DEPARTMENT OF HEALTH AND HUM	AN SERVICES	CENTERS FOR MED	ICARE & MEDICA	ID SERVICES
MEDI	CARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID:	LMKM
PART I	- TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Fac	ility ID: 00858
1. MEDICARE/MEDICAID PROVIDER NO.	3. NAME AND ADDRESS OF FACILITY		4. TYPE OF ACTION:	<u>7</u> (L8)
(L1) 245239 2 STATE VENDOR OR MEDICAID NO	(L3) GUARDIAN ANGELS HEALTH & RE (L4) 1500 EAST THIRD AVENUE	HAB CENTER	1. Initial	2. Recertification

2.STATE VENDOR OR MEDICAID NO. (L2) 863278200			(L4) 1500 EAST (L5) HIBBING, N		IUE	(L6) <b>5</b>	5746	<ol> <li>Initial</li> <li>Termination</li> <li>Validation</li> <li>On-Site Visit</li> </ol>	<ol> <li>Recertification</li> <li>CHOW</li> <li>Complaint</li> <li>Other</li> </ol>
5. EFFECTIVE DATE (L9)	E CHANGE OF OV	WNERSHIP	<ol> <li>PROVIDER/SU</li> <li>01 Hospital</li> </ol>	PPLIER CATEO 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	8. Full Survey Aft	er Complaint
<ol> <li>DATE OF SURVE</li> <li>ACCREDITATION         <ul> <li>0 Unaccredited</li> <li>2 AOA</li> </ul> </li> </ol>		2021 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENE 12/31	DING DATE: (L35)
11LTC PERIOD OF	CERTIFICATION		10.THE FACILITY	' IS CERTIFIED	AS:				
From (a) : To (b) :			X A. In Complia Program Re Compliance	equirements		11	ical Personnel	The Following Requirer 6. Scope of 7. Medical I	Services Limit
12.Total Facility Beds	;	<b>90</b> (L18)	1. A	cceptable POC		4. 7-Day 5. Life S	v RN (Rural SN)	F) 8. Patient Ro 9. Beds/Roo	
13.Total Certified Bec	ls	<b>90</b> (L17)		pliance with Pro and/or Applied	0		*	(L12)	11
14. LTC CERTIFIED	BED BREAKDOW	N				15. FACILITY M	IEETS		
18 SNF	18/19 SNF 90	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
(L37)	(L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY	AGENCY REMAN	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):				
17. SURVEYOR SIG	NATURE		Date :			18. STATE SURV	VEY AGENCY	APPROVAL	Date:
Teresa Ament, Ur	nit Supervisor		0	6/17/2021	(1.10)	Joanne Simon, En	forcement Specia	alist	06/17/2021

· · · · · · · · · · · · · · · · · · ·		(L19)		(L20)
P	ART II - TO BE COMP	LETED BY HCFA REGIONA	L OFFICE OR SINGLE STATE A	GENCY
19. DETERMINATION OF ELIGIE         _X1. Facility is Eligible to        2. Facility is not Eligible	o Participate	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	<ol> <li>Statement of Financial Solve</li> <li>Ownership/Control Interest I</li> <li>Both of the Above :</li> </ol>	
22. ORIGINAL DATE OF PARTICIPATION 10/01/1981	23. LTC AGREEMENT BEGINNING DATE	24. LTC AGREEMENT ENDING DATE	26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIVE SANG	(L25)	02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination	06-Fail to Meet Agreement OTHER
(L27)	A. Suspension of Admi	ssions: (L44)	04-Other Reason for Withdrawal	07-Provider Status Change 00-Active
	B. Rescind Suspension	(L45)		
28. TERMINATION DATE:		MEDIARY/CARRIER NO.	30. REMARKS	
	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETER 06/02. (L32)	2021 (L33)	DETERMINATION APPROVAL	



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



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	<b>CENTERS FOR MEDICARE &amp; MEDI</b>	CAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: LMKM
<b>PART I - TO BE COMPLETED BY THE STATE</b>	SURVEY AGENCY	Facility ID: 00858

MEMORALEVALUE ALCAP ROVDER NO.         1. AARE AND ADDESS OF PACILITY         4. TYPE OF ACTION \$\bar{2}\$           1. (1)         24231         (2)         (2)         (2)         (2)           2.TOTE VENDOR ON MIDEXAD NO.         (2)         (2)         (2)         (2)         (2)           2.TOTE VENDOR ON MIDEXAD NO.         (2) <th></th> <th>PART I -</th> <th>TO BE COMPI</th> <th>LETED BY 1</th> <th>THE STAT</th> <th><b>FE SURVEY</b> A</th> <th>AGENCY</th> <th></th> <th>Fac</th> <th>cility ID: 00858</th>		PART I -	TO BE COMPI	LETED BY 1	THE STAT	<b>FE SURVEY</b> A	AGENCY		Fac	cility ID: 00858
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St. ACCEPTITION STATUS:		GE OF OWNERSHIP				( )	22 CLIA			
From (a):       A. In Compliance With Program Requirements:       and/O. Approved Waters CT The Following Requirements:       Compliance With Program Requirements:       Complia	8. ACCREDITATION STATU 0 Unaccredited 1	S:(L10) TJC	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC				G DATE: (L35)
14. LTC CERTIFIED BED BREAKDOWN       15. DACLITY MEETS         18 SNF       18/19 SNF       19 SNF       LCF       IID         16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):       16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):       18. STATE SURVEY AGENCY APPROVAL       Date::         17. SURVEYOR SIGNATURE       Date :       18. STATE SURVEY AGENCY APPROVAL       Date::       Joanne Simon, Enforcement Specialist       05/28/2021         PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINCLE STATE AGENCY         19. DETERMINATION OF ELGIBILITY       20. COMPLIANCE WITH CIVIL       21. 1. Statement of Financial Solvency (HCFA-2572)       1. Onerchip/Courol Interest Declosure State (HCFA-1513)         2. ALT : Facility is Eligible to Participate       (L21)       24. LTC AGREEMENT       24. LTC AGREEMENT       24. LTC AGREEMENT       26. TERMINATION ACTION:       (L30)         VOLUNTARY         0101/1981       (L24)       (L41)       (L25)         25. LTC AGREEMENT       24. LTC AGREEMENT       26. TERMINATION ACTION:       (L30)         VOLUNTARY         02. DITERMEDIARY/CARRIER NO.       03-REMARKS       04-Reit/Balt/Balt/Palt/Balt/Balt/Palt/Balt/Palt/Balt/Palt/Balt/Palt/Balt/Palt/Palt/Palt/Palt/Palt/Palt/Palt/P	From (a) : To (b) : 12.Total Facility Beds	<b>90</b> (L18)	A. In Complia Program Re Compliance 1. A	ance With equirements e Based On: .cceptable POC		2. Tech 3. 24 H 4. 7-Da	nical Personnel Iour RN ay RN (Rural SN	6. So 7. M F) 8. Pa	cope of Serv ledical Direc atient Room S	ices Limit ctor
18 SNF       18 J9 SNF       19 SNF       LCF       IID       1861 (e) (1) or 1861 (j) (1):       (1.5)         (L37)       (L38)       (L39)       (L42)       (L43)       (L43)         16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):			Requirements	and/or Applied	Waivers:	* Code:	B*	(L12)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):         17. SURVEYOR SIGNATURE       Date :         18. STATE SURVEY AGENCY APPROVAL       Date:         Sativa Bushey, HFE - NE II       05/25/2021 (L19)       Joanne Simon, Enforcement Specialist       05/28/2021 (L20)         PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINCLE STATE AGENCY         19. DETERMINATION OF ELIGIBILITY       20. COMPLIANCE WITH CIVIL RIGHTS ACT:       1. I. Statement of Financial Solveney (HCFA-2572) 2. Ownehig/Courto Interest Disclosure Start (HCFA-1513) 3. Both of the Above :       21. I. Statement of Financial Solveney (HCFA-2572) 2. Ownehig/Courto Interest Disclosure Start (HCFA-1513) 3. Both of the Above :         22. ORIGINAL DATE       23. LTC AGREEMENT       24. LTC AGREEMENT       26. TERMINATION ACTION: (L30)         VOLUNTARY       00       INVOLUNTARY       00-Final dol Solveney (HCFA-2572)         10.001/1981       (L21)       26. TERMINATION ACTION: (L30)       (L30)         (L24)       (L41)       (L25)       03-Final in the Hath/Safery 00-Statisficition W/ Reimbursement 03-Risk of Involunary Termination 04-Other Reason for Withdrawal       OTHER 07-Frovider Status Change 00-Active         28. TERMINATION DATE:       29. INTERMEDIARY/CARRIER NO. 00130       30. REMARKS         31. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE       30. REMARKS	18 SNF 18/1	9 SNF 19 SNF	ICF	IID				(I	.15)	
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Sativa Bushey, HFE - NE II       05/25/2021       joanne Simon, Enforcement Specialis       05/28/2021       (120)         PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY         19. DETERMINATION OF ELIGIBILITY       20. COMPLIANCE WITH CIVIL RIGHTS ACT:       21. 1. Statement of Financial Solveney (HCFA-2572)       2. Ownership/Control Interest Disclosure Statt (HCFA-1513)         2. Facility is not Eligible       (L21)       24. LTC AGREEMENT       24. LTC AGREEMENT       26. TERMINATION ACTION:       (L30)         VOLUNTARY 00 PARTICIPATION 10/00/1981       0.120       0.2002       0.300         (L24)       (L41)       (L25)       0.4002       0.5Fail to Meet Agreement 02-Dissatisfaction W/ Reimbursement (L27)       0.5Fail to Meet Agreement 00-Resci dSuspension Date:       0.444/         (L27)       B. Rescind Suspension Date:       (L44)       0.444/       0.4002       0.40130         28. TERMINATION DATE:       29. INTERMEDIARY/CARRIER NO. 00130       0.30. REMARKS       0.0. REMARKS         00130         (L28)       (L31)       31. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE       0.30. REMARKS	16. STATE SURVEY AGENC	Y REMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):					
Galarde Sinfort, Envircement Operations       00/20/20/2011 (120)         Datifier Sinfort, Envircement Operations       00/20/20/2011 (120)         PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY         19. DETERMINATION OF ELIGIBILITY       20. COMPLIANCE WITH CIVIL RIGHTS ACT:       1. 1. Statement of Financial Solvency (HCFA-2572)       2. 1. 1. Statement of Financial Solvency (HCFA-2572)         2. Facility is not Eligible       (121)         2. Facility is not Eligible       (121)         2. Facility is not Eligible       (121)         2. ORIGINAL DATE       23. LIC AGREEMENT       24. LIC AGREEMENT       24. LIC AGREEMENT         10/01/1981       (120)         0	17. SURVEYOR SIGNATURI	3	Date :			18. STATE SUR	RVEY AGENCY	APPROVAL		Date:
19. DETERMINATION OF ELIGIBILITY       20. COMPLIANCE WITH CIVIL RIGHTS ACT:       21. 1. Statement of Financial Solvency (HCFA-2572)          2. Facility is not Eligible to Participate       (L21)       20. COMPLIANCE WITH CIVIL RIGHTS ACT:          2. Facility is not Eligible to Participate       (L21)       20. COMPLIANCE WITH CIVIL RIGHTS ACT:          2. Facility is not Eligible to Participate       (L21)       20. COMPLIANCE WITH CIVIL RIGHTS ACT:          2. Facility is not Eligible       (L21)       20. COMPLIANCE WITH CIVIL RIGHTS ACT:       20. Compliance with Civil Rights ACT:          2. Facility is not Eligible       (L21)       20. Compliance with Civil Rights ACT:       20. Compliance with C	Sativa Bushey, HFE	- NE II	0	05/25/2021	(L19)	Joanne Simo	on, Enforceme	nt Specialist		05/28/2021 (L20)
I. Facility is Eligible to Participate       2. Facility is not Eligible       (L21)       3. Both of the Above :       3. Both of the Above :         2. ORIGINAL DATE       23. LTC AGREEMENT       24. LTC AGREEMENT       26. TERMINATION ACTION:       (L30)         OF PARTICIPATION       BEGINNING DATE       ENDING DATE       26. TERMINATION ACTION:       (L30)         (L24)       (L41)       (L25)       01-Merger, Closure       06-Fail to Meet Health/Safety         02-Dissatisfaction W/ Reimbursement       06-Fail to Meet Agreement       03-Risk of Involuntary Termination       07-HER         (L27)       7. ALTERNATIVE SANCTIONS       (L44)       04-Other Reason for Withdrawal       07-Provider Status Change         (L27)       B. Rescind Suspension Date:       (L45)       30. REMARKS       01-Active         28. TERMINATION DATE:       29. INTERMEDIARY/CARRIER NO.       30. REMARKS       30. REMARKS         31. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE       (L31)		PART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	<b>OFFICE OF</b>	R SINGLE ST	FATE AGE	NCY	
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		(L32)			(L33)	DETERMIN	ATION APPF	ROVAL		



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.

Guardian Angels Health & Rehab Center May 6, 2021 Page 2

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

Guardian Angels Health & Rehab Center May 6, 2021 Page 3

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates

Guardian Angels Health & Rehab Center May 6, 2021 Page 4 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

	-				9		APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				СОМ	E SURVEY IPLETED
		245239	B. WING				C 30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
				1	500 EAST THIRD AVENUE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER		ŀ	HBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E (	000			
	compliance with Ap Preparedness Required conducted during a	h 4/30/21, a survey for pendix Z, Emergency uirements, §483.73(b)(6) was standard recertification was IN compliance.					
F 000	signature is not req page of the CMS-29 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents. TS	FC	000			
	recertification surve facility by the Minne determine if your fa requirements of 42	h 4/30/21, a standard ey was completed at your esota Department of Health to icility was in compliance with CFR Part 483, Subpart B, ong Term Care Facilities. Your compliance.					
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 554 SS=D	onsite revisit of you validate substantial regulations has bee Resident Self-Admi	in Meds-Clinically Approp	F٤	554			5/26/21
	§483.10(c)(7) The r	right to self-administer					
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically 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.

DEDARTMENT OF LICALTU AND LUMANN SERVICES

		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM	05/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE	E SURVEY PLETED
		245239	B. WING	÷			_ 30/2021
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			1500 EAST THIRD AVENUE HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 554	defined by §483.21 this practice is clinic This REQUIREMEN by: Based on observat review, the facility fa not self-administer assessed and acco 2 residents (R24) re Findings include: R24's Face Sheet p R24's diagnoses in heart beat), hyperter reflux disorder, stro (underactive thyroic cholesterol), and dia R24's quarterly Min dated 3/4/21, indica and understood oth R24's care plan init preferred nursing to medications as present R24's Medication S dated 4/18/19, indication state what each medication not able to self-administer medications per physical store, set up, administer medications per physical store, set up, administer medications per physical store, set up, administer medications per physical store physical store, set up, administer medications per physical store physical store physical store physical store physical medications per physical store physical	hterdisciplinary team, as (b)(2)(ii), has determined that cally appropriate. NT is not met as evidenced ion, interview, and document ailed to ensure a resident did medications (SAM) as rding to the care plan for 1 of eviewed for SAM. orinted 4/28/21, indicated cluded atrial flutter (irregular ension, gastro-esophageal ke, hypothyroidism I), hyperlipidemia (high abetes. imum Data Assessment, ited R24 was cognitively intact ers. ated 11/21/18, indicated R24 o store and administer scribed. elf Administration assessment eated R24 could not correctly edication was for and what on was to be taken, and was ninister her medications. R24's d R24 was to receive licensed nurse who would nister, and document all ysician's orders.	F	554	<ul> <li>F554 Resident Self- Admin Meds- Clinically Appropriate.</li> <li>DON and/or designee will implement corrective action for resident affected this practice (R24):</li> <li>R24 no longer resides at this care cer LPN-A was re-educated by DON on 4/27/21 regarding self-administration of medications policy.</li> <li>All residents have the potential to be impacted by this practice.</li> <li>DON and/or designee will implement measures to ensure this practice does reoccur including:</li> <li>The Self-Administration of Medication Residents policy was reviewed, with n updates needed.</li> <li>All licensed nursing staff will be education the Self-Administration of Medication by Residents.</li> <li>All residents SAM assessments will be reviewed for accuracy by the Nurse Managers and updated as needed.</li> <li>Random audits on appropriate administering of medications per residents self-administration assessmi will be completed by DON and/or designee, three times a week for three</li> </ul>	nter. of s not n by no ated ion ne nent ne	
	R24's physician ord	lers included orders for:			weeks, two times a week for two week		

Facility ID: 00858

If continuation sheet Page 2 of 16

		AND HUMAN SERVICES				FORM	05/17/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED
		245239	B. WING				C 30/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE IBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 554	Continued From pa	ge 2	F 5	54			
	- Acetaminophen 5 by mouth per day a	00 milligrams (mg) one tablet t 8:00 a.m.			and weekly thereafter starting 5/24	/21.	
	(DR) 81 mg by mou a.m. - Folic acid (vitamin per day at 8:00 a.m	pated (EC) delayed release outh one time per day at 8:00 n B) 1 mg by mouth one time n. 5 mg by mouth one time per			Monitoring will be reported to the Q Assurance Committee quarterly ar needed. The Quality Assurance Committee will make recommenda for ongoing monitoring. Completion Date: 5/26/21	nd as	
	micrograms (mcg) 8:00 a.m. - Women's Multivita mouth one time per	by mouth one time per day at amin Hi Potency one tablet by day at 8:00 a.m. lers lacked directives for R24					
	Record (eMAR) ind following medicatio a.m. medication pa -Acetaminophen 50 -Aspirin enteric coa 81 mg -Folic acid (vitamin -Norvasc (for high b -Synthroid (for hypo (mcg) - women's multivita R24's eMAR lacked	00 milligrams (mg) one tablet ted (EC) delayed release (DR) B) 1 mg blood pressure) 2.5 mg bthyroidism) 25 micrograms min hi potency one tablet d directives for SAM.					
	(LPN)-A was obser of medications with left R24's room whi one at a time.	a.m. licensed practical nurse ved to leave a medication cup R24 in her room. LPN-A then le R24 took her medications					
		3 a.m. LPN-A was interviewed ally left R24's medications with					

If continuation sheet Page 3 of 16

		AND HUMAN SERVICES				FORM	05/17/2021 APPROVED 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED C		
		245239	B. WING				30/2021		
NAME OF	PROVIDER OR SUPPLIER		·		REET ADDRESS, CITY, STATE, ZIP CODE				
GUARDI	AN ANGELS HEALTH	& REHAB CENTER		1500 EAST THIRD AVENUE HIBBING, MN 55746					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 554	her because she w staff stayed with he have a physician's medications, but wa order. LPN-A chec computer and verifi SAM. LPN-A stated ones to get the orde On 4/27/21, at 11:0 registered nurse (R R24. RN-A verified SAM. RN-A stated orders if she was d for safe SAM. On 4/30/21, at 9:21 (DON) verified staff with medications w assessed to be safe a physician's order. The facility policy S Medication by Resi the interdisciplinary determine the resid self-administer thei wished to SAM. If S safe, the IDT would the resident to active extent that was dee Safe/Clean/Comfor CFR(s): 483.10(i) (1 §483.10(i) Safe Em The resident has a comfortable and ho	ould not take them if nursing ould not take them if nursing or. LPN-A stated R24 should order for self-administration of as not sure if she did have an ked for orders on the ied R24 did not have orders for d the unit managers were the ers. 8 a.m. LPN-A asked 2N)-A about SAM orders for I R24 did not have orders to he would assess and get etermined to be appropriate a.m. the director of nursing f should not leave a resident hen they had not been e with SAM, and did not have reelf-Administration of dents revised 1/18, directed team (IDT) to assess and lent's ability to safely r medications if the resident SAM is determined to not be d consider options that allowed vely participate in SAM to the emed safe. table/Homelike Environment 1)-(7)	F 5				5/26/21		

Facility ID: 00858

If continuation sheet Page 4 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OME		FORM	APPROVED				
			(X2) MUL	TIPL			0938-0391
			ì í			Сом	PLETED
		245239	B WING				0
NAME OF F	PROVIDER OR SUPPLIER	240203	5		TREET ADDRESS, CITY, STATE, ZIP CODE	04/、	30/2021
GUARDI	AN ANGELS HEALTH	& REHAB CENTER		1	500 EAST THIRD AVENUE		
				Н	IBBING, MN 55746		
				x			(X5) COMPLETION
	REGULATORY OR L	SC IDENTIFYING INFORMATION)				RIATE	DATE
			1	1	,		
F 584	Continued From pa	ge 4	F 5	84			
	supports for daily live	ving safely.					
	The facility must pro	ovide-					
	§483.10(i)(1) A safe	e, clean, comfortable, and					
		onal belongings to the extent					
	independence and	does not pose a safety risk.					
	•						
	8483 10(i)(2) House	ekeening and maintenance					
	and comfortable int	erior;					
	§483.10(i)(3) Clean	bed and bath linens that are					
	in good condition;						
	§483.10(i)(4) Privat	e closet space in each					
	8483 10(i)(5) Adea	uate and comfortable lighting					
	8483 10(i)(6) Comf	ortable and safe temperature					
		n a temperature range of 71 to					
	OT F, and						
	•	e maintenance of comfortable					
		NT is not met as evidenced					
	by:						
		tion, interview, and document ailed to clean and maintain			F584 Safe/Clean/Comfortable/Hor Environment	nelike	

		AND HUMAN SERVICES			O		APPROVE 0938-039
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245239	B. WING				
	PROVIDER OR SUPPLIER	243233	<u>  D. WING -</u>		TREET ADDRESS, CITY, STATE, ZIP CODE	04/3	30/2021
					500 EAST THIRD AVENUE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER		Н	IIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 584	Continued From pa	ngo 5		01			
r 304	sheepskin covering of 8 residents (R1, R37) reviewed for s equipment. Findings include: R1's Face Sheet pr diagnoses which in (a medical condition becomes progressi blurred vision), and R1's significant cha dated 4/13/21, indic intact. On 4/29/21, at 8:41 wheelchair arms we matted, and the left and noted to have a rested. On 4/29/21, at 1:41 was interviewed. R	inted 4/30/21, identified cluded macular degeneration n in which the lens of the eye vely opaque, resulting in glaucoma. ange Minimum Data set (MDS) cated R1 was cognitively a.m. the sheepskins on R1's ere noted to be gray in color, t sheepskin was worn down a hole where R1's elbow a.m. registered nurse (RN)-A RN-A stated sheepskins on the nt were used to protect the	F 5	84	<ul> <li>DON and/or designee will impleme corrective action for residents affect this practice (R1, R12, R21,R25, R R37)</li> <li>R1, R12, R21, R25, R32, and R37 have their sheepskin replaced.</li> <li>All residents who utilize sheepskin protection have potential to be impa- by this practice.</li> <li>DON and/or designee will impleme measures to ensure this practice do reoccur including:</li> <li>A Care of Sheepskin Policy was created All nursing and environmental server staff will be educated on the Care of Sheepskin policy.</li> <li>Housekeeping checklist will be upd Environmental Service Director to i monitoring of sheepskin that is utiliz resident s room and/or on wheeled Sheepskin will be removed by housekeeping during cleaning of wheelchair or room and sent to the</li> </ul>	etted by 32 and will for skin acted nt oes not eated. ices of lated by nclude zed in hair.	
	against the equipm housekeeping staff weekly, and would sheepskins at that t	n pressure or scrapping skin ent. RN-A further stated cleaned the wheelchairs replace or clean the time if needed. 2 p.m. nursing assistant			laundry to be cleaned or replaced it able to be laundered. Housekeepin to notify nursing staff for need of replacement. All resident equipment will be review sheepskin use and removed and	g staff	
	(NA)-E was intervie unsure who was re- replacing the sheep equipment. NA-E w wheelchair arms we	wed. NA-E stated he was sponsible for washing or oskins on the resident's verified R1's sheepskin on her ere soiled and worn, and . NA-E asked R1 if she would			replaced as needed Nursing staff education will include, nursing staff notice sheepskin to be or dingy in appearance, sheepskin replaced with new sheepskin and	e dirty	

Facility ID: 00858

If continuation sheet Page 6 of 16

		AND HUMAN SERVICES				FORM	05/17/2021 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED C	
		245239	B. WING					
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE IIBBING, MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 584	Continued From pa	ide 6	F 5	584				
		on her wheelchair replaced,			laundered if able. Sheepskin to be medical supply room.	kept in		
	diagnoses which in	printed 4/20/21, identified cluded peripheral vascular blood vessels with reduced nbs).		Random audits condition of sheep be completed by DON and/or desi three times a week x two weeks, t times a week x two weeks, and th weekly thereafter starting 5/24/21.		gnee nen two		
	R12's significant ch indicated R12 was	ange MDS dated 2/5/21, cognitively intact.	DS dated 2/5/21, Monitor ly intact. Assuration		Monitoring will be reported to the C Assurance Committee quarterly an	Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance		
	wheelchair arms we	a.m. the sheepskins on R12's ere noted to be gray in color ated the sheepskin keeps her rms.			Committee will make recommenda for ongoing monitoring. Completion Date: 5/26/21	itions		
		printed 4/30/21, identified cluded muscle weakness.						
		S dated 2/24/21, indicated cognitively impaired.						
		3 a.m. the sheepskin on R21's erved to be gray in color, and						
	diagnoses which in of one side of the b	ce Sheet printed 4/30/21, identified s which included hemiplegia (paralysis de of the body) following cerebral (stroke) affecting right dominant side.						
	R25's quarterly MD was cognitively inta	S dated 3/1/21, indicated R25 ict.						
	R25 stated the she looked "dirty, matte seen the staff remo	a.m. R25 was interviewed. epskin on her wheelchair d." R25 stated she has never ove them for cleaning, and it g her. R25 also said the						

If continuation sheet Page 7 of 16

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245239	B. WING				C 30/2021
NAME OF F	PROVIDER OR SUPPLIER		L I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	04/	50/2021
					500 EAST THIRD AVENUE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER		ŀ	IIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 584	Continued From pa sheepskins looked -at 9:26 a.m. NA-C the sheepskins on e someone sends the as there were not re looked at the sheep and verified they loo be washed or replac R32's Face Sheet p diagnoses which ine R32's quarterly MD R32 was severely of On 4/28/21, at 9:32 wheelchair arms we color and matted. On 4/29/21, at 8:30 NA-A stated the she there to protect resi housekeeping wash were supposed to re	ge 7 worn out. was interviewed. NA-C stated equipment get cleaned when em to the wash "not very often" eplacements available. NA-C oskins on R25's wheelchair, oked dirty, matted, and should ced. orinted 4/30/21, identified cluded muscle weakness. S dated 3/10/21, indicated ognitively impaired. a.m. the sheepskins on R32's ere observed to be gray in a.m. NA-A was interviewed. eepskin on equipment was dent's arms. NA-A stated hed the wheelchairs and they emove and wash the	F 5		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
	the sheepskins wer name and that they NA-A looked at she	e wheelchairs. NA-A thought e marked with the resident were washed twice a week. eepskins on the arms of R32's ted they looked dingy and ould be washed.					
	R37's Face Sheet p diagnoses which we	printed 4/30/21, identified eakness.					
	R37's quarterly MD R37 was severely c	S dated 3/19/21, indicated ognitively impaired.					
	On 4/27/21, at 11:3	8 a.m. the sheepskins on					

If continuation sheet Page 8 of 16

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /		E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _			PLETED
		245239	B. WING _				C 30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE IIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	R37's wheelchair and sheepskins were gr On 4/28/21, at 8:44 interviewed and stat "a couple of times a housekeeping staff them in the laundry back to the resident clean. L-A stated if where the sheepskins clean sheepskins to -at 8:49 a.m. occup interviewed. OT-D s sheepskins returne were worn out he w order replacements sheepskins on R32 were worn out, no la -at 8:55 a.m. RN-A it was everyone's re sheepskins for repla was not a system in were cleaned on a condition. -at 9:11 a.m. house interviewed. H-B stat monthly. H-B was n about sheepskins o not used in her area	rms were observed. The ray in color and matted. A a.m. laundry staff (L)-A was ited wheelchairs are washed a month." L-A stated remove the sheepskin, put for washing, and bring them t's room when they were they could not determine ins came from, they gave the o therapy. Autional therapist (OT)-D was stated he would look at d from the laundry and if they yould throw them out, and a. OT-D looked at the 's wheelchair, he verified they onger providing a cushion. was interviewed. RN-A stated esponsibility to ensure ean and not worn out. RN-A ild come to him about worn out acements. RN-A stated there in place to ensure sheepskins regular basis and in good	F 58	84			
	(DON) was interview	7 a.m. the director of nursing wed. The DON stated she notice if the sheepskins were					

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION		TE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	. ,			MPLETED
						С
		245239	B. WING		04	/30/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER		1500 EAST THIRD AVENUE HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 584	Continued From pa	ge 9 The DON stated the	F 58	4		
	the laundry when th DON verified there	"might" bring the sheepskin to hey clean the wheelchairs. The was no process in place to kins on equipment were clean				
	Disinfection Progra staff to ensure that be properly cleaned environmental servi a list of cleaning an employee(s) respon that all staff are res standards of cleanli to resident care equ environment of care	Identifiable Information	F 84	2		5/26/21
	<ul> <li>(i) A facility may not resident-identifiable</li> <li>(ii) The facility may resident-identifiable</li> <li>accordance with a c agrees not to use o</li> </ul>	release information that is				
	professional standa	cordance with accepted ards and practices, the facility ical records on each resident				

If continuation sheet Page 10 of 16

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245239	B. WING _				C 30/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE IIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	<ul> <li>(iii) Readily accessi (iv) Systematically of §483.70(i)(2) The fa all information conta regardless of the fo records, except whe (i) To the individual, representative when (ii) Required by Law (iii) For treatment, p operations, as perm with 45 CFR 164.50 (iv) For public healt neglect, or domestic activities, judicial ar law enforcement pu purposes, research medical examiners, a serious threat to h by and in compliand §483.70(i)(3) The fa record information a unauthorized use.</li> <li>§483.70(i)(4) Medic for- (i) The period of tim (ii) Five years from there is no requirem (iii) For a minor, 3 y legal age under Sta</li> </ul>	ble; and brganized acility must keep confidential ained in the resident's records, rm or storage method of the en release is- or their resident re permitted by applicable law; v; bayment, or health care nitted by and in compliance 06; h activities, reporting of abuse, c violence, health oversight nd administrative proceedings, irposes, organ donation purposes, or to coroners, funeral directors, and to avert health or safety as permitted be with 45 CFR 164.512. acility must safeguard medical against loss, destruction, or cal records must be retained he required by State law; or the date of discharge when hent in State law; or rears after a resident reaches ite law.	F 84	42	DEFICIENCY)		
	(i) Sufficient informa (ii) A record of the r	nedical record must contain- ation to identify the resident; esident's assessments; sive plan of care and services					

		AND HUMAN SERVICES	_		FC	ORM /	05/17/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION (X3)	COMF	E SURVEY PLETED
		245239	B. WING			04/3	, 80/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE IIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E	(X5) COMPLETION DATE
F 842	provided; (iv) The results of a and resident review determinations con (v) Physician's, num professional's progi (vi) Laboratory, rad services reports as This REQUIREMEN by: Based on interview facility failed to ens Life-Sustaining Trea accurately complete code status for 2 of had a modified POI Findings include: R56's Face Sheet p was admitted to the diagnoses included hypertensive urgen blood pressure read and no damage to cognitive communic thinking and how so R56's POLST signed care physician on 4 wished to have care (CPR) which would including interventic as indicated, in the	any preadmission screening v evaluations and ducted by the State; se's, and other licensed ress notes; and iology and other diagnostic required under §483.50. NT is not met as evidenced v and document review, the ure the Provider Orders for atment (POLST) was ed to clearly reflect resident 2 residents (R56, R43) who LST with special instructions.	F	342	F842 Resident Records DON and/or designee will implement corrective action for resident affected to 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 impace by this practice. DON and/or designee will implement measures to ensure this practice does reoccur including: DON reviewed the Cardiopulmonary Resuscitation and Advance Care Plant policies, with no updates need. All facility resident POLST will be reviewed to ensure clear instructions a updated as needed by the nurse unit managers and DON. Education will be provided by the DON and/or designee to nurse unit manager 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.	e cted s not ning and J rs s nce nit	

Facility ID: 00858

		AND HUMAN SERVICES				FORM	05/17/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	`́сом	E SURVEY PLETED C
		245239	B. WING				30/2021
-	PROVIDER OR SUPPLIER	& REHAB CENTER		15	TREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST THIRD AVENUE IBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	out and the "Do No (DNR)" box was ch CPR box that was so of the page, after th black stamp with la "ORIGINAL" and pa hand written "wants second section on wanted selective the treatment, no intuba- interventions or me consider less invas transfer to the hosp R56's Care Plan Hi R56's advanced dir Intubation wants ch POLST," with the a R56 was "DNR-No compressions only." R56's Care Plan Hi advanced directives 4/29/21, and identif as "Full Code-See only no intubation", directed staff R56 w POLST-Chest com On 4/27/21, at 9:57 record (eMAR) hea directives were "DN compressions no in On 4/27/21, at 12:2 (RN)-B verified info Care Plan directed could not ensure st	th Attempt Resuscitation hecked immediately below the scribbled out. To the right side he DNR statement, was a large capital letters that read, artially over the stamp was is CPR" in black ink. The the POLST indicated R56 eatment, to include medical ation, advanced airway echanical ventilation, but may bive airway support and bital. istory initiated 4/7/21, indicated rectives were "DNR-No hest comressions (sp)-See approach that directed staff intubation-wants -See POLST." istory indicated R56's is problem was revised on fied R56's advanced directives POLST-chest compressions with the approach that was "Full Code-See pressions only no intubation." Y a.m. R56's electronic medical ider indicated R56's advanced NR-See POLST-wants	F8	42	Random audits monitoring clarity or residents POLST will be completed DON and/or designee three times a for two weeks, two times a week for weeks, and weekly thereafter starti 5/24/21. Monitoring will be reported to the Q Assurance Committee quarterly an needed. The Quality Assurance Committee will make recommenda for ongoing monitoring. Completed Date: 5/26/21	l by the a week r two ng uality d as	

		AND HUMAN SERVICES				FOR	M APPROVED
							D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		ATE SURVEY MPLETED
			A. BUILDI	ING			С
		245239	B. WING			04	4/30/2021
NAME OF F	ROVIDER OR SUPPLIER		· [	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDIA	AN ANGELS HEALTH	& REHAB CENTER		1	1500 EAST THIRD AVENUE		
OUAND!		d REIAD OLATER		ŀ	HIBBING, MN 55746		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
					DEFICIENCY)		
F 842	Continued From pa	ge 13	F 8	42	2		
		ter wanted CPR but no					
		-					
	R43's admission Mi	inimum Data Set (MDS) dated					
		R43 was cognitively intact.					
	R43's Face Sheet r	printed $4/28/21$ indicated					
		us (upper arm) with routine					
		on (high blood pressure), and					
	restless legs syndro	ome.					
	RA3's POI ST signs	ad by R43's family member					
	( ),						
	Attempt Resuscitati						
		in the event R43 had no					
		5					
	and was not dated,						
	R43's Physician Or	ders dated 3/18/21, indicated					
		Complete POLST Profile.					
		anna dala di kasala a Kasalita a 20					
		p.m. licensed practical nurse					
	stated R56's daugh intubation, and the fine with her wishes it did not work. RN- the check mark for did not read the har R43's admission Mi 3/24/21, indicated F R43's Face Sheet p R43's diagnoses ind (thigh), right humer healing, hypertensio restless legs syndro R43's POLST signet (FM-E), undated wit 4/8/21, indicated R4 Attempt Resuscitation resuscitation status pulse and was not b hand written instruct and was not dated, R43's Chart header screen shot on 4/28 indicated "Shock or On 4/28/21, at 3:06	ter wanted CPR but no doctor had signed it, and was a for CPR, but nothing further if -B verified staff could look at DNR and not do CPR if they nd written directive. inimum Data Set (MDS) dated R43 was cognitively intact. orinted 4/28/21, indicated cluded fractures of right femur us (upper arm) with routine on (high blood pressure), and ome. ed by R43's family member th R43's physician dated 43 had selected, "Do Not ion (DNR)" for her in the event R43 had no oreathing. The POLST had ctions "shock one time only" signed or initialed. ders dated 3/18/21, indicated complete POLST Profile. provided by the facility with a 8/21, Advance Directive nce only DNR."					

	-	AND HUMAN SERVICES						FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIP		CONSTRUCTION	0		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	` ´						PLETED
									С
		245239	B. WING					04/:	30/2021
NAME OF F	PROVIDER OR SUPPLIER			.,	STR	REET ADDRESS, CITY, STATE, ZIP COL	ЭE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER				0 EAST THIRD AVENUE			
					HIE	BBING, MN 55746			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI)	х		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI			(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG			CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPF	RIATE	DATE
			p.						
F 842	Continued From pa	ae 14	F 8	42	2				
	-	e would not start chest	10	942	2				
	-	ould only shock her once.							
	LPN-B further indic	ated if she was looking at the							
		he likely wouldn't notice the							
	shock once instruct	lions.							
	-at 3:11 p.m. RN-A	was interviewed. RN-A stated							
	he would expect sta	aff to get the automated							
		r (AED) and put it on R43, and							
		I-A stated he recalled talking							
		ember, and the FM-E was as what they wanted. RN-A							
		esponsibility the facility had for							
	using an AED and r	not following the prompts.							
	at 2,20 n m tha D(	ON was interviewed. The DON							
		ON was interviewed. The DON as aware of R43's wishes to							
		k. The DON stated it was her							
	expectation that sta	iff would place the AED on							
		e AED to give instructions to							
		e DON stated she did not							
		f to follow any prompts for ping compressions. The DON							
		d not give instructions to give							
		ency medical service (EMS)							
		e a shock after they arrived							
		OLST. The DON did not know							
	prompts.	e an AED and not follow the							
		1 a.m. FM-E was interviewed.							
		his mom's wishes to only have							
		CPR. FM-E stated the facility of one shock							
	and no CPR.	cat the rating of one brook							
		C was interviewed. LPN-C							
		training for CPR and AED use sing school. He stated he							

Facility ID: 00858

If continuation sheet Page 15 of 16

	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/17/2021 APPROVED 0938-0391
STATEMENT OF D AND PLAN OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245239	B. WING			C 30/2021
NAME OF PROV	/IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE		
GUARDIAN A	ANGELS HEALTH	& REHAB CENTER		HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
rec LPI to g giv foll see ond he On inte ma sta an He DC yea sta bre The Ca cap NE CU NC IS 0 The rev foll sea ond he	N-C stated the Al give breaths, do d ve a shock. LPN-C low the AED pron en a POLST with ce. LPN-C stated would talk with h a 4/30/21, at 10:20 erviewed. The DC anagers fill out PC ated the AED and outside instructo eart Association o DN stated nursing ars. The DON stated ft to follow the insection of the follow the insection of the follow the insection e facility provided pitals the instruction EVER ADAPT, UF JRRENT POLST. DTATION. IF THA COMPLETED. e policy Advance viewed/amended lowing: The POLST form dates or revisions d/or legal represent nefits of CPR (per sociation) will be	the facility every two years. ED gives instructions on when compressions, and when to C stated it was important to npts. LPN-C stated he had not written instructions for shock d if he saw a POLST like that is nurse manager. 0 a.m. the DON was ON stated her and the nurse OLST documents. The DON CPR training is provided by or trained by the American in AED use and CPR. The g staff are trained every two ated she would expect nursing structions the AED gave for ons, and delivering shocks. d training materials, Advance e Study undated. In bold all ions included the following: PDATE OR CHANGE A . NEVER CORRECT A AT IS NEEDED, A NEW FORM e Care Planning 2/19/18, directed the ST form itself is never revised. must be completed with any s, and signed by the resident entative. The risks and er the American Heart explained to the resident order to assist them in	F 842			

Facility ID: 00858

If continuation sheet Page 16 of 16



Electronically delivered May 6, 2021

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

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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>. 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.

Re: State Nursing Home Licensing Orders Event ID: LMKM11

## Guardian Angels Health & Rehab Center May 6, 2021 Page 2

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

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00858	B. WING		04/3	C 0/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTI	T THIRD AV MN 55746	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
Vinnesota D	was conducted at y the Minnesota Dep facility was found N State Licensure and orders are issued. I	TS: n 4/30/21, a licensing survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN d the following correction Please indicate in your prrection you have reviewed				
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Electronically Signed

STATE FORM

If continuation sheet 1 of 17

05/13/21

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
ND F LAIN	OF CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING:			
		00858	B. WING			C 30/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		1500 EA	ST THIRD AVE			
UARDI	AN ANGELS HEALTH	I & REHAB CENTI HIBBING	6, MN 55746			
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2 000	Continued From pa	ane 1	2 000		• /	
2 000		-	2 000			
	these orders and id be completed.	dentify the date when they will				
	Minnesota Departr	nent of Health is documenting				
	the State Licensing	g Correction Orders using				
		ag numbers have been sota state statutes/rules for				
		he assigned tag number				
		left column entitled "ID Prefix				
	Tag." The state sta	atute/rule out of compliance is				
		nary Statement of Deficiencies	"			
		es the "To Comply" portion of er. This column also includes				
		are in violation of the state				
		atement, "This Rule is not met				
		ollowing the surveyors findings				
	Time period for Co	Method of Correction and				
	Time period for Co					
		o participate in the electronic				
	•	ensure orders consistent with				
	the Minnesota Dep Informational Bulle					
		.state.mn.us/facilities/regulatio				
		_1.html The State licensing				
		ted on the attached Minnesota				
	•	alth orders being submitted to				
		Although no plan of correction ate Statutes/Rules, please				
		rrected" in the box available for	-			
		n indicate in the electronic				
		cess, under the heading				
		ne date your orders will be				
	Minnesota Departr	electronically submitting to the nent of Health.				
	PLEASE DISREG	ARD THE HEADING OF THE				
		N WHICH STATES,				
	"PROVIDER'S PLA	AN OF CORRECTION." THIS				
	APPLIES TO FED	ERAL DEFICIENCIES ONLY.				

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	СОМ	E SURVEY PLETED
		00858	B. WING			C 30/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
CUARDI	AN ANGELS HEALTH	8 DEHAR CENTI 1500 EAS	ST THIRD AVE	INUE		
GUARDI		HIBBING	, MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA IS NO REQUIREM CORRECTION FO	R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES.				
2 625	MN Rule 4658.0450 Contents; In Gener	) Subp. 1 A-P Clinical Record al	2 625			5/26/21
	record, including n A. the condition admission; B. temperature pressure, according subpart 2, item C. the resident according to part 4 D. the resident and attitudes; E. observations interventions provid responsible for care of the r confidential commu- religious person F. significant of behavior, orientatio nursing home, G. date, time, o method of administ the signature of persons who admir H. a report of a three months prior in part 4658.08 I. reports of lab	s height and weight, 658.0520, subpart 2, item J; 's general condition, actions, s, assessments, and led by all disciplines resident, with the exception of unications with nnel; bservations on, for example, n, adjustment to the judgment, or moods; quantity of dosage, and ration of all medications, and f the nurse or authorized histered the medication; tuberculin test within the to admission, as described				

Minnesota Department of Health STATE FORM

LMKM11

If continuation sheet 3 of 17

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	`	) DATE SURVEY COMPLETED	
		00858	B. WING		C 04/30/2021	
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
BUARDI	AN ANGELS HEALTH	& REHAB CENTI	ST THIRD AV 6, MN 55746	<b>ENUE</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
2 625	K. dates and tin health care practitio L. visits to clini M. any orders of comprehensive pla N. any change habits or appetite; O. pertinent far resident's general of P. results of the resident assessme comprehensive part 4658.0400. This MN Requirem by: Based on interview facility failed to ens Life-Sustaining Trea accurately complete code status for 2 of had a modified POI Findings include: R56's Face Sheet p was admitted to the diagnoses included hypertensive urgen blood pressure rea	nes of visits by all licensed oners; cs or hospitals; or instructions relative to the n of care; in the resident's sleeping ctors regarding changes in the		Corrected		

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00858	B. WING		C 04/30/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTI	ST THIRD AVE 6, MN 55746	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 625	Continued From pa	ige 4	2 625			
	wished to have care (CPR) which would including intervention as indicated, in the was not breathing. out and the "Do No (DNR)" box was ch CPR box that was so of the page, after th black stamp with la "ORIGINAL" and pa hand written "wants second section on wanted selective treatment, no intuba- interventions or me	k/5/21, indicated R56 had diopulmonary resuscitation require full treatment, ons and mechanical ventilation event R56 had no pulse and The CPR box was scribbled t Attempt Resuscitation ecked immediately below the scribbled out. To the right side the DNR statement, was a rge capital letters that read, artially over the stamp was s CPR" in black ink. The the POLST indicated R56 eatment, to include medical ation, advanced airway techanical ventilation, but may ive airway support and bital.				
	R56's advanced dir Intubation wants ch					
	advanced directives 4/29/21, and identif as "Full Code-See only no intubation", directed staff R56 v	story indicated R56's s problem was revised on ied R56's advanced directives POLST-chest compressions with the approach that vas "Full Code-See pressions only no intubation."				
	record (eMAR) hea	a.m. R56's electronic medical der indicated R56's advanced IR-See POLST-wants ntubation."				

If continuation sheet 5 of 17

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
						С
		00858	B. WING		04/	30/2021
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
UARDI	AN ANGELS HEALTH	& REHAB CENTI	ST THIRD AVE 6, MN 55746	NUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 625	Continued From pa	ge 5	2 625			
	(RN)-B verified info Care Plan directed could not ensure st and see R56 wante stated R56's daugh intubation, and the fine with her wishes it did not work. RN	2 p.m. registered nurse rmation on the eMAR and DNR first, and stated she aff would look beyond DNR ed chest compressions. RN-B ter wanted CPR but no doctor had signed it, and was s for CPR, but nothing further i -B verified staff could look at DNR and not do CPR if they nd written directive.				
		inimum Data Set (MDS) dated R43 was cognitively intact.				
	R43's diagnoses in (thigh), right humer	printed 4/28/21, indicated cluded fractures of right femur us (upper arm) with routine on (high blood pressure), and ome.				
	(FM-E), undated wi 4/8/21, indicated R4 Attempt Resuscitat resuscitation status pulse and was not I	in the event R43 had no breathing. The POLST had ctions "shock one time only"				
		ders dated 3/18/21, indicated : Complete POLST Profile.				
		provided by the facility with a 8/21, Advance Directive nce only DNR."				
	On 4/28/21, at 3:06	p.m. licensed practical nurse				

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00858	B. WING			C 04/30/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
GUARDI	AN ANGELS HEALTH	& REHAB CENTI	ST THIRD AVE 6, MN 55746	NUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
2 625	Continued From pa	ige 6	2 625				
	POLST and said sh compression and w LPN-B further indic POLST in a hurry s shock once instruct -at 3:11 p.m. RN-A he would expect sta external defibrillato shock her once. RN with R43's family m insistent that this w was unsure what re	iewed. LPN-B looked at R43's ne would not start chest yould only shock her once. ated if she was looking at the he likely wouldn't notice the tions. was interviewed. RN-A stated aff to get the automated r (AED) and put it on R43, and N-A stated he recalled talking nember, and the FM-E was as what they wanted. RN-A esponsibility the facility had for not following the prompts.					
	stated the facility w only have one shoc expectation that sta R43 and wait for the deliver a shock. Th expect nursing staf giving breaths or do stated if the AED di a shock, the emerg personnel could giv and reviewed the P	ON was interviewed. The DON as aware of R43's wishes to k. The DON stated it was her aff would place the AED on e AED to give instructions to e DON stated she did not f to follow any prompts for bing compressions. The DON d not give instructions to give pency medical service (EMS) re a shock after they arrived OLST. The DON did not know e an AED and not follow the					
	FM-E stated it was one shock, but no (	1 a.m. FM-E was interviewed. his mom's wishes to only have CPR. FM-E stated the facility out the futility of one shock					
	stated he received	C was interviewed. LPN-C training for CPR and AED use rsing school. He stated he					

STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION       (N) PROVIDER SUPPLIERCIA DEWTIFICATION NUMBER:       (n) MULTINE CONSTRUCTION A BULLING:	Minnesota	Department of He	alth			FORM	APPROVED
00868         B.WIN	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
GUARDIAN ANGELS HEALTH & REHAB CENT         1500 EAST THIRD AVENUE HIBBING, MM 55745           OWIDE FREEK REACH DEFICIENCY MUST BE PRECIDED BY FULL CROSS-REFERENCED TO THE ARCTION SHOULD BE ERACH DEFICIENCY MUST BE PRECIDED BY FULL TAG         PROVIDER'S PLAN OF CORRECTION (EACH OPRECINCY AUST BE PRECIDED BY FULL TAG         PROVIDER'S PLAN OF CORRECTION (EACH OPRECINCY AUST BE PRECIDED BY FULL TAG         PROVIDER'S PLAN OF CORRECTION (EACH OPRECINCY AUST BE PRECIDED BY FULL TAG         PROVIDER'S PLAN OF CORRECTION (EACH OPRECINCY AUST BE PRECIDED BY FULL TAG         PROVIDER'S PLAN OF CORRECTION (EACH OPRECINCY AUST BE PRECIDED BY FULL TAG         PROVIDER'S PLAN OF CORRECTION (EACH OPRECINCY AUST BE PRECIDED BY FULL TAG         PROVIDER'S PLAN OF CORRECTION (EACH OPRECINCY AUST BE PRECIDED BY FULL TAG         PROVIDER'S PLAN OF CORRECTION (EACH OPRECINCY TAG         COMMENT (EACH OPRECINCY (EACH OPRECINCY AUST BE CIDENT THING NOTMATION)         DEFICIENT TAG         COMMENT (EACH OPRECINCY (EACH OPRECINCY AUST BE AD (EACH OPRECINC)         COMMENT TAG         COMMENT TAG         COMMENT (EACH OPRECINCY (EACH OPRECINC)         COMMENT (EACH OPRECINCY (EACH OPRECINC)         COMMENT (EACH OPRECINC)         COMMENT (EACH OPRECINCE)         COMMENT (EACH OPRE			00858	B. WING			-
GUARDIAN ANGLES THEALTH & REMARK CENT         HIBBING, MN 55746           (M) ID PREFX TXC         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY DIASTE PRECEDED BY FULL RECULTIONY OR LSC DENTIFYING INFORMATION)         ID PREFX TAG         D PREFX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE DEFICIENCY)         ((N) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE DEFICIENCY)         ((N) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE DEFICIENCY)         ((N) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE DEFICIENCY)         ((N) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE DEFICIENCY)         ((N) (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)         ((N) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE DEFICIENCY)         ((N) (EACH CORRECTIVE ACTION SHOULD BE ACTION SHOULD BE DEFICIENCY)         ((N) (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)         ((N) (EACH CORRECTIVE ACTION SHOULD BE ACTION SHOULD BE DEFICIENCY)         ((N) (EACH CORRECTIVE ACTION SHOULD BE ACTION SHOULD BE ACTION SHOULD BE ACTION SHOULD BE ACTION SHOULD BE ACTION SHOULD SHOULD BE ACTION SHOULD BE ACTION SHOULD BE ACTION SHOULD SHOULD BE ACTION SHOULD BE ACTION SHOULD BE ACTION SHOULD BE ACTION SHOULD SHOULD ACTION SHOULD BE ACTION SHOULD SHOULD ACTION SHOULD BE ACTION SHOULD SHOULD ACTION SHOULD ACTION SHOULD ACTION ACTION IF THAT IS NEEDED, A NEW FORM IS COMPLETED. <td< th=""><th>NAME OF PRO</th><th>VIDER OR SUPPLIER</th><th>STREET AD</th><th>DRESS, CITY, S<sup>-</sup></th><th>TATE, ZIP CODE</th><th></th><th></th></td<>	NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
HIBBING, MY 55745           PRECEND FOR INSTRUCT OF DEFICIENCIES TAG         IPACH ECACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR IS CIDENTIFYING INFORMATION)         IPACE TAG         IPACE ICACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         IPACE TAG         IPACE ICACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         IPACE TAG         IPACE CONSERVERTING ACTION SHOULD BE CROSERVERTING ACTION SHOULD BE CROSERVERTING ACTION SHOULD BE TAG         COMMENTS IPACE DEFICIENCY         CO			A DELLAR CENTL 1500 EAS	T THIRD AVE	NUE		
PREFIX       IEACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       TAG       IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED to THE APPROPRIATE       COMPLETE         2 625       Continued From page 7       2 625       2 625       Image: Complete the Appropriate instructions on when to give breaths, do compressions, and when to give a shock. LPN-C stated the Xas important to follow the AED prompts. LPN-C stated he had not seen a POLST was important to follow the AED prompts. LPN-C stated he nad 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.       Image: Complete the AED gives instructions for shock once. LPN-C stated from and CPR. The DON stated nersing is provided by an outside instructor trained by the American Heart Association on AED use and CPR. The DON stated nersing staff are trained every two years. The DON stated and wing 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.	GUARDIAN	ANGELS HEALTH	A REHAD CENTI HIBBING,	MN 55746			
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 as 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 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.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	COMPLETE
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 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.	2 625 C	ontinued From pa	ge 7	2 625			
	LF to gi fo se or he O in m st ar Hu D ye st br TT C c a NI C NI S TT re fo A up ar be ar ar ar st ar ar st ar st ar ar st ar ar ar ar ar ar ar ar ar ar ar ar ar	PN-C stated the A give breaths, do d ive a shock. LPN-C ollow the AED prom- een a POLST with nce. LPN-C stated e would talk with h an 4/30/21, at 10:24 terviewed. The DO banagers fill out PC tated the AED and n outside instructo eart Association o ON stated nursing ears. The DON sta- treaths, compression he facility provided are Planning Case apitals the instruct EVER ADAPT, UF URRENT POLST. OTATION. IF THA S COMPLETED. he policy Advance eviewed/amended ollowing: The POLS new POLST form pdates or revisions nd/or legal represe enefits of CPR (pe ssociation) will be nd/or designee, in	ED gives instructions on when compressions, and when to C stated it was important to npts. LPN-C stated he had not written instructions for shock I if he saw a POLST like that is nurse manager. 0 a.m. the DON was ON stated her and the nurse DLST documents. The DON CPR training is provided by r trained by the American n AED use and CPR. The g staff are trained every two ated she would expect nursing structions the AED gave for ons, and delivering shocks. d training materials, Advance e Study undated. In bold all ions included the following: PDATE OR CHANGE A .NEVER CORRECT A .T IS NEEDED, A NEW FORM Care Planning 2/19/18, directed the ST form itself is never revised. must be completed with any s, and signed by the resident entative. The risks and er the American Heart explained to the resident order to assist them in				

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		A. BUILDING			С
	00858	B. WING			30/2021
PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
AN ANGELS HEALTH	& REHAB CENTI		ENUE		
	TEMENT OF DEFICIENCIES	ID			(X5)
		PREFIX TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLET DATE
Continued From pa	ge 8	2 625			
develop, review and procedures to ensu Life-Sustaining Trea completed to clearly status who have mo instructions. The Do all appropriate staff procedures. The D monitoring systems compliance.	d/or revise policies and re the Provider Orders for atment (POLST) is accurately y reflect the resident code odified POLST special ON or designee could educate on the policies and ON or designee could develop to ensure ongoing				
Medications Self Ac Subp. 4. Self-adm self-administer med resident assessmen care as required in 4658.0405 indicate	inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there				5/26/21
by: Based on observati review, the facility fa not self-administer assessed and acco 2 residents (R24) re Findings include: R24's Face Sheet p	on, interview, and document ailed to ensure a resident did medications (SAM) as rding to the care plan for 1 of eviewed for SAM.		Corrected		
	OF CORRECTION PROVIDER OR SUPPLIER AN ANGELS HEALTH SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa The Director of Nur develop, review and procedures to ensu Life-Sustaining Treat completed to clearly status who have mainstructions. The Director of Nur develop, review and procedures to ensu Life-Sustaining Treat completed to clearly status who have mainstructions. The Director of Nur develop, review and procedures. The Director of Nur develop, review and procedures. The Director of Nur all appropriate staff procedures. The Director of Nur all a	OF CORRECTION       IDENTIFICATION NUMBER:         00858       00858         PROVIDER OR SUPPLIER       STREET AI         AN ANGELS HEALTH & REHAB CENTI       1500 EA: HIBBING         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       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 develop monitoring systems to ensure ongoing compliance.         TIME PERIOD FOR CORRECTION: Twenty-one (21) days.       Time PERIOD FOR CORRECTION: Twenty-one (21) days.         MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin       Subp. 4. Self-administration. A resident may self-administer medications if the 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	OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING         00858       B. WING	OF CORRECTION       IDENTIFICATION NUMBER:       A.BUILDING:         00858       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         NA ANGELS HEALTH & REHAB CENTI       1500 EAST THIRD AVENUE         NUMMARY STATEMENT OF DEFICIENCIES       ID         SUMMARY STATEMENT OF DEFICIENCIES       ID         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         Continued From page 8       2 625         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 develop monitoring systems to ensure ongoing compliance.         TIME PERIOD FOR CORRECTION: Twenty-one (21) days.       21565         Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive plan of care as required in parts 4658.0400 and 4658.0400 indicate this practice is safe and there is a written order from the attending physician.       21565         This MN Requirement is not met as evidenced by:       Corrected         Based on observation, interview, and document review, the facility failed to ensure a resident did on self-administer medications (SAM) as assessed and according to the care plan for 1 of 2 residents (R24) reviewed for SAM.       Corrected         Findings include:       R24's Face Sheet printed 4/28/21, indicated	OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:       COM         00858       B. WING       004/         PROVIDER OR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL       ID       PROVIDER'S PLAN OF CORRECTION SHOULD BE         SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL       ID       PREVIDENT'S CONSTRUCTION SHOULD BE         Continued From page 8       ID       PREVIDENT'S IN STATEMENT OF DEFICIENCY       CROSS-REFERENCED TO THE APPROPRIATE         Deficiency rol LG: DENTIFYING INFORMATION       ID       PREVIDENT'S IN STATEMENT OF DEFICIENCY       CROSS-REFERENCED TO THE APPROPRIATE         Continued From page 8       2 625       CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY         Continued From page 8       2 625       CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY         Continued From page 8       2 525       CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY         Continued From page 8       2 525       CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY         Continued From bage 8       2 525       CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY         Continued From bage 8       2 525       CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY         Continued Store only relesignee could develop moniloring systems to

Minnesota Department of Health STATE FORM

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If continuation sheet 9 of 17

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Continued From pa	age 9	21565			
(underactive thyroid), hyperlipidemia (high cholesterol), and diabetes.					
dated 3/4/21, indic	ated R24 was cognitively intact				
preferred nursing t	o store and administer				
dated 4/18/19, indi state what each medicat not able to self-adr assessment direct medications from a store, set up, admi	cated R24 could not correctly edication was for and what ion was to be taken, and was minister her medications. R24's ed R24 was to receive a licensed nurse who would inister, and document all				
<ul> <li>Acetaminophen 5 by mouth per day a</li> <li>Aspirin enteric co (DR) 81 mg by mo a.m.</li> <li>Folic acid (vitamin per day at 8:00 a.m.</li> </ul>	500 milligrams (mg) one tablet at 8:00 a.m. bated (EC) delayed release uth one time per day at 8:00 n B) 1 mg by mouth one time n.				
day at 8:00 a.m. - Synthroid (for hyp micrograms (mcg) 8:00 a.m. - Women's Multivit	oothyroidism) tablet, 25 by mouth one time per day at amin Hi Potency one tablet by				
	OF CORRECTION PROVIDER OR SUPPLIER AN ANGELS HEALTH SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pa (underactive thyroi cholesterol), and d R24's quarterly Min dated 3/4/21, indic and understood ot R24's care plan ini preferred nursing t medications as pre R24's Medication S dated 4/18/19, indi state what each m time each medicat not able to self-adu assessment direct medications from a store, set up, admi medications per pl R24's physician or - Acetaminophen S by mouth per day a - Aspirin enteric co (DR) 81 mg by mo a.m. - Folic acid (vitami per day at 8:00 a.m. - Norvasc tablet, 2. day at 8:00 a.m. - Women's Multivit	OF CORRECTION       IDENTIFICATION NUMBER:         00858       00858         PROVIDER OR SUPPLIER       STREET A         AN ANGELS HEALTH & REHAB CENTI       1500 EA: HIBBING         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Continued From page 9         Continued From page 9       (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 prom 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	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00858       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, S'         SUMMARY STATEMENT OF DEFICIENCIES       1500 EAST THIRD AVE HIBBING, MN 55746         SUMMARY STATEMENT OF DEFICIENCIES       ID PREFIX         REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX         TAG       21565         (underactive thyroid), hyperlipidemia (high cholesterol), and diabetes.       21565         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. - Norvasc tablet, 2.5 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. - Sopithroid (for hypothyroidism) tablet, 25 micrograms (mcg) by mouth one time per day at 8:00 a.m.	OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:       00858     B. WING       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       NA ANGELS HEALTH & REHAB CENTI     1500 EAST THIRD AVENUE       HIBBING, MN     55746       SUMMARY STATEMENT OF DEFICIENCIES     D       REGULATORY OR LSC IDENTIFYING INFORMATION)     D       PREFIX     CROSS-REFERENCE TO TO DEFICIENCIES       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     D       REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX       Continued From page 9     21565       (underactive thyroid), hyperlipidemia (high cholesterol), and diabetes.     21565       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.       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WING       004/2         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         NANGELS HEALTH & REHAB CENTI       1500 EAST THIRD AVENUE HIBBING, MN 55746       PROVIDER'S PLAN OF CORRECTION (EACH OPERCENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH OPERCENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Continued From page 9       21565       (underactive thyroid), hyperlipidemia (high cholesterol), and diabetes.       PREFIX AGD 21565         R24's quarterly Minimum Data Assessment, dated 3/4/21, indicated R24 was cognitively intact and understood others.       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 for and what time each medication was for and what time each medication was to be taken, and was not able to self-administer her medications. R24's sasessment 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. - Folic acid (vitamin B) 1 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. - Women's Multivitamin Hi Potency one tablet by       Nomen's Multivitamin Hi Potenc

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:	······		с
		00858	B. WING			30/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
UARDI	AN ANGELS HEALTH	L& REHAB CENTI	ST THIRD AVE 6, MN 55746	NUE		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLE DATE
21565	Continued From pa	age 10	21565			
	following medicatio a.m. medication pa -Acetaminophen 50 -Aspirin enteric coa 81 mg -Folic acid (vitamin -Norvasc (for high I -Synthroid (for hypo (mcg) - women's multivita R24's eMAR lacked On 4/27/21, at 9:08 (LPN)-A was obser of medications with left R24's room whi one at a time. On 4/27/21, at 11:0 and stated she usu her because she w staff stayed with he have a physician's medications, but w order. LPN-A chec computer and veriff SAM. LPN-A state ones to get the ord On 4/27/21, at 11:0 registered nurse (F R24. RN-A verified SAM. RN-A stated	20 milligrams (mg) one tablet ated (EC) delayed release (DR B) 1 mg blood pressure) 2.5 mg othyroidism) 25 micrograms amin hi potency one tablet d directives for SAM. B a.m. licensed practical nurse ved to leave a medication cup n R24 in her room. LPN-A ther ile R24 took her medications 03 a.m. LPN-A was interviewed vally left R24's medications with rould not take them if nursing er. LPN-A stated R24 should order for self-administration of as not sure if she did have an sked for orders on the ied R24 did not have orders fo d the unit managers were the				
	(DON) verified staf	l a.m. the director of nursing f should not leave a resident hen they had not been				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION		E SURVEY PLETED
						С
		00858	B. WING		04/	30/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GUARDI	AN ANGELS HEALTH	& REHAB CENTI	ST THIRD AVE 6, MN  55746	INUE		
(X4) ID	_	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	DATE
21565	Continued From pa	ige 11	21565			
	assessed to be safe a physician's order.	e with SAM, and did not have				
	Medication by Resi the interdisciplinary determine the resid self-administer thei wished to SAM. If S safe, the IDT would	elf-Administration of dents revised 1/18, directed v team (IDT) to assess and lent's ability to safely r medications if the resident SAM is determined to not be d consider options that allowed vely participate in SAM to the emed safe.				
	The director of nurs review applicable p ensure residents' a administration of m	THOD OF CORRECTION: sing (DON) or designee could olicies and procedures to re assessed timely with self edications; then provide staff lity assurance committee ompliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21695	MN Rule 4658.141 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			5/26/21
	provide housekeep necessary to maint comfortable interior	eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting,				
	by: Based on observati	ent is not met as evidenced ion, interview, and document ailed to clean and maintain		Corrected		

If continuation sheet 12 of 17

Minnesc	ota Department of He	ealth			FORM	APPROVE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00858	B. WING			C 30/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTI	ST THIRD AVE 6, MN 55746	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21695	Continued From pa	age 12	21695			
	sheepskin covering of 8 residents (R1,	is on resident equipment for 6 R12, R21, R25, R32, and sheepskin covers on				
	Findings include:					
	diagnoses which in (a medical condition	rinted 4/30/21, identified cluded macular degeneration n in which the lens of the eye ively opaque, resulting in glaucoma.				
		ange Minimum Data set (MDS) cated R1 was cognitively				
	wheelchair arms we matted, and the left	a.m. the sheepskins on R1's ere noted to be gray in color, t sheepskin was worn down a hole where R1's elbow				
	was interviewed. R resident's equipme resident's skin from against the equipm housekeeping staff	a.m. registered nurse (RN)-A RN-A stated sheepskins on the nt were used to protect the n pressure or scrapping skin ent. RN-A further stated cleaned the wheelchairs replace or clean the time if needed.				
	(NA)-E was intervie unsure who was re- replacing the sheep equipment. NA-E wheelchair arms we should be replaced	2 p.m. nursing assistant wed. NA-E stated he was sponsible for washing or oskins on the resident's verified R1's sheepskin on her ere soiled and worn, and . NA-E asked R1 if she would on her wheelchair replaced,				

	ita Department of He IT OF DEFICIENCIES	alth (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI F	E CONSTRUCTION		SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00858	B. WING			C 30/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTI	ST THIRD AVE , MN 55746	NUE		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI	ION SHOULD BE	(X5) COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC		DAIL
21695	Continued From pa	ge 13	21695			
	and R1 stated, "yes	S."				
		printed 4/20/21, identified				
		cluded peripheral vascular blood vessels with reduced nbs).				
	R12's significant change MDS dated 2/5/21, indicated R12 was cognitively intact.					
	wheelchair arms we	a.m. the sheepskins on R12's ere noted to be gray in color ated the sheepskin keeps her rms.				
		printed 4/30/21, identified cluded muscle weakness.				
		S dated 2/24/21, indicated cognitively impaired.				
		3 a.m. the sheepskin on R21's rved to be gray in color, and				
	diagnoses which in of one side of the b	printed 4/30/21, identified cluded hemiplegia (paralysis ody) following cerebral ffecting right dominant side.				
	R25's quarterly MD was cognitively inta	S dated 3/1/21, indicated R25 ct.				
	R25 stated the shee looked "dirty, matte seen the staff remo	a.m. R25 was interviewed. epskin on her wheelchair d." R25 stated she has never ove them for cleaning, and it her. R25 also said the worn out.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00858	B. WING			C 30/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTI	T THIRD AVE	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21695	-at 9:26 a.m. NA-C the sheepskins on e someone sends the as there were not re looked at the sheep and verified they loo be washed or replace R32's Face Sheet p diagnoses which ind R32's quarterly MDR R32 was severely c On 4/28/21, at 9:32 wheelchair arms we color and matted. On 4/29/21, at 8:30 NA-A stated the she there to protect resi housekeeping wash were supposed to re sheepskins from the the sheepskins wer name and that they NA-A looked at she wheelchair, she stat looked like they sho R37's Face Sheet p diagnoses which we R37's quarterly MDR R37 was severely c	was interviewed. NA-C stated equipment get cleaned when em to the wash "not very often" eplacements available. NA-C skins on R25's wheelchair, oked dirty, matted, and should ced. orinted 4/30/21, identified cluded muscle weakness. S dated 3/10/21, indicated ognitively impaired. a.m. the sheepskins on R32's ere observed to be gray in a.m. NA-A was interviewed. eepskin on equipment was dent's arms. NA-A stated ned the wheelchairs and they emove and wash the e wheelchairs. NA-A thought e marked with the resident were washed twice a week. eepskins on the arms of R32's ted they looked dingy and ould be washed. orinted 4/30/21, identified eakness. S dated 3/19/21, indicated	21695			

STATEMEN	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		ESURVEY	
AND PLAN OF CORRECTION IDENTIFICATION N		IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	OMPLETED	
		00858	B. WING			C 30/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GUARDI	AN ANGELS HEALTH	& REHAB CENTI 1500 EA	ST THIRD AVE	NUE			
		HIBBING	, MN 55746				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21695	Continued From pa	ige 15	21695				
	interviewed and sta "a couple of times a housekeeping staff them in the laundry back to the residen clean. L-A stated if where the sheepsk clean sheepskins to -at 8:49 a.m. occup interviewed. OT-D s sheepskins returne were worn out he w order replacements sheepskins on R32 were worn out, no la -at 8:55 a.m. RN-A it was everyone's re sheepskins were cl stated the NAs wou sheepskins for repl was not a system in	4 a.m. laundry staff (L)-A was atted wheelchairs are washed a month." L-A stated remove the sheepskin, put for washing, and bring them t's room when they were they could not determine ins came from, they gave the o therapy. bational therapist (OT)-D was stated he would look at d from the laundry and if they yould throw them out, and s. OT-D looked at the t's wheelchair, he verified they onger providing a cushion. was interviewed. RN-A stated esponsibility to ensure ean and not worn out. RN-A ald come to him about worn ou acements. RN-A stated there in place to ensure sheepskins regular basis and in good	t				
	monthly. H-B was n about sheepskins o not used in her area On 4/30/21, at 10:1	ated wheelchairs are cleaned not sure about what to do on wheelchairs, stated they are a. 7 a.m. the director of nursing	,				
	depends on staff to soiled or worn out. housekeeping staff the laundry when th	wed. The DON stated she notice if the sheepskins were The DON stated the "might" bring the sheepskin to ney clean the wheelchairs. The was no process in place to					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED C
		00858	B. WING	·····	04/	30/2021
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
UARDI	AN ANGELS HEALTH	& REHAB CENTI	ST THIRD AVE , MN 55746	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From pa	ge 16	21695			
	ensure the sheepsl and in good repair.	kins on equipment were clean				
	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					
	ensure ongoing cor TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

STATEMENT OF DEFICIENCIE AND PLAND CORRECTION     (XI) PROVIDERSUPPLIER/LIMITER     OC) MULTIPLE CONSTRUCTION A BUILDING 01 - AMAN BUILDING 01 A BUILDING 01 - AMAN BUILDING 01 BUILDING 01 - BUILDING 01 BUILDING 01 BUILDI			AND HUMAN SERVICES			C		APPROVED
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     100001001       (PAL)     SUMAMARY STATEMENT OF DEFICIENCES     STREET ADDRESS, CITY, STATE, ZIP CODE     1000000000000000000000000000000000000	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY. STATE. 21 CODE       GUARDIAN ANGELS HEALTH & REHAB CENTER     150 DEST TIERD AVENUE       (W) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES     150 DEST TIERD AVENUE       (W) ID TAC     SUMMARY STATEMENT OF DEFICIENCIES     10 DEST TIERD AVENUE       (K) 000     INITIAL COMMENTS     PREVISE REALT OF CORRECTION (EACH ORDERCIVE AUGUST EPREVENDING THE DEFICIENCIES STATE (EACH ORDERCIVE) VISIT EFRECED BY FULL (EACH ORDERCIVE) VISIT EFRECED BY FULL (EACH ORDERCIVE ACTION SPORTHUSE (EACH ORDERCIVE) TO THE APPROPRIATE DEFICIENCY     000 DEST TIERD AVENUE (EACH ORDERCIVE ACTION SPORTHUSE)       K 000     INITIAL COMMENTS     K 000       FIRE SAFETY     A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time 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. YOUR SIGNAUREAT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2667 WILL BE USED AS VERIFICATION OF COMPLIANCE WITH THE REGULATION OF COMPLIANCE WITH THE REGULATION OF CORPECTION IS NOT REQUIRED.       UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REFUSIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTATIAL COMPLANCE 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			245239	B. WING	;		04/	27/2021
PREFIX TAG       CEACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LISC DENTIFYING INFORMATION)       PREFIX TAG       CEACH CORRECTIVE ACTION SHOULD BE DEFICIENCY       COMPLETING DEFICIENCY         K 000       INITIAL COMMENTS       K 000         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 complicate 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 (KPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.         THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO COMPLIANCE.         UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR VERIFICATION.         IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.         PLEASE RETURN THE PLAN OF DEFICIENCIES (K TAGS) TO:			& REHAB CENTER		1	500 EAST THIRD AVENUE	<u> </u>	
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-2687 WILL BE USED AS VERIFICATION OF COMPLIANCE.         UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSTIE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH HOUR VERIFICATION.         IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.         PLEASE RETURN THE PLAN OF CORRECTION IS NOT REQUIRED.         PLEASE RETURN THE PLAN OF CORRECTION IS NOT REQUIRED.         PLASE RETURN THE PLAN OF CORRECTION IS NOT REQUIRED.         PLASE RETURN THE PLAN OF CORRECTION IS NOT REQUIRED.         PLASE RETURN THE PLAN OF CORRECTION IS NOT REQUIRED.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	) BE	COMPLETION
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, APAPER COPY OF THE PLAN OF CORRECTION IS NOT REGUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRST SAFETY DEFICIENCIES (K TAGS) TO: MARCHYLLEGAS (K TAGS) TO: MARCHYLLEG	K 000	INITIAL COMMEN	TS	K	000			
Minnesota Department of Public Safety, Stale         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 24 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-2667 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 FLAN OF CORRECTION IS NOT         REQUIRED.         PLEASE RETURN THE PLAN OF         CORNACCE WITH YOUR VERIFICATION.         ADBORATORY DIRECTORS OR PROVIDERSUPPLIER REPRESENTATIVES SIGNATURE         ADBORATORY DIRECTORS OR PROVIDERSUPPLIER REPRESENTATIVES SIGNATURE		FIRE SAFETY						
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: ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE NTLE (%) DATE		Minnesota Departn Fire Marshal Divisio Guardian Angels H found not in compli participation in Mec Subpart 483.70(a), 2012 edition of Nat Association (NFPA	nent of Public Safety, State on. At the time of this survey, ealth & Rehab Center was ance with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection ) Standard 101, Life Safety					
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.       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:       ITLE       (X6) DATE		ALLEGATION OF ( DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS					
OF THE PLAN OF CORRECTION IS NOT REQUIRED.       PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:       Image: Constant of Cons		ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN					
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		OF THE PLAN OF						
		CORRECTION FO	R THE FIRE SAFETY					
			DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 05/13/202 <sup>2</sup>

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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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES       FORM         CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB NC         STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DAT         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING 01 - MAIN BUILDING 01       (X3) DAT							APPROVED
							0938-0391
			` '				
		245239	B. WING			04/2	27/2021
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GUARDI	AN ANGELS HEALTH	& REHAB CENTER					
				~			(X5) COMPLETION
				x	CROSS-REFERENCED TO THE APPROPI		DATE
K 000	Continued From pa	ge 1	K 0	00			
	HEALTH CARE FIR	RE INSPECTIONS					
	By e-mail to:						
	FM.HC.Inspections	@state.mn.us					
	THE PLAN OF COR	DRRECTION FOR EACH					
	DEFICIENCY MUS	T INCLUDE ALL OF THE					
	FOLLOWING INFO	RMATION:				CORRECTIVE ACTION SHOULD BE COMPLÉTION EFERENCED TO THE APPROPRIATE DATE	
		iption of the corrective action correct the deficiency.					
		asures that will be put in place ency does not reoccur.					
		facility plans to monitor future ure solutions are sustained.					
	4. Identify who is reactions and monitor	esponsible for the corrective ring of compliance.					
	5. The actual or pro the remedy.	oposed date for completion of					
	1-story building with The original building was determined to I In 1968, 1973, & 19 to the building that II(111) construction.	uilding: ealth and Rehab Center, is a a small partial basement. g was constructed in 1964 and be of Type II(111) construction. 91 additions were constructed was determined to be of Type . In 1990 a Type V (111) (nonresident use area) was					

If continuation sheet Page 2 of 4

		AND HUMAN SERVICES				FORM	05/25/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION D1 - MAIN BUILDING 01	(X3) DAT	E SURVEY PLETED
		245239	B. WING			04/	27/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		-
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE IBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000 K 712 SS=E	partial basement w to be of Type II(111 wing was construct with a small partial was determined to The building is fully also has a fire alarr detection in the cor corridors that is mo department notifica The facility has a ca census of 62 at the The requirements of are NOT MET. Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the signal and simulation conditions. Fire dril unexpected times u least quarterly on e with procedures an established routine between 9:00 PM a announcement may alarms. 19.7.1.4 through 19	<ul> <li>Do a 1-story building with a as added that was determined ) constructed. In 2011 another ed that is a one story building mechanical basement that be of Type II(000).</li> <li>If sprinklered throughout and m system with smoke ridors and spaces open to the onitored for automatic fire tion.</li> <li>apacity of 90 beds and had a time of the survey.</li> <li>bo 42 CFR, Subpart 483.70(a)</li> <li>and the survey for a fire alarm on of emergency fire is are held at expected and under varying conditions, at ach shift. The staff is familiar d is aware that drills are part of . Where drills are conducted and 6:00 AM, a coded y be used instead of audible</li> </ul>	К 0				5/26/21

Facility ID: 00858

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		AND HUMAN SERVICES				FORM	05/25/2021 APPROVED 0938-0391	
							DATE SURVEY COMPLETED	
		245239	B. WING			04/2	27/2021	
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 55746					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 712	<ul> <li>available document the facility failed to in accordance with Code" 2012 edition 19.7.1.6, during the deficient conditions residents.</li> <li>Findings include:</li> <li>On 04/27/2021, at of of all available fire of interview with the M following deficient of 1. The facility failed evening shift fire dr the 3 p.m. hour.</li> <li>2. The facility failed shift fire drills by co a.m. hour.</li> </ul>	erview and a review of the tation, it was determined that vary the times of the fire drills the NFPA 101 "The Life Safety , sections 19.7.1.2 and e last 12 months. These s could affect 90 of 90 10:00 a.m., during the review drill documentation and an Maintenance Supervisor the conditions were found: d to vary the times of the rills by conducting 3 fire drills in d to vary the times of the night onducting 3 fire drills in the 1	K	712	K 712 ESD or designee will implement cor action to prevent reoccurrence ESD and/or designee will implement measures to ensure this practice do reoccur including: * Updating the Quarterly Nursing Ho Fire Drills form to indicate variation requirements. * ESD and ESD staff will be provide education on proper variations of scheduling fire drills * Audits will be completed for monit by the ESD and/or designee two tim monthly to ensure future compliance * Monitoring will be reported to the O Assurance Committee quarterly and needed. The Quality Assurance Committee will make recommendat for ongoing monitoring. Environmental Services Director is responsible for the corrective action monitoring of compliance Completed Date: 5/26/21	nt bes not ome ed oring nes e Quality d as tions		

If continuation sheet Page 4 of 4