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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: O7C3
Facility ID: 00858

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

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

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

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02//17/2017** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Teresa Ament, Unit Supervisor — 03/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 05/01/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00130** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **02/27/2017** (L33)

DETERMINATION APPROVAL

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,

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245239	A. Building B. Wing	2/17/2017

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225 Reg. # 483.12(a)(3)(4)(c)(1)-(4) LSC	Correction Completed 02/08/2017	ID Prefix F0226 Reg. # 483.12(b)(1)-(3), 483.95(c)(1)-(3) LSC	Correction Completed 02/08/2017	ID Prefix F0278 Reg. # 483.20(g)-(j) LSC	Correction Completed 02/08/2017
ID Prefix F0282 Reg. # 483.21(b)(3)(ii) LSC	Correction Completed 02/08/2017	ID Prefix F0323 Reg. # 483.25(d)(1)(2)(n)(1)-(3) LSC	Correction Completed 02/08/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TA/mm	DATE 03/20/2017	SIGNATURE OF SURVEYOR 29433	DATE 02/17/2017
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/30/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245239 (Y1)	A. Building 01 - MAIN BUILDING 01 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 02/08/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TL/mm	DATE 03/20/2017	SIGNATURE OF SURVEYOR 27200	DATE 02/13/2017
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/28/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: O7C3
Facility ID: 00858

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **12/30/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

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

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

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

12. Total Facility Beds **85** (L18)
13. Total Certified Beds **85** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Susan Frericks, HPR SWS — Date: 01/30/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Mark Meath, Enforcement Specialist — Date: 02/27/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **10/01/1981** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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:

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

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

Informal Dispute Resolution - 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. 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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING ______ B. WING ______	C 12/30/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. Investigations of complaints H5239055 and H5239056 were completed. The complaint was substantiated related to H5239056. Deficiency issued at F225 and F226. The complaint related to H5239055 was not substantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=E	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect,	F 225		2/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING ______ B. WING ______	C 12/30/2016

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F 225	Continued From page 1	F 225		

exploitation, mistreatment of residents or misappropriation of their property; or

(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING ______ B. WING ______	C 12/30/2016

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F 225	Continued From page 2 (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure allegations of mistreatment were reported to the state agency and/or thoroughly investigated for 3 of 6 residents (R1, R82, R47) reviewed for abuse. Findings include: R1 was interviewed on 12/27/16, at 3:25 p.m. When questioned about abuse, R1 stated a staff member had put her on the toilet like a rag doll. R1 stated she did not want the nursing assistant (NA) in her room anymore. R1 stated she reported it to the office, and the NA no longer works with her. During a follow-up interview on 12/28/16, at 6:13 p.m. R1 stated she had complained about a nursing assistant and described the NA involved, though could not recall the name. R1 stated the NA had roughly removed her bed covers, roughly put her on the toilet and roughly put on a new pad. R1 stated the NA had not said a word to her. R1 reported she felt it was intentionally done to hurt her and stated she yelled loudly to get out and stay out. R1 stated they had had problems with the NA previously and the office knew who it was right	F 225	F225 Guardian Angel's goal is to ensure any allegations of mistreatment are reported to the State Agency and are thoroughly investigated. •Resident R1 was re-interviewed and indicated concern was followed up to their satisfaction. •Resident R82 was re-interviewed and indicated concern was followed up to their satisfaction. •Resident R47 was re-interviewed and indicated had no care concerns. All residents could be potentially affected. •All interviewable residents were interviewed to ensure there were no further allegations of mistreatment. Social Services will direct the Abuse investigation Process. DON and Nurse Managers responsible for follow up and will give a daily status report on their	

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	245239	A. BUILDING ______ B. WING ______	C 12/30/2016

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F 225	Continued From page 3 away. R1 stated she had not seen the NA recently. 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 indicated R1 required extensive assistance of one staff for bed mobility, transfers, ambulation, and toilet use, and had occasional incontinence of bladder. R1's Care Plan printed on 12/29/16, indicated R1 required staff assistance with ambulation and directed staff to encourage to walk to and from the bathroom with one assist and a four-wheeled walker. R1's care plan indicated R1 was able to make her needs known and was oriented to person place and time, and was vulnerable due to periods of increased confusion and short-term memory deficits. 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 on that date, that R1 had reported the night NA as having handled her roughly and was fast with her cares, and threw the bed covers up on her. The report indicated R1 had told the NA to be careful due to her shoulder pain, but the NA continued to be rough during a transfer to and from bed. R1 had denied abuse/neglect at that time, but did not want NA to work with her any longer. The report indicated the plan was to investigate and	F 225	assignments related to the abuse investigation. Any allegations of abuse will be monitored by the QAPI Committee monthly. •NA-B was suspended pending investigation. •NA-B was disciplined, re-educated and is being closely monitored by Supervisory staff which includes shift supervisor scheduled on the unit NA-B is assigned for closer monitoring and supervision. • Shift Supervisor performing audits during cares for NA-B while on shift. •NA-B not assigned to R1 or R82. The licensed nurse on duty or another NAR will provide cares during that shift for R1 and R82. All facility staff will be trained on the facility Maltreatment Prohibition policies including the definitions of all types of Abuse and Neglect, the guidelines for reporting allegations of Abuse and Neglect, and the updated Regulations regarding Abuse and Neglect, by 02/08/17. Random observational care audits (specifically on handling the resident during cares) will be completed daily X 2 weeks, then 3x a week X 4 weeks and weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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	245239	A. BUILDING ______ B. WING ______	C 12/30/2016

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F 225	Continued From page 4	F 225	Completion date: 02/08/17	

Continued From page 4

interview other residents on the unit and provide additional education and training to the NA-B, who was identified as the night NA on duty who provided cares to R1 on 9/8/16. The facility was unable to provide evidence of investigation or interviews of other residents.

R1's progress notes lacked documentation of R1's complaints regarding NA-B.

A review of the facility vulnerable adult reports to the state agency revealed no reports had been made to the state agency regarding mistreatment for R1.

On 12/30/16, at 8:30 a.m. the director of nursing (DON) stated she did not report this situation as abuse. The DON verified R1 had cognitive deficits and poor judgement, so this concern should have been reported as potential abuse. The DON stated residents are asked right away if a reported situation is abuse, but the DON realized the resident's judgement may not be accurate. The DON stated she would now report R1's concern as abuse.

R82 was interviewed on 12/27/16, at 3:15 p.m. When questioned about abuse, R82 stated NA-B threw her into a chair like a rag-a-muffin, and could no longer come into her room.

R82's Face Sheet dated 12/29/16, indicated R82's diagnoses included a degenerative disease of the nervous system, gait and mobility abnormalities, and weakness.

R82's significant change MDS dated 11/21/16, indicated R82 was cognitively intact, required extensive assistance of one staff for bed mobility,

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	245239	A. BUILDING ______ B. WING ______	C 12/30/2016

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F 225	Continued From page 5	F 225		

transfers, ambulation in the room, and toilet use.

R82's care plan printed 12/29/16, indicated R82 required assistance of one staff for transfers with a gait belt due to unsteady gait and impaired cognition. R82's care plan further indicated R82 was vulnerable related to cognitive status and had periods of increased confusion and short-term memory deficits and a variable mental function.

A Concerns Report Form dated 11/21/16, indicated R82 had reported that NA-B was rough with her during wheelchair transfers. The form indicated R82 denied abuse and neglect at that time. The Concerns Report Form filled out by the SS-D indicated the corrective action would be to investigate, additional education and training, and the possibility of discipline as determined by the administrator and DON.

The facility was unable to provide documentation regarding interviews of other residents on the unit. Follow-up with R82 indicated R82 denied abuse.

On 12/30/16, at 8:30 a.m. the DON stated DON verified R82 had cognitive deficits and poor judgement, so this concern should have been reported as potential abuse. The DON stated residents are asked right away if it is abuse, but realized their judgement may not be accurate. The DON stated she would now report R82's concern as abuse.

R47's Face Sheet printed 12/30/16, indicated R47's diagnoses included difficulty in walking and repeated falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING ______ B. WING ______	C 12/30/2016

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F 225	Continued From page 6 R47's quarterly MDS dated 11/1/16, indicated R47 had a moderately impaired cognitive status, and required extensive assistance of 2 staff for bed mobility, transfers, and toilet use. R47's care plan printed on 12/29/16, indicated R47 was non-ambulatory, required staff assistance of 2 for transfers and bed mobility, and had an increased risk for pain related to a history of low back pain and acute pain due to arthritis. R47's care plan further indicated R47 was vulnerable related to cognitive status and had periods of increased confusion and short-term memory deficits and a variable mental function. An Incident Report submission to the state agency regarding an incident dated 7/10/16, indicated R47 had reported that a night NA had handled him roughly, and was crabby while putting R47 back to bed after toileting. R47 was unable to identify the NA by name. On 7/11/16, SS-D interviewed R47, who denied abuse and neglect. The NA identified was NA-D. The facility's investigative report dated 7/11/16, indicated R47 had reported a NA on the night shift had been rough, rude and impatient during cares. The report indicated it had been determined that no abuse had occurred. The investigation lacked interview with the identified NA-D, and interviews with other residents on the unit. On 12/29/16, at 2:01 p.m. SS-D stated the facility's take on the concern reports for R1 and R82 was that they no longer wanted NA-B working with them. SS-D was not sure why R1's and R82's concerns were not reported to the	F 225		

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	245239	A. BUILDING ______ B. WING ______	C 12/30/2016

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F 225	Continued From page 7	F 225		

state agency, and R47's was reported. SS-D stated the administrator decides which incidents are reported.

On 12/29/16, at 2:37 p.m. during an interview with the DON and the assistant director of nursing (ADON) present, the DON stated R1's concern was not reported as potential abuse because R1 denied abuse and neglect at that time. The DON stated there was no intent to harm R1, and NA-B was just moving very fast with cares. R1 just did not want NA-B working with her any longer. The DON stated R82's concern in 11/16, was not reported as abuse because she denied abuse and neglect, and NA-B was just moving fast. R82 did not want NA-B to work with her anymore. The DON stated it was not an intentional attempt to harm her. During the interview, the DON verified both R1 and R82 had confusion. The DON stated they had discussed the situation, and decided R47's incident was more purposeful, so they reported that one. The DON stated NA-B received retraining on resident rights, mistreatment, and positioning, and NA-B can no longer work with R1 and R82. The DON stated they interviewed other residents, and supervisors on duty monitor staff by watching staff. The DON was unable to provide documentation of interviews with other residents, or of staff monitoring.

On 12/30/16, at 8:48 a.m. the administrator stated the facility looks at their policy, and discuss concerns to decide if a concern should be reported to the state agency. The administrator stated the facility will discuss a concern by phone or by text if it occurs off hours. The administrator stated if the concern is rough handling by staff, and the resident has cognitive deficits, they report

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	245239	A. BUILDING ______ B. WING ______	C 12/30/2016

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F 225	Continued From page 8 it to the state agency. The administrator stated that he does not always know at the time if the resident has a cognitive impairment or not. The administrator verified concerns should be reported to the state agency, and then investigated, if there is any question. The facility policy and procedure for Skilled Nursing Facility (SNF) Maltreatment Reporting Guidelines dated 10/3/16, directed staff to immediately report suspected abuse to the administrator and to the state agency. The facility policy and procedure for SNF Maltreatment Investigation and Reporting dated 1/30/16, directed an initial investigation must be conducted immediately to determine what happened and whether the incident required reporting to the state agency. The stated agency and administrator were to be notified of all reportable incidents immediately, and immediate interventions were to be initiated to prevent any further occurrences, then further investigation would be completed and submitted to the state agency.	F 225		
F 226 SS=E	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to	F 226		2/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING ______ B. WING ______	C 12/30/2016

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F 226	Continued From page 9 investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure allegations of mistreatment were reported to the state agency and/or thoroughly investigated for 3 of 6 residents (R1, R82, R47) reviewed for abuse. Findings include: The facility policy and procedure for Skilled Nursing Facility (SNF) Maltreatment Reporting Guidelines dated 10/3/16, directed staff to immediately report suspected abuse to the administrator and to the state agency. The facility policy and procedure for SNF	F 226	F226 Guardian Angel's goal is to follow our Maltreatment Prohibition policies regarding reporting and investigating all alleged incidents of mistreatment. Resident R1 was re-interviewed and indicated concern was followed up to their satisfaction. Resident R82 was re-interviewed and indicated concern was followed up to their satisfaction. Resident R47 was re-interviewed and	

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F 226

Continued From page 10

Maltreatment Investigation and Reporting dated 1/30/16, directed an initial investigation must be conducted immediately to determine what happened and whether the incident required reporting to the state agency. The stated agency and administrator were to be notified of all reportable incidents immediately, and immediate interventions were to be initiated to prevent any further occurrences, then further investigation would be completed and submitted to the state agency.

R1 was interviewed on 12/27/16, at 3:25 p.m. When questioned about abuse, R1 stated a staff member had put her on the toilet like a rag doll. R1 stated she did not want the nursing assistant (NA) in her room anymore. R1 stated she reported it to the office, and the NA no longer works with her. During a follow-up interview on 12/28/16, at 6:13 p.m. R1 stated she had complained about a nursing assistant and described the NA involved, though could not recall the name. R1 stated the NA had roughly removed her bed covers, roughly put her on the toilet and roughly put on a new pad. R1 stated the NA had not said a word to her. R1 reported she felt it was intentionally done to hurt her and stated she yelled loudly to get out and stay out. R1 stated they had had problems with the NA previously and the office knew who it was right away. R1 stated she had not seen the NA recently.

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)

F 226

indicated had no care concerns.
All residents could be potentially affected.
•All interviewable residents were interviewed to ensure there were no further allegations of mistreatment.

Facility staff will be trained on the facility Maltreatment Prohibition policies including the
definitions of all types of Abuse and Neglect,
the guidelines for reporting allegations of Abuse and Neglect, and the updated Regulations regarding Abuse and Neglect by 02/08/17.

•NA-B was suspended pending investigation.
•NA-B was disciplined, re-educated and is being closely monitored by Supervisory staff which includes shift supervisor scheduled on the unit NA-B is assigned for closer monitoring and supervision.
•Shift Supervisor performing audits during cares for NA-B while on shift.
•NA-B not assigned to R1 or R82. The licensed nurse on duty or another NAR will provide cares during that shift for R1 and R82.

Any allegations of abuse will be monitored by the QAPI Committee monthly.

Random observational care audits (specifically on handling the resident during cares) will be
completed daily X 2 wks, then 3x a week x 4 weeks, and weekly thereafter, to ensure Maltreatment Prohibition policies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING ______ B. WING ______	C 12/30/2016

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F 226	Continued From page 11 assessment dated 12/8/16, indicated R1 had a moderate cognitive impairment, understood others and understands others. The MDS further indicated R1 required extensive assistance of one staff for bed mobility, transfers, ambulation, and toilet use, and had occasional incontinence of bladder. R1's Care Plan printed on 12/29/16, indicated R1 required staff assistance with ambulation and directed staff to encourage to walk to and from the bathroom with one assist and a four-wheeled walker. R1's care plan indicated R1 was able to make her needs known and was oriented to person place and time, and was vulnerable due to periods of increased confusion and short-term memory deficits. 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 on that date, that R1 had reported the night NA as having handled her roughly and was fast with her cares, and threw the bed covers up on her. The report indicated R1 had told the NA to be careful due to her shoulder pain, but the NA continued to be rough during a transfer to and from bed. R1 had denied abuse/neglect at that time, but did not want NA to work with her any longer. The report indicated the plan was to investigate and interview other residents on the unit and provide additional education and training to the NA-B, who was identified as the night NA on duty who provided cares to R1 on 9/8/16. The facility was unable to provide evidence of investigation or interviews of other residents. R1's progress notes lacked documentation of R1's complaints regarding NA-B.	F 226	are being followed. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 02/08/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 12	F 226		

A review of the facility vulnerable adult reports to the state agency revealed no reports had been made to the state agency regarding mistreatment for R1.

On 12/30/16, at 8:30 a.m. the director of nursing (DON) stated she did not report this situation as abuse. The DON verified R1 had cognitive deficits and poor judgement, so this concern should have been reported as potential abuse. The DON stated residents are asked right away if a reported situation is abuse, but the DON realized the resident's judgement may not be accurate. The DON stated she would now report R1's concern as abuse.

R82 was interviewed on 12/27/16, at 3:15 p.m. When questioned about abuse, R82 stated NA-B threw her into a chair like a rag-a-muffin, and could no longer come into her room.

R82's Face Sheet dated 12/29/16, indicated R82's diagnoses included a degenerative disease of the nervous system, gait and mobility abnormalities, and weakness.

R82's significant change MDS dated 11/21/16, indicated R82 was cognitively intact, required extensive assistance of one staff for bed mobility, transfers, ambulation in the room, and toilet use.

R82's care plan printed 12/29/16, indicated R82 required assistance of one staff for transfers with a gait belt due to unsteady gait and impaired cognition. R82's care plan further indicated R82 was vulnerable related to cognitive status and had periods of increased confusion and short-term memory deficits and a variable mental

F 226 | F 226

Continued From page 13
function.

A Concerns Report Form dated 11/21/16, indicated R82 had reported that NA-B was rough with her during wheelchair transfers. The form indicated R82 denied abuse and neglect at that time. The Concerns Report Form filled out by the SS-D indicated the corrective action would be to investigate, additional education and training, and the possibility of discipline as determined by the administrator and DON.

The facility was unable to provide documentation regarding interviews of other residents on the unit. Follow-up with R82 indicated R82 denied abuse.

On 12/30/16, at 8:30 a.m. the DON stated DON verified R82 had cognitive deficits and poor judgement, so this concern should have been reported as potential abuse. The DON stated residents are asked right away if it is abuse, but realized their judgement may not be accurate. The DON stated she would now report R82's concern as abuse.

R47's Face Sheet printed 12/30/16, indicated R47's diagnoses included difficulty in walking and repeated falls.

R47's quarterly MDS dated 11/1/16, indicated R47 had a moderately impaired cognitive status, and required extensive assistance of 2 staff for bed mobility, transfers, and toilet use.

R47's care plan printed on 12/29/16, indicated R47 was non-ambulatory, required staff assistance of 2 for transfers and bed mobility, and had an increased risk for pain related to a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 14	F 226		

history of low back pain and acute pain due to arthritis. R47's care plan further indicated R47 was vulnerable related to cognitive status and had periods of increased confusion and short-term memory deficits and a variable mental function.

An Incident Report submission to the state agency regarding an incident dated 7/10/16, indicated R47 had reported that a night NA had handled him roughly, and was crabby while putting R47 back to bed after toileting. R47 was unable to identify the NA by name. On 7/11/16, SS-D interviewed R47, who denied abuse and neglect. The NA identified was NA-D.

The facility's investigative report dated 7/11/16, indicated R47 had reported a NA on the night shift had been rough, rude and impatient during cares. The report indicated it had been determined that no abuse had occurred. The investigation lacked interview with the identified NA-D, and interviews with other residents on the unit.

On 12/29/16, at 2:01 p.m. SS-D stated the facility's take on the concern reports for R1 and R82 was that they no longer wanted NA-B working with them. SS-D was not sure why R1's and R82's concerns were not reported to the state agency, and R47's was reported. SS-D stated the administrator decides which incidents are reported.

On 12/29/16, at 2:37 p.m. during an interview with the DON and the assistant director of nursing (ADON) present, the DON stated R1's concern was not reported as potential abuse because R1 denied abuse and neglect at that time. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 15 stated there was no intent to harm R1, and NA-B was just moving very fast with cares. R1 just did not want NA-B working with her any longer. The DON stated R82's concern in 11/16, was not reported as abuse because she denied abuse and neglect, and NA-B was just moving fast. R82 did not want NA-B to work with her anymore. The DON stated it was not an intentional attempt to harm her. During the interview, the DON verified both R1 and R82 had confusion. The DON stated they had discussed the situation, and decided R47's incident was more purposeful, so they reported that one. The DON stated NA-B received retraining on resident rights, mistreatment, and positioning, and NA-B can no longer work with R1 and R82. The DON stated they interviewed other residents, and supervisors on duty monitor staff by watching staff. The DON was unable to provide documentation of interviews with other residents, or of staff monitoring. On 12/30/16, at 8:48 a.m. the administrator stated the facility looks at their policy, and discuss concerns to decide if a concern should be reported to the state agency. The administrator stated the facility will discuss a concern by phone or by text if it occurs off hours. The administrator stated if the concern is rough handling by staff, and the resident has cognitive deficits, they report it to the state agency. The administrator stated that he does not always know at the time if the resident has a cognitive impairment or not. The administrator verified concerns should be reported to the state agency, and then investigated, if there is any question.	F 226		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		2/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 16 (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the comprehensive assessment accurately described	F 278	F278 DON and/or designee will implement corrective action for Resident R75	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 17 oral status for 1 of 1 residents (R75) reviewed for dental. Findings include: R75's Face Sheet printed on 12/29/16, indicated diagnoses that included aphasia (inability to speak) and dysphagia (trouble swallowing) following cerebral infarction (stroke). R75's admission Minimum Data Set (MDS) dated 8/9/16, indicated R75 had severely impaired cognition and no speech. The MDS also indicated R75 sometimes understood what was said, and responded adequately to simple direct communication. The significant change Minimum Data Set (MDS) dated 12/22/16, indicated R75 had no natural teeth or tooth fragments. R75's Care Plan dated 8/12/16, indicated R75 had upper and lower dentures. The care plan also indicated R75 declined a dental appointment, directed staff to offer mouth rinse/wash with a.m. and p.m. cares, and to rinse and place dentures/partial to soak overnight. R75's Care Guide updated on 12/22/16, indicated R75 had upper and lower dentures, and to soak partial at night and replace dentures in the morning. On 12/29/16, at 7:38 a.m. nursing assistant (NA)-G stated R75 did not have dentures. On 12/27/16, at 1:53 p.m. R75 was observed to have several bottom teeth and tooth fragments and no upper teeth. On 12/29/16, at 7:51 a.m. R75 took a full upper denture out of her mouth to show the surveyor upon questioning. On 12/29/16, at 2:40 p.m. registered nurse	F 278	affected by this practice by: •Resident R75's dental status was assessed 01/20/17. •Resident R75's care plan was updated and reflects current dental status, goal, and approaches based on assessment 01/20/17. •Modification of Section L of Comprehensive Assessment ARD date, 12/22/16, was completed to reflect accurate information regarding dental status for Resident R75. DON and/or designee will assess residents having potential to being affected by this practice including: •All residents have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: •All staff who are involved in completing the collection of data and assessment for Section L of the MDS will be educated on how to accurately complete Section L of the MDS by 2/8/17. DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including: •Oral status assessment audits will be completed on all current residents, to ensure assessments are accurate and are coded accurately on Section L of the MDS, by 2/8/17. •3 oral assessment audits will be completed weekly x 4 weeks, beginning the week of 1/30/17, then 2x weekly x 2 weeks, then weekly thereafter. •Monitoring will be reported to Quality Assurance Committee quarterly and as	

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F 278	Continued From page 18 (RN)-F stated nurse managers make observations for the MDS related to oral/dental status. RN-F stated the MDS nurses verify information but do not collect it. On 12/29/16, at 2:45 p.m. RN-E verified R75 has bottom teeth and tooth fragments, and that the quarterly MDS was incorrectly coded. The facility policy MDS 3.0 Assessment dated 10/23/12, indicated the MDS Coordinator was responsible for completing all sections not otherwise assigned (including section L). The policy outlined steps and timeleines for correction of errors.	F 278	needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 02/08/17	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care plan interventions to prevent falls were implemented for 1 of 3 residents (R82) reviewed for falls. Findings include: R82's Face Sheet printed 12/29/16, identified diagnoses that included degenerative disease of the nervous system, gait and mobility	F 282	F282: DON and/or designee will implement corrective action for Resident R82 affected by this practice by: • NA-A was educated on 12/28/16 on following plan of care and foot pedals to be applied, per care plan, for Resident R82. •Wheelchair pedals were placed immediately on Resident R82's	2/8/17

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F 282	Continued From page 19 abnormalities, and weakness. R82's significant change Minimum Data Set (MDS) assessment dated 11/21/16, indicated R82 was cognitively intact, required extensive assistance of one staff for transfers, ambulation in the room, and toilet use, and required extensive assistance of two staff for ambulation in the hall. R82's progress note for functional and safety/care area assessment (CAA) dated 12/16/16, indicated R82 had a history of falls, unsteady gait, and short term memory loss related to a previous traumatic brain injury. R82's CAA indicated R82 had short term memory loss, poor judgement, and a cognitive impairment, and had multiple falls, including a fall on 12/15/16, resulting in a hospitalization. Fall Risk Assessments dated 9/22/16, 11/9/16, 12/17/16, and 12/22/16, indicated R82 was at risk for falls. A review of R82's progress notes since admission revealed R82 had 9 falls between 10/26/16, and 12/20/16, with the fall on 11/1/16 resulting in rib fractures and a clavicle fracture requiring surgery, and a fall on 12/14/16, out of the wheelchair while being moved to her bedroom by staff, resulting in a laceration on her head requiring an evaluation in the emergency room. The progress notes indicated the interdisciplinary team met regarding each fall and initiated interventions to prevent further falls. R82's progress note dated 12/16/16, indicated a new intervention included foot pedals were to be applied to the wheelchair while staff assisted with wheeling.	F 282	wheelchair after occurrence on date observed during survey on 12/28/16. •All nursing staff will be educated on Resident R82’s safety portion care plan for use of foot pedals by 02/08/17. DON and/or designee will assess residents having potential to being affected by this practice including: •All residents that receive staff assistance, based on assessed plan of care, could be affected by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: •Resident Care Plan Policy was reviewed and revised. •All staff will be educated on Resident Care Plan Policy by 02/08/17. DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including: • 3 care plan intervention audits will be completed weekly x 4 weeks, beginning the week of 1/30/17, then 2x a weekly x2 weeks, then weekly thereafter. •Monitoring will be reported to Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion date: 2/08/17	

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F 282	Continued From page 20	F 282		

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. 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.

A facility policy and procedure for following the

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F 282	Continued From page 21 care plan was not received.	F 282		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions to prevent falls were implemented for 1 of 3 residents (R82) reviewed for falls. Findings include:	F 323	F323: DON and/or designee will implement corrective action for Resident R82 affected by this practice by: •NA-A was educated on 12/28/16 on following plan of care and foot pedals to be applied, per care plan, for Resident	2/8/17

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F 323	Continued From page 22 R82's Face Sheet printed 12/29/16, identified diagnoses that included degenerative disease of the nervous system, dementia with behavioral disturbance, gait and mobility abnormalities, and weakness. R82's significant change Minimum Data Set (MDS) assessment dated 11/21/16, indicated R82 was cognitively intact, required extensive assistance of one staff for transfers, ambulation in the room, and toilet use, and required extensive assistance of two staff for ambulation in the hall. R82's progress note for functional and safety/care area assessment (CAA) dated 12/16/16, indicated R82 had a history of falls, unsteady gait, and short term memory loss related to a previous traumatic brain injury. R82's CAA indicated R82 had short term memory loss, poor judgement, and a cognitive impairment, and had multiple falls, including a fall on 12/15/16, resulting in a hospitalization. Fall Risk Assessments dated 9/22/16, 11/9/16, 12/17/16, and 12/22/16, indicated R82 was at risk for falls. A review of R82's progress notes since admission revealed R82 had 9 falls between 10/26/16, and 12/20/16, with the fall on 11/1/16 resulting in rib fractures and a clavicle fracture requiring surgery, and a fall on 12/14/16, out of the wheelchair while being moved to her bedroom by staff, resulting in a laceration on her head requiring an evaluation in the emergency room. The progress notes indicated the interdisciplinary team met regarding each fall and initiated interventions to prevent further falls. R82's progress note dated 12/16/16,	F 323	R82. •Wheelchair pedals were placed immediately on Resident R82's wheelchair after occurrence on date observed during survey on 12/28/16. •All nursing staff will be educated on Resident R82's safety portion care plan for use of foot pedals by 02/08/17. DON and/or designee will assess residents having potential to being affected by this practice including: •All residents with care planned intervention of foot pedals to be applied to W/C for wheeling with staff assistance have potential to be affected. DON and/or designee will implement measures to ensure this practice does not reoccur including: •All staff will be educated on following plan of care for safety interventions to prevent falls and injuries by 02/08/17. •Falls Policy was reviewed. •All staff will be educated on Falls Policy by 02/08/17. •Care Plan Policy was reviewed and revised. •All staff will be educated on Care Plan Policy by 02/08/17. DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including: • 3 safety intervention assessment audits will be performed weekly, beginning the week of 1/30/17, then 2x weekly x weeks, then weekly thereafter. •Monitoring will be reported to Quality Assurance Committee quarterly and as needed. The Quality Assurance	

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F 323	Continued From page 23 indicated a new intervention included foot pedals were to be applied to the wheelchair while staff assisted with wheeling. 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. 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	F 323	Committee will make recommendations for ongoing monitoring. Completion date: 02/08/17	

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F 323	Continued From page 24 (DON) stated the foot pedals were initiated for R82 immediately after the fall on 12/14/16. A facility policy and procedure for following the care plan was not received.	F 323		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______________	**12/28/2016**

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

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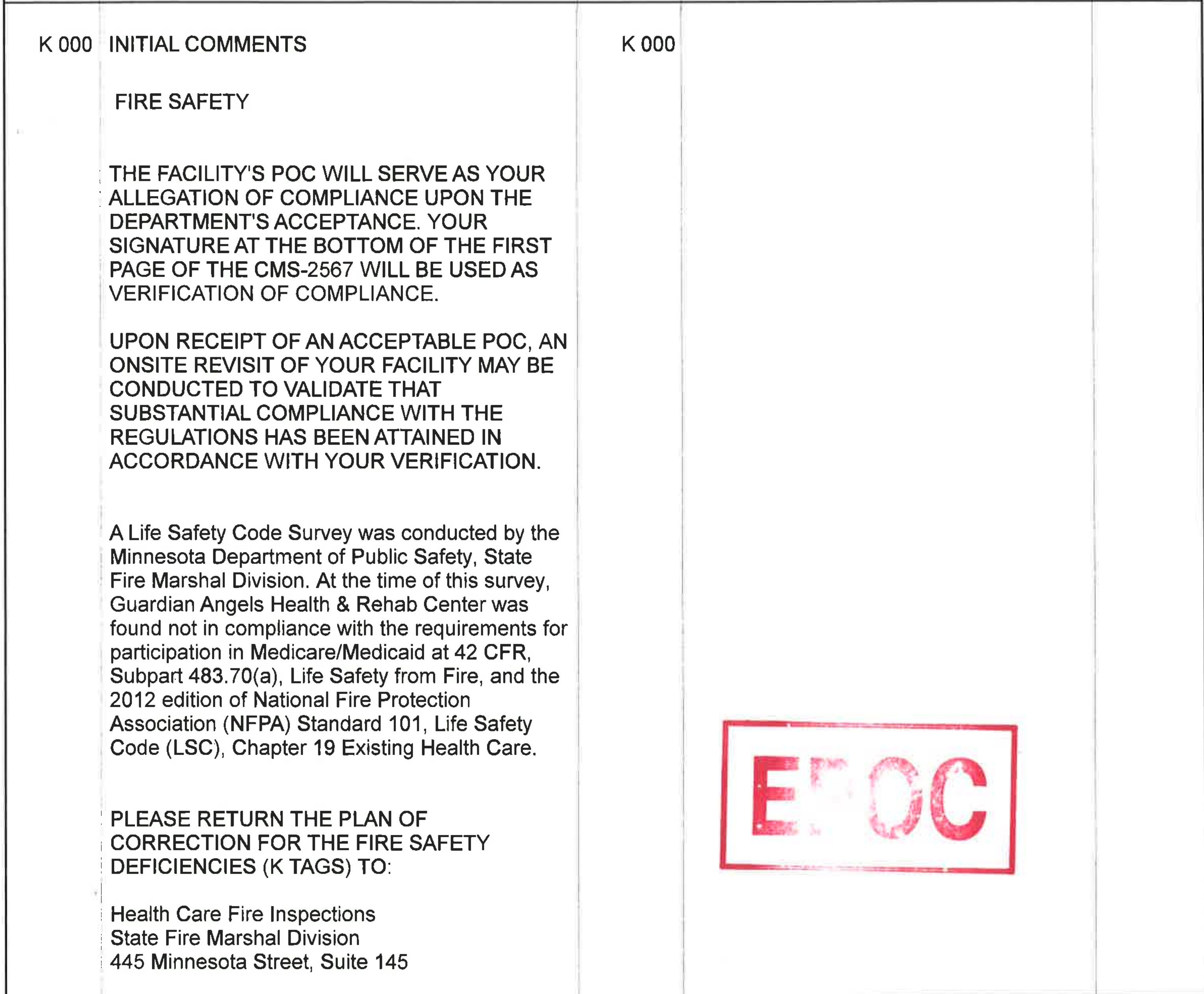

K 000 INITIAL COMMENTS — K 000

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Guardian Angels Health & Rehab Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145

EPOC

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

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K 000	Continued From page 1 St. Paul, MN 55101 Or by e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Guardian Angels Health and Rehab Center, is a 1-story building with a small partial basement. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1968, 73, & 91 additions were constructed to the building that was determined to be of Type II(111) construction. In 1990 a Type V (111) administrative wing (non resident use area) was constructed. In 2006 a 1-story building with a partial basement was added that was determined to be of Type II(111) constructed. In 2011 another wing was constructed that is a one story building with a small partial mechanical basement that was determined to be of Type II(000). Because the original building and its additions meet the construction type allowed for existing buildings.	K 000		

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K 000	Continued From page 2 The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 85 beds and had a census of 78 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler	K 321		2/8/17

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K 321	Continued From page 3 Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 16 of 78 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:30 a.m. to 2:30 p.m. on 12/28/2016, observations revealed that the door to soiled utility located in the Bennett Park wing room was not equipped with a door closing device. The soiled utility room is greater than 50 square feet and requires the door to be self-closing and positively latching into the frame. This deficient condition was confirmed by a Maintenance Supervisor.	K 321	K321 In order to comply with NFPA 101 and LSC 2012 section 19.3.2.1 Guardian Angels H&R will complete the following: A door closing device will be installed on the door to the soiled utility room in the Bennett Park Wing. Installation will include verification that the door is positively latching into the frame when closed. The ESD will verify completion. Completion date: 2/08/2017	

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