER** B. WING _____	**04/06/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Guardian Angels Care Center Building 02 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Facilities. Guardian Angels Care Center Building 2 is a 1-story building with a partial basement built in 2007 and was determined to be of Type V (111) construction. The addition was surveyed to existing under Building 2 due to the building type of construction. The building is fully sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 120 beds and had a census of 104 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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