DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEE	DICARE & MEDICAID SERVICES
	MEDIC	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: 07C3
	PART I -	TO BE COMPI	LETED BY T	THE STAT	FE SURVEY AGENCY	Facility ID: 00858
1. MEDICARE/MEDICAID PROVIDER (L1) 245239	NO.	3. NAME AND AD (L3) GUARDIAN			REHAB CENTER	4. TYPE OF ACTION: <u>7 (</u> L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO (L2) 863278200	-	(L4) 1500 EAST (L5) HIBBING, M		UE	(L6) 55746	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	VNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 6. DATE OF SURVEY 02//17/2 8. ACCREDITATION STATUS: 	2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 0 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b) :		U U	equirements		2. Technical Personnel	6. Scope of Services Limit
			e Based On:		3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	85 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	(F) 8. Patient Room Size
13.Total Certified Beds	85 (L17)	X B. Not in Com	upliance with Pros	zram	5. Life Safety Code	9. Beds/Room
			and/or Applied V		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
85						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMAR	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Teresa Ament, Unit Supervi	sor	0	3/20/2017	(L19)	Mark Meath,	Enforcement Specialist 05/01/2017 (L20)
PART	II - TO BE	COMPLETED H	BY HCFA RE	EGIONAI	COFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIBILIT <u>X</u> 1. Facility is Eligible to Part 			IPLIANCE WITH ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) : :
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 10/01/1981	BEGINNING	J DATE	ENDING DA	ГЕ	VOLUNTARY0001-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	e
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00130				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)	02/27/2017		(L33)	DETERMINATION APPI	ROVAL

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

I IAL II

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5239

Based on review of the facility's plan of correction, the facility is back in compliance with the Federal requirements identified as deficient at the time of the December 30, 2016 survey.

In addition, deficiencies cited under F225 and F226 related to complaint investigation number H5239056 were deteremined to be in compliance.

Effective February 8, 2017, the facility is certified for 85 skilled nursing facility beds.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245239

May 1, 2017

Mr. Geoffrey Ryan, Administrator Guardian Angels Health & Rehabilitation Center 1500 East Third Avenue Hibbing, MN 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 February 8, 2017 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

mark meath

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

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 20, 2017

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

RE: Project Number S5239031 and H5239056

Dear Mr. Kessler:

On January 13, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard extended survey, completed on December 30, 2016 that included an investigation of complaint number H5239056. 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.

On February 17, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 13, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 30, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 8, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 30, 2016, effective February 8, 2017 and therefore remedies outlined in our letter to you dated January 13, 2017, will not be imposed.

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

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

Sincerely, Mart Meeth

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245239 _{Y1}	B. Wing	Y2	2/17/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDIAN ANGELS HEALTH & REHAB CENTER		1500 EAST THIRD AVENUE		
		HIBBING, MN 55746		

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

ITE	м	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0225	Correction	ID Prefix	F0226		Correction	ID Prefix	F0278		Correction
Reg. #	483.12(a)(3)(4)(c)	(1)-(4) Completed	Reg. #		b)(1)-(3), c)(1)-(3)	Completed	Reg. #	483.20(g)-(j)		Completed
LSC		02/08/2017	LSC			02/08/2017	LSC			02/08/2017
ID Prefix	F0282	Correction	ID Prefix	F0323		Correction	ID Prefix			Correction
Reg. #	483.21(b)(3)(ii)	Completed	Reg. #	483.25(d)(1)(2)(n)(1)-(3)	Completed	Reg. #			Completed
LSC		02/08/2017	LSC			02/08/2017	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			-	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			-	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			-	LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS) TA/mm	date 03/20/2	017	SIGNATURE OF SU	JRVEYOR	29433	I	оате 02/17	/2017
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE			1	DATE	
FOLLOW	JP TO SURVEY CC 16	DMPLETED ON			ANY UNCORRECTE				YES	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01			
245239 _{Y1}	B. Wing	Y2	2/13/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDIAN ANGELS HEALTH & REHAB CENTER		1500 EAST THIRD AVENUE		
		HIBBING MN 55746		

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

ITEI	м	DATE	ITEM	D	ATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix		Correction	ID Prefix	Co	rrection	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	Со	mpleted	Reg. #		Completed
LSC	K0321	02/08/2017				LSC		_
ID Prefix		Correction	ID Prefix	Co	rrection	ID Prefix		Correction
Reg. #		Completed	Reg. #	Сог	mpleted	Reg. #		Completed
LSC						LSC		
ID Prefix		Correction	ID Prefix	Coi	rrection	ID Prefix		Correction
Reg. #		Completed	Reg. #	Сог	mpleted	Reg. #		Completed
LSC						LSC		_
ID Prefix		Correction	ID Prefix	Coi	rrection	ID Prefix		Correction
Reg. #		Completed	Reg. #	Сог	mpleted	Reg. #		Completed
LSC						LSC		_
ID Prefix		Correction	ID Prefix	Con	rrection	ID Prefix		Correction
Reg. #		Completed	Reg. #	Сог	mpleted	Reg. #		Completed
LSC			LSC			LSC		_
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/mm	date 03/20/2017	SIGNATURE OF SURVE	yor 27200)	DATE 02/1	3/2017
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWI 12/28/20 ⁻	JP TO SURVEY CO 16	DMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					s 🗆 no

O7C322

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR ME	DICARE & MEDICAID SERVICES		
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: 07C3		
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00858		
1. MEDICARE/MEDICAID PROVID (L1) 245239	ER NO.	3. NAME AND AD (L3) GUARDIAN			REHAB CENTER	4. TYPE OF ACTION: <u>2 (</u> L8) 1. Initial 2. Recertification		
2.STATE VENDOR OR MEDICAID N (L2) 863278200	40.	(L4) 1500 EAST (L5) HIBBING, N		UE	(L6) 55746	3. Termination4. CHOW5. Validation6. Complaint		
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEG 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
8. ACCREDITATION STATUS:)/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID		FISCAL YEAR ENDING DATE: (L35) 12/31		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OF 1/SP	12 RHC	16 HOSPICE	12/01		
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	' IS CERTIFIED	AS:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b) :		Ŭ	equirements e Based On:		2. Technical Personnel			
		^			3. 24 Hour RN 4. 7-Day RN (Rural SI	7. Medical Director		
12. Total Facility Beds	85 (L18)	1. A	cceptable POC					
13.Total Certified Beds	85 (L17)	X B. Not in Com			5. Life Safety Code	9. Beds/Room		
14. LTC CERTIFIED BED BREAKDO	WN	Requirements	and/or Applied V	warvers:	* Code: B *	(L12)		
14. LTC CERTIFIED BED BREARDC	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
18 SINF 18/19 SINF 85	19 5101	ICI	IID		1801 (6) (1) 01 1801 (1) (1).			
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Susan Frericks, HPR SW	/S	0	1/30/2017	(L19)	Mark Meath, E	inforcement Specialist 02/27/2017 (L20)		
PA	RT II - TO BE	COMPLETED F	BY HCFA RE	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF ELIGIBII	JTY		IPLIANCE WITH	H CIVIL		nncial Solvency (HCFA-2572)		
X 1. Facility is Eligible to I	Participate	RIGH	ITS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
 Facility is not Eligible 	-							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)		
OF PARTICIPATION 10/01/1981	BEGINNINC	J DATE	ENDING DA	TE	VOLUNTARY 0 01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-FIOVIdel Status Change		
(L27)	D. Descind St	spansion Data	(L44)			00-Active		
	D. Reschiu Si	uspension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		00130						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		
	· /			· · · · /				



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

lectronically delivered January 13, 2017

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

RE: Project Number S5239031, H5239055 and H5239056

Dear Mr. Kessler:

On December 30, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 30, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5239055 that was found to be unsubstantiated and investigation of complaint number H5239056 was found to be substantiated at F225 and F226.

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:

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

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

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

<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:

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

Email: Teresa.Ament@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 8, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 30, 2017 (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 June 30, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525 Guardian Angels Health & Rehabilitation Center January 13, 2017 Page 6 Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

	-	& MEDICAID SERVICES					APPROVED
							0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		COMF	E SURVEY PLETED
		245239	B. WING _			(12/3	C 30/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE		
				1500 EAST THIRD AVENUE			
GUARDI	AN ANGELS HEALTH			HIBBING, MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F 00	0			
		rvey was conducted and tion(s) were also completed at dard survey.					
	H5239056 were con substantiated relate	mplaints H5239055 and mpleted. The complaint was ed to H5239056. Deficiency F226. The complaint related not substantiated.					
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 tic submission of the POC will ion of compliance.					
F 225 SS=E	on-site revisit of you validate that substa regulations has bee your verification.)-(4) INVESTIGATE/REPORT	F 22	25			2/8/17
	(a) The facility must	<u>t</u> -					
	(3) Not employ or o who-	therwise engage individuals					
		l guilty of abuse, neglect, propriation of property, or court of law;					
		ng entered into the State concerning abuse, neglect,					
LABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE			(X6) DATE
Electron	ically Signed						01/23/2017

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.

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	0MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED
		245239	B. WING				C 30/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE IIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	misappropriation of (iii) Have a disciplin or her professional body as a result of exploitation, mistreat misappropriation of (4) Report to the St licensing authorities actions by a court of which would indicat nurse aide or other (c) In response to a exploitation, or mist (1) Ensure that all a abuse, neglect, exp including injuries of misappropriation of reported immediate after the allegation cause the allegation serious bodily injury the events that caus abuse and do not re the administrator of officials (including to adult protective seri- for jurisdiction in lor accordance with Sta- procedures.	atment of residents or their property; or ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property. ate nurse aide registry or s any knowledge it has of f law against an employee, e unfitness for service as a facility staff. Illegations of abuse, neglect, reatment, the facility must: ateleged violations involving loitation or mistreatment, unknown source and resident property, are and, if the events that n involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other o the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established	F 2	225			
	officials (including to adult protective ser- for jurisdiction in lor accordance with Sta procedures. (2) Have evidence to	o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established that all alleged violations are					

If continuation sheet Page 2 of 25

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245239	B. WING		С
	PROVIDER OR SUPPLIER	243239	D. WING _	STREET ADDRESS, CITY, STATE, ZIP CC	12/30/2016
	AN ANGELS HEALTH	& REHAB CENTER		1500 EAST THIRD AVENUE HIBBING, MN 55746	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIO
F 225	 exploitation, or mist investigation is in pre- (4) Report the result administrator or his representative and with State law, inclu- Agency, within 5 wo if the alleged violatic corrective action me This REQUIREMEN by: Based on observat review, the facility far mistreatment were and/or thoroughly in (R1, R82, R47) revi Findings include: R1 was interviewed When questioned a member had put he R1 stated she did n (NA) in her room ar reported it to the off works with her. Dur 12/28/16, at 6:13 p. complained about a described the NA in recall the name. R1 removed her bed co toilet and roughly pu NA had not said a w 	potential abuse, neglect, creatment while the rogress. Its of all investigations to the or her designated to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate ust be taken. NT is not met as evidenced tion, interview and document ailed to ensure allegations of reported to the state agency nvestigated for 3 of 6 residents	F 2	 F225 Guardian Angel's goal is to e allegations of mistreatment a to the State Agency and are investigated. Resident R1 was re-intervie indicated concern was follow satisfaction. Resident R82 was re-intervi indicated concern was follow satisfaction. Resident R47 was re-intervi indicated had no care concern was follow satisfaction. Resident R47 was re-intervi indicated had no care concern was follow satisfaction. Social Services will direct the 	are reported thoroughly wed and yed up to their ewed and yed up to their ewed and rns. ially affected. yere were no tment.
	she yelled loudly to stated they had had	ally done to hurt her and stated get out and stay out. R1 I problems with the NA office knew who it was right		Social Services will direct the investigation Process. DON a Managers responsible for fol will give a daily status report	and Nurse low up and

Facility ID: 00858

If continuation sheet Page 3 of 25

		AND HUMAN SERVICES	I		(APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION	СОМ	E SURVEY PLETED
		245239	B. WING _				C 30/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			AST THIRD AVENUE NG, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	Continued From pa	age 3	F 22	25			
	-	e had not seen the NA		ass	signments related to the abuse estigation.	!	
	 R1's Face Sheet printed 12/29/16, indicated R1's diagnoses included muscle weakness, abnormalities of gait and mobility, and overactive bladder. R1's quarterly Minimum Data Set (MDS) assessment dated 12/8/16, indicated R1 had a moderate cognitive impairment, understood others and understands others. The MDS further 			•NA invo •NA bei sta	y allegations of abuse will be n the QAPI Committee monthly. A-B was suspended pending estigation. A-B was disciplined, re-educate ng closely monitored by Super ff which includes shift supervis neduled on the unit NA-B is ass	ed and is visory or	
	indicated R1 requir staff for bed mobilit	ed extensive assistance of one ty, transfers, ambulation, and occasional incontinence of		for • Sl car •NA	closer monitoring and supervis hift Supervisor performing aud es for NA-B while on shift. A-B not assigned to R1 or R82 ensed nurse on duty or another	sion. its during . The	
	required staff assis	nted on 12/29/16, indicated R1 tance with ambulation and courage to walk to and from			provide cares during that shift d R82.	for R1	
	walker. R1's care p make her needs kn person place and ti	one assist and a four-wheeled olan indicated R1 was able to nown and was oriented to me, and was vulnerable due to id confusion and short-term		Ma the def Neg alle	facility staff will be trained on t Itreatment Prohibition policies initions of all types of Abuse an glect, the guidelines for reporti egations of use and Neglect, and the upda	including nd ng	
	A Concerns Report Form completed by the social services director (SS)-D dated 9/9/16, indicated it was reported to the assistant director of nursing			Reg by	gulations regarding Abuse and 02/08/17.	Neglect,	
	having handled her cares, and threw th report indicated R1 due to her shoulded	1 had reported the night NA as roughly and was fast with her be bed covers up on her. The had told the NA to be careful r pain, but the NA continued to ransfer to and from bed. R1		(sp dur cor	ndom observational care audit ecifically on handling the resid ring cares) will be npleted daily X 2 weeks, then ek X 4 weeks and weekly there	ent 3x a	
	had denied abuse/r want NA to work wi	heglect at that time, but did not th her any longer. The report was to investigate and		Co	dit results will be brought to the mmittee for review and further ommendations.		

Facility ID: 00858

	TH AND HUMAN SERVICES RE & MEDICAID SERVICES				FORM	02/17/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
	245239	B. WING	i			C 30/2016
NAME OF PROVIDER OR SUPPLI	ER			TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GUARDIAN ANGELS HEAL	TH & REHAB CENTER			500 EAST THIRD AVENUE IIBBING, MN 55746		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
additional educa who was identifia provided cares to unable to provided interviews of oth R1's progress no R1's complaints A review of the fa the state agency made to the stat for R1. On 12/30/16, at (DON) stated sh abuse. The DON deficits and poor should have bee The DON stated a reported situat realized the resid accurate. The D R1's concern as R82 was intervie When questione threw her into a could no longer of R82's Face Shee R82's diagnoses of the nervous s abnormalities, an	esidents on the unit and provide tion and training to the NA-B, ed as the night NA on duty who o R1 on 9/8/16. The facility was e evidence of investigation or er residents. thes lacked documentation of regarding NA-B. acility vulnerable adult reports to revealed no reports had been e agency regarding mistreatment 3:30 a.m. the director of nursing e did not report this situation as I verified R1 had cognitive judgement, so this concern n reported as potential abuse. residents are asked right away if on is abuse, but the DON dent's judgement may not be DN stated she would now report abuse. wed on 12/27/16, at 3:15 p.m. d about abuse, R82 stated NA-B chair like a rag-a-muffin, and come into her room. et dated 12/29/16, indicated included a degenerative disease ystem, gait and mobility		225	Completion date: 02/08/17		

If continuation sheet Page 5 of 25

DEPART CENTE		FORM	APPROVED 0938-0391				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245239	B. WING	-			C 30/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	50/2010
GUARDI	AN ANGELS HEALTH			1	500 EAST THIRD AVENUE		
GUANDI	AN ANGELS HEALTH	& REHAD CENTER		Н	IBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	transfers, ambulation R82's care plan prin required assistance a gait belt due to un	ge 5 on in the room, and toilet use. nted 12/29/16, indicated R82 of one staff for transfers with nsteady gait and impaired re plan further indicated R82	F 2	25			
	was vulnerable rela had periods of incre	ted to cognitive status and eased confusion and deficits and a variable mental					
	indicated R82 had r with her during whe indicated R82 denie time. The Concerns SS-D indicated the investigate, addition	Form dated 11/21/16, reported that NA-B was rough elchair transfers. The form ed abuse and neglect at that a Report Form filled out by the corrective action would be to nal education and training, and copline as determined by the DON.					
	regarding interviews	able to provide documentation s of other residents on the R82 indicated R82 denied					
	verified R82 had co judgement, so this or reported as potentia residents are asked realized their judger	0 a.m. the DON stated DON gnitive deficits and poor concern should have been al abuse. The DON stated d right away if it is abuse, but ment may not be accurate. e would now report R82's					
		printed 12/30/16, indicated cluded difficulty in walking and					

If continuation sheet Page 6 of 25

CENTERS FOR MEDICARE & N	ND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1)) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		pleted C
	245239	B. WING _			30/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDIAN ANGELS HEALTH & R	REHAB CENTER		1500 EAST THIRD AVENUE HIBBING, MN 55746		
PREFIX (EACH DEFICIENCY MUS	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
 R47 had a moderately i and required extensive bed mobility, transfers, R47's care plan printed R47 was non-ambulato assistance of 2 for transand had an increased r history of low back pair arthritis. R47's care plawas vulnerable related had periods of increases short-term memory def function. An Incident Report sub agency regarding an invindicated R47 had repor handled him roughly, ar putting R47 back to be unable to identify the N SS-D interviewed R47, neglect. The NA identifii The facility's investigati indicated R47 had repor shift had been rough, rucares. The report indicated report indicated R47 had reports investigation lacked interviews wunit. On 12/29/16, at 2:01 p. 	dated 11/1/16, indicated impaired cognitive status, e assistance of 2 staff for , and toilet use. d on 12/29/16, indicated ory, required staff nsfers and bed mobility, risk for pain related to a in and acute pain due to lan further indicated R47 d to cognitive status and ed confusion and ficits and a variable mental omission to the state ncident dated 7/10/16, orted that a night NA had and was crabby while ed after toileting. R47 was NA by name. On 7/11/16, y who denied abuse and fied was NA-D. tive report dated 7/11/16, ported a NA on the night rude and impatient during cated it had been use had occurred. The terview with the identified with other residents on the o.m. SS-D stated the oncern reports for R1 and	F 22			

Facility ID: 00858

If continuation sheet Page 7 of 25

		AND HUMAN SERVICES				FORM	: 02/17/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	CON	E SURVEY IPLETED
		245239	B. WING				C / 30/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			1500 EAST THIRD AVENUE HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	Continued From pa	ige 7	F 2	225	5		
		R47's was reported. SS-D rator decides which incidents					
	the DON and the as (ADON) present, the was not reported as denied abuse and r stated there was not was just moving ve not want NA-B worl DON stated R82's of reported as abuse and neglect, and N did not want NA-B to DON stated it was harm her. During the both R1 and R82 he they had discussed R47's incident was reported that one. T received retraining mistreatment, and longer work with R ⁻¹ they interviewed oth on duty monitor state was unable to provi- interviews with other monitoring. On 12/30/16, at 8:4 stated the facility wo or by text if it occur- stated if the concer	7 p.m. during an interview with ssistant director of nursing le DON stated R1's concern s potential abuse because R1 neglect at that time. The DON o intent to harm R1, and NA-B ry fast with cares. R1 just did king with her any longer. The concern in 11/16, was not because she denied abuse A-B was just moving fast. R82 to work with her anymore. The not an intentional attempt to ne interview, the DON verified ad confusion. The DON stated the situation, and decided more purposeful, so they The DON stated NA-B on resident rights, positioning, and NA-B can no 1 and R82. The DON stated her residents, and supervisors ff by watching staff. The DON ide documentation of er residents, or of staff -8 a.m. the administrator oks at their policy, and discuss if a concern should be e agency. The administrator ill discuss a concern by phone s off hours. The administrator n is rough handling by staff, as cognitive deficits, they report					

Facility ID: 00858

If continuation sheet Page 8 of 25

		AND HUMAN SERVICES				FORM	02/17/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CON	E SURVEY IPLETED C
		245239	B. WING				30/2016
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE IBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225 F 226 SS=E	that he does not alw resident has a cogr administrator verifie reported to the state investigated, if there The facility policy an Nursing Facility (SN Guidelines dated 10 immediately report administrator and to The facility policy an Maltreatment Inves 1/30/16, directed a conducted immedia happened and whe reporting to the state and administrator w reportable incidents interventions were further occurrences would be completed agency. 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES 483.12 (b) The facility mus written policies and (1) Prohibit and pre exploitation of resid resident property,	cy. The administrator stated ways know at the time if the nitive impairment or not. The ed concerns should be e agency, and then e is any question. Ind procedure for Skilled NF) Maltreatment Reporting 0/3/16, directed staff to suspected abuse to the o the state agency. Ind procedure for SNF tigation and Reporting dated in initial investigation must be ately to determine what ther the incident required te agency. The stated agency vere to be notified of all s immediately, and immediate to be initiated to prevent any s, then further investigation d and submitted to the state 33.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC t develop and implement procedures that:	F 2	225			2/8/17
	(2) Establish policie	es and procedures to					

Facility ID: 00858

If continuation sheet Page 9 of 25

	245239		ING	001	PLETED
NAME OF PROVIDER OR SUPPLIER	& REHAB CENTER	B. WING	STREET ADDRESS, CITY, STATE 1500 EAST THIRD AVENUE HIBBING, MN 55746	12/3	C 30/2016
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		O THE APPROPRIATE	(X5) COMPLETION DATE
 §483.95, 483.95 (c) Abuse, neglect, the freedom from all requirements in § 44 provide training to the ducates staff on- (c)(1) Activities that exploitation, and miproperty as set forth (c)(2) Procedures for neglect, exploitation resident property (c)(3) Dementia maprevention. This REQUIREMENT by: Based on observatt review, the facility farmistreatment were provide the facility for the facil	In allegations, and as required at paragraph and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum constitute abuse, neglect, sappropriation of resident in at § 483.12. For reporting incidents of abuse, in, or the misappropriation of nagement and resident abuse IT is not met as evidenced ion, interview and document ailed to ensure allegations of reported to the state agency investigated for 3 of 6 residents ewed for abuse.	F 2	F226 F226 Guardian Angel's goal Maltreatment Prohibitiv regarding reporting an alleged incidents of mi Resident R1 was re-in indicated concern was satisfaction. Resident R82 was re-i indicated concern was satisfaction. Resident R47 was re-i	on policies d investigating all istreatment. terviewed and followed up to their nterviewed and followed up to their	

Facility ID: 00858

If continuation sheet Page 10 of 25

	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MU	тірі	E CONSTRUCTION		0938-039 SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
						C)
		245239	B. WING			12/3	80/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE HBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 226	Continued From pa Maltreatment Inves	age 10 tigation and Reporting dated	F 2	26	indicated had no care concerns.		
	1/30/16, directed a conducted immedia happened and whe	in initial investigation must be ately to determine what ther the incident required te agency. The stated agency			All residents could be potentially aff •All interviewable residents were interviewed to ensure there were no further allegations of mistreatment.	C	
	reportable incidents interventions were further occurrences	vere to be notified of all s immediately, and immediate to be initiated to prevent any s, then further investigation			Facility staff will be trained on the fa Maltreatment Prohibition policies in the	cluding	
	would be completed an agency.	d and submitted to the state d on 12/27/16, at 3:25 p.m.			definitions of all types of Abuse and Neglect, the guidelines for reporting allegation Abuse and Neglect, and the update	ons of	
	When questioned a member had put he	about abuse, R1 stated a staff er on the toilet like a rag doll. not want the nursing assistant			Regulations regarding Abuse and N by 02/08/17.		
	reported it to the of works with her. Dur	nymore. R1 stated she fice, and the NA no longer ring a follow-up interview on			 •NA-B was suspended pending investigation. •NA-B was disciplined, re-educated 		
	complained about a described the NA in	m. R1 stated she had a nursing assistant and ivolved, though could not			being closely monitored by Supervis staff which includes shift supervisor scheduled on the unit NA-B is assig	gned	
	removed her bed control toilet and roughly p	I stated the NA had roughly overs, roughly put her on the ut on a new pad. R1 stated the word to her. R1 reported she			for closer monitoring and supervision •Shift Supervisor performing audits cares for NA-B while on shift. •NA-B not assigned to R1 or R82.	during	
	felt it was intentiona she yelled loudly to stated they had had	ally done to hurt her and stated get out and stay out. R1 d problems with the NA office knew who it was right			licensed nurse on duty or another N will provide cares during that shift fo and R82.	JAR	
	away. R1 stated sh recently.	e had not seen the NA			Any allegations of abuse will be mo by the QAPI Committee monthly.	nitored	
	diagnoses included	rinted 12/29/16, indicated R1's I muscle weakness, it and mobility, and overactive			Random observational care audits (specifically on handling the resider during cares) will be completed daily X 2 wks, then 3x a x 4 weeks, and weekly thereafter, to	week	
	R1's quarterly Minir	mum Data Set (MDS)			ensure Maltreatment Prohibition po		

Facility ID: 00858

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY
		245239					C / 30/2016
NAME OF	PROVIDER OR SUPPLIER		ľ	ST	REET ADDRESS, CITY, STATE, ZIP CODE		00/2010
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			00 EAST THIRD AVENUE BBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<u> </u>	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 226	assessment dated moderate cognitive others and understa indicated R1 requires staff for bed mobilit toilet use, and had o bladder. R1's Care Plan prin required staff assist directed staff to end the bathroom with o walker. R1's care p make her needs kn person place and the periods of increased memory deficits. A Concerns Report services director (S was reported to the on that date, that R having handled her cares, and threw th report indicated R1 due to her shoulder be rough during a th had denied abuse/r want NA to work wit indicated the plan w interview other resid additional education who was identified a provided cares to R unable to provide e interviews of other n	 12/8/16, indicated R1 had a impairment, understood ands others. The MDS further ed extensive assistance of one y, transfers, ambulation, and occasional incontinence of ted on 12/29/16, indicated R1 tance with ambulation and courage to walk to and from one assist and a four-wheeled olan indicated R1 was able to own and was oriented to me, and was vulnerable due to d confusion and short-term Form completed by the social S)-D dated 9/9/16, indicated it assistant director of nursing 1 had reported the night NA as roughly and was fast with her e bed covers up on her. The had told the NA to be careful pain, but the NA continued to ransfer to and from bed. R1 heglect at that time, but did not th her any longer. The report vas to investigate and dents on the unit and provide n and training to the NA-B, as the night NA on duty who 11 on 9/8/16. The facility was vidence of investigation or 	F 22		are being followed. Audit results will be brought to the Committee for review and further recommendations. Completion date: 02/08/17	e QAPI	

If continuation sheet Page 12 of 25

		AND HUMAN SERVICES					FORM	APPROVED
		& MEDICAID SERVICES				0		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		COM	E SURVEY PLETED
		245239	B. WING					C 30/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE	, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE IIBBING, MN 55746			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD O THE APPROPF	BE	(X5) COMPLETION DATE
F 226	Continued From pa	ige 12	F 2	226				
	the state agency re	lity vulnerable adult reports to vealed no reports had been gency regarding mistreatment						
	(DON) stated she d abuse. The DON ve deficits and poor jue should have been r The DON stated re a reported situation realized the resider	0 a.m. the director of nursing did not report this situation as erified R1 had cognitive dgement, so this concern reported as potential abuse. sidents are asked right away if is abuse, but the DON nt's judgement may not be I stated she would now report puse.						
	When questioned a	ed on 12/27/16, at 3:15 p.m. about abuse, R82 stated NA-B air like a rag-a-muffin, and me into her room.						
	R82's diagnoses in	dated 12/29/16, indicated cluded a degenerative disease em, gait and mobility weakness.						
	indicated R82 was extensive assistance	hange MDS dated 11/21/16, cognitively intact, required be of one staff for bed mobility, on in the room, and toilet use.						
	required assistance a gait belt due to ur cognition. R82's ca was vulnerable rela had periods of incre	nted 12/29/16, indicated R82 e of one staff for transfers with nsteady gait and impaired re plan further indicated R82 ated to cognitive status and eased confusion and r deficits and a variable mental						

If continuation sheet Page 13 of 25

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES		TIDI			. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · · /	E SURVEY IPLETED
						1	С
		245239	B. WING			12/	30/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE HBBING, MN 55746		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI		(¥5)
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DAIL
			I				
F 226	Continued From pa	ge 13	F 2	226			
	function.						
	A Concorne Poport	Form dated 11/21/16,					
		reported that NA-B was rough					
	with her during whe	elchair transfers. The form					
		ed abuse and neglect at that					
		Report Form filled out by the corrective action would be to					
		nal education and training, and					
		cipline as determined by the					
	administrator and D	JON.					
	The facility was una	able to provide documentation					
		s of other residents on the					
	unit. Follow-up with abuse.	R82 indicated R82 denied					
	abase.						
		0 a.m. the DON stated DON					
		gnitive deficits and poor concern should have been					
		al abuse. The DON stated					
	residents are asked	l right away if it is abuse, but					
		ment may not be accurate.					
	concern as abuse.	e would now report R82's					
		printed 12/30/16, indicated					
	repeated falls.	cluded difficulty in walking and					
		S dated 11/1/16, indicated					
		ely impaired cognitive status, sive assistance of 2 staff for					
	bed mobility, transfe						
	-						
		nted on 12/29/16, indicated latory, required staff					
		transfers and bed mobility,					
		ed risk for pain related to a					

If continuation sheet Page 14 of 25

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	LE CONSTRUCTION	1	U936-0391 E SURVEY
AND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:					PLETED
		245239	B. WING				C 30/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	50/2010
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE		
				H	IIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	history of low back arthritis. R47's care was vulnerable rela had periods of incres short-term memory function. An Incident Report agency regarding a indicated R47 had r handled him roughl putting R47 back to unable to identify th SS-D interviewed R neglect. The NA ide The facility's investi indicated R47 had shift had been roug cares. The report in determined that no investigation lacked NA-D, and interview unit. On 12/29/16, at 2:0 facility's take on the R82 was that they r	pain and acute pain due to e plan further indicated R47 ted to cognitive status and eased confusion and deficits and a variable mental submission to the state n incident dated 7/10/16, reported that a night NA had y, and was crabby while bed after toileting. R47 was ie NA by name. On 7/11/16, 47, who denied abuse and entified was NA-D. gative report dated 7/11/16, reported a NA on the night h, rude and impatient during ndicated it had been abuse had occurred. The d interview with the identified ws with other residents on the 1 p.m. SS-D stated the e concern reports for R1 and no longer wanted NA-B	F 2	26			
	and R82's concerns state agency, and F stated the administr are reported. On 12/29/16, at 2:3 the DON and the as (ADON) present, th was not reported as	SS-D was not sure why R1's s were not reported to the R47's was reported. SS-D rator decides which incidents 7 p.m. during an interview with ssistant director of nursing e DON stated R1's concern s potential abuse because R1 neglect at that time. The DON					

If continuation sheet Page 15 of 25

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245239	B. WING				C 30/2016
NAME OF F	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CUADDI	AN ANGELS HEALTH			1	500 EAST THIRD AVENUE		
GUANDI	AN ANGELS REALTR	& REHAD CENTER		H	IIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	was just moving ver not want NA-B work DON stated R82's of reported as abuse it and neglect, and NA did not want NA-B t DON stated it was in harm her. During th both R1 and R82 has they had discussed R47's incident was reported that one. T received retraining mistreatment, and p longer work with R1 they interviewed oth on duty monitor stat was unable to provi interviews with other monitoring. On 12/30/16, at 8:4 stated the facility loc concerns to decide reported to the state stated the facility wi or by text if it occurs stated if the concern and the resident has it to the state agend that he does not alw resident has a cogn administrator verifie reported to the state investigated, if there 483.20(g)-(j) ASSE	 a intent to harm R1, and NA-B ry fast with cares. R1 just did king with her any longer. The concern in 11/16, was not because she denied abuse A-B was just moving fast. R82 to work with her anymore. The not an intentional attempt to be interview, the DON verified ad confusion. The DON stated the situation, and decided more purposeful, so they The DON stated NA-B on resident rights, positioning, and NA-B can no and R82. The DON stated her residents, and supervisors ff by watching staff. The DON de documentation of er residents, or of staff 8 a.m. the administrator oks at their policy, and discuss if a concern should be e agency. The administrator ill discuss a concern by phone s off hours. The administrator n is rough handling by staff, s cognitive deficits, they report cy. The administrator stated ways know at the time if the hitive impairment or not. The ed concerns should be e agency, and then e is any question. SSMENT 	F 2				2/8/17
SS=D	ACCURACY/COOF	RDINATION/CERTIFIED					

If continuation sheet Page 16 of 25

		AND HUMAN SERVICES				FORM	02/17/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY PLETED C
		245239	B. WING	i			30/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE HBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 278	Continued From pa	ige 16	F	278			
		sessments. The assessment lect the resident's status.					
	(h) Coordination A registered nurse each assessment v participation of hea						
	(i) Certification(1) A registered nurthe assessment is a	rse must sign and certify that completed.					
		who completes a portion of the sign and certify the accuracy of assessment.					
	(j) Penalty for Falsi (1) Under Medicare who willfully and kn	e and Medicaid, an individual					
	resident assessme	ial and false statement in a nt is subject to a civil money than \$1,000 for each					
	and false statemen	individual to certify a material t in a resident assessment is oney penalty or not more than sessment.					
	material and false s This REQUIREME	ement does not constitute a statement. NT is not met as evidenced					
	review, the facility f	tion, interview and document ailed to ensure the sessment accurately described			F278 DON and/or designee will impleme corrective action for Resident R75	ent	

Facility ID: 00858

If continuation sheet Page 17 of 25

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FC OMB	ED: 02/17/201 RM APPROVE NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED C
		245239	B. WING			12/30/2016
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE IIBBING, MN 55746	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From pa	ge 17	F2	278		
	oral status for 1 of dental.	1 residents (R75) reviewed for			affected by this practice by: •Resident R75's dental status was assessed 01/20/17.	
	Findings include:	winted on 10/00/10 indicated			 Resident R75's care plan was updated and reflects current dental status, goal, 	
	diagnoses that inclusion speak) and dyspha	printed on 12/29/16, indicated uded aphasia (inability to gia (trouble swallowing)			and approaches based on assessment 01/20/17. •Modification of Section L of	
	following cerebral ir	nfarction (stroke). inimum Data Set (MDS) dated			Comprehensive Assessment ARD date 12/22/16, was completed to reflect accurate information regarding dental),
	8/9/16, indicated R	75 had severely impaired beech. The MDS also indicated			status for Resident R75. DON and/or designee will assess	
	responded adequat				residents having potential to being affected by this practice including:	
	Data Set (MDS) da	e significant change Minimum ted 12/22/16, indicated R75 n or tooth fragments.			 All residents have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does 	not
	had upper and lowe	ted 8/12/16, indicated R75 or dentures. The care plan also			reoccur including: •All staff who are involved in completing	9
		ned a dental appointment, er mouth rinse/wash with a.m. d to rinse and place			the collection of data and assessment Section L of the MDS will be educated how to accurately complete Section L of	on
	Guide updated on 1	soak overnight. R75's Care 2/22/16, indicated R75 had ntures, and to soak partial at			the MDS by 2/8/17. DON and/or designee will monitor corrective actions to ensure effectivene	ISS
	night and replace d	entures in the morning.			of these actions including: •Oral status assessment audits will be	
		8 a.m. nursing assistant did not have dentures.			completed on all current residents, to ensure assessments are accurate and coded accurately on Section L of the	are
	have several bottor	3 p.m. R75 was observed to n teeth and tooth fragments			MDS, by 2/8/17. •3 oral assessment audits will be	
		. On 12/29/16, at 7:51 a.m. er denture out of her mouth to upon questioning.			completed weekly x 4 weeks, beginning the week of 1/30/17, then 2x weekly x 2 weeks, then weekly thereafter.	
	On 12/29/16, at 2:4	0 p.m. registered nurse			 Monitoring will be reported to Quality Assurance Committee quarterly and as 	

Facility ID: 00858

If continuation sheet Page 18 of 25

						. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY
			-			С
		245239	B. WING		12/	30/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER		1500 EAST THIRD AVENUE HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 278	Continued From pa	age 18	F 27	3		
	(RN)-F stated nurs observations for the	e managers make e MDS related to oral/dental d the MDS nurses verify		needed. The Quality Assurance Committee will make recommen for ongoing monitoring. Completion Date: 02/08/17	dations	
		5 p.m. RN-E verified R75 has both fragments, and that the incorrectly coded.				
	10/23/12, indicated responsible for con otherwise assigned	IDS 3.0 Assessment dated the MDS Coordinator was npleting all sections not I (including section L). The is and timeleines for correction				
F 282 SS=D	483.21(b)(3)(ii) SEI PERSONS/PER C	RVICES BY QUALIFIED ARE PLAN	F 28	2		2/8/17
		ive Care Plans ded or arranged by the facility, comprehensive care plan,				
	accordance with ea	qualified persons in ach resident's written plan of NT is not met as evidenced				
	Based on observa review, the facility f interventions to pre	tion, interview, and document ailed to ensure care plan event falls were implemented (R82) reviewed for falls.		F282: DON and/or designee will impler corrective action for Resident R8 affected by this practice by: • NA-A was educated on 12/28/1	32	
	Findings include:			following plan of care and foot p be applied, per care plan, for Re	edals to	
		printed 12/29/16, identified uded degenerative disease of		R82. •Wheelchair pedals were placed immediately on Resident R82's		

Facility ID: 00858

If continuation sheet Page 19 of 25

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COM	0938-039 E SURVEY PLETED C
		245239	B. WING			30/2016
NAME OF F	PROVIDER OR SUPPLIER		• [STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GUARDI	AN ANGELS HEALTH	& REHAB CENTER		1500 EAST THIRD AVENUE HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 282	Continued From pa	ige 19	F 28	2		
	abnormalities, and	weakness.		wheelchair after occurrence on da		
	(MDS) assessment	nange Minimum Data Set t dated 11/21/16, indicated R82 act, required extensive		 observed during survey on 12/28/ •All nursing staff will be educated Resident R82's safety portion car for use of foot pedals by 02/08/17 	on e plan	
	in the room, and to	staff for transfers, ambulation ilet use, and required ce of two staff for ambulation in		DON and/or designee will assess residents having potential to being affected by this practice including •All residents that receive staff as based on assessed plan of care,	sistance,	
	area assessment (indicated R82 had and short term mer traumatic brain inju had short term mer and a cognitive imp	e for functional and safety/care CAA) dated 12/16/16, a history of falls, unsteady gait, mory loss related to a previous ry. R82's CAA indicated R82 mory loss, poor judgement, pairment, and had multiple I on 12/15/16, resulting in a		 affected by this practice. DON and/or designee will implem measures to ensure this practice reoccur including: Resident Care Plan Policy was reand revised. All staff will be educated on Resi Care Plan Policy by 02/08/17. DON and/or designee will monitor corrective actions to ensure effect 	ent does not eviewed dent	
		ents dated 9/22/16, 11/9/16, 2/16, indicated R82 was at risk		 of these actions including: 3 care plan intervention audits w completed weekly x 4 weeks, beg the week of 1/30/17, then 2x a weeks 	inning	
	revealed R82 had 9 12/20/16, with the f fractures and a clav and a fall on 12/14/ being moved to her a laceration on her in the emergency re	or ogress notes since admission of falls between 10/26/16, and all on 11/1/16 resulting in rib vicle fracture requiring surgery, (16, out of the wheelchair while bedroom by staff, resulting in head requiring an evaluation oom. The progress notes isciplinary team met regarding		weeks, then weekly thereafter. •Monitoring will be reported to Qu Assurance Committee quarterly a needed. The Quality Assurance Committee will make recommend for ongoing monitoring. Completion date: 2/08/17	nd as	
	each fall and initiate further falls. R82's indicated a new inte	ed interventions to prevent progress note dated 12/16/16, ervention included foot pedals to the wheelchair while staff				

If continuation sheet Page 20 of 25

STATE MENT OF DEPROCENCIES AND FLAN OF CORRECTION (M) PROVIDERSUPFILIER/LINE UDENTIFICATION NUMBER: V245239 VIING			AND HUMAN SERVICES				FORM	: 02/17/2017 APPROVED . 0938-0391
245239 B. WING 12/30/2016 INAME OF PROVIDER OR SUPPLIEN STREET ADDRESS, CITY, STATE, ZIP CODE 300 EAST THIRD AVENUE 100 EAST THIRD AVENUE 000 EAST THIRD AVENUE							COM	IPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY, STRIE ZIP CODE ION TO BE AND THE ZIP CODE ISO EAST THIRD AVENUE IDENT TAGE SUMMARY STATEMENT OF DEFICIENCIES IPACID SUMMARY STATEMENT OF DEFICIENCIES IPACID RECULATORY OR LSC DENTIFYING INFORMATION PREFIX RECULATORY OR LSC DENTIFYING INFORMATION F 282 Continued From page 20 R82'S Current Care Plan printed on 12/29/16, indicated R82 had impaired decision making and was at risk for fails. R82's care plan approaches for fail prevention directed staff to apply foot pedals to the wheelchair when staff were pushing her, dated 12/16/16. R82'S Care Guide updated 12/22/16, and was loaded inside her closel door, directed staff to put foot pedals on R82's wheelchair when staff were pushing her. On 12/28/16, at 6:20 p.m. nursing assistant (INA)-A assisted R82 toked to NA-A about a fail she recently had. R82 toked NA-A about a fail she recently had. R82 toked NA-A about fails he recently had. R82 toked NA-A about fails he recently had. R82 toked NA-A staff was pushing her in the wheelchair when her foot pedals that were in the corner of the dresser/shelving unit near the doorway. NA-A was asked about the foot pedals for the Wree pushing her in the wheelchair at that time. NA-A stated she did not think R82 needed to have them. On 12/29/16, at 2:37 p.m. director of nursing (IDN)-stated the foot pedals were initiated for R82 immediately after the fail on 12/14/16.			245239	B. WING				
EQUADAM ANGELS HEALTH & REHAB CENTER HIBBING, MN 55746 (%) ID PREFIX TWO SUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EE APPROXIMATION) ID PREFIX (EACH DEFICIENCY MUST EE APPROXIMATION) PREFIX PREFIX (EACH DEFICIENCY) PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY) USE (EACH DEFICIENCY) F 282 Continued From page 20 RB2's Current Care Plan printed on 12/29/16, indicated R82 had impaired decision making and was at risk for falls. R82's care plan approaches for fall prevention directed staff to put toot peddals to the wheelchair when staff were pushing her, dated 12/16/16. F 282 R82's Care Guide updated 12/22/16, and was located inside her closet door, directed staff to put foot peddals on R82's wheelchair when staff were pushing her. F 282 On 12/28/16, at 6:20 p.m. nursing assistant (INA)-A assisted R82 trom the toliet to her wheelchair. R82 stated she wanted to play the game that was being held in the dining room. NA-A placed a pressure alarm on R82's wheelchair. R82 talked to NA-A shout a fall she recently had. R82 told NA-A staff was pushing her in the wheelchair when her foot pedals that were in the doorway. NA-A was asked about the foot pedals for R82's wheelchair at that time. NA-A stated she did not think R82 needed to have them. On 12/29/16, at 2:37 p.m. director of nursing (INN)-A varified the foot pedals were to be on R82's wheelchair at that time. NA-A stated the Gare Guide stere was to be viewed by staff prior to caring for the resident. On 12/29/16, at 2:37 p.m. director of nursing (DON) stated the foot pedals were initiated for R82 immediately after the fall on 12/14/16.	NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CMULT PREFIX SUMMARY STATEMENT OF DEFICIENCES INC U Department Processing Departmen	GUARDI	AN ANGELS HEALTH	& REHAB CENTER					
Preferx TxG read-to DeFIGENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TxG read-to construct the appropriate DEFICIENCY construct to the approprise DEFICIENCY <td></td> <td></td> <td></td> <td></td> <td>Н</td> <td>,</td> <td></td> <td></td>					Н	,		
 R82's Current Care Plan printed on 12/29/16, indicated R82 had impaired decision making and was at risk for falls. R82's care plan approaches for fall prevention directed staff to apply foot pedals to the wheelchair when staff were pushing her, dated 12/16/16. R82's Care Guide updated 12/22/16, and was located inside her closet door, directed staff to put foot pedals on R82's wheelchair when staff were pushing her. On 12/28/16, at 6:20 p.m. nursing assistant (NA)-A assisted R82 from the toilet to her wheelchair. R82 stated she wanted to play the game that was being held in the dining room. NA-A placed a pressure alarm on R82's wheelchair and the dising room. NA-A placed a pressure alarm on R82's wheelchair out of the bedroom, propelling R82 past the foot pedals that were in the order of the dresser/shelving unit near the doorway. NA-A was asked about the foot pedals for R82's wheelchair at that time. NA-A stated she did not think R82 needed to have them. On 12/29/16, at 9:53 a.m. registered nurse (RN)-A verified the Care Guide sheet was to be viewed by staff prior to caring for the resident. On 12/29/16, at 2:37 p.m. director of nursing (DON) stated the foot pedals were initiated for R82 immediately after the fall on 12/14/16. 	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLÉTION
 indicated R82 had impaired decision making and was at risk for falls. R82's care plan approaches for fall prevention directed staff to apply foot pedals to the wheelchair when staff were pushing her, dated 12/16/16. R82's Care Guide updated 12/22/16, and was located inside her closet door, directed staff to put foot pedals on R82's wheelchair when staff were pushing her. On 12/28/16, at 6:20 p.m. nursing assistant (NA)-A assisted R82 from the toilet to her wheelchair. R82 stated she wanted to play the game that was being held in the dining room. NA-A placed a pressure alarm on R82's wheelchair when her foot pedals that were in the order of the dresser/shelving unit near the doorway. NA-A staff was pushing her in the wheelchair when her foot had gotten caught. NA-A propelled R82 past the foot pedals that were in the correr of the dresser/shelving unit near the doorway. NA-A was asked about the foot pedals for R82's wheelchair at that time. NA-A stated she did not think R82 needed to have them. On 12/29/16, at 9:53 a.m. registered nurse (RN)-A verified the foot pedals were to be on R82's wheelchair when staff were pushing the chair. RN-A stated the Care Guide sheet was to be viewed by staff prior to caring for the resident. On 12/29/16, at 2:37 p.m. director of nursing (DON) stated the foot pedals were initiated for R82 immediately after the fall on 12/14/16. 	F 282		-	F 2	82			
 R82's Care Guide updated 12/22/16, and was located inside her closet door, directed staff to put foot pedals on R82's wheelchair when staff were pushing her. On 12/28/16, at 6:20 p.m. nursing assistant (NA)-A assisted R82 from the toilet to her wheelchair. R82 stated she wanted to play the game that was being held in the dining room. NA-A placed a pressure alarm on R82's wheelchair. R82 talked to NA-A about a fall she recently had. R82 told NA-A staff was pushing her in the wheelchair when her foot had gotten caught. NA-A propelled R82's wheelchair out of the bedroom, propelling R82 past the foot pedals that were in the corner of the dresser/shelving unit near the doorway. NA-A was asked about the foot pedals for R82's wheelchair at that time. NA-A stated she did not think R82 needed to have them. On 12/29/16, at 9:53 a.m. registered nurse (RN)-A verified the foot pedals were to be on R82's wheelchair when staff were pushing the chair. RN-A stated the Care Guide sheet was to be viewed by staff prior to caring for the resident. On 12/29/16, at 2:37 p.m. director of nursing (DON) stated the foot pedals were initiated for R82 immediately after the fall on 12/14/16. 		indicated R82 had was at risk for falls. for fall prevention d pedals to the whee	impaired decision making and R82's care plan approaches lirected staff to apply foot lchair when staff were pushing					
 (NA)-A assisted R82 from the toilet to her wheelchair. R82 stated she wanted to play the game that was being held in the dining room. NA-A placed a pressure alarm on R82's wheelchair. R82 talked to NA-A about a fall she recently had. R82 told NA-A statif was pushing her in the wheelchair when her foot had gotten caught. NA-A propelled R82's wheelchair out of the bedroom, propelling R82 past the foot pedals that were in the corner of the dresser/shelving unit near the doorway. NA-A was asked about the foot pedals for R82's wheelchair at that time. NA-A stated she did not think R82 needed to have them. On 12/29/16, at 9:53 a.m. registered nurse (RN)-A verified the foot pedals were to be on R82's wheelchair when staff were pushing the chair. RN-A stated the Care Guide sheet was to be viewed by staff prior to caring for the resident. On 12/29/16, at 2:37 p.m. director of nursing (DON) stated the foot pedals were initiated for R82 immediately after the fall on 12/14/16. 		R82's Care Guide I located inside her of foot pedals on R82	updated 12/22/16, and was closet door, directed staff to put					
 (RN)-A verified the foot pedals were to be on R82's wheelchair when staff were pushing the chair. RN-A stated the Care Guide sheet was to be viewed by staff prior to caring for the resident. On 12/29/16, at 2:37 p.m. director of nursing (DON) stated the foot pedals were initiated for R82 immediately after the fall on 12/14/16. 		(NA)-A assisted R8 wheelchair. R82 sta game that was bein NA-A placed a press wheelchair. R82 tal recently had. R82 tal recently had	22 from the toilet to her ated she wanted to play the ng held in the dining room. ssure alarm on R82's ked to NA-A about a fall she old NA-A staff was pushing her then her foot had gotten elled R82's wheelchair out of elling R82 past the foot pedals mer of the dresser/shelving vay. NA-A was asked about the 's wheelchair at that time.					
(DON) stated the foot pedals were initiated for R82 immediately after the fall on 12/14/16.		(RN)-A verified the R82's wheelchair w chair. RN-A stated be viewed by staff p	foot pedals were to be on hen staff were pushing the the Care Guide sheet was to prior to caring for the resident.					
A facility policy and procedure for following the		(DON) stated the fo	pot pedals were initiated for					
		A facility policy and	procedure for following the					

Facility ID: 00858

If continuation sheet Page 21 of 25

		AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: 02/17/ FORM APPRC MB NO. 0938-0	OVED
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
		245239	B. WING		C 12/30/201	6
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER		1500 EAST THIRD AVENUE HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	ETION
F 282	Continued From pa	ge 21	F 282	2		
F 323 SS=D	care plan was not r 483.25(d)(1)(2)(n)(HAZARDS/SUPER	I)-(3) FREE OF ACCIDENT	F 32:	3	2/8/17	,
	(d) Accidents. The facility must en	sure that -				
		vironment remains as free rds as is possible; and				
		eceives adequate supervision ices to prevent accidents.				
	appropriate alternation bed rail. If a bed or must ensure correct	e facility must attempt to use tives prior to installing a side or side rail is used, the facility it installation, use, and rails, including but not limited ments.				
	(1) Assess the resid from bed rails prior	dent for risk of entrapment to installation.				
		s and benefits of bed rails with dent representative and obtain rior to installation.				
	appropriate for the	bed's dimensions are resident's size and weight. NT is not met as evidenced				
	Based on observative review, the facility facili	ion, interview, and document ailed to ensure interventions to mplemented for 1 of 3 iewed for falls.		F323: DON and/or designee will impleme corrective action for Resident R82 affected by this practice by: •NA-A was educated on 12/28/16 or		
	Findings include:			following plan of care and foot peda be applied, per care plan, for Resid	lls to	

Facility ID: 00858

If continuation sheet Page 22 of 25

	-	AND HUMAN SERVICES			PRINTED: FORM OMB NO.	APPROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245239	B. WING _		(12/3) 80/2016
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER		1500 EAST THIRD AVENUE HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 323	diagnoses that inclu the nervous system disturbance, gait ar weakness. R82's significant ch (MDS) assessment was cognitively inta assistance of one s in the room, and toi extensive assistance the hall. R82's progress note area assessment (0 indicated R82 had a and short term mer traumatic brain inju had short term mer and a cognitive imp falls, including a fal hospitalization. Fall Risk Assessme 12/17/16, and 12/22 for falls. A review of R82's p revealed R82 had s 12/20/16, with the f fractures and a clav and a fall on 12/14/ being moved to her a laceration on her in the emergency ro indicated the interd each fall and initiate	age 22 brinted 12/29/16, identified uded degenerative disease of a, dementia with behavioral and mobility abnormalities, and hange Minimum Data Set t dated 11/21/16, indicated R82 act, required extensive staff for transfers, ambulation ilet use, and required ce of two staff for ambulation in e for functional and safety/care CAA) dated 12/16/16, a history of falls, unsteady gait, mory loss related to a previous ry. R82's CAA indicated R82 mory loss, poor judgement, bairment, and had multiple I on 12/15/16, resulting in a ents dated 9/22/16, 11/9/16, 2/16, indicated R82 was at risk progress notes since admission 0 falls between 10/26/16, and all on 11/1/16 resulting in rib vicle fracture requiring surgery, (16, out of the wheelchair while r bedroom by staff, resulting in head requiring an evaluation pom. The progress notes isciplinary team met regarding ed interventions to prevent progress note dated 12/16/16,	F 32	 R82. Wheelchair pedals were place immediately on Resident R82' wheelchair after occurrence or observed during survey on 12/ All nursing staff will be educat Resident R82's safety portion for use of foot pedals by 02/08 DON and/or designee will asseresidents having potential to b affected by this practice includ All residents with care planne intervention of foot pedals to b W/C for wheeling with staff as: have potential to be affected. DON and/or designee will impl measures to ensure this practic reoccur including: All staff will be educated on for for care for safety interventions falls and injuries by 02/08/17. Falls Policy was reviewed. All staff will be educated on F by 02/08/17. Care Plan Policy was reviewed revised. All staff will be educated on C Policy by 02/08/17. DON and/or designee will mor corrective actions to ensure effor these actions including: 3 safety intervention assessr will be performed weekly, begi week of 1/30/17, then 2x week then weekly thereafter. Monitoring will be reported to Assurance Committee quarter needed. The Quality Assurance 	s n date 28/16. ted on care plan 9/17. ess eing ing: d e applied to sistance lement ice does not ollowing plan to prevent alls Policy ed and care Plan hitor fectiveness nent audits nning the cly x weeks, Quality ly and as	

Facility ID: 00858

If continuation sheet Page 23 of 25

ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245239	B. WING	_			C 30/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			500 EAST THIRD AVENUE IBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 323	Continued From pa	age 23	F 3	23			
		ervention included foot pedals to the wheelchair while staff ling.			Committee will make recommend for ongoing monitoring. Completion date: 02/08/17	ations	
	indicated R82 had was at risk for falls for fall prevention of	e Plan printed on 12/29/16, impaired decision making and . R82's care plan approaches lirected staff to apply foot lchair when staff were pushing 6.					
	located inside her of	updated 12/22/16, and was closet door, directed staff to put 's wheelchair when staff were					
	(NA)-A assisted R8 wheelchair. R82 sta game that was bein NA-A placed a pres wheelchair. R82 ta recently had. R82 ta recently had. R82 ta in the wheelchair w caught. NA-A proper the bedroom, proper that were in the cor- unit near the doorw foot pedals for R82	20 p.m. nursing assistant bit from the toilet to her ated she wanted to play the hig held in the dining room. assure alarm on R82's liked to NA-A about a fall she old NA-A staff was pushing her when her foot had gotten belled R82's wheelchair out of belling R82 past the foot pedals oner of the dresser/shelving vay. NA-A was asked about the is wheelchair at that time. d not think R82 needed to					
	(RN)-A verified the R82's wheelchair w chair. RN-A stated	3 a.m. registered nurse foot pedals were to be on then staff were pushing the the Care Guide sheet was to prior to caring for the resident.					

Facility ID: 00858

If continuation sheet Page 24 of 25

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
			A. BUILD			(C
	PROVIDER OR SUPPLIER	245239	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	12/3	30/2016
					500 EAST THIRD AVENUE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER			IIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	R82 immediately af	poot pedals were initiated for ter the fall on 12/14/16. procedure for following the	F3	323			

Facility ID: 00858

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 101 - MAIN BUILDING 01		E SURVEY IPLETED
		245239	B. WING		12	00/0040
	PROVIDER OR SUPPLIER	243233		STREET ADDRESS, CITY, STATE, ZIP CODE	1 12	28/2016
				1500 EAST THIRD AVENUE		
GUARDI	AN ANGELS HEALTH	& REHAB CENTER		HIBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMEN	rs	K 000			
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM VERIFICATION OF UPON RECEIPT C	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS COMPLIANCE. OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE				
	CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/					
	Minnesota Departn Fire Marshal Divisi Guardian Angels H found not in compli participation in Mec Subpart 483.70(a), 2012 edition of Nat Association (NFPA	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, ealth & Rehab Center was ance with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety ter 19 Existing Health Care.		Eman]	
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY				
	Health Care Fire In State Fire Marshal 445 Minnesota Stre	Division				

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.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · /	IPLE CONSTRUCTION			TE SURVEY
		245239	B. WING			10	/28/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE		12012010
GUARDI	AN ANGELS HEALTH	& REHAB CENTER		1500 EAST THIRD HIBBING, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRED DRRECTIVE ACTION SHI FERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 000	Continued From pa St. Paul, MN 5510 Or by e-mail to bot	1	K 0	00			
	Marian.Whitney@s and Angela.Kappenma	state.mn.us					
	DEFICIENCY MUS	what has been, or will be, done					
	2. The actual, or p	roposed, completion date.					
	responsible for cor	rection and monitoring to ence of the deficiency.				11. #	
	1-story building with The original building was determined to In 1968, 73, & 91 at the building that was II(111) construction administrative wing constructed. In 20 partial basement we to be of Type II(11) wing was construct	lealth and Rehab Center, is a th a small partial basement. by was constructed in 1964 and be of Type II(111) construction. additions were constructed to as determined to be of Type h. In 1990 a Type V (111) g (non resident use area) was 06 a 1-story building with a vas added that was determined 1) constructed. In 2011 another ted that is a one story building mechanical basement that					
	was determined to	be of Type II(000). Because g and its additions meet the					

Facility ID: 00858

If continuation sheet Page 2 of 5

PRINTED: 01/23/2017

ATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	. 0938-039 TE SURVEY
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01	- MAIN BUILDING 01		MPLETED
		245239	B. WING		12	/28/2016
AME OF I	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		
GUARDI	AN ANGELS HEALTH	H & REHAB CENTER		0 EAST THIRD AVENUE BBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
K 000	Continued From p	age 2	K 000			
	facility has a fire a detection in the co corridors that is m department notific have either heat d	y sprinklered throughout. The arm system with smoke rridors and spaces open to the onitored for automatic fire ation. Other hazardous areas etection or smoke detection alarm system in accordance a State Fire Code.				
	census of 78 at the	capacity of 85 beds and had a e time of the survey. It 42 CFR, Subpart 483.70(a) is				
K 321 SS=D	NOT MET as evid	enced by: ous Areas - Enclosure	K 321			2/8/17
	Hazardous areas a having 1-hour fire fire rated doors) of system in accorda approved automat option is used, the other spaces by si doors in accordan self-closing or auto have nonrated or f that do not exceed the door. Describe the floor	are protected by a fire barrier resistance rating (with 3/4-hour r an automatic fire extinguishing nce with 8.7.1. When the ic fire extinguishing system areas shall be separated from moke resisting partitions and ce with 8.4. Doors shall be omatic-closing and permitted to field-applied protective plates I 48 inches from the bottom of and zone locations of hat are deficient in REMARKS.				
	Area	Automatic Sprinkler				

		· · · · · · · · · · · · · · · · · · ·	0.0			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
		245239	B, WING		12/28	8/2016
	PROVIDER OR SUPPLIER	۹	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			1	500 EAST THIRD AVENUE		
GUARDI/	AN ANGELS HEALT	H & REHAB CENTER	н	IBBING, MN 55746		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE ((X5) COMPLETIO DATE
K 321	Continued From p	ane 3	K 321			
	Separation N	-	11 02 1	<i>a</i>		
		-Fired Heater Rooms	i)			
		er than 100 square feet)				
		nance, and Paint Shops			()	
		ooms (exceeding 64 gallons)				
	e. Trash Collection		d in the			
	(exceeding 64 gal					
		prage Rooms/Spaces				
	(over 50 square fe					
		classified as Severe				
	Hazard - see K32					
	This STANDARD	is not met as evidenced by:				
	Based on observation	ations and staff interview, it was		K321		
	revealed that the f	facility has failed to provide		In order to comply with NFPA 101 a		
		for 1 of several hazardous		LSC 2012 section 19.3.2.1 Guardia		
		oughout the facility in		Angels H&R will complete the follow	wing:	
		NFPA 101 "The Life Safety				
		n (LSC) section 19.3.2.1. This		A door closing device will be install		
		is could in the event of a fire,		the door to the soiled utility room in		
		flames to spread throughout the		Bennett Park Wing. Installation will		
		and areas making them		include verification that the door is		
		could negatively affect the		positively latching into the frame w	hen	
	e 1	s for 16 of 78 residents as well		closed.		
	as an undetermine	ed number of staff, and visitors.		The ESD will verify completion.		
				Completion date: 2/08/2017		
	Findings include:					
	On facility tour be	tween 11:30 a.m. to 2:30 p.m.				
		oservations revealed that the				
		ty located in the Bennett Park				
		ot equipped with a door closing				
		d utility room is greater than 50				
		equires the door to be				
		ositively latching into the frame.	÷			
	This deficient con					

3

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FOR	D: 01/23/2017 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING		ATE SURVEY OMPLETED
		245239	B: WING		1	2/28/2016
	ROVIDER OR SUPPLIER	I & REHAB CENTER		STREET ADDRESS, CITY 1500 EAST THIRD AVE HIBBING, MN 5574	Y, STATE, ZIP CODE	2
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
-						
FORM CMS-25	67(02-99) Previous Version	s Obsolete Event ID: 076	C321	Facility ID: 00858	If continuation	sheet Page 5 of 5