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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LUP2
Facility ID: 00858

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/15/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **85** (L18)

13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NEII 04/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/05/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00130
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/26/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5239

On April 15, 2015 a Post Certification Revisit (PCR) was completed at this facility to verify correection of deficiencies not corrected at the time of the March 12, 2015 PCR. Based on the revisit, we have deteremined the deficiencies were corrected as of April 10, 2015.

As a result of this visit, we discontinued the Category 1 remedy of State monitoring, effective April 10, 2015.

In addition, we recommended to the CMS Region V Office, that the following action related to the imposed remedy outlined in our letters of March 20, 2015 and March 27, 2015, which CMS Region V Office concurred and authorized this Department to notify the facility:

- Mandatory denial of payment for new Medicare adn Medicaid Admissions (DPNA), effective April 15, 2015 be rescinded.

Since DPNA did not go into effect, the facility would not be subject to a two year loss of NATCEP that would have begun April 15, 2015. Refer to the CMS 2567b for health only.

At the time the facility achieved substantial compliance (effective date April 10, 2015), the facility was certified for 92 skilled nursing facility beds.

Effective, May 1, 2015, the facility laid away seven beds, which reduced their certified beds to 85 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245239

May 5, 2015

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

Dear Mr. Ryan:

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 April 10, 2015 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

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

cc: Licensing and Certification File

April 17, 2015

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

RE: Project Number S5239029

Dear Mr. Ryan:

On March 20, 2015, this Department recommended to the Centers for Medicare and Medicaid Services (CMS), CMS concurred and authorized this Department to inform you of the following enforcement action:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 15, 2015. (42 CFR 488.417 (b))

In our letter of March 20, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 15, 2015, due to denial of payment for new admissions.

On March 27, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 1, 2015. (42 CFR 488.422)

In addition, on March 27, 2015, this Department recommended to the Centers for Medicare and Medicaid Services (CMS), the following action related to the remedy outlined in our letter of March 27, 2015:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 15, 2015 remain in effect. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on January 15, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 12, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On April 15, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on March 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 10, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on April 15, 2015, as of April 10, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 10, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letters of March 20, 2015 and March 27, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 15, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 15, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 15, 2015, is to be rescinded.

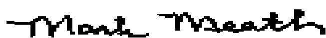
In our letters of March 20, 2015 and March 27, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 15, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 10, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,



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

Enclosure

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245239	A. Building B. Wing	4/15/2015

Name of Facility	Street Address, City, State, Zip Code
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

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

(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0165** Reg. # **483.10(f)(1)** LSC	**04/10/2015**
ID Prefix **F0241** Reg. # **483.15(a)** LSC	**04/10/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**04/10/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	**04/10/2015**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	**04/10/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**04/10/2015**
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By CC/mm	Date: 04/16/2015	Signature of Surveyor: 18618	Date: 04/15/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/15/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LUP2
Facility ID: 00858

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **03/12/2015** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **05 HHA** **09 ESRD** **13 PTIP** **22 CLIA** **02 SNF/NF/Dual** **06 PRTF** **10 NF** **14 CORF** **03 SNF/NF/Distinct** **07 X-Ray** **11 ICF/IID** **15 ASC** **04 SNF** **08 OPT/SP** **12 RHC** **16 HOSPICE**

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **92** (L18)
13.Total Certified Beds **92** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 3. 24 Hour RN __ 4. 7-Day RN (Rural SNF) __ 5. Life Safety Code __ 6. Scope of Services Limit __ 7. Medical Director __ 8. Patient Room Size __ 9. Beds/Room
* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	92			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 04/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **10/01/1981** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)
27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

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

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **00130** (L31)
30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE **02/26/2015** (L33)

Posted 04/16/2015 Co.

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM   STATE AGENCY REMARKS

CCN: 24-5239

On March 12, 2015 a Post Certification Revisit (PCR) was completed to verify the facility had corrected deficiciencies issued pursuant to the January 16, 2015 standard survey. We presumed based on the plan of correction, that the facility had achieved substantial compliance. Based on our PCR, we determined the facility had not achieved substantial compliance. The most serious deficiency at the time of the PCR was found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate kjeopardy (Level D). As a result the facility has not achieve substantial compliance. This Department imposed the following Cateogry 1 remedy:

- State Monitoring effective April 1, 2015 (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V office, CMS concurred and authorized this Department to notify the facility of the following remedy imposition:

- Mandatory Denial of Payment for new Medicare and Medicaid Admissions (DPNA), effective April 15, 2015 (42 CFR 488.417(b))

If DPNA goes into effect the facility would be subject to a two year loss of NATCEP, effective April 15, 2015.

Refer to the CMS 2567b and CMS 2567 along with the provider's plan of correction. PCR to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 7273

March 20, 2015

Mr Geoffrey Ryan, Administrator
Guardian Angels Health & Rehabilitation Center
1500 East Third Avenue
Hibbing, Minnesota 55746

Dear Mr. Ryan:

On January 29, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 15, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

However, compliance with the health deficiencies issued pursuant to the January 15, 2015 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found 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), whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective April 15, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective April 15, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 15, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Guardian Angels Health & Rehab Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 15, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 15, 2015 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

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

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

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 7310

March 27, 2015

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

RE: Project Number S5239029

Dear Mr. Ryan:

On March 20, 2015, this Department recommended to the Centers for Medicare and Medicaid Services (CMS), CMS concurred and authorized this Department to inform you of the following enforcement action:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 15, 2015. (42 CFR 488.417 (b))

Also, this Department notified you in our letter of March 20, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 15, 2015.

This was based on deficiencies cited by this Department during a standard survey completed on January 15, 2015, and lack of verification of substantial compliance at the time of our March 20, 2015 notice. The most serious deficiencies were found 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), whereby corrections were required.

On March 12, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 23, 2015. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on March 12, 2015. The deficiencies not corrected are as follows:

F0165 -- S/S: D -- 483.10(f)(1) -- Right To Voice Grievances Without Reprisal
F0241 -- S/S: D -- 483.15(a) -- Dignity And Respect Of Individuality
F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
F0431 -- S/S: D -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals

In addition, at the time of this revisit, we identified the following deficiencies:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0315 -- S/S: D -- 483.25(d) -- No Catheter, Prevent Uti, Restore Bladder

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, this Department is imposing the following Category 1 remedy:

- State Monitoring effective April 1, 2015. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of March 20, 2015:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 15, 2015 remain in effect. (42 CFR 488.417 (b))

As we notified you in our letter of March 20, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 15, 2015.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 302-6151 Fax: (218) 723-2359

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 15, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

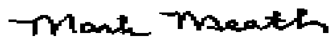
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Sincerely,

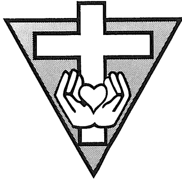


Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File



Guardian Angels
Health & Rehabilitation Center

April 2, 2015

RECEIVED
APR 03 2015
MN Dept of Health
Duluth

Christine Campbell, R.N., Unit Supervisor
Health Regulation Division
Licensing and Certification Section
Minnesota Department of Health
Northeast District Office
11 East Superior Street, Suite 290
Duluth, MN 55802-2007

Ms. Campbell:

Enclosed you will find the corrections to the federal deficiencies issued during the survey revisit conducted March 10th through March 12th, 2015. If you have any questions regarding the corrections to the deficiencies, feel free to contact me by email or by phone at (218) 231-8106.

Respectfully Submitted,

Geoffrey Ryan, Administrator
Guardian Angels Health and Rehabilitation Center

1500 East Third Avenue Hibbing, MN 55746
Phone: 218-263-7583 Fax: 218-231-8111 www.guardianangels.sfhs.org
Member St. Francis Health Services
EOE/AA

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

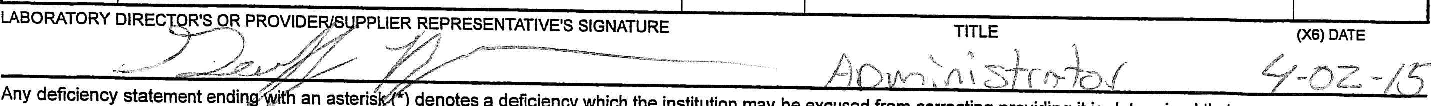
RECEIVED

PRINTED: 03/27/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING APR 03 2015 B. WING MN Dept of Health Duluth	R 03/12/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 165} SS=D	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure concerns about long call light response times were addressed for 1 of 1 resident (R116) requesting assistance with toileting care needs, resulting in incontinence of urine. Findings include: R116 presented a computer print out of a call light log dated 2/27/15 during an interview on 3/10/15, at 4:15 p.m. This log indicated R116's call light had been on and not responded to for 87.3 minutes at 7:48 a.m., 17.6 minutes at 10:44 a.m.,	{F 165} OK 4/7/15 W		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 4-02-15

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

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{F 165}	Continued From page 1 16.5 minutes at 11:59 a.m., 15.2 minutes at 7:12 a.m., and 12.4 minutes at 9:37 a.m. R116 stated she was incontinent when she had to wait 87 minutes, and felt bad about that. R116 stated she put herself on the floor so staff would respond. R116 stated she told them about the long wait times for call lights to be answered, but "they don't listen." R116 stated she would not let them get her off the floor until she talked to the administrator. R116 stated she was told the administrator was not in the building, but when she insisted on talking to him prior to getting off the floor, he came to see her a short time later. R116 stated the administrator told her there were better ways to get his attention. The significant change Minimum Data Set (MDS) dated 12/18/14, indicated R116 was cognitively intact and presented no behavioral issues. R116 required extensive assistance of two with toileting, transfers and bed mobility. R116 's care plan dated 7/21/14, indicated R116 was incontinent of bladder, on a scheduled program due to functional incontinence and required a mechanical sling lift and assist of two for transferring on and off the toilet. The signed physician orders dated 3/4/15, indicated R116 was receiving Lasix (a diuretic) 40 milligrams (mg) by mouth daily. A nursing progress note dated 2/27/15, at 2:05 p.m. indicated R116 was upset in the morning due to increased call light time, resulting in an incontinent episode. R116 stated if she had to wait more than 30 minutes again, they would be sorry. 16 minutes later R116 was on the floor. R116 stated she put herself on the floor because she was sick of having to wait too long to have the call light answered and resulting incontinence.	{F 165}	**F165:** DON and/or designee will implement corrective action for resident (R116) affected by this practice by: • R116 was reassessed regarding call light response times for toileting assistance. DON and/or designee will assess residents having the potential to be affected by this practice including: • GA will ensure any resident concerns regarding call light response times are addressed and corrected. DON and/or designee will implement measures to ensure that this practice does not recur including: • R116 care plan was reviewed and revised. • Nursing staff will be educated on updated care plan for R116's toileting needs DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • All cognitively intact residents will be interviewed regarding satisfaction with call light response times and toileting assistance. • Any residents with concerns will be followed up on and the resident will be re-interviewed by DON/designees 3x/week until resident indicates that concern is resolved, then weekly thereafter until compliance achieved. • 3 call light audits will be performed weekly at various times to ensure ongoing compliance, until compliance is achieved, then quarterly thereafter. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: April 10, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING ______ B. WING ______	R 03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 165}	Continued From page 2 R116 waited on the floor until the administrator and social services came to the room. R116 expressed her concern and continued to refuse to get off the floor. R116 was put on safety checks every 10 minutes and during the first safety check, she allowed staff to bring her to the bathroom and put her back in her chair. A risk vs benefit was reviewed with R116, and she refused to sign it. R116's care plan was revised on 3/2/15, with the addition of a behavior concern indicating R116 was quick to anger and made threatening statements. The care plan directed staff to answer call light timely, ask if anything was needed, listen to concerns and validate feelings, spend 1:1 time, and approach in a calm, direct manner. R116's care plan indicated a risk benefit was in place to address putting self on the floor "in protest." The care guide updated 3/10/15, used by direct care staff, indicated R116 was on a scheduled toileting routine and used a mechanical sling with two assist to transfer on and off the toilet. The care guide directed staff to answer the call light within 10 minutes. An incident report dated 2/27/15, at 12:01 p.m., indicated R116 placed self on the floor "in protest" and interventions were initiated to keep R116 safe. Immediate interventions included leaving call light within reach and 10 minute safety checks. Other interventions included discussing the risk/benefit of putting herself on the floor, and a recliner lift chair assessment. The root cause of the incident was identified as R116 placed self on the floor "in protest." There was no indication in the report that the resident's protest was	{F 165}		

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{F 165}	Continued From page 3 related to the long call light response times or what was done to address that concern. The interdisciplinary team (IDT) reviewed the incident on 3/2/15. Interventions at that time, included call light in reach, personal items in reach, use of non-skid footwear, and clutter removed. Although R116 verbalized she placed herself on the floor due to long call light wait times, the root cause analysis and IDT meeting note failed to address the long call light waits. The licensed social worker (LSW)-A, did initiate a concern form with R116 regarding the long call light wait, and provided her the ombudsman information. During an interview on 3/12/15, at 1:00 p.m. the director of nursing (DON) stated when there is a grievance or complaint, a concern form is completed and goes to the appropriate person or department to address. The staff is educated. The follow-up is put on the form and it is followed up with the staff and resident until it is resolved. The assistant director of nursing (ADON) stated she had been called to R116's room on the day of the incident and R116 had lifted up the lift recliner to slide self down to the floor. The ADON verified R116 was upset about the long call light waits. Registered Nurse (RN)-A verified R116 had waited 87 minutes for her call light to be answered and had been incontinent of urine. RN-A stated R116 indicated they would be sorry and a short time later, put herself on the floor. RN-A stated she worked on a plan to help assure the call lights would be answered. LSW-A stated she worked on a concern form with R116 and has followed up with her. The facility policy and procedure for use of call lights revised 1/15, indicated the facility's goal was to answer call lights within 5-7 minutes, call	{F 165}		

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{F 165}	Continued From page 4 light reports are reviewed by nursing on a daily basis, and any call lights that are over the goal were reviewed with the nursing staff on the shift to determine why the call light went over the goal. The policy and procedure further indicated any concerns would be followed up with the resident as soon as possible, and the staff was encouraged to use the Resident Concern Form to communicate any resident concerns.	{F 165}		
{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure resident dignity when staff failed to provide residents with requested toileting assistance and removed dentures during a private conversation for 1 of 1 residents (R67). Findings include: R67 was not consistently treated with dignity. According to his care plan printed and provided as current on 3/12/15, R67 was oriented, made decisions independently and expressed his needs. During interview on 3/12/15 at 11:21 a.m., nursing assistant (NA)-E stated that R67 had a mind "like a steel trap and his current memory is good too." Registered nurse (RN)-C also stated that R67 "knows what is going on."	{F 241}		

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{F 241}	Continued From page 5 The care plan indicated R67 was on a toileting plan. Staff was to toilet R67 on first rounds and ask about toileting at the end of night shift. Staff was to also toilet upon request. R67's care plan identified to assist with one or two staff and to follow the same scheduled toileting times for bowel continence. R67's Care Guide, last updated on 3/9/15, directed nursing assistants on the provision of cares. It indicated R67 needed an assist of one staff with toileting, transfer and ambulation. His toileting schedule matched that of his care plan. During an interview on 3/11/15, at 1:35 p.m., R67 indicated that he didn't "get much respect." R67 specified he would put his [call] light on at night if he needed to urinate, or had just urinated and didn't ask for assistance in time. He would also put the call light on if he woke up wet and needed to get changed. According to R67 the night staff would tell him he was dry when he knew he was wet, and didn't check to verify if he was wet or dry. R67 stated staff "don't want to be bothered." R67 further stated at times the night nursing assistant would leave him in a wet brief until 5:45 a.m. or 6:00 a.m. so they only had to change his brief once. During the interview on 3/11/15, at 1:35 p.m. R67 clearly stated he wanted to walk to the bathroom, even at night. This required his walker and an assist of one staff person. Night staff had told him he couldn't walk to the bathroom. He stated the night shift don't want him to get up - they won't walk anybody to the bathroom. R67 again stated staff make sure they come in at approximately 6:00 a.m. to change him. R67 believed staff waited until just before 6:00 a.m. to ensure he is dry, "just in case anybody checks."	{F 241}	**F241:** DON and/or designee will implement corrective action for resident (R67) affected by this practice by: • NA-F staff re-educated on R67's toileting choices regarding assist to the bathroom at night • NA-E staff re-educated on R67's dignity with oral cares. DON and/or designee will assess residents having the potential to be affected by this practice including: • GA will promote care for residents in an environment that maintains and enhances resident's dignity. DON and/or designee will implement measures to ensure that this practice does not recur including: • Incontinent Products-TENA policy was reviewed and revised. • All NAR staff will be re-educated on Resident's Rights, including honoring resident's toileting choices, and dignity with oral cares, and the Incontinent Products-TENA policy revision. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • All cognitively intact residents will be interviewed regarding satisfaction with call light response times and toileting assistance. • Any residents with concerns will be followed up on and the resident will be re-interviewed by DON/designees 3x/week until resident indicates that concern is resolved, then weekly thereafter until compliance achieved. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: April 10, 2015	

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{F 241}	Continued From page 6	{F 241}		

In the interview on 3/11/15, at 1:35 p.m., R67 indicated approximately 2 nights a week staff forget to clip the call light to his pajamas. It was the last thing they do before finishing his bedtime routine. R67 stated his voice was too soft for him to call out for help. Due to his Parkinson's if he can't reach his call light he couldn't be heard. R67 was not aware if staff checked on him every two hours or not, as he would be sleeping. R67 stated again, "I try to call out for help but my voice is too low."

Completing the interview on 3/11/15, at 1:35 p.m. R67 stated when he had the urge, he would use his call button to call for help when he needed to go to the bathroom. "They say I can't. They boss me." R67 said that it made him feel insignificant. "But," he added, "I'm going to die anyway."

In a follow-up interview on 3/12/15, at 10:22 a.m., R67 restated that he used the call light before urinating, or when he realized he was wet. He used a brief at night in case of incontinence but wanted to walk to the toilet when he was aware of the urge to void.

In the middle of the interview on 3/12/15, at 10:22 a.m., NA-E opened the closed room door, without being invited in by R67, and entered. NA-E went to the roommate's side of the room first. When directly asked, NA-E stated she needed to clean [R67's] dentures. NA-E then removed the dentures from R67's mouth. R67 did not want to talk without his dentures, so the interview was interrupted until NA-E returned his dentures.

When the interview continued on 3/12/15, at approximately 10:45 a.m., R67 explained that the previous night he had a soft bowel movement just

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{F 241}	Continued From page 7 after 12:00 a.m. He put his call light on and it was answered by NA-F. According to R67, NA-F did not check his "backside", nor did NA-F provide perineal cares or change his brief. R67 stated he was not changed until NA-E came at approximately 6:30 a.m., walked him to the toilet and cleaned him up. During interview on 3/12/15, at 11:21 a.m., NA-E confirmed when she arrived to work, R67 was usually the first one up. NA-E confirmed R67 walked to the bathroom toilet with one assist and his walker that morning. In an interview on 3/12/15 at 12:19 p.m., registered nurse (RN)-C stated that R67 had been in physical therapy and was changed to an assist of one staff. He was doing well with one assist. RN-C confirmed R67 is on a two-hour check & change (if needed) for days and nights and that he used his call light. The director of nursing (DON) was interviewed on 3/12/15, at 1:23 p.m. The DON stated staff are to follow the care plan for toileting, including at night. The DON stated if someone was capable of using the toilet, they were to be allowed to use the toilet at night. Staff was to follow the care plan and ensure that residents remained as continent as possible and to be changed if needed. The DON also stated having dentures removed in the middle of a conversation was a concern and a dignity issue.	{F 241}		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		

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F 282	Continued From page 8	F 282		

F 282 (summary statement):

accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure the care plan for repositioning was followed for 1 of 3 residents (R91) reviewed for pressure ulcers.

Findings include:

R91's quarterly Minimum Data Set (MDS) dated 1/28/15, indicated R91 was cognitively intact, required extensive assist of one staff for bed mobility and extensive assist of two staff for toileting, and was occasionally incontinent of urine and frequently incontinent of bowel. The MDS further indicated R91 had no pressure ulcers during that assessment. R91's face sheet identified diagnoses that included but not exclusive to dementia with depressive features, diabetes, and difficulty walking.

The care plan dated 2/16/15, directed staff to reposition R91 every one hour and as needed and to keep the bed at less than a 45 degree angle. The care guide (utilized by nursing assistants to provide direct care) updated 2/19/15, directed staff to reposition R91 every one hour in bed and chair.

During continuous observations on 3/10/15, from 3:12 p.m. through 4:00 p.m., R91 was lying in bed leaning slightly to the right, facing toward the door, with the head of the bed (HOB) up approximately 30 degrees. AT 3:35 p.m. the HOB was increased to 45 degrees, however no other

F 282 (provider's plan of correction):

F282: DON and/or designee will implement corrective action for resident (R91) affected by this practice by:

- R91 had new tissue tolerance tests completed, which showed the resident was appropriate for every 2 hour turning and repositioning program. Treatment and services for R91 pressure ulcer were reviewed and care plan was revised as appropriate.

DON and/or designee will assess residents having the potential to be affected by this practice including:

- GA will ensure the care plan for repositioning is followed for any resident with a pressure ulcer.

DON and/or designee will implement measures to ensure that this practice does not recur including:

- Nursing staff will be re-educated on R91's care plan interventions.
- All care plans for residents with pressure ulcers were reviewed to ensure necessary treatment and services are being provided.

DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including:

- Audits of any residents with pressure ulcers will be completed by the DON/designee 3x/week, to ensure positioning is being provided according to the residents plan of care, until compliance is achieved.
- The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring.

Completion Date: April 10, 2015

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	245239	A. BUILDING ______ B. WING ______	R 03/12/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 9 position changes were made. Nursing assistant (NA)-A entered R91's room at 4:00 p.m. and at 4:08 p.m., exited the room with R91 in a wheelchair. During an interview on 03/10/2015, at 4:15 p.m. NA-A verified R91 had not been repositioned since before she came in to work at 2:30 p.m. and verified she had not repositioned R 91 until getting her up. NA-A stated she did not realize R91 was to be repositioned every hour and thought R91 was still to be repositioned every two hours. NA-A stated the repositioning times are in the care plans and are on the repositioning sheets, and verified she had not checked either one prior to caring for R91. On 3/10/15, at approximately 5:45 p.m. the director of nursing (DON) provided the current toileting and assignment sheet which directed staff to reposition R91 every one hour. The facility policy and procedure for Resident Care Plan revised 12/14, directed all disciplines to use the resident care plan to plan and assign care for all disciplines. The undated policy titled Resident Care Plan, indicated the information in the care plan is based on the results of the comprehensive assessment.	F 282		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	{F 314}		

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{F 314}	Continued From page 10 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure repositioning assistance was provided to prevent progression of a pressure ulcer for 1 of 3 residents (R91) reviewed for pressure ulcers. Findings include: R91 was cognitively intact, required extensive assist of one staff for bed mobility and extensive assist of two staff for toileting, and was occasionally incontinent of urine and frequently incontinent of bowel according to the quarterly Minimum Data Set (MDS) dated 1/28/15. The MDS further indicated R91 had no pressure ulcers. R91's face sheet identified diagnoses that included but not exclusive to dementia with depressive features, diabetes, and difficulty walking. The care plan dated 2/16/15, directed staff to reposition R91 every one hour and as needed and to keep the bed at less than a 45 degree angle. The care guide updated 2/19/15, directed staff to reposition R91 every one hour in bed and chair. The skin condition report dated 2/16/15, indicated R91's Stage III pressure ulcer (an injury to skin caused by prolonged pressure that involves full skin thickness) on the coccyx (tailbone) was first noted on 2/14/15, and staff had noted the skin to	{F 314}	**F314:** DON and/or designee will implement corrective action for resident (R91) affected by this practice by: • R91 had new tissue tolerance tests completed, which showed the resident was appropriate for every 2 hour turning and repositioning program. Treatment and services for R91 pressure ulcer were reviewed and care plan was revised as appropriate. DON and/or designee will assess residents having the potential to be affected by this practice including: • GA will ensure that residents with a pressure ulcer receive necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. DON and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff will be re-educated on R91's care plan interventions. • All care plans for residents with pressure ulcers were reviewed to ensure necessary treatment and services are being provided.	

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{F 314}	Continued From page 11 be intact on 2/13/15. The report indicated the pressure ulcer measured 2.4 centimeters in length x 1.0 cm in width x 0.2 cm in depth. The skin condition report documentation indicated pressure reducing or relieving devices were in place in bed and chair, and protein supplements were administered. The documentation identified R91's risk factors. The physician's nursing home note dated 2/17/15, indicated R91 had developed a sacral pressure ulcer and wouldn't always stay off her back, even when positioned to the side. The physician stated she was told it was a Stage III pressure ulcer. The skin condition report dated 2/26/15, indicated the Stage III pressure ulcer on the coccyx measured 1.1 cm x 0.8 cm x 0.1 cm and had moderate drainage. The skin condition report documentation indicated current interventions would be continued, including an adhesive barrier dressing to be changed every 3 days and as needed, an overlay airflow mattress, and repositioning every hour. The skin condition report dated 3/4/15, indicated the pressure ulcer measured 0.9 cm x 0.7 cm. x 0.1 cm. During continuous observations on 3/10/15, from 3:12 p.m. through 4:00 p.m., R91 was lying in bed leaning slightly to the right, facing toward the door, with the head of the bed up approximately 30 degrees. A nursing assistant entered the room at 3:22 p.m. but made no change in R91's position. The licensed nurse entered the room at 3:35 p.m. and made no change in position, other than elevating the head of the bed to approximately 45 degrees to administer medications. The head of the bed remained at 45 degrees when the nurse left the room. Nursing	{F 314}	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • A comprehensive skin audit will be performed on any new pressure ulcer, to ensure that the necessary treatment and services are being provided. • Random audits of any residents with pressure ulcers will be completed by the DON/designee 3x/week, to ensure positioning is being provided according to the residents plan of care, until compliance is achieved. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: April 10, 2015	

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{F 314}	Continued From page 12 assistant (NA)-A entered R91's room at 4:00 p.m. and at 4:08 p.m., exited the room with R91 in a wheelchair. During an interview on 3/10/15, 4:15 p.m. NA-A verified R91 had not been repositioned since before she came in to work at 2:30 p.m. and verified she had not repositioned her until getting her up. NA-A stated she did not realize R91 was to be repositioned every hour and thought R91 was still to be repositioned every two hours. NA-A stated the repositioning times were in the care plans and were on the repositioning sheets, and verified she had not checked either one prior to caring for R91. On 3/10/15, at approximately 5:45 p.m., the director of nursing (DON) provided the current toileting and assignment sheet which directed staff to reposition R91 every one hour. During observations on 3/11/15, at 1:05 p.m. the assistant director of nursing (ADON) and registered nurse (RN)-A did the weekly pressure ulcer assessment. After removing the adhesive barrier dressing from the coccyx pressure ulcer, which had a moderate amount of tan drainage, the wound was cleansed and measured. The wound measurements were 0.9 centimeters (cm) in length x 0.3 cm in width x 0.1 cm in depth. The ADON stated it was improved from the previous week. During an interview on 3/12/15, at 1:00 p.m. the DON stated resident care needs and changes were communicated to staff through the report board, the care plan book, the toileting sheet, and the care guide. The DON verified staff should read these before caring for the resident, and if	{F 314}		

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{F 314}	Continued From page 13 the staff member had not worked on the unit recently, they should still know the resident care needs. The facility policy and procedure for Resident Care Plan revised 12/14, directed all disciplines to use the resident care plan to plan and assign care for all disciplines. The undated policy titled Resident Care Plan, indicated the information in the care plan is based on the results of the comprehensive assessment.	{F 314}		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure adequate toileting assistance was provided during the night shift to 1 of 1 resident (R67) reviewed requiring assist of one staff member. Findings include: R67's care plan printed and provided as current on 3/12/15, identified he was oriented, made	F 315		

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F 315	Continued From page 14 decisions independently and expressed his needs. During interview on 3/12/15 at 11:21 a.m., nursing assistant (NA)-E stated that R67 had a mind "like a steel trap and his current memory is good too." Registered nurse (RN)-C also stated that R67 "knows what is going on." The care plan also indicated R67 was on a toileting plan, specifically toilet upon rising, before brunch and siesta snack, before supper and bedtime. Staff was to toilet on first rounds and ask about toileting at the end of night shift. Staff was to also toilet upon request. R67's care plan identified to assist with one or two staff and to follow the same scheduled toileting times for bowel continence. R67's Care Guide, last updated on 3/9/15, directed nursing assistants on the provision of cares. It indicated R67 needed an assist of one staff with toileting, transfer and ambulation. His toileting schedule matched that of his care plan. During an interview on 3/11/15, at 1:35 p.m., R67 indicated he would put his [call] light on at night if he needed to urinate, or had just urinated and didn't ask for assistance in time. He would also put the call light on if he woke up wet and needed to get changed. According to R67 the night staff would tell him he was dry when he knew he was wet, and didn't check to verify if he was wet or dry. R67 stated staff "don't want to be bothered." R67 further stated at times the night nursing assistant would leave him in a wet brief until 5:45 a.m. or 6:00 a.m. so they only had to change his brief once. During the interview on 3/11/15, at 1:35 p.m. R67 stated there was a time this winter when he was sick and he couldn't walk to the bathroom, but that time had ended. R67 clearly stated he	F 315	**F315:** DON and/or designee will implement corrective action for resident (R67) affected by this practice by: • R67 had a bowel and bladder assessment completed, including residents toileting choices. • NA-F was re-educated regarding honoring R67's toileting choices. DON and/or designee will assess residents having the potential to be affected by this practice including: • GA will ensure residents who are incontinent of bladder receive appropriate treatment and services to restore as much bladder function as possible. DON and/or designee will implement measures to ensure that this practice does not recur including: • R67's toileting care plan was reviewed and revised according to assessment. • Incontinent Products-TENA policy was reviewed and revised. • All NAR staff will be re-educated on Resident's Rights, including honoring resident's toileting choices, and the Incontinent Products-TENA policy revision.	

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F 315	Continued From page 15 wanted to walk to the bathroom, even at night. This required his walker and an assist of one staff person. Night staff had told him he couldn't walk to the bathroom. He stated the night shift didn't want him to get up - they won't walk anybody to the bathroom. R67 again stated staff make sure they come in at approximately 6:00 a.m. and change him. R67 believed staff waited until just before 6:00 a.m. to ensure he was dry, "just in case anybody checks." During interview on 3/11/15, at 1:35 p.m. R67 stated when he had the urge, he would use his call button to call for help when he needed to go to the bathroom. "They say I can't. They boss me." R67 said that it made him feel insignificant. "But," he added, "I'm going to die anyway." In a follow-up interview on 3/12/15, at 10:22 a.m., R67 restated that he used the call light before urinating, or after when he realized he was wet. He used a brief at night in case of incontinence but wanted to walk to the toilet when he was aware of the urge to void. At approximately 10:45 a.m., R67 explained that the previous night he had a soft bowel movement just after 12:00 a.m. He put his call light on and it was answered by NA-F. According to R67, NA-F did not check his "backside", nor did NA-F provide perineal cares or change his brief. R67 stated he was not changed until NA-E came at approximately 6:30 a.m., walked him to the toilet and cleaned him up. During interview on 3/12/15, at 11:21 a.m., NA-E confirmed when she arrived to work, R67 was usually the first one up. NA-E confirmed R67 walked to the bathroom toilet with one assist and his walker that morning.	F 315	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • All cognitively intact residents will be interviewed regarding satisfaction with call light response times and toileting assistance. • Any residents with concerns will be followed up on and the resident will be re-interviewed by DON/designee 3x/week until resident indicates that concern is resolved, then weekly thereafter, until compliance is achieved. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: April 10, 2015	

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F 315	Continued From page 16 In an interview on 3/12/15 at 12:19 p.m., registered nurse (RN)-C stated that R67 had been in physical therapy and just changed to an assist of one staff. He was doing well with one assist. RN-C confirmed R67 is on a two-hour check & change (if needed) for days and nights and that he used his own call light. The director of nursing (DON) was interviewed on 3/12/15, at 1:23 p.m. The DON stated staff are to follow the care plan for toileting, including at night. The DON stated if someone is capable of using the toilet, they were to be allowed to use the toilet at night. Staff was to follow the care plan and ensure that residents remain as continent as possible and to be changed if needed.	F 315		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	{F 431}		

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{F 431}	Continued From page 17 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired medications were removed for 2 of 2 residents (R114, R59) randomly reviewed for medication storage in the overstock cupboard in 1 of 4 medication rooms. Findings include: On 3/11/2015, at 8:59 a.m., licensed practical nurse (LPN)-B, provided opportunity for observation of the Home Acres medication cart, medication room and medication refrigerator. LPN-B explained that each medication room in the facility, including the medication room in Home Acres, had a cupboard labeled "overstock." There was a separate area where medications were put for destruction. During the observation and interview on 3/11/2015, at 8:59 a.m., LPN-B selected two bottles for review from the overstock cupboard. One bottle of propranolol 40 milligram (mg) tablets labeled for R114 was removed. It had an expiration date of 2/27/15. LPN-B checked her	{F 431}	**F431:** DON and/or designee will implement corrective action affected by this practice by: • Facility will not have expired medications on the medication carts, in the overstock medication cupboard, or in the medication refrigerators. DON and/or designee will assess the potential to be affected by this practice including: • All facility medication carts, overstock medication cupboards and medication refrigerators. DON and/or designee will implement measures to ensure that this practice does not recur including: • The procedure for Expired Medications was reviewed and updated. • All nursing staff will be educated on the updated Expired Medication policy. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 3 additional expired medication audits will be performed weekly until compliance is achieved, to ensure no medications are kept in storage past the manufacturer's expiration date and all expired medications are kept in the designated area to be destroyed. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: April 10, 2015	

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{F 431}	Continued From page 18	{F 431}		

medication administration record (MAR) and R114 was still taking this medication. LPN-B stated the overstock cupboard was not where medications were stored for destruction. LPN-B stated the bottle should be put in the area set aside for medication destruction, which she did at that time. Review of R114's Physicians Order Sheet confirmed that she was still scheduled to take propranolol 40 mg by mouth 3 times a day for hypertension.

A bottle of naproxen sodium 220 mg labeled for use by R59 was in the Home Acres Medication Room Overstock Cupboard. The expiration date on this bottle was 2/22/15. Looking at the MAR, LPN-B stated that R59 still took naproxen sodium for chronic pain. LPN-B placed the expired bottle of naproxen sodium in the area labeled for destruction of medications.

On 3/11/15, at 9:29 a.m., LPN-B confirmed the overstock cupboard is not the place for expired medication. LPN-B further explained that both bottles of medication needed to be destroyed.

During an interview on 3/12/15, at approximately 4:00 p.m. the director of nursing (DON) stated the purpose of the facility's overstock cupboard was to keep extra medication on hand for resident's. The DON specified the facility needed to destroy expired medications. The DON explained there is a separate cupboard in each medication room for medications that need destruction. She stated it was a separate area from the overstock cupboard. The DON identified the current facility policy was for nurses to destroy expired medications immediately.

On 3/12/15 at 4:05 p.m., the DON provided the

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{F 431}	Continued From page 19 current facility policy, last revised in 1/15 that confirmed: 1. "Licensed nurse will remove all expired medications from the medications carts, medication rooms, or medication refrigerators immediately and will destroy medication." 2. "All medication carts, medication refrigerators and medication rooms will be audited for expired medications daily." 3. "At no time will a medication be kept longer than the manufacturer's expiration date."	{F 431}		

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245239	A. Building B. Wing	3/12/2015

Name of Facility	Street Address, City, State, Zip Code
GUARDIAN ANGELS HEALTH & REHAB CENTER	1500 EAST THIRD AVENUE HIBBING, MN 55746

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0176 Reg. # 483.10(n) LSC	03/12/2015	ID Prefix F0242 Reg. # 483.15(b) LSC	03/12/2015	ID Prefix F0329 Reg. # 483.25(l) LSC	03/12/2015
ID Prefix F0365 Reg. # 483.35(d)(3) LSC	03/12/2015	ID Prefix F0371 Reg. # 483.35(i) LSC	03/12/2015	ID Prefix F0372 Reg. # 483.35(i)(3) LSC	03/12/2015
ID Prefix F0441 Reg. # 483.65 LSC	03/12/2015	ID Prefix F0463 Reg. # 483.70(f) LSC	03/12/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	03/27/2015	34089	03/12/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/15/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LUP2
Facility ID: 00858

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/15/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **92** (L18)

13.Total Certified Beds **92** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	92			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Killoran, HFE NEII 02/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/26/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 000 8044 5377

January 29, 2015

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

RE: Project Number S5239029

Dear Mr. Ryan:

On January 14, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Mdicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: chris.campbell@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 23, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 14, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 14, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

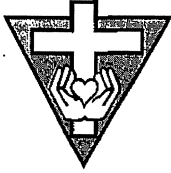
Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File

5239s15



Guardian Angels
Health & Rehabilitation Center

February 10, 2015

Christine Campbell, R.N., Unit Supervisor
Health Regulation Division
Licensing and Certification Section
Minnesota Department of Health
Northeast District Office
11 East Superior Street, Suite 290
Duluth, MN 55802-2007

Re. Addendum to corrections for deficiencies cited on Federal Survey conducted January 11th, 2015 through January 15th, 2015.

Ms. Campbell:

Here are the addendum's to the deficiencies as discussed by phone call on February 10th, 2015.

F165 (Under DON and/or designee will implement measures to ensure that this practice does not recur including)

- All staff will be educated on the use of the concerns report form.

F241 (Under DON and/or designee will implement measures to ensure that this practice does not recur including) add to second bullet: "and to protect and promote dignity in regard to toileting needs."

F242 (Under DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including), add to first bullet: 1 bathing audit "on all residents" will be performed weekly to ensure ongoing compliance beginning the week of 2-10-15, until compliance is achieved, then quarterly thereafter.
Add bullet to state: "residents will be asked of bathing preferences upon admission and at their quarterly care conference".

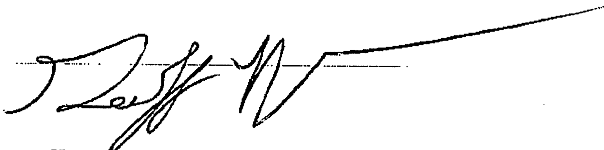
F329 (Under DON and/or designee will assess residents having the potential to be affected by this practice including) Bullet to now read, "All residents who are receiving antidepressants".

F365 (Under Dietary Manager and/or designee will monitor corrective actions to ensure the effectiveness of these actions including) Add to first bullet, Three observational audits "per week".

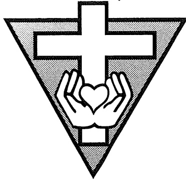
F371 From first statement, change to: "Dietary Manager and/or designee will implement corrective action by".

F372 (Under Environmental Services Director and/or designee will monitor corrective actions to ensure the effectiveness of these actions including) Change bullet to read, "Environmental Services Director will conduct an audit three times per week to monitor for refuse containment and use of the refuse lids, beginning the week of 2-10-15.

Respectfully Submitted,



Geoffrey Ryan, Administrator
Guardian Angels Health and Rehabilitation Center



Guardian Angels
Health & Rehabilitation Center

RECEIVED
FEB 09 2015
MN Dept of Health
Duluth

February 6, 2015

Christine Campbell, R.N., Unit Supervisor
Health Regulation Division
Licensing and Certification Section
Minnesota Department of Health
Northeast District Office
11 East Superior Street, Suite 290
Duluth, MN 55802-2007

Ms. Campbell:

Enclosed you will find the corrections to the federal deficiencies issued during the survey conducted January 11th through January 15th, 2015. I am requesting that a supervisor from another district review the deficiency F165 as we discussed by phone on January 29th and the supporting documentation of our ongoing auditing and follow up that I emailed you on January 30th, 2015. If you have any questions regarding the corrections to the deficiencies, feel free to contact me by email or by phone at (218) 231-8106.

Respectfully Submitted,

Geoffrey Ryan, Administrator
Guardian Angels Health and Rehabilitation Center

1500 East Third Avenue Hibbing, MN 55746
Phone: 218-263-7583 Fax: 218-231-8111 www.guardianangels.sfhs.org

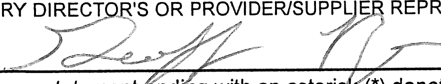
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING FEB 09 2015 B. WING MN Dept of Health Duluth	01/15/2015 ~~01/14/2015~~

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (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 FORM 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.	F 000	Exit date is 1/15/2015 per CC ML	
F 165 SS=D	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure prompt efforts were made to resolve ongoing grievances regarding toileting needs for 1 of 4 residents (R28) reviewed for long call light waiting times. Findings include: R28 was admitted on 9/9/10, with diagnoses of paralysis agitans, ataxia and presenile dementia as indicated from the Face Sheet dated 1/15/15.	F 165 2/11/15 2/10/15 ok c addendum		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2-06-15



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING ______ B. WING ______	01/14/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 165	Continued From page 1 The Quarterly Minimum Data Set (MDS) dated 12/22/14, indicated R28 moderate cognitive impairment, and required assist of one for transfers and toileting needs. R28's care plan dated 10/4/14, indicated R28 was occasionally incontinent of bowel and bladder, was on a scheduled toileting program, and required assist of one to walk to and from toilet. When interviewed on 1/12/15 at 8:48 a.m. R28 stated he had to wait "a long time" for the call light, sometimes up to half an hour." R28 reported having incontinent episodes while waiting for the call light to be answered. During interview on 1/15/15, at 9:32 a.m. R28 clarified he had an accident when having to wait. R28 stated, "I have told staff, but it doesn't make any difference. There is nothing to do because it already happened [incontinence]. I hate it when I go in my pants." Review of Social Services Survey/Call Lights Summaries completed for R28 dated 9/24/14 - 12/31/14, indicated R28 verbalized concerns about long call light waits when needing to use the bathroom. According to the General Nursing Observation dated 12/22/14, R28 was on Lasix (diuretic) 20 mg every 8:00 am. When interviewed on 1/14/15, at 10:29 a.m. the director of nursing (DON) stated the call light response goal was 5 to 7 minutes. The DON further stated nurse managers and supervisors ran call light reports every shift to review for long call lights. If a long call light wait was brought up staff would pull the report log and address the issue right away. The DON also indicated residents could fill out a concern form.	F 165	**F165:** DON and/or designee will implement corrective action for resident (R28) affected by this practice by: • Resident R28 will have their call light answered in a timely manner. Social Services will follow up with R28 each week, until compliance is achieved, to ensure concerns are addressed. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents who are cognitively able to use a call light. DON and/or designee will implement measures to ensure that this practice does not recur including: • The procedure for Use of Call Lights was reviewed and updated. • All staff will be educated on the updated procedure and the importance of answering call lights timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING ______ B. WING ______	01/14/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 165	Continued From page 2 During an interview on 1/14/15, at 4:13 p.m. the administrator stated it was a corporate decision to destroy the call light logs after review. "Quite frankly we don't want it used against us. We address concerns right away." During an interview on 1/15/15, at 1:22 p.m. the licensed social worker (LSW) stated anyone could fill out a Concerns Report Form. The LSW further identified that when a concern is received it was addressed with the resident/family. The concern was provided to nursing to address if it was a nursing concern. The LSW stated she completed call light audits in 9/14 and 10/14 to assure lights were responded to "in a timely manner." The LSW stated she took R28's concerns of long call light response times and incontinence to RN-B. The LSW stated while there were no official grievances, she was aware of ongoing concerns from R28 of long call light wait times. The LSW acknowledged if an incontinence episode happened once, "it's once too many." The LSW indicated nursing looked at a resolution to the call light concerns. During an interview on 01/15/2015, at 3:33 p.m., registered nurse (RN) -B verified she was aware of R28's concerns of long call light wait times. RN-B stated she followed up with R28 and made "adjustments to his care plan." RN-B acknowledged she did not run a call light report on a daily basis but monitored her pager for issues with R28. RN-B verified she had no documentation addressing R28's concerns with call lights and toileting but "social services would have this." Review of the undated	F 165	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 3 call light audits will be performed weekly at various times to ensure ongoing compliance beginning the week 2-10-15, until compliance is achieved, then quarterly thereafter. • Five residents will be interviewed per week, for call light response satisfaction, beginning the week of 2-10-15 until compliance is achieved, then quarterly thereafter. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. • DON attended resident council meeting on 2-2-15 to go over how to file a complaint with the residents. Completion Date: 2-23-15	

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F 165	Continued From page 3 Complaints/Concerns/Suggestions section in the Guardian Angels Resident Information Packet indicated that for an informal complaint, staff and resident/families were encouraged to discuss any concerns or complaints with the nurse manager in charge of the unit. If discussion with the nurse manager was not helpful, staff and resident/families would be encouraged to report to Social Services as soon as possible. For a formal complaint, a Concern Report was to be completed when an informal resolution to a complaint has not occurred. The resident would be informed of the investigation, the recommendation made and actions taken.	F 165		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess safety for self administration of medications (SAM) for 1 of 1 residents (R60) observed to self administer medications. Findings include: R60 was not assessed to be safe to self administer inhaled medications. On 1/11/15, at 6:25 p.m. R60 was observed lying in bed receiving a nebulizer treatment	F 176	**F176:** DON and/or designee will implement corrective action for resident (R60) affected by this practice by: • Resident R60 no longer resides at our facility. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents that receive nebulizer treatments. • All residents who are not appropriate to self-administer medications. DON and/or designee will implement measures to ensure that this practice does not recur including: • The procedure for Nebulizer Treatments was reviewed and updated. • All licensed nurses will be educated on the updated procedure and the importance of appropriate nebulizer administration. • The procedure for Self-Administration of Medications was reviewed and updated. • All licensed nurses will be educated on the updated policy for Self-Administration of Medications.	

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F 176	Continued From page 4 administered via face mask. R60's roommate was also present in the room. There was no staff observed outside R60's room or in the hall. At 6:35 p.m. registered nurse (RN)-D entered the room, removed the mask, turned off the machine and rinsed the mask and nebulizer medication cup in the sink in R60's bathroom. The interdisciplinary team (IDT) evaluation for the self administration of medications dated 11/21/14, indicated R60 had dementia with cognitive impairment which indicated R60 was not an appropriate candidate to self administer medications. The evaluation further directed licensed staff to store, document, and administer all medications and treatments per the physician's order daily. On 1/14/14, at 9:30 a.m. RN-E verified R60 was not to be left alone while receiving the nebulizer treatment. On 1/14/15, at 10:15 a.m. the director of nursing (DON) was interviewed. The DON stated she would expect the nurse to stay with a resident receiving a nebulizer treatment if assessed to be unable to SAM. The facility's Self Administration of Medication by Resident policy reviewed and revised on 12/14, indicated the purpose was to assure all medications were administered safely. The policy identified residents would not be permitted to administer or retain medications in their rooms unless ordered by the physician and approved by the IDT.	F 176	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 3 self-administration of medication audits will be performed weekly at various times to ensure ongoing compliance beginning the week 2-10-15, until compliance is achieved, then quarterly thereafter. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 2-23-15	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 5 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure dignity when staff failed to respond to a call light in a timely manner for 1 of 4 residents (R116) who requested assistance with toileting care needs, resulting in incontinence of urine. Findings include: Although staff answered R116's call light, she was left alone in her room waiting for assistance resulting in R116 being incontinent of urine. R116 was embarrassed. The Progress Notes by Resident by Staff Member sheet dated 12/18/14 revealed multiple diagnoses including: right femur fracture, muscle weakness, general non-ambulatory and required extensive assist of two for toileting tasks with use of a mechanical stand up lift. A significant change Minimum Data Set (MDS) dated 12/18/14, indicated R116 was cognitively intact and presented no behavioral issues. R116 required extensive assistance of two with toileting, transfers and bed mobility. R116 ' s care plan dated 7/21/14, indicated R116 was incontinent of bladder, was on a scheduled program due to functional incontinence and required a mechanical sling lift and assist of two for transferring on and off the toilet.	F 241	**F241:** DON and/or designee will implement corrective action for resident (R116) affected by this practice by: • Resident (R116) toileting needs will be met by staff answering call light in a timely manner. Social Services will follow up with R116 each week, until compliance is achieved, to ensure concerns are addressed. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents who need assistance with toileting tasks. DON and/or designee will implement measures to ensure that this practice does not recur including: • The policy for Use of Call Lights was revised and updated. • All staff will be educated on the updated policy and the importance of answering call lights in a timely manner.	

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F 241	Continued From page 6 R116 was interviewed on 1/12/15, at 10:22 a.m. and identified delayed call light response times as a concern. R116 stated the "usual waits are 10-15 minutes." R116 stated there were longer delays with night shift call lights as well as brunch time, "it can be over 20 minutes." R116 stated she had to wait as long as an hour for toileting assistance. When staff did come back to help she voided on the floor during the transfer. I was embarrassed. I have always been independent and it is hard to depend on others to perform private cares. " During a follow-up interview on 1/15/15, at 9:18 a.m. R116 stated that call lights do not get answered right away. "Like this Tuesday afternoon, they answered my call light right away, turned it off but then had to leave to help someone else. They turned on the water in the sink, a washcloth plugged it and we had a flood in my room, the water was clear out to the door. " R116 again stated one night she had to wait 45 minutes or more. " I needed to go to the bathroom, they got me up, I was in the sling for the standup lift and sitting on the side of the bed. She left to get another person and when they came back it was so long that when they lifted me, I voided on the floor because I couldn ' t hold it any more. I felt real bad. " The director of nursing was interviewed on 1/14/15, at 10:29 a.m. regarding call light response times. DON stated their goal was to respond within 5 to 7 minutes and nurse managers and supervisors run call light reports every shift to review for long call light waits. If a long call light wait is brought to our attention, we pull the report log and address the issue right away. Residents can always fill out a concerns	F 241	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 3 call light audits will be performed weekly at various times to ensure ongoing compliance beginning the week 2-10-15, until compliance is achieved, then quarterly thereafter. • Five residents will be interviewed per week, for call light response satisfaction, beginning the week of 2-10-15 until compliance is achieved, then quarterly thereafter. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 2-23-15	

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F 241	Continued From page 7 report form. We don ' t save call light reports, they are deleted. DON stated when a call light goes on the nursing aide is paged immediately, after 5 minutes the cart nurse is notified per pager and after 10 minutes the nurse manager, DON and administrator are all paged. During an interview on 1/14/15, at 4:13 p.m. the administrator stated " it was a corporate decision to destroy the call light logs, we went back and forth and decided not to keep them. Quite frankly we don ' t want it used against us. We address concerns right away. " During an interview on 1/15/15, at 1:22 p.m. the licensed social worker (LSW) stated that she goes to talk with R116 about other things and she " mentioned the long wait times. " . During an interview on 01/15/2015, at 3:33 p.m., registered nurse (RN-B) who was nurse manager on the unit stated she did not know anything about the urinary incontinence while transferring nor the concern of R116 waiting for help. " I don ' t recall hearing about this incident, it would be proper for the aides to report it to the nurse. I don ' t run a report every single day to check the call lights, I have a pager that if over 10 minutes when I ' m here I get a message that the call light has been on 10 or more minutes. " Review of the undated Supervisor Checklist indicated " call light report run one hour previous to end of shift and distributed to cart nurses, to meet with NAR ' s [nursing assistants] as a team and discuss what happened and a written plan for improvement on the back signed by all members of the team NAR ' s, LPN ' s [licensed practical nurses]/RN ' s. "	F 241		

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F 242	Continued From page 8	F 242		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure bathing preferences regarding frequency of bathing was honored for 1 of 3 residents (R1) reviewed for choices. Findings include: R1 was interviewed on 1/11/15, at 6:28 p.m. and stated she was not able to have a bath as often as she would like. R1 stated staff had asked her if she would like more than one bath a week and she has told them yes. R1 also stated she had asked for a tub bath twice a week, but only receives a tub bath weekly. On 1/14/15, at 8:53 a.m. R1 continued to state that she has told staff she would like two baths a week, yet continues to receive one bath a week. R1's Face Sheet dated 6/20/13, identified diagnoses that included generalized muscle weakness, gait abnormality. and hearing loss. R1's quarterly Minimum Data Set (MDS) dated 10/23/14, indicated R1 was cognitively intact, and required extensive assistance of one staff with bathing. The care plan dated 9/11/14, directed R1	F 242	**F242:** DON and/or designee will implement corrective action for resident (R1) affected by this practice by: • Resident (R1) bathing preference was changed to reflect tub bath 2 times per week on her care plan and bathing schedule. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents in the facility. DON and/or designee will implement measures to ensure that this practice does not recur including: • All residents and/or responsible parties will be interviewed on bathing preferences with any changes updated on the care plan and bathing schedule. • A policy for Bathing Schedules was adopted. • The policy for Resident Rights was reviewed. • All nursing staff will be educated on the new Bathing Schedule Policy and Resident Rights Policy.	

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F 242	Continued From page 9 required staff assistance with bathing related to weakness and for safety awareness, and required assistance of one staff to transfer in and out of bath and one staff for bathing. The care plan also identified R1 received a bath every Monday morning. On 1/14/15, at 10:46 a.m. registered nurse (RN)-C stated residents are able to have more than one bath a week. RN-C further stated he was unaware R1 wanted more than one bath a week. On 1/15/15, at 1:30 p.m. the director of nursing (DON) was interviewed and stated resident's bathing frequency preferences are asked on admission, and again quarterly. The DON further stated if a resident would like a bath more than once a week, the nursing assistants report to the nurse manager, who would honor the resident's preference. The facility policy and procedure on Resident Rights dated 5/05, directed the facility will encourage residents to participate in planning their daily care routines.	F 242	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 1 bathing audit will be performed weekly to ensure ongoing compliance beginning the week 2-10-15, until compliance is achieved, then quarterly thereafter. • DON attended resident council meeting on 2-2-15 and educated the residents on informing the nursing staff if they would like a change in their bathing preference. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 2-23-15	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate interventions were in place to prevent the development of a pressure ulcer for 1 of 1 residents (R132) reviewed for pressure ulcers. Findings include: R132's significant change Minimum Data Set (MDS) with a target date of 1/2/15, indicated that R132 needed extensive assistance with bed mobility, transferring, and dressing. The MDS Brief Inventory of Mental Status identified moderate cognitive impairment. According to a 10/15/2014, progress note, R132 was admitted for therapy and healing after a surgical repair of a fractured right hip from a fall at home. The Face Sheet dated 1/14/2015, included diagnoses of edema and chronic kidney disease. A Skin Care Plan was added to R132's care plan on 10/27/214. The accompanying goal identified R132 would be free from clinical signs and symptoms of skin breakdown by 1/31/15. Approaches included having R132 float heels while in bed and wear heel boots at all times when not in therapy. The Care Plan noted R132 refused at times. The Skin Condition Report identified a new pressure ulcer on R132's right heel on 11/6/14, and specified that this was the first recording of that ulcer. This pressure ulcer was described as	F 314	**F314:** DON and/or designee will implement corrective action for resident (R132) affected by this practice by: • Resident (R132) care plan was updated reflecting intervention changes and non-compliance with those interventions. • Resident (R132) risk and benefit for non-compliance with interventions to promote healing of pressure ulcer and to prevent further pressure ulcers was completed with resident R132's responsible party. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents in the facility. DON and/or designee will implement measures to ensure that this practice does not recur including: • The policy for Skin Documentation was reviewed and updated. • All nursing staff will be educated on the updated Skin Documentation policy.	

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F 314	Continued From page 11 a Stage 2 ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough), 3.1 centimeters (cm) long by 3.0 cm wide and a depth of 0.1 cm. The note also indicated the wound was not present on admission. Entries to the Skin Condition Report continued weekly from the initial 11/6/14 entry until 1/13/15. The note on 1/13/15, specified no recent changes were made to the treatment orders for this site and pressure reducing or relieving devices were in place. Treatments implemented on 11/7/14, as described on the Physician's Order Sheet included: heel boots at all times, elevate heels. On 12/27/14, an additional treatment was added: cleanse right heel, apply skin prep, Solosite, apply Allevyn every 3 days and as needed (PRN). On 12/28/14, keep legs elevated was also added as a treatment order. R132 was observed on 1/13/15, at 1:11 p.m. kicking off her heel boots and at 1:40 p.m. with tennis shoes on her feet. R132 still had tennis shoes on her feet at 3:04 p.m. R132 was observed on 1/14/15, at 8:57 a.m. with shoes and socks on. Licensed Practical Nurse (LPN)-B explained that R132 had a doctor's appointment later that morning. On 1/14/15, at 3:31 p.m. registered nurse (RN)-C verified that R132 was admitted with no pressure ulcers. RN-C stated the facility started interventions on admission because of R132's risk of pressure ulcers. R132 would kick off her heel protectors and pillows at night. RN-C stated R132 had "lots of edema" (swelling) of her ankles on admission, and they adjusted her Lasix	F 314	DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • All residents with pressure ulcers will have their care plans updated by 2-10-15 reflecting all appropriate interventions. • A pressure ulcer audit will be performed on all new admissions beginning the week of 2-10-15 until compliance is achieved and then quarterly thereafter. • A pressure ulcer audit will be performed on all residents who have a new pressure ulcer beginning the week of 2-10-15. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion date: 2-23-15	

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F 314	Continued From page 12 (diuretic for treating edema) in an effort to reduce her edema. RN-C stated R132 is "always kicking" off her heel boots. RN-C stated when the wound started it was a dark, red, blistered area. RN-C provided a Skin Condition Report dated 11/6/14, and explained that the pressure ulcer started as a Stage 2 ulcer on that date. RN-C described the wound on 1/14/15, as unstageable due to slough in the wound bed. R132 was observed on 1/15/15, at 9:31 a.m. in her wheelchair with tennis shoes and socks on her feet. R132's feet were not elevated but were flat on the floor. RN-C verified that the resident had tennis shoes on and this was not directed by the care plan. RN-C stated that R132 places the shoes on herself and staff was aware not to place shoes on her. RN-C then took the shoes off and put gripper socks on R132. Observation of the wound on 1/15/15 at 10:27 a.m. indicated the ulcer was 1.4 cm x 1.1 cm and light tan/brown in color with 100% slough. The heels were blanchable and R1332 had no complaints of pain. In an interview on 1/15/15, at 10:23 a.m. RN-C explained that staff would find R132's dressings and heel boots in the bed. R132 removed them herself. RN-C stated R132 told him she does not like the heel boots. There was no evidence the interventions had been re-assessed or altered. Skin Condition Reports on 11/11/14, and on 11/22/14, indicated R132 kicked off her heel boots. As early as 11/12/14, progress notes referenced R132 kicking off her heel boots at night. On 1/15/2015, at 2:28 p.m. the director of nursing	F 314		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13 (DON) and the assistant director of nursing (ADON) indicated that staff were to provide education and put the heel boots back on R132. Staff should then check on the resident more frequently. The DON and ADON further explained staff should document, educate and intervene and the facility should change the care plan. The facility recognized R132's risk for pressure ulcers upon admission and documented R132's non-compliance with the care plan. However, the facility failed to modify the interventions to address R132's concerns with the current interventions. Further, there was no evidence of education with R132/family concerning the risk/benefit of consistent implementation of assessed interventions.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		

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	245239	A. BUILDING ______ B. WING ______	01/14/2015

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drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure justification of use for an antidepressant medication including evidence of minimal effective dose for 1 of 3 residents (R3) who were reviewed for unnecessary medications.

Findings include:

R3's face sheet dated 1/15/15, identified the diagnoses of vascular dementia and osteoarthrosis. There was no diagnosis of a mood disorder identified.

R3's Physician's Order Sheet dated 11/13/14, specified an order for Remeron (antidepressant) 15 milligram (mg) tablet one time per day at bedtime for general osteoarthrosis. The start date for the Remeron was listed as 4/29/14. During an interview on 1/15/15, at 2:27 p.m. the director of nursing (DON), verified the order for Remeron was linked to the wrong diagnosis.

R3's psychotropic drug use care plan dated 7/22/14, indicated, "daily use Remeron with Dx [diagnosis] of dementia/underweight." Remeron does have the sometimes beneficial side effect of increased appetite/weight. Approaches included, "monitor for target behaviors every shift, chart

F 329

F329: DON and/or designee will implement corrective action for resident (R3) affected by this practice by:

- Resident (R3) will have a risk vs benefit completed by the MD for use of Remeron, including appropriate diagnosis for use. We will ask the physician to elaborate on his previous risk benefit in regard to resident's medication regimen.

DON and/or designee will assess residents having the potential to be affected by this practice including:

- All residents in the facility.

DON and/or designee will implement measures to ensure that this practice does not recur including:

- All resident medications will be reviewed to ensure they are linked to the appropriate diagnosis.
- The policy for Unnecessary Medications was reviewed.
- All licensed nurses will be educated on the Unnecessary Medications Policy.

DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including:

- All Pharmacy Consultant recommendations will be reviewed by the DON.
- An education sheet on what is required for a risk vs benefit will be given to all rounding physicians.
- The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring.

Completion date: 2-23-15

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F 329	Continued From page 15 and report." Target behaviors were decreased appetite with inadequate intake. The dietary progress notes dated 8/31/14 to 1/14/15, indicated R3's weight was stable or slightly increased from 8/31/14 to 1/14/15. Further review of facility documents revealed the Consultant Pharmacist's Review on 9/11/14, specified R3 had been on Remeron for more than one year and asked if the current dose was still indicated. The consultant pharmacist suggested course of action was, "If appropriate, please consider a reduction in the Remeron to 7.5 mg q HS [every bedtime]. If a reduction is not appropriate, please document risk vs. benefit per CMS [Centers for Medicare and Medicaid Services] regulations." The medical record lacked evidence of a risk-benefit discussion regarding continuation of current Remeron use and dosage. In a progress note dated 9/11/14, R3's physician rejected this recommendation and identified "Dementia is noted." The physician further documented "Medications were again reviewed and look to be appropriate, look to be minimal effective does, including the Remeron which Pharmacy recommended discontinuing or weaning off. With her being so frail, I think any changes in her medication when things are not broken here is a bad thing." No risk/benefit was documented. The pharmacy Psychotropic Med Use Detail Report for 10/14, identified a risk-benefit was requested of the physician on 7/14. No response was noted as of 10/22/14. Further documentation from the consultant pharmacist on 11/19/14, noted an irregularity due to the length of time	F 329		

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F 329	Continued From page 16 since the last dose reduction consideration and requested consideration of a reduction or a risk vs. benefit statement to support the dose/use of the medication.	F 329		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper food consistency was provided for 2 of 5 residents (R2, R67) reviewed for a pureed diet. Findings include: R2 did not consistently receive a pureed diet. R2's diagnoses included uncomplicated senile dementia. An order dated 12/18/14, on the Physician's Order Sheet, identified a pureed diet and thin liquids. R2's care plan was also changed on 12/18/14 to include a problem area of "difficulty swallowing regular texture foods". The approach was "pureed diet or as recommended by S/T [speech therapy]". On 1/12/15, at 8:21 a.m. R2 was observed sitting alone in her room with toast and juice in front of her on a bedside table. The toast was buttered, but otherwise dry. Half of the toast was eaten, many crumbs were on the front of R2's shirt, and	F 365		

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small bits of toast were on the floor. The facility's Standard Diets policy, reviewed and revised on 6/25/09 specified under pureed diet breads could be pre-gelled, pureed, or per pureed recipes.

On 1/13/2015, at approximately 10:45 a.m. R2 was observed having brunch which included ground sausage and scrambled eggs. The menu, referred to by staff as the "tray ticket", was set at each resident's place setting listed the following menu items for R2's brunch on 1/13/15: malt of meal, buttermilk pancake (pureed), sausage links (pureed), and pineapple (pureed).

On 1/13/15, at 1:14 p.m. registered nurse (RN)-C stated pureed food were blended in the kitchen and the diet slips stated what the diet and consistency was for each resident. When asked about snack carts, RN-C replied, "new staff ask and the regular staff know who gets what." He explained the snack cart process: kitchen staff bring carts to the unit and staff distributed food from the cart to residents.

In an interview on 1/13/15 at 1:29 p.m., the dietary manager (DM) stated she received diet order changes from the ST and she informed the kitchen staff. The DM was responsible to inform kitchen staff, make a note in the communication book, and change the resident's diet on the diet list.

The DM confirmed her list of resident diets specified R2's diet was pureed, and "finger foods". When asked to define pureed food, the DM stated it is food that has been put in a blender: mashed potatoes, plain yogurt, or ice cream. When asked how a resident would eat pureed food with their fingers, the DM replied, "I

F 365

F365: Dietary Manager and/or designee will implement corrective action for resident (R2 and R67) affected by this practice by:

- Resident (R2 and R67) will receive foods consistent with their ordered diet consistency.
- Resident R67 had risk vs benefit completed regarding risk of aspiration.

Dietary Manager and/or designee will assess residents having the potential to be affected by this practice including:

- All residents in the facility on mechanically altered diets.

Dietary Manager and/or designee will implement measures to ensure that this practice does not recur including:

- All resident diets are being reviewed to ensure all are consistent with ST recommendations and MD orders on the care plan, meal tickets, physician orders, and dietary sheets.
- Dietary sheets were implemented on all snack carts, nurse's stations and both serving kitchens. Included with these dietary sheets are instructions of what foods can be served for altered consistency diets. (mechanical soft, pureed plus, and pureed).
- Dietary folders were placed at all nurses stations for dietary staff to put changes with orders in for nursing staff to seek orders and for nursing staff to communicate any order changes to dietary staff.
- Dietary Manager to update all dietary sheets with any changes with a residents diets.
- A Dietary/Nursing Communication policy was implemented that details the changes above.
- All Dietary and Nursing Staff will be educated on the communication policy.

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F 365	Continued From page 18 guess that's a mistake." Observation of R2's tray ticket during this interview revealed R2's alert was "assist with meals." On 1/13/2015, at 1:41 p.m. nursing assistant (NA)-K was assisting NA-L with toileting R2. While R2 was in the bathroom, NA-L went out to the hall and returned with cookies for R2's snack. NA-L stated this is what R2 usually received. NA-L put the cookies on the bedside table in R2's room. After completing assistance with R2 in the bathroom, NA-K and NA-L pushed R2 up to the table. When asked if R2 could have the cookie, NA-K stated, "Yes, they give it to her all the time." When asked how she knew R2's diet, NA-K replied, "Dietary knows, I rely on them." When asked if R2 needed supervision, NA-K, stated "No." In an interview on 1/13/2015, at 2:30 p.m. the speech therapist (ST), stated residents should not be handed a cookie if they are on a pureed diet. She also specified residents should not get ground meat if on a pureed diet. Cookies should be softened and meat should be pureed. The ST stated R2 was having choking issues on a mechanical soft diet. When she changed R2's diet to pureed, she told the DM, either verbally or by email, and the DM "told everyone". On 1/13/2014, at 2:44 p.m. the DM stated diet changes were written in the kitchen communication book and on the menus set at each table setting for meals. The DM also explained that diet changes were written on the snack monitoring form which listed each resident's name and diet. She stated nursing assistants know about diets because they get it in their schooling and at orientation to the facility.	F 365	Dietary Manager and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Three observational audits, beginning the week of 2-10-15, will be completed to review for correct diet orders, allowable food given to residents, performed at various meal and snack passes. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion date: 2-23-15	

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During this interview, the kitchen communication book was observed. On 12/15/14, R2 was identified with a pureed diet. The snack cart pages were then observed and R2 was listed as a "regular " diet. The DM stated, "I just made a mistake."

On 1/13/2015, at approximately 3:30 p.m. the dietician (D) stated toast and cookies were not included in a pureed diet unless specified for a resident or softened in milk.

On 1/14/2015 at 8:35 a.m., R2 was alone in her room out of sight of the open doorway. She was sitting with a sandwich and juice in front of her. The crusts of the sandwich were removed. The sandwich and juice were untouched. R2 stated she was hungry, but did not reach for the food or juice in front of her. Record review on 1/14/2015 at approximately 8:50 a.m. revealed a physician order for a speech evaluation was requested and received on 1/13/15. The speech evaluation was completed on 1/13/15 and the physician order sheet specified: "upgrade resident food consistency as resident is back to baseline". The medical record lacked documentation that the facility called the family about the diet change.

In a telephone interview on 1/14/2015 at 9:28 a.m., family member (FM)-1 stated that he had asked for the pureed diet, due to R2's lower teeth being all gone. FM-1 had been feeding R2 prior to leaving for the winter two weeks ago. FM-1 observed R2 couldn't chew and ate better on a pureed diet. FM-1 stated that R2 can talk, but has problems chewing. FM-1 stated R2 had trouble swallowing liquids and sometimes choked. FM-1 had not been notified that the facility had switched R2 back to a mechanical soft

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diet on 1/13/15. FM-1 said he would request that R2 go back to the pureed diet.

R67's Face Sheet dated 12/31/14, identified diagnoses that included dysphagia (difficulty swallowing) and pneumonitis due to solids and liquids. R67's quarterly Minimum Data Set (MDS) dated 10/9/14, identified a diagnosis of Parkinson's disease. The MDS also identified R67 was cognitively intact. The MDS further identified R67 had no signs or symptoms of possible swallow disorder, was on a mechanically altered diet, and was independent with eating after food was set up.

The care plan dated 7/24/14, indicated R67 required a pureed plus diet with honey thickened liquids due to trouble chewing. On 12/24/14, R67 was admitted to the hospital with the diagnosis of aspiration pneumonia (a pneumonia that occurs when food, saliva, or liquids are breathed into the lungs). R67 was discharged from the hospital and readmitted to the facility on 12/31/14. On 12/31/14, the progress notes indicated R67 would be monitored for swallowing and aspiration.

On 1/14/15, at 8:33 a.m. R67 was observed sitting in a wheelchair in his room. R67 was feeding himself breakfast, which consisted of 1/2 slice of toast with jelly, a 6 ounce (oz) glass of thickened water and a 6 oz glass of thickened orange juice. R67 was eating the toast, and stated he was a little phlegmy. R67's nose was running, he was coughing, and he continued to eat the toast and take sips of both the orange juice and the water. R67 continued to cough and wipe his nose/mouth while eating. R67 stated he coughs when he eats anything. R67 further stated staff will suction him if he is unable to cough any

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F 365	Continued From page 21 food or fluids out. When R67 finished the toast, he coughed a large amount of clear phlegm with brown secretions onto a paper plate. No staff came into his room during the breakfast meal. On 1/14/15, at 10:51 a.m. R67 was served brunch, which consisted of a bowel of oatmeal, mashed potatoes with butter, scrambled eggs, applesauce and 4 oz of thickened orange juice. R67 ate the meal with no coughing or runny nose. The speech/language pathologist (SLP) came into the room to observe the meal, and asked R67 how the toast went down at breakfast. R67 responded it did not go down very well. On 1/14/15, at 11:43 a.m. the SLP was interviewed and stated R67 had less difficulty today at brunch. The SLP stated she does swallowing evaluations for R67 at the brunch meal, she usually comes in about 10:30 a.m. The SLP also stated she had not observed R67 during the breakfast meal. The SLP further stated she had not explained the risk versus benefits of eating toast and other foods he chose because she thought someone else had done it. On 1/14/15, at 1:30 p.m. the director of nursing (DON) was interviewed and stated staff should be checking on R67 when he chose to eat in his room. On 1/14/15, at 1:45 p.m. registered nurse (RN)-C was interviewed and stated he had reviewed the risk of aspiration with R67 when he chose to eat foods other then pureed foods, but had not documented it. On 1/14/15, at 3:25 p.m. R67 was interviewed and stated he had more problems coughing in the	F 365		

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F 365	Continued From page 22 morning and at night. R67 stated he coughed on toast because he was served that in the morning and not later in the day. He further stated it might be better if he received it later in the day. R67 said he had just eaten an egg salad sandwich without difficulty. R67 further stated nobody had talked to him about the risk of aspiration pneumonia with eating. When asked if he would make his own decisions regarding what types of food he ate, R67 replied not necessarily, he would listen consider any information provided before making a decision.	F 365		
F 371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was stored at the proper temperature in 2 of 2 neighborhood refrigerators that contained resident snacks. This had the potential to affect 79 of 80 residents residing in the facility, who received food from the refrigerators. In addition, the facility failed to ensure cleanliness of food baking pans, and the large mixer. This had the potential to affect 79 of 80 residents residing in	F 371		

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F 371	Continued From page 23 the facility, who ate food prepared in the kitchen. Findings include: During an observation on 1/13/15, at 9:12 a.m. the neighborhood kitchen in Bennett Park had 14 ice creams in the freezer door which were partially frozen. There were no thermometers in the refrigerator or the freezer. There were no temperature monitoring evident in the kitchen area. During an interview on 1/13/15, at 9:45 a.m. the dietary manager (DM) stated nursing monitored the temperatures on the unit refrigerators. During an interview on 1/13/15, at 10:31 a.m. the director of nursing (DON) stated dietary was monitoring temperatures of the neighborhood refrigerators. On 1/13/15 at 11:07 a.m., thermometers were present in the freezer and the refrigerator. On 1/15/15, at 9:32 a.m. the Bennett Park freezer was -12 degrees and the food was frozen, the refrigerator temperature read 38 degrees and the food was cold. There was no evidence of monitoring temperatures until a log was initiated on 1/13/15. The temperature reading for the refrigerator was 50 degrees on 1/13/15. Maintenance was informed at that time. On 1/15/15, at 9:58 a.m., the Home Acres freezer temperature read -2 degrees and the food was frozen; the refrigerator reading was 30 degrees and the food was cold. Temperature readings had been recorded daily since initiation of the monitoring log on 1/13/15.	F 371	**F371:** Dietary Manager and/or designee will implement corrective action for resident (R28) affected by this practice by: • The temperatures are being monitored in the two refrigerators and freezers that contain resident snacks. • The mixer located in the kitchen is cleaned after each use. • New baking pans and muffin tins were purchased to replace those deemed uncleanable. Dietary Manager and/or designee will assess residents having the potential to be affected by this practice including: • All residents have the potential to be affected by this practice. Dietary Manager and/or designee will implement measures to ensure that this practice does not recur including: • The policy for monitoring temperatures of refrigerators and freezers was updated to include who is responsible for monitoring of the temps. • The policy for Cleaning of the Food Mixer was updated. • All Dietary staff will be educated on the policy for monitoring temperatures, equipment operations and cleaning procedures, and to notify the DM when any cooking pans can no longer be properly cleaned due to age.	

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F 371	Continued From page 24 The policy and procedure for refrigerator and Freezer Temperature Monitoring, revised 9/3/07, directed every refrigerator and freezer must be equipped with an internal thermometer, even if equipped with an external thermometer. Temperatures for refrigerators should be between 34 degrees Fahrenheit and 40 degrees Fahrenheit. The temperatures for freezers should be 0 degrees Fahrenheit and -10 degrees Fahrenheit. All unit temperatures were to be recorded twice daily on the record of refrigeration temperatures form. Records were to be maintained for 6 months. Recording of temperatures for the refrigerator and freezer units were the responsibility of the appointed position. During the initial kitchen tour on 1/11/15, at 1:40 p.m. with cook (C)-A, the large mixer had white debris on the upper outer rim. C-A verified the mixer had been cleaned and was ready for use. C-A was able to easily flake off the white debris and stated the other cook had made a fruit salad earlier. In addition, 4 muffin tins and 2 cake pans had crusty debris. There was dark, baked on debris in the corners/edges of the pans. The baking pans were on the rack and ready for use. C-A asked the cook to wash them again. During a tour and interview on 1/13/15, at 9:45 a.m. the dietary manager (DM) stated the muffin tins and cake pans had been removed from service, since they were old and not cleanable. The remaining baking pans were observed to be free of debris. The large mixer was also without debris. The policy and procedure for Mechanical Dishwashing Procedures revised 4/07, directed	F 371	Dietary Manager and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • A weekly audit will be completed on all refrigerators and freezers in the neighborhood kitchens and main kitchen to ensure proper operating temperatures. • Three observational audits will be completed each week beginning the week of 2-10-14, to ensure proper cleaning and condition of kitchen equipment as well as cooking/baking pans and utensils. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 2-23-15	

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F 371	Continued From page 25 staff to check all items for cleanliness at the clean end of the dish table. Items that are not cleaned are to be re-washed. Pots and pans are to be free of carbon buildup, grease, and food particles. The policy and procedure for Usage, Cleaning, and Storage of Dietary Pans and Utensils revised 4/07, directed that all pans and utensils used for baking or serving food are to be clean and sanitized prior to each use. Any pans or utensils that become irreversibly stained and/or unclean able are to be reported to the Food Service Director for replacement and discarded. The policy and procedure for Equipment Operations and Cleaning Procedures revised 4/07, directed the mixer to cleaned daily after each use.	F 371		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure proper containment of garbage in the outside dumpsters. This has the potential to affect all 80 residents who reside in the facility. Findings include: During the initial tour on 1/11/15 at 1:40 p.m. with the cook (C)-A, the outside garbage dumpster was overflowing with several bags piled on top of the dumpster. The dumpster was too full to close	F 372		

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F 372	Continued From page 26 the lid. There were enough bags of garbage on top to partially fill another dumpster. C-A stated the garbage is picked up on Mondays, Wednesdays, and Fridays. The cover of the dumpster for recyclables was also open. C-A stated the recyclable dumpster was picked up on Tuesdays and Thursdays. On 1/14/15, at 8:35 a.m., both the garbage and recyclable dumpster lids were open on one side of each dumpster. The garbage dumpster was approximately 1/4 full and the recyclable dumpster was approximately 1/3 full. On 1/14/15 at 10:00 a.m., during the tour with the environmental services director (ESD), the garbage and the recyclable dumpster lids were open again. The ESD verified they were "always open". During an observation on 1/15/15, at 9:52 a.m., the garbage dumpsters were uncovered with the lids up. The garbage dumpster was 1/2 full. Animal paw prints, similar to racoon and/or squirrel were visible in the snow around the front of of the garbage dumpster. During an interview and observation on 1/15/15, at 10:53 a.m. the ESD verified the dumpster lids were open and there were animal prints around the dumpster. The ESD also verified the sliding door on the back of the dumpster was broken off on one side, making it impossible to completely close dumpster, so he would order a new one. The ESD stated he did not have policies and procedures regarding garbage service or garbage containment.	F 372	**F372:** Environmental Services Director and/or designee will implement corrective action for affected by this practice by: • A new sliding door for the rear of the dumpster was requested to be replaced by the facility garbage vendor. • A policy and procedure was developed for garbage service and garbage containment. Environmental Services Director and/or designee will assess residents having the potential to be affected by this practice including: • All residents have the potential to be affected by this practice. Environmental Services Director and/or designee will implement measures to ensure that this practice does not recur including: • All Janitorial and Maintenance staff were inserviced on the Garbage Service and Containment policy. Environmental Services Director and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Environmental Services Director will conduct a weekly audit to monitor for refuse containment and use of the refuse lids, beginning the week of 2-10-15. Completion Date: 2-23-15	
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 SS=D	Continued From page 27 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 431	**F431:** DON and/or designee will implement corrective action affected by this practice by: • Facility will not have expired medications on the medication carts, in the medication rooms, or in the medication refrigerators. DON and/or designee will assess the potential to be affected by this practice including: • All facility medication carts, medications rooms and medication refrigerators. All residents could be affected. DON and/or designee will implement measures to ensure that this practice does not recur including: • The procedure for Expired Medications was reviewed by the pharmacy consultant and updated. • An updated expired medication list has been posted in all medication rooms. • All licensed nursing staff will be educated on the updated Expired Medication policy. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 3 additional expired medication audits will be performed weekly at various times to ensure ongoing compliance beginning the week 2-10-15, until compliance is achieved, then quarterly thereafter. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 2-23-15	

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F 431	Continued From page 28 review, the facility failed to ensure expired medications were no longer in use, and remove them from the medication carts in 2 of 4 medication carts. Findings include: On 1/15/15, at 1:58 p.m. during review of the medication cart on the Brooklyn unit, an Advair Diskus inhaler for R139 was noted to have an open date of 12/13/14. Licensed practical nurse (LPN)-D verified R139 continued to receive the Advair Diskus inhaler, and verified the inhaler was expired 30 days after it was opened. On 1/15/15, at 2:24 p.m. during review of the medication cart on Merryview unit, a vial of Humalog insulin for R34 was noted to have an expiration date of 1/12/15. Registered nurse (RN)-F verified R 34 continued to receive the Humalog insulin, and verified the insulin was expired. On 1/15/15, at 2:35 p.m. the director of nursing (DON) was interviewed and verified nursing is responsible to check the medication carts for expired medications. The manufacture's package insert for Advair Diskus inhaler directs to discard the Advair Diskus inhaler one month after opening the foil pouch. The manufacture's package insert for Humalog insulin directs to throw away an open vial after 28 days of use. The facility policy and procedure on Dating of Medications dated 1/08, directed medications that exceed the label expiration date will be removed from storage and destroyed according to	F 431		

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F 431	Continued From page 29 procedure.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper hand hygiene was performed to prevent cross-contamination in the food preparation area in the neighborhood kitchen. This had the potential to affect 41 of 80 residents who received food from this neighborhood kitchen. In addition, the facility failed to ensure medical multi-use cold, gel packs were not stored in the neighborhood freezer and were stored separately from residents' food to prevent cross-contamination. This had the potential to affect 41 of 80 residents who received food from the refrigerator/freezer. Findings include: During observation on 1/13/15, at 8:54 a.m. nursing assistant (NA)-D was observed to touch the garbage lid three times in the neighborhood kitchen, while preparing toast for a resident. The garbage lid was observed to have a large amount of various food spills and food debris on the inside and outside of the lid. After touching the garbage lid, NA-D opened the drawer next to the stove and removed packets and placed them on the counter. NA-D also removed paper squares from a box on the counter and used them to remove the toast from the toaster and buttered the toast while holding it with the paper. Two, unopened jelly packs were observed on the counter, next to the toast. NA-D stated she washed her hands before and after each preparing food for each resident. NA-D stated she was washing her hands and sanitizing before	F 441	**F441:** DON and/or designee will implement corrective action affected by this practice by: • Ensuring all staff use proper infection control techniques when preparing food • All cold compresses are not stored in freezers containing food products. DON and/or designee will assess the potential to be affected by this practice including: • All residents in the facility. DON and/or designee will implement measures to ensure that this practice does not recur including: • The policy for Cold Compress was reviewed. • All nursing staff will be educated on the updated Cold Compress policy. • The Infection Control-General policy was reviewed. • All staff will be educated on the Infection Control-General Policy. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • 3 Infection Control audits will be completed weekly during meal times, beginning the week 2-10-15, until compliance is achieved, then quarterly thereafter. • 3 audits will be completed weekly to ensure cold compresses are stored per policy, beginning the week 2-10-15, until compliance is achieved, then quarterly thereafter. • The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 2-23-15	

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F 441	Continued From page 31 removing the toast and buttering it. NA-D verified she may have missed washing her hands or sanitizing during the preparation of the toast. NA-D opened the drawer, where there were jelly packs, peanut butter, and cup lids inside. NA-D verified she may have removed the jelly from the drawer. During an interview on 1/13/15, at 9:45 a.m. the dietary manager (DM) stated the protocol for preparing food included washing hands before starting, and after touching things, such as handles. The DM stated staff should change gloves and wash hands between tasks. The DM verified NA-D should have washed hands after touching the garbage and other things in the kitchen. The DM stated staff have been educated and repeatedly reminded to wash their hands. The DM stated she talks to new staff during orientation and nursing also provided handwashing education. During an interview on 1/13/15, at 10:31 a.m. the director of nursing (DON) verified NA-D should have washed her hands after touching the garbage. The policy and procedure for Infection Control-General Practice revised 4/2/09, directed staff to wash hands frequently utilizing the hand washing procedure: after taking out garbage, after handling soiled dishes or utensils, frequently during food preparation, after touching raw meat, poultry or eggs, and anytime hands become soiled. During an observation on 1/13/15, at 9:12 a.m. a neighborhood freezer that contained resident ice cream also contained three re-usable cold, gel	F 441		

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F 441	Continued From page 32 packs. The gel packs were unlabeled and were not stored in separate bags. On 1/13/15, at 9:41 a.m. registered nurse (RN)-B verified the multi-use gel packs in the neighborhood freezer were used by residents and should be stored in the medication room freezer, not with residents' food. On 1/13/15, at 10:31 a.m. the DON verified the multi-use cold, gel packs should not have been in the neighborhood freezer with resident food. On 01/13/15, at 10:37 a.m. RN-B further stated there were 41 residents who would use the food contained in the neighborhood freezer/refrigerator. The policy and procedure for Compress (Cold) dated 9/14, directed staff to store cold packs in the freezer in the med room refrigerator.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure call lights were available and functioning properly for 3 of 35 residents (R20, R100, R116) reviewed for call lights.	F 463		

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F 463

Continued From page 33

Findings include:

R20's quarterly Minimum Data Set (MDS) dated 12/11/14, indicated R20 had moderate cognitive deficits, and was able to communicate needs clearly. R20's face sheet dated 1/15/15, indicated R20's diagnoses included dementia (memory loss) and difficulty walking.

During observations on 1/12/15, at 8:48 a.m. R20's room call light was turned on by R20 and was checked for functioning. The call light lit up in the room, but was not displayed on the hall monitor or the nursing assistant (NA)/nurse pagers. NA-D stated and demonstrated that the pagers did not indicate the call light had been turned on. NA-D notified maintenance/janitor (M)-C, who removed the call light box from the wall and brought it outside the room and turned it on. The hall monitor and the NA/nurse pager did work. It was brought back in and connected to the wall and the call light cord and checked; it worked on the hall monitor and the NA/nurse pager.

R100's annual MDS dated 12/22/14, indicated R100 was cognitively intact and was able to clearly communicate needs. R100's face sheet indicated R100's diagnoses included polyneuropathy.

During observations on 1/12/15, at 9:46 a.m. R100 stated the room call light had been on for 45 minutes. The light on the call light box, indicated the call light had been turned on, but neither the hall monitor or the NA/nurse pagers indicated the call light was on. The call light was re-set in R100's room. The licensed practical nurse (LPN)-A responded to the call light.

F 463

F463: Environmental Services Director and/or designee will implement corrective action affected by this practice by:

- Residents (R20, R100, R116) call lights are available and functioning properly.

Environmental Services Director and/or designee will assess the potential to be affected by this practice including:

- All residents in the facility who are cognitively able to use their call lights.

Environmental Services Director and/or designee will implement measures to ensure that this practice does not recur including:

- The procedure for Use of Call Lights was reviewed and updated.
- Environmental Services Staff were educated on the new procedure in regard to the weekly facility check of all devices.

Environmental Services Director and/or designee will monitor corrective actions to ensure the effectiveness of these actions including:

- Environmental Services Director will review the weekly facility checks as well as monitor the system by computer, beginning the week 2-10-15.
- The monitoring results will be reported to the Quality Assurance Committee quarterly. The Quality Assurance Committee will make recommendations for ongoing monitoring.

Completion Date: 2-23-15

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F 463	Continued From page 34 Maintenance (M)-A was notified immediately and he checked the call light with the computer, and said it worked. M-A stated the call lights are checked when someone moves out of the room and when it is reported to not be working properly. M-A stated there was not a regular schedule for checking call light functioning. R116's comprehensive significant change MDS dated 12/18/14, indicated R116 was cognitively intact and was able to clearly communicate needs. R116's face sheet dated 1/15/15, indicated diagnoses included peripheral neuropathy and osteoarthrosis (arthritis). During observations on 1/12/15, at 11:13 a.m. R116's room call light did not work when it was initially turned on. The call light was re-set by R116, and turned on again. It was displayed on the hall monitor and the NA/nurse pagers. During an interview and tour on 1/14/15, at 10:00 a.m. the environmental services director (ESD) stated he checked the call lights function with the computer weekly, and the computer will detect when a call light battery is getting low or is not functioning. If the battery is low, they change it. The ESD stated that if one was missing, staff report it to him and he replaces it. He also stated he will not take call lights out of visual sight of the resident's room to fix it, because it is usually a battery, which he can replace at the nurse's station. The ESD stated, if he had to take it further away to repair it, he would leave the resident with the bathroom call light or an alternative. During an interview on 1/14/15, at 2:17 p.m., the ESD stated it was their procedure and his	F 463		

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F 463	Continued From page 35 expectation that a replacement call light would be placed in the resident's room when a call light is taken from the room. He specified that if it was a double room, they would use the spare. The ESD stated that he did not have a policy and procedure for checking function of the call lights and did not have a policy and procedure for replacing the call light when the call light was removed from the room. On 1/14/15, at approximately 2:30 p.m. during the tour, M-A stated he replaced the battery for R42 on 1/12/15. The facility policy and procedure for Use of Call Light revised 9/14, directed staff to report any defective call lights to the nurse immediately. Update maintenance as well of any defective call lights. Make sure and replace the defective call light with a functioning call light, until the defective call light is fixed. It further directed in the event of an emergency where call lights do not work, a bell or personal alarm devices will be used.	F 463		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES F5239027
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	01/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Guardian Angels Health & Rehab Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Guardian Angels Health and Rehab Center, is a 1-story building with a small partial basement. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1968, 73, & 91 additions were constructed to the building that was determined to be of Type II(111) construction. In 1990 a Type V (111) administrative wing (non resident use area) was constructed. It is properly separated from the rest of the building. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 96 beds and had a census of 87 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is met.	K 000		

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES F5239027
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **02 - 2006 ADDITION** B. WING ______	01/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Guardian Angels Care Center Building 2 was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Guardian Angels Care Center Building 2 is a 1-story building with a partial basement, Type II(111), constructed in 2006. In 2011 another wing was constructed to "New", that is one story, with a small partial mechanical basement Type II(000) .The building is fully sprinkled protected throughout. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 96 beds and had a census of 87 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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