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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LMKM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00858

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245239**

2.STATE VENDOR OR MEDICAID NO.
(L2) **863278200**

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **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)
12/31

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (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
	90			
(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 :
Teresa Ament, Unit Supervisor 06/17/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 06/17/2021 (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
10/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00130
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/02/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2021

CMS Certification Number (CCN): 245239

Administrator
Guardian Angels Health & Rehab Center
1500 East Third Avenue
Hibbing, MN 55746

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 May 26, 2021 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 17, 2021

Administrator
Guardian Angels Health & Rehab Center
1500 East Third Avenue
Hibbing, MN 55746

RE: CCN: 245239
Cycle Start Date: May 30, 2021

Dear Administrator:

On June 10, 2021, the Minnesota Department(s) 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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LMKM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00858

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/30/2021** (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)
12/31

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

12.Total Facility Beds **90** (L18)
13.Total Certified Beds **50** (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
	50			
(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 :
Sativa Bushey, HFE - NE II 05/25/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 05/28/2021 (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
10/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00130
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
May 6, 2021

Administrator
Guardian Angels Health & Rehab Center
1500 East Third Avenue
Hibbing, MN 55746

RE: CCN: 245239
Cycle Start Date: April 30, 2021

Dear Administrator:

On April 30, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 30, 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 30, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/26/21, through 4/30/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was 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 4/26/21, through 4/30/21, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		5/26/21

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

Electronically Signed | 05/13/2021

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
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 1 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident did not self-administer medications (SAM) as assessed and according to the care plan for 1 of 2 residents (R24) reviewed for SAM. Findings include: R24's Face Sheet printed 4/28/21, indicated R24's diagnoses included atrial flutter (irregular heart beat), hypertension, gastro-esophageal reflux disorder, stroke, hypothyroidism (underactive thyroid), hyperlipidemia (high cholesterol), and diabetes. R24's quarterly Minimum Data Assessment, dated 3/4/21, indicated R24 was cognitively intact and understood others. R24's care plan initiated 11/21/18, indicated R24 preferred nursing to store and administer medications as prescribed. R24's Medication Self Administration assessment dated 4/18/19, indicated R24 could not correctly state what each medication was for and what time each medication was to be taken, and was not able to self-administer her medications. R24's assessment directed R24 was to receive medications from a licensed nurse who would store, set up, administer, and document all medications per physician's orders. R24's physician orders included orders for:	F 554	F554 Resident Self- Admin Meds-Clinically Appropriate. DON and/or designee will implement corrective action for resident affected by this practice (R24): R24 no longer resides at this care center. LPN-A was re-educated by DON on 4/27/21 regarding self-administration of medications policy. All residents have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The Self-Administration of Medication by Residents policy was reviewed, with no updates needed. All licensed nursing staff will be educated on the Self-Administration of Medication by Residents. All residents SAM assessments will be reviewed for accuracy by the Nurse Managers and updated as needed. Random audits on appropriate administering of medications per residents self-administration assessment will be completed by DON and/or designee, three times a week for three weeks, two times a week for two weeks,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 2 - Acetaminophen 500 milligrams (mg) one tablet by mouth per day at 8:00 a.m. - Aspirin enteric coated (EC) delayed release (DR) 81 mg by mouth one time per day at 8:00 a.m. - Folic acid (vitamin B) 1 mg by mouth one time per day at 8:00 a.m. -Norvasc tablet, 2.5 mg by mouth one time per day at 8:00 a.m. - Synthroid (for hypothyroidism) tablet, 25 micrograms (mcg) by mouth one time per day at 8:00 a.m. - Women's Multivitamin Hi Potency one tablet by mouth one time per day at 8:00 a.m. R24's physician orders lacked directives for R24 to self-administer medications. R24's electronic Medication Administration Record (eMAR) indicated R24 received the following medications on 4/27/21, for the 8:00 a.m. medication pass: -Acetaminophen 500 milligrams (mg) one tablet -Aspirin enteric coated (EC) delayed release (DR) 81 mg -Folic acid (vitamin B) 1 mg -Norvasc (for high blood pressure) 2.5 mg -Synthroid (for hypothyroidism) 25 micrograms (mcg) - women's multivitamin hi potency one tablet R24's eMAR lacked directives for SAM. On 4/27/21, at 9:08 a.m. licensed practical nurse (LPN)-A was observed to leave a medication cup of medications with R24 in her room. LPN-A then left R24's room while R24 took her medications one at a time. On 4/27/21, at 11:03 a.m. LPN-A was interviewed and stated she usually left R24's medications with	F 554	and weekly thereafter starting 5/24/21. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 5/26/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 3 her because she would not take them if nursing staff stayed with her. LPN-A stated R24 should have a physician's order for self-administration of medications, but was not sure if she did have an order. LPN-A checked for orders on the computer and verified R24 did not have orders for SAM. LPN-A stated the unit managers were the ones to get the orders. On 4/27/21, at 11:08 a.m. LPN-A asked registered nurse (RN)-A about SAM orders for R24. RN-A verified R24 did not have orders to SAM. RN-A stated he would assess and get orders if she was determined to be appropriate for safe SAM. On 4/30/21, at 9:21 a.m. the director of nursing (DON) verified staff should not leave a resident with medications when they had not been assessed to be safe with SAM, and did not have a physician's order. The facility policy Self-Administration of Medication by Residents revised 1/18, directed the interdisciplinary team (IDT) to assess and determine the resident's ability to safely self-administer their medications if the resident wished to SAM. If SAM is determined to not be safe, the IDT would consider options that allowed the resident to actively participate in SAM to the extent that was deemed safe.	F 554		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 4 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to clean and maintain	F 584	F584 Safe/Clean/Comfortable/Homelike Environment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 5 sheepskin coverings on resident equipment for 6 of 8 residents (R1, R12, R21, R25, R32, and R37) reviewed for sheepskin covers on equipment. Findings include: R1's Face Sheet printed 4/30/21, identified diagnoses which included macular degeneration (a medical condition in which the lens of the eye becomes progressively opaque, resulting in blurred vision), and glaucoma. R1's significant change Minimum Data set (MDS) dated 4/13/21, indicated R1 was cognitively intact. On 4/29/21, at 8:41 a.m. the sheepskins on R1's wheelchair arms were noted to be gray in color, matted, and the left sheepskin was worn down and noted to have a hole where R1's elbow rested. On 4/29/21, at 1:41 a.m. registered nurse (RN)-A was interviewed. RN-A stated sheepskins on the resident's equipment were used to protect the resident's skin from pressure or scrapping skin against the equipment. RN-A further stated housekeeping staff cleaned the wheelchairs weekly, and would replace or clean the sheepskins at that time if needed. On 4/29/21, at 3:32 p.m. nursing assistant (NA)-E was interviewed. NA-E stated he was unsure who was responsible for washing or replacing the sheepskins on the resident's equipment. NA-E verified R1's sheepskin on her wheelchair arms were soiled and worn, and should be replaced. NA-E asked R1 if she would	F 584	DON and/or designee will implement corrective action for residents affected by this practice (R1, R12, R21,R25, R32 and R37) R1, R12, R21, R25, R32, and R37 will have their sheepskin replaced. All residents who utilize sheepskin for skin protection have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: A Care of Sheepskin Policy was created. All nursing and environmental services staff will be educated on the Care of Sheepskin policy. Housekeeping checklist will be updated by Environmental Service Director to include monitoring of sheepskin that is utilized in resident□s room and/or on wheelchair. Sheepskin will be removed by housekeeping during cleaning of wheelchair or room and sent to the laundry to be cleaned or replaced if not able to be laundered. Housekeeping staff to notify nursing staff for need of replacement. All resident equipment will be reviewed for sheepskin use and removed and replaced as needed Nursing staff education will include, if nursing staff notice sheepskin to be dirty or dingy in appearance, sheepskin will be replaced with new sheepskin and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 like the sheepskin on her wheelchair replaced, and R1 stated, "yes." R12's Face Sheet printed 4/20/21, identified diagnoses which included peripheral vascular disease (narrowed blood vessels with reduced blood flow to the limbs). R12's significant change MDS dated 2/5/21, indicated R12 was cognitively intact. On 4/27/21, at 8:50 a.m. the sheepskins on R12's wheelchair arms were noted to be gray in color and matted. R12 stated the sheepskin keeps her from banging her arms. R21's Face Sheet printed 4/30/21, identified diagnoses which included muscle weakness. R21's quarterly MDS dated 2/24/21, indicated R21 was severely cognitively impaired. On 4/28/21, at 10:03 a.m. the sheepskin on R21's siderails were observed to be gray in color, and matted. R25's Face Sheet printed 4/30/21, identified diagnoses which included hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke) affecting right dominant side. R25's quarterly MDS dated 3/1/21, indicated R25 was cognitively intact. On 4/30/21, at 9:19 a.m. R25 was interviewed. R25 stated the sheepskin on her wheelchair looked "dirty, matted." R25 stated she has never seen the staff remove them for cleaning, and it had been bothering her. R25 also said the	F 584	laundered if able. Sheepskin to be kept in medical supply room. Random audits condition of sheepskin will be completed by DON and/or designee three times a week x two weeks, then two times a week x two weeks, and then weekly thereafter starting 5/24/21. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 5/26/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7	F 584		

sheepskins looked worn out.

-at 9:26 a.m. NA-C was interviewed. NA-C stated the sheepskins on equipment get cleaned when someone sends them to the wash "not very often" as there were not replacements available. NA-C looked at the sheepskins on R25's wheelchair, and verified they looked dirty, matted, and should be washed or replaced.

R32's Face Sheet printed 4/30/21, identified diagnoses which included muscle weakness.

R32's quarterly MDS dated 3/10/21, indicated R32 was severely cognitively impaired.

On 4/28/21, at 9:32 a.m. the sheepskins on R32's wheelchair arms were observed to be gray in color and matted.

On 4/29/21, at 8:30 a.m. NA-A was interviewed. NA-A stated the sheepskin on equipment was there to protect resident's arms. NA-A stated housekeeping washed the wheelchairs and they were supposed to remove and wash the sheepskins from the wheelchairs. NA-A thought the sheepskins were marked with the resident name and that they were washed twice a week. NA-A looked at sheepskins on the arms of R32's wheelchair, she stated they looked dingy and looked like they should be washed.

R37's Face Sheet printed 4/30/21, identified diagnoses which weakness.

R37's quarterly MDS dated 3/19/21, indicated R37 was severely cognitively impaired.

On 4/27/21, at 11:38 a.m. the sheepskins on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8	F 584		

R37's wheelchair arms were observed. The sheepskins were gray in color and matted.

On 4/28/21, at 8:44 a.m. laundry staff (L)-A was interviewed and stated wheelchairs are washed "a couple of times a month." L-A stated housekeeping staff remove the sheepskin, put them in the laundry for washing, and bring them back to the resident's room when they were clean. L-A stated if they could not determine where the sheepskins came from, they gave the clean sheepskins to therapy.

-at 8:49 a.m. occupational therapist (OT)-D was interviewed. OT-D stated he would look at sheepskins returned from the laundry and if they were worn out he would throw them out, and order replacements. OT-D looked at the sheepskins on R32's wheelchair, he verified they were worn out, no longer providing a cushion.

-at 8:55 a.m. RN-A was interviewed. RN-A stated it was everyone's responsibility to ensure sheepskins were clean and not worn out. RN-A stated the NAs would come to him about worn out sheepskins for replacements. RN-A stated there was not a system in place to ensure sheepskins were cleaned on a regular basis and in good condition.

-at 9:11 a.m. housekeeper (H)-B was interviewed. H-B stated wheelchairs are cleaned monthly. H-B was not sure about what to do about sheepskins on wheelchairs, stated they are not used in her area.

On 4/30/21, at 10:17 a.m. the director of nursing (DON) was interviewed. The DON stated she depends on staff to notice if the sheepskins were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9 soiled or worn out. The DON stated the housekeeping staff "might" bring the sheepskin to the laundry when they clean the wheelchairs. The DON verified there was no process in place to ensure the sheepskins on equipment were clean and in good repair. The facility policy Environmental Cleaning and Disinfection Program revised 1/8/18, directed staff to ensure that furniture and equipment can be properly cleaned and disinfected. The environmental services supervisor would maintain a list of cleaning and disinfection tasks and the employee(s) responsible for these tasks. Ensure that all staff are responsible for ensuring high standards of cleanliness/disinfection with regard to resident care equipment, medical devices, and environment of care.	F 584		
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;	F 842		5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 10 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, 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	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 11 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (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 the Provider Orders for Life-Sustaining Treatment (POLST) was accurately completed to clearly reflect resident code status for 2 of 2 residents (R56, R43) who had a modified POLST with special instructions. Findings include: R56's Face Sheet printed 4/28/21, indicated R56 was admitted to the facility on 4/5/21, with diagnoses included cerebral infarction (stroke), hypertensive urgency (blood pressure spikes with blood pressure readings are 180/110 or higher and no damage to the body's organs), and cognitive communication deficit (difficulty with thinking and how someone uses language.). R56's Physicans Order Sheet dated 4/28/21, directed completion of the POLST Profile for advanced directives on 4/5/21. R56's POLST signed by R56 and R56's primary care physician on 4/5/21, indicated R56 had wished to have cardiopulmonary resuscitation (CPR) which would require full treatment, including interventions and mechanical ventilation as indicated, in the event R56 had no pulse and was not breathing. The CPR box was scribbled	F 842	F842 Resident Records DON and/or designee will implement corrective action for resident affected by this practice (R56, R43) R56 and R43 POLST will be reviewed again and updated to clearly reflect the resident□s code status. All residents have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: DON reviewed the Cardiopulmonary Resuscitation and Advance Care Planning policies, with no updates need. All facility resident POLST will be reviewed to ensure clear instructions and updated as needed by the nurse unit managers and DON. Education will be provided by the DON and/or designee to nurse unit managers on proper documentation of resident POLST and to clearly reflect the resident□s code status. Review of the resident code status was added to Social Services care conference checklist for review quarterly. Nurse Unit Manager will be responsible for making any necessary updates.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 12 out and the "Do Not Attempt Resuscitation (DNR)" box was checked immediately below the CPR box that was scribbled out. To the right side of the page, after the DNR statement, was a black stamp with large capital letters that read, "ORIGINAL" and partially over the stamp was hand written "wants CPR" in black ink. The second section on the POLST indicated R56 wanted selective treatment, to include medical treatment, no intubation, advanced airway interventions or mechanical ventilation, but may consider less invasive airway support and transfer to the hospital. R56's Care Plan History initiated 4/7/21, indicated R56's advanced directives were "DNR-No Intubation wants chest comressions (sp)-See POLST," with the approach that directed staff R56 was "DNR-No intubation-wants compressions only-See POLST." R56's Care Plan History indicated R56's advanced directives problem was revised on 4/29/21, and identified R56's advanced directives as "Full Code-See POLST-chest compressions only no intubation", with the approach that directed staff R56 was "Full Code-See POLST-Chest compressions only no intubation." On 4/27/21, at 9:57 a.m. R56's electronic medical record (eMAR) header indicated R56's advanced directives were "DNR-See POLST-wants compressions no intubation." On 4/27/21, at 12:22 p.m. registered nurse (RN)-B verified information on the eMAR and Care Plan directed DNR first, and stated she could not ensure staff would look beyond DNR and see R56 wanted chest compressions. RN-B	F 842	Random audits monitoring clarity of residents POLST will be completed by the DON and/or designee three times a week for two weeks, two times a week for two weeks, and weekly thereafter starting 5/24/21. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completed Date: 5/26/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 13 stated R56's daughter wanted CPR but no intubation, and the doctor had signed it, and was fine with her wishes for CPR, but nothing further if it did not work. RN-B verified staff could look at the check mark for DNR and not do CPR if they did not read the hand written directive. R43's admission Minimum Data Set (MDS) dated 3/24/21, indicated R43 was cognitively intact. R43's Face Sheet printed 4/28/21, indicated R43's diagnoses included fractures of right femur (thigh), right humerus (upper arm) with routine healing, hypertension (high blood pressure), and restless legs syndrome. R43's POLST signed by R43's family member (FM-E), undated with R43's physician dated 4/8/21, indicated R43 had selected, "Do Not Attempt Resuscitation (DNR)" for her resuscitation status in the event R43 had no pulse and was not breathing. The POLST had hand written instructions "shock one time only" and was not dated, signed or initialed. R43's Physician Orders dated 3/18/21, indicated Advance directives: Complete POLST Profile. R43's chart header provided by the facility with a screen shot on 4/28/21, Advance Directive indicated "Shock once only DNR." On 4/28/21, at 3:06 p.m. licensed practical nurse (LPN)-B was interviewed. LPN-B looked at R43's	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 14	F 842		

POLST and said she would not start chest compression and would only shock her once. LPN-B further indicated if she was looking at the POLST in a hurry she likely wouldn't notice the shock once instructions.

-at 3:11 p.m. RN-A was interviewed. RN-A stated he would expect staff to get the automated external defibrillator (AED) and put it on R43, and shock her once. RN-A stated he recalled talking with R43's family member, and the FM-E was insistent that this was what they wanted. RN-A was unsure what responsibility the facility had for using an AED and not following the prompts.

-at 3:39 p.m. the DON was interviewed. The DON stated the facility was aware of R43's wishes to only have one shock. The DON stated it was her expectation that staff would place the AED on R43 and wait for the AED to give instructions to deliver a shock. The DON stated she did not expect nursing staff to follow any prompts for giving breaths or doing compressions. The DON stated if the AED did not give instructions to give a shock, the emergency medical service (EMS) personnel could give a shock after they arrived and reviewed the POLST. The DON did not know if it was okay to use an AED and not follow the prompts.

On 4/29/21, at 10:31 a.m. FM-E was interviewed. FM-E stated it was his mom's wishes to only have one shock, but no CPR. FM-E stated the facility did talk with him about the futility of one shock and no CPR.

-at 9:52 a.m. LPN-C was interviewed. LPN-C stated he received training for CPR and AED use when he was in nursing school. He stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 15	F 842		

received training at the facility every two years. LPN-C stated the AED gives instructions on when to give breaths, do compressions, and when to give a shock. LPN-C stated it was important to follow the AED prompts. LPN-C stated he had not seen a POLST with written instructions for shock once. LPN-C stated if he saw a POLST like that he would talk with his nurse manager.

On 4/30/21, at 10:20 a.m. the DON was interviewed. The DON stated her and the nurse managers fill out POLST documents. The DON stated the AED and CPR training is provided by an outside instructor trained by the American Heart Association on AED use and CPR. The DON stated nursing staff are trained every two years. The DON stated she would expect nursing staff to follow the instructions the AED gave for breaths, compressions, and delivering shocks.

The facility provided training materials, Advance Care Planning Case Study undated. In bold all capitals the instructions included the following: NEVER ADAPT, UPDATE OR CHANGE A CURRENT POLST. NEVER CORRECT A NOTATION. IF THAT IS NEEDED, A NEW FORM IS COMPLETED.

The policy Advance Care Planning reviewed/amended 2/19/18, directed the following: The POLST form itself is never revised. A new POLST form must be completed with any updates or revisions, and signed by the resident and/or legal representative. The risks and benefits of CPR (per the American Heart Association) will be explained to the resident and/or designee, in order to assist them in making an informed decision.

Electronically delivered
May 6, 2021

Administrator
Guardian Angels Health & Rehab Center
1500 East Third Avenue
Hibbing, MN 55746

Re: State Nursing Home Licensing Orders
Event ID: LMKM11

Dear Administrator:

The above facility was surveyed on April 26, 2021 through April 30, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/26/21, through 4/30/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings;	2 625		5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 3 K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Provider Orders for Life-Sustaining Treatment (POLST) was accurately completed to clearly reflect resident code status for 2 of 2 residents (R56, R43) who had a modified POLST with special instructions. Findings include: R56's Face Sheet printed 4/28/21, indicated R56 was admitted to the facility on 4/5/21, with diagnoses included cerebral infarction (stroke), hypertensive urgency (blood pressure spikes with blood pressure readings are 180/110 or higher and no damage to the body's organs), and cognitive communication deficit (difficulty with thinking and how someone uses language.). R56's Physicans Order Sheet dated 4/28/21, directed completion of the POLST Profile for advanced directives on 4/5/21.	2 625	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 4 R56's POLST signed by R56 and R56's primary care physician on 4/5/21, indicated R56 had wished to have cardiopulmonary resuscitation (CPR) which would require full treatment, including interventions and mechanical ventilation as indicated, in the event R56 had no pulse and was not breathing. The CPR box was scribbled out and the "Do Not Attempt Resuscitation (DNR)" box was checked immediately below the CPR box that was scribbled out. To the right side of the page, after the DNR statement, was a black stamp with large capital letters that read, "ORIGINAL" and partially over the stamp was hand written "wants CPR" in black ink. The second section on the POLST indicated R56 wanted selective treatment, to include medical treatment, no intubation, advanced airway interventions or mechanical ventilation, but may consider less invasive airway support and transfer to the hospital. R56's Care Plan History initiated 4/7/21, indicated R56's advanced directives were "DNR-No Intubation wants chest comressions (sp)-See POLST," with the approach that directed staff R56 was "DNR-No intubation-wants compressions only-See POLST." R56's Care Plan History indicated R56's advanced directives problem was revised on 4/29/21, and identified R56's advanced directives as "Full Code-See POLST-chest compressions only no intubation", with the approach that directed staff R56 was "Full Code-See POLST-Chest compressions only no intubation." On 4/27/21, at 9:57 a.m. R56's electronic medical record (eMAR) header indicated R56's advanced directives were "DNR-See POLST-wants compressions no intubation."	2 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 5 On 4/27/21, at 12:22 p.m. registered nurse (RN)-B verified information on the eMAR and Care Plan directed DNR first, and stated she could not ensure staff would look beyond DNR and see R56 wanted chest compressions. RN-B stated R56's daughter wanted CPR but no intubation, and the doctor had signed it, and was fine with her wishes for CPR, but nothing further if it did not work. RN-B verified staff could look at the check mark for DNR and not do CPR if they did not read the hand written directive. R43's admission Minimum Data Set (MDS) dated 3/24/21, indicated R43 was cognitively intact. R43's Face Sheet printed 4/28/21, indicated R43's diagnoses included fractures of right femur (thigh), right humerus (upper arm) with routine healing, hypertension (high blood pressure), and restless legs syndrome. R43's POLST signed by R43's family member (FM-E), undated with R43's physician dated 4/8/21, indicated R43 had selected, "Do Not Attempt Resuscitation (DNR)" for her resuscitation status in the event R43 had no pulse and was not breathing. The POLST had hand written instructions "shock one time only" and was not dated, signed or initialed. R43's Physician Orders dated 3/18/21, indicated Advance directives: Complete POLST Profile. R43's chart header provided by the facility with a screen shot on 4/28/21, Advance Directive indicated "Shock once only DNR." On 4/28/21, at 3:06 p.m. licensed practical nurse	2 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 6	2 625		

(LPN)-B was interviewed. LPN-B looked at R43's POLST and said she would not start chest compression and would only shock her once. LPN-B further indicated if she was looking at the POLST in a hurry she likely wouldn't notice the shock once instructions.

-at 3:11 p.m. RN-A was interviewed. RN-A stated he would expect staff to get the automated external defibrillator (AED) and put it on R43, and shock her once. RN-A stated he recalled talking with R43's family member, and the FM-E was insistent that this was what they wanted. RN-A was unsure what responsibility the facility had for using an AED and not following the prompts.

-at 3:39 p.m. the DON was interviewed. The DON stated the facility was aware of R43's wishes to only have one shock. The DON stated it was her expectation that staff would place the AED on R43 and wait for the AED to give instructions to deliver a shock. The DON stated she did not expect nursing staff to follow any prompts for giving breaths or doing compressions. The DON stated if the AED did not give instructions to give a shock, the emergency medical service (EMS) personnel could give a shock after they arrived and reviewed the POLST. The DON did not know if it was okay to use an AED and not follow the prompts.

On 4/29/21, at 10:31 a.m. FM-E was interviewed. FM-E stated it was his mom's wishes to only have one shock, but no CPR. FM-E stated the facility did talk with him about the futility of one shock and no CPR.

-at 9:52 a.m. LPN-C was interviewed. LPN-C stated he received training for CPR and AED use when he was in nursing school. He stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 7	2 625		

received training at the facility every two years. LPN-C stated the AED gives instructions on when to give breaths, do compressions, and when to give a shock. LPN-C stated it was important to follow the AED prompts. LPN-C stated he had not seen a POLST with written instructions for shock once. LPN-C stated if he saw a POLST like that he would talk with his nurse manager.

On 4/30/21, at 10:20 a.m. the DON was interviewed. The DON stated her and the nurse managers fill out POLST documents. The DON stated the AED and CPR training is provided by an outside instructor trained by the American Heart Association on AED use and CPR. The DON stated nursing staff are trained every two years. The DON stated she would expect nursing staff to follow the instructions the AED gave for breaths, compressions, and delivering shocks.

The facility provided training materials, Advance Care Planning Case Study undated. In bold all capitals the instructions included the following: NEVER ADAPT, UPDATE OR CHANGE A CURRENT POLST. NEVER CORRECT A NOTATION. IF THAT IS NEEDED, A NEW FORM IS COMPLETED.

The policy Advance Care Planning reviewed/amended 2/19/18, directed the following: The POLST form itself is never revised. A new POLST form must be completed with any updates or revisions, and signed by the resident and/or legal representative. The risks and benefits of CPR (per the American Heart Association) will be explained to the resident and/or designee, in order to assist them in making an informed decision.

SUGGESTED METHODS OF CORRECTIONS:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 8 The Director of Nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure the Provider Orders for Life-Sustaining Treatment (POLST) is accurately completed to clearly reflect the resident code status who have modified POLST special instructions. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 625		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident did not self-administer medications (SAM) as assessed and according to the care plan for 1 of 2 residents (R24) reviewed for SAM. Findings include: R24's Face Sheet printed 4/28/21, indicated R24's diagnoses included atrial flutter (irregular heart beat), hypertension, gastro-esophageal reflux disorder, stroke, hypothyroidism	21565	Corrected	5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 9	21565		

(underactive thyroid), hyperlipidemia (high cholesterol), and diabetes.

R24's quarterly Minimum Data Assessment, dated 3/4/21, indicated R24 was cognitively intact and understood others.

R24's care plan initiated 11/21/18, indicated R24 preferred nursing to store and administer medications as prescribed.

R24's Medication Self Administration assessment dated 4/18/19, indicated R24 could not correctly state what each medication was for and what time each medication was to be taken, and was not able to self-administer her medications. R24's assessment directed R24 was to receive medications from a licensed nurse who would store, set up, administer, and document all medications per physician's orders.

R24's physician orders included orders for:
- Acetaminophen 500 milligrams (mg) one tablet by mouth per day at 8:00 a.m.
- Aspirin enteric coated (EC) delayed release (DR) 81 mg by mouth one time per day at 8:00 a.m.
- Folic acid (vitamin B) 1 mg by mouth one time per day at 8:00 a.m.
-Norvasc tablet, 2.5 mg by mouth one time per day at 8:00 a.m.
- Synthroid (for hypothyroidism) tablet, 25 micrograms (mcg) by mouth one time per day at 8:00 a.m.
- Women's Multivitamin Hi Potency one tablet by mouth one time per day at 8:00 a.m.
R24's physician orders lacked directives for R24 to self-administer medications.

R24's electronic Medication Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 10	21565		

Record (eMAR) indicated R24 received the following medications on 4/27/21, for the 8:00 a.m. medication pass:
-Acetaminophen 500 milligrams (mg) one tablet
-Aspirin enteric coated (EC) delayed release (DR) 81 mg
-Folic acid (vitamin B) 1 mg
-Norvasc (for high blood pressure) 2.5 mg
-Synthroid (for hypothyroidism) 25 micrograms (mcg)
- women's multivitamin hi potency one tablet
R24's eMAR lacked directives for SAM.

On 4/27/21, at 9:08 a.m. licensed practical nurse (LPN)-A was observed to leave a medication cup of medications with R24 in her room. LPN-A then left R24's room while R24 took her medications one at a time.

On 4/27/21, at 11:03 a.m. LPN-A was interviewed and stated she usually left R24's medications with her because she would not take them if nursing staff stayed with her. LPN-A stated R24 should have a physician's order for self-administration of medications, but was not sure if she did have an order. LPN-A checked for orders on the computer and verified R24 did not have orders for SAM. LPN-A stated the unit managers were the ones to get the orders.

On 4/27/21, at 11:08 a.m. LPN-A asked registered nurse (RN)-A about SAM orders for R24. RN-A verified R24 did not have orders to SAM. RN-A stated he would assess and get orders if she was determined to be appropriate for safe SAM.

On 4/30/21, at 9:21 a.m. the director of nursing (DON) verified staff should not leave a resident with medications when they had not been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 11 assessed to be safe with SAM, and did not have a physician's order. The facility policy Self-Administration of Medication by Residents revised 1/18, directed the interdisciplinary team (IDT) to assess and determine the resident's ability to safely self-administer their medications if the resident wished to SAM. If SAM is determined to not be safe, the IDT would consider options that allowed the resident to actively participate in SAM to the extent that was deemed safe. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed timely with self administration of medications; then provide staff education. The quality assurance committee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to clean and maintain	21695	Corrected	5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 12	21695		

sheepskin coverings on resident equipment for 6 of 8 residents (R1, R12, R21, R25, R32, and R37) reviewed for sheepskin covers on equipment.

Findings include:

R1's Face Sheet printed 4/30/21, identified diagnoses which included macular degeneration (a medical condition in which the lens of the eye becomes progressively opaque, resulting in blurred vision), and glaucoma.

R1's significant change Minimum Data set (MDS) dated 4/13/21, indicated R1 was cognitively intact.

On 4/29/21, at 8:41 a.m. the sheepskins on R1's wheelchair arms were noted to be gray in color, matted, and the left sheepskin was worn down and noted to have a hole where R1's elbow rested.

On 4/29/21, at 1:41 a.m. registered nurse (RN)-A was interviewed. RN-A stated sheepskins on the resident's equipment were used to protect the resident's skin from pressure or scrapping skin against the equipment. RN-A further stated housekeeping staff cleaned the wheelchairs weekly, and would replace or clean the sheepskins at that time if needed.

On 4/29/21, at 3:32 p.m. nursing assistant (NA)-E was interviewed. NA-E stated he was unsure who was responsible for washing or replacing the sheepskins on the resident's equipment. NA-E verified R1's sheepskin on her wheelchair arms were soiled and worn, and should be replaced. NA-E asked R1 if she would like the sheepskin on her wheelchair replaced,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 13 and R1 stated, "yes." R12's Face Sheet printed 4/20/21, identified diagnoses which included peripheral vascular disease (narrowed blood vessels with reduced blood flow to the limbs). R12's significant change MDS dated 2/5/21, indicated R12 was cognitively intact. On 4/27/21, at 8:50 a.m. the sheepskins on R12's wheelchair arms were noted to be gray in color and matted. R12 stated the sheepskin keeps her from banging her arms. R21's Face Sheet printed 4/30/21, identified diagnoses which included muscle weakness. R21's quarterly MDS dated 2/24/21, indicated R21 was severely cognitively impaired. On 4/28/21, at 10:03 a.m. the sheepskin on R21's siderails were observed to be gray in color, and matted. R25's Face Sheet printed 4/30/21, identified diagnoses which included hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke) affecting right dominant side. R25's quarterly MDS dated 3/1/21, indicated R25 was cognitively intact. On 4/30/21, at 9:19 a.m. R25 was interviewed. R25 stated the sheepskin on her wheelchair looked "dirty, matted." R25 stated she has never seen the staff remove them for cleaning, and it had been bothering her. R25 also said the sheepskins looked worn out.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 14 -at 9:26 a.m. NA-C was interviewed. NA-C stated the sheepskins on equipment get cleaned when someone sends them to the wash "not very often" as there were not replacements available. NA-C looked at the sheepskins on R25's wheelchair, and verified they looked dirty, matted, and should be washed or replaced. R32's Face Sheet printed 4/30/21, identified diagnoses which included muscle weakness. R32's quarterly MDS dated 3/10/21, indicated R32 was severely cognitively impaired. On 4/28/21, at 9:32 a.m. the sheepskins on R32's wheelchair arms were observed to be gray in color and matted. On 4/29/21, at 8:30 a.m. NA-A was interviewed. NA-A stated the sheepskin on equipment was there to protect resident's arms. NA-A stated housekeeping washed the wheelchairs and they were supposed to remove and wash the sheepskins from the wheelchairs. NA-A thought the sheepskins were marked with the resident name and that they were washed twice a week. NA-A looked at sheepskins on the arms of R32's wheelchair, she stated they looked dingy and looked like they should be washed. R37's Face Sheet printed 4/30/21, identified diagnoses which weakness. R37's quarterly MDS dated 3/19/21, indicated R37 was severely cognitively impaired. On 4/27/21, at 11:38 a.m. the sheepskins on R37's wheelchair arms were observed. The sheepskins were gray in color and matted.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 15 On 4/28/21, at 8:44 a.m. laundry staff (L)-A was interviewed and stated wheelchairs are washed "a couple of times a month." L-A stated housekeeping staff remove the sheepskin, put them in the laundry for washing, and bring them back to the resident's room when they were clean. L-A stated if they could not determine where the sheepskins came from, they gave the clean sheepskins to therapy. -at 8:49 a.m. occupational therapist (OT)-D was interviewed. OT-D stated he would look at sheepskins returned from the laundry and if they were worn out he would throw them out, and order replacements. OT-D looked at the sheepskins on R32's wheelchair, he verified they were worn out, no longer providing a cushion. -at 8:55 a.m. RN-A was interviewed. RN-A stated it was everyone's responsibility to ensure sheepskins were clean and not worn out. RN-A stated the NAs would come to him about worn out sheepskins for replacements. RN-A stated there was not a system in place to ensure sheepskins were cleaned on a regular basis and in good condition. -at 9:11 a.m. housekeeper (H)-B was interviewed. H-B stated wheelchairs are cleaned monthly. H-B was not sure about what to do about sheepskins on wheelchairs, stated they are not used in her area. On 4/30/21, at 10:17 a.m. the director of nursing (DON) was interviewed. The DON stated she depends on staff to notice if the sheepskins were soiled or worn out. The DON stated the housekeeping staff "might" bring the sheepskin to the laundry when they clean the wheelchairs. The DON verified there was no process in place to	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: _____ B. WING _____	C 04/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 16 ensure the sheepskins on equipment were clean and in good repair. The facility policy Environmental Cleaning and Disinfection Program revised 1/8/18, directed staff to ensure that furniture and equipment can be properly cleaned and disinfected. The environmental services supervisor would maintain a list of cleaning and disinfection tasks and the employee(s) responsible for these tasks. Ensure that all staff are responsible for ensuring high standards of cleanliness/disinfection with regard to resident care equipment, medical devices, and environment of care. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures on cleaning and/or replacing sheep skin padding on equipment. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/27/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Guardian Angels Health & Rehab Center was found not in 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. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/13/2021

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
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/27/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Inspected as one building: Guardian Angels Health and Rehab Center, is a 1-story building with a small partial basement. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1968, 1973, & 1991 additions were constructed to the building that was determined to be of Type II(111) construction. In 1990 a Type V (111) administrative wing (nonresident use area) was	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/27/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 constructed. In 2006 a 1-story building with a partial basement was added that was determined to be of Type II(111) constructed. In 2011 another wing was constructed that is a one story building with a small partial mechanical basement that was determined to be of Type II(000). The building is fully sprinklered throughout and also 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 90 beds and had a census of 62 at the time of the survey. The requirements of 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 712		5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/27/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 3 Based on staff interview and a review of the available documentation, it was determined that the facility failed to vary the times of the fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition, sections 19.7.1.2 and 19.7.1.6, during the last 12 months. These deficient conditions could affect 90 of 90 residents. Findings include: On 04/27/2021, at 10:00 a.m., during the review of all available fire drill documentation and an interview with the Maintenance Supervisor the following deficient conditions were found: 1. The facility failed to vary the times of the evening shift fire drills by conducting 3 fire drills in the 3 p.m. hour. 2. The facility failed to vary the times of the night shift fire drills by conducting 3 fire drills in the 1 a.m. hour. This deficient condition was verified by the Maintenance Supervisor.	K 712	K 712 ESD or designee will implement corrective action to prevent reoccurrence ESD and/or designee will implement measures to ensure this practice does not reoccur including: * Updating the Quarterly Nursing Home Fire Drills form to indicate variation requirements. * ESD and ESD staff will be provided education on proper variations of scheduling fire drills * Audits will be completed for monitoring by the ESD and/or designee two times monthly to ensure future compliance * Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Environmental Services Director is responsible for the corrective actions and monitoring of compliance Completed Date: 5/26/21	