



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 21, 2024

Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

RE: CCN: 245012
Cycle Start Date: May 16, 2024

Dear Administrator:

On June 4, 2024, we notified you a remedy was imposed. On June 10, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 7, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 19, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 4, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 19, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



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June 21, 2024

Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

Re: Reinspection Results
Event ID: V7G312

Dear Administrator:

On June 10, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 16, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
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June 4, 2024

Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

Re: State Nursing Home Licensing Orders
Event ID: V7G311

Dear Administrator:

The above facility was surveyed on May 14, 2024 through May 16, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

Guardian Angels Care Center

June 4, 2024

Page 2

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

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

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

Susie Haben, Regional Operations Supervisor, Rapid Response

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

Midtown Square

3333 Division Street, Suite 212

Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 06/03/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2024
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330		
(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 On 5/14/24, through 5/16/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H50123645C (MN00103145) H50123646C (MN00103147), with deficiency cited at F689. The immediate jeopardy began on 5/6/24, when nurse aid (NA) assisted R1 to the bathroom, left her on the toilet, and exited the bathroom. While R1 was in the bathroom alone, she stood up and fell to her right side which resulted in a two-inch laceration to left forearm, two skin tears, two centimeters (cm), on right knee, and two skin tears above right knee. R1 rated right hip/leg pain at 8/10 (0-to-10 Pain Scale, this scale uses numbers from 0 to 10. A score of 0 means no pain, while 10 represents the worst pain a person has ever experienced) and unable to move right leg. R1 was transferred to the hospital and was diagnosed with an intertrochanteric (area located between the hip joint and the upper portion of the femur) fracture which required surgical intervention. The director of nursing (DON) and administrator were notified of the IJ on 5/15/24, at 6:40 p.m. The IJ was removed on 5/16/24, at 3:45 p.m. following verification of an acceptable removal plan however, noncompliance remained at the lower scope and severity level D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/29/2024

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

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F 000	Continued From page 1 The above findings constituted substandard quality of care, and an extended survey was conducted on 5/16/24. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care planned supervision to prevent falls for 1 of 3 residents (R1) reviewed for accidents. This resulted in an immediate jeopardy (IJ) situation for R1 when she sustained a right femur (leg) fracture during a fall that required surgical intervention while attempting to self-transfer unsupervised in the bathroom.	F 689	F689 This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet	6/7/24	

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F 689	Continued From page 2 The immediate jeopardy began on 5/6/24, when nurse aid (NA) assisted R1 to the bathroom, left her on the toilet, and exited the bathroom. While R1 was in the bathroom alone, she stood up and fell to her right side which resulted in a two-inch laceration to left forearm, two skin tears, two centimeters (cm), on right knee, and two skin tears above right knee. R1 rated right hip/leg pain at 8/10 (0-to-10 Pain Scale, this scale uses numbers from 0 to 10. A score of 0 means no pain, while 10 represents the worst pain a person has ever experienced) and unable to move right leg. R1 was transferred to the hospital and was diagnosed with an intertrochanteric (area located between the hip joint and the upper portion of the femur) fracture which required surgical intervention. The director of nursing (DON) and administrator were notified of the IJ on 5/15/24, at 6:40 p.m. The IJ was removed on 5/16/24, at 3:45 p.m. following verification of an acceptable removal plan however, noncompliance remained at the lower scope and severity level D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's admission Minimum Data Set (MDS) dated 4/27/24, identified intact cognition and no behaviors. R1 required substantial to maximal assistance for toileting hygiene and was dependent on staff to safely stand from a sitting position, and all transfers. R1 was frequently incontinent of bowel and bladder. R1's medical diagnoses included hypertension (HTN), atrial fibrillation (AFIB) (abnormal rapid heart rhythm), fracture with multiple trauma, renal failure,	F 689	requirements established by state and federal law. • All nursing staff caring for R1 have been educated regarding her fall risk and that she is never to be left alone in the bathroom. • A 100% audit will be completed to ensure that all Kardex's were reviewed with proper information relating to transfers to the toilet. Education will be provided to all current nursing resident assistants to ensure that they are able to identify all transfers to the toilet found on the Kardex. All nursing staff have been trained on the use of the Kardex and the need to review contents daily prior to providing cares to residents. Staff will be educated never to leave a resident alone in the bathroom when the Kardex indicates not to do so. • The following measures will be taken to protect all residents within our scope of practice including: - o Reviewing and updating the policy and procedure for Care Plan/Kardex Development/Use. - o Education will be provided to all current licensed nursing staff and current nursing assistant residents on reviewing the Care Plan/Kardex ongoing. • A 30% audit of Kardex review by NA/R's will be conducted weekly via PCC to ensure staff are viewing the Kardex at the start of their shift. This percentage will continue for 30 days, then decrease to		

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F 689	Continued From page 3 obstructive uropathy (flow of urine is blocked), arthritis, depression, past history of falls, and recent surgery for fracture repair. R1 received diuretics (increases urine output), anticoagulant (thins the blood), and insulin. R1's Care Area Assessment (CAA) dated 4/27/24, identified R1 had hearing and vision impairment, confusion, disorientation, forgetfulness, complications of immobility such as contractures and incontinence. R1 had functional limitation in range of motion, increased risk for falls, shortness of breath upon exertion, and history of pain. R1's Saint Louis University Mental Status (SLUMS) (detects mild cognition impairment and dementia) dated 4/23/24, identified a score of 19/30 and indicated dementia. R1's Fall Risk Assessment dated 4/21/24, identified a fall with fracture occurred within six months prior to admission, weakness, gait impairment, and impairment of one side of lower extremity. R1's Fall Risk Assessment dated 5/14/24, identified lack of safety and awareness due to new environment, impairment of both lower sides of extremities, wore a walking boot, weakness, and gait impairment. R1 had pre-admission fall which resulted in left foot fracture and recent fall at the facility which resulted in right hip fracture. R1 required manual stand assist (MSA) with assist of one per therapy. Staff were not to leave R1 alone unattended in bathroom. R1's care plan last updated 4/24/24, identified R1 had mobility and activities of daily living deficits	F 689	10% for 60 days (total of 90 days). • 10% audits of direct cares related to toileting will be performed with residents to ensure staff are following plan of care per Kardex for a period of 30 days. Then 10% monthly for 60 days (total of 90 days). • Monitoring for corrective action will be performed by the DON or designee to ensure that the deficient practice is being corrected. • Audits results will be presented and reviewed at QA/QAPI meetings. • The date of correction will be June 7, 2024.		

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F 689	Continued From page 4 due to previous left lower leg fracture, did not walk, required assist of one to stand, and transferred with walking boot on. Staff were directed to anticipate needs. R1 had a history of repeated falls. Staff were instructed to not leave R1 alone in the bathroom, fall risk. Review of R1's care plan dated 4/24/24, lacked evidence R1 preferred female care givers or was modest in the bathroom. R1's Kardex undated, identified transfer with assist of one, manual stand with walking boot. "Need To Know" section included: "DO NOT LEAVE ALONE in Bathroom, Fall Risk!!! Resident does not walk." R1's progress note dated 5/6/2024, at 11:55 p.m. identified at 10:00 p.m. nursing assistant (NA) reported to nurse R1 had fallen on right side while she was being assisted in bathroom. R1 reported she stood up off toilet by herself and then suddenly she was on her right side. R1 sustained a two-inch laceration to left forearm actively bleeding, two skin tears two centimeters (cm) circular shape on right knee, and two circular shape skin tears above right knee. R1 rated right hip/leg pain at 8/10 and was unable to move right leg. No bruising or bleeding noted. On call triage provider notified with new orders to be sent to emergency department. R1 was hesitant to go, refused at first, but then decided was best to be seen right away. Emergency medical system (EMS) transferred R1 at approximately 11:00 p.m. to local hospital. R1's x-ray of pelvis dated 5/7/24, identified intertrochanteric (hip) fracture.	F 689			

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F 689	Continued From page 5 R1's hospital discharge dated 5/11/24, identified principal diagnosis closed intertrochanteric (IT) fracture of the right femur with routine healing. R1 had a recent ankle fracture on 4/2/24. Per report, R1 had a witnessed fall at her nursing home facility while transferring to the toilet. R1 was on Coumadin, imaging revealed a right IT fracture, right psoas (deep within the body near the pelvis and spine) muscle and iliacus (triangle shaped muscle located in pelvic bone) muscle hematoma (an abnormal pooling of blood under the skin that resulted from broken or ruptured blood vessels). T6 and T7 and sacral fractures. R1 demonstrated profound anemia, hgb 5.2. at admission due to trauma and received three units of blood (packed red blood cells) transfusions. R1 had a right hip intramedullary (IM) (a rod placed into the hollow center of the femur/bone) surgical procedure on 5/8/24. R1's facility incident/fall risk management report dated 5/6/24, identified R1 had been assisted to the bathroom and then fell in bathroom onto her right side. R1 sustained a right trochanter fracture, laceration of left forearm and right forearm, and skin tear of right knee. R1's hemoglobin (measures amount of oxygen carried in the red blood cells to the body's organs) 5.2 grams per deciliter (gm/dl) (normal range for woman 11.6 to 15 gm/dl) was extremely low. Contributing factor identified as NA having left R1 unattended in the bathroom, impulsivity, and history of repeated falls. Review of State Agency report dated 5/7/24, indicated on 5/6/24, at approximately 11:00 p.m. NA-A reported to licensed practical nurse (LPN)-A that R1, while being assisted in bathroom, stood up off the toilet by herself and then suddenly was	F 689			

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F 689	Continued From page 6 on her right side. R1 had right hip/leg pain of 8/10 and unable to move leg. R1 was transferred to local hospital via EMS. Per R1's care plan and Kardex was not to be left unattended in the bathroom. Upon initial incident interview, LPN-A's perspective was R1 was not left unattended in the bathroom. On 5/7/24, at 5:00 p.m. NA-A was interviewed again by director of nursing (DON) and indicated R1 asked him to step out of the bathroom because she felt embarrassed. NA-A stepped outside the door, did not see what happened, and heard R1 fall, and quickly entered the bathroom. NA-A presumed she stood up by the sink to brush her teeth and then fell. NA-A failed to follow R1's care plan and was suspended from work until investigation was completed. NA-A stated he understood R1 was care planned to have staff stay in the bathroom with R1 as a fall intervention and it was listed on the Kardex. Review of facility investigation five-day report dated 5/13/24, identified R1's care plan was correct, up to date, and indicated staff were instructed to not leave R1 unattended in bathroom alone. NA-A admitted he left the bathroom, felt R1 was embarrassed, did not supervise through the open door. Later when NA-A was interviewed, he corrected his story indicating he brought R1 to bathroom, was asked to step out by the resident, he exited bathroom, closed door, stood outside of door and heard R1 fall onto the floor. NA-A confirmed during interview he was aware R1 was not to be left alone in bathroom. Report identified facility wide nursing education would be given. Review of a handwritten document provided by nurse manager (RN)-A on 5/15/24, identified nine	F 689			

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F 689	Continued From page 7 staff had documented they worked directly with R1 under the cares section in PCC from 5/11/24, through 5/14/24. -5/11/24 NA-F -5/12/24 NA-G, NA-H, NA-I -5/13/24 NA-J, NA-K, NA-L -5/14/24 NA-E and NA-M Review of facility "On the Spot Education" on 5/15/24, revealed seven out of nine staff provided direct care for R1 and had not received the required re-education related to supervision after R1 had fallen in bathroom and fractured her right hip on 5/6/24, and prior to her return to facility on 5/11/24. During an interview on 5/14/24, at 9:00 a.m., R1 stated she fell at home, had surgery to repair left lower leg and shattered parts of left foot, adding, a walking boot was worn to protect the foot. R1 stated she had a fall at the facility in the bathroom not too long ago. R1 indicated she required assistance in the bathroom and was aware she was not to be left in there alone. R1 also stated she had fallen many times in bathroom prior to admission to nursing home and felt comfortable having a male in there with her. R1 indicated she did not ask NA-A to leave the bathroom the night that she fell, and she was unsure if the door was closed or open. R1 stated she informed NA-A she planned on using the toilet since she was already in the bathroom. R1 verified she stood up from toilet, in front of her wheelchair, pivoted to sit down, and then fell to the floor. R1 shared that the feeling was awful to be in the bathroom alone after the fall but once NA-A found her, he hollered for help. R1 indicated when her right leg was moved, she yelled out a lot and they took her to the hospital.	F 689			

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F 689	Continued From page 8 During an observation on 5/14/24, at 11:05 a.m. R1 sat in wheelchair in her room. NA-D and NA-E entered R1's room and assisted her to the bathroom using the mechanical stand lift machine. NA-D and NA-E were observed to lower R1 onto the toilet and then proceeded to exit the bathroom and closed the door. NA-D and NA-E stood in the bedroom and conversed with R1's daughter for approximately seven minutes. After approximately four minutes NA-E asked R1 while door was still closed if she needed help. R1 responded no. Seven minutes had passed and then NA-E and NA-D opened the door and R1 remained sitting on toilet. Once R1 was finished using the bathroom, NA-D and NA-E assisted R1 back to her bedroom using the mechanical stand lift. During observation facility staff failed to follow care planned intervention to stay in the bathroom with R1 for safety. During interview on 5/14/24, at 2:00 p.m. NA-E stated R1's short term memory was not the best. NA-E stated R1 needed assistance of at least one in bathroom to get on and off toilet. NA-E stated prior to working with residents today she had reviewed Kardex but was unaware R1 was not to be left alone in the bathroom. NA-E stated she did not stay with R1 in the bathroom earlier today when she was in the bathroom, closed the door, and waited in the bedroom. NA-E stated had seen R1 become impulsive, get up on her own when with her. NA-E indicated would have been important to remain in the bathroom for safety to avoid falls. NA-E stated had not received education since her fall or prior to assisting her to the bathroom today. Follow up interview on 5/14/24, at 2:40 p.m. NA-E	F 689			

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

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FORM APPROVED
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F 689	Continued From page 9 stated later today she was approached by management and read a training document, and signed to acknowledge she received the education regarding R1 who should not be left alone in bathroom. During an interview on 5/14/24, at 2:43 p.m. NA-D stated R1 required assist of one to two and a manual stand lift to transfer, depending on her strength that day. NA-D verified she had looked at R1's Kardex and transfer sheet prior to the start of the shift. NA-D stated R1 could be in the bathroom alone, with door closed but was not sure and wished the Kardex was posted in the room so that staff would know for sure. NA-D indicated she felt uncomfortable when they left R1 in the bathroom alone earlier, was not aware at that time she was not to be left alone and probably should have opened the bathroom door but chose not to and relied on the other NA. NA-D verified she had received and signed a document of "On the Spot Training" today, but was not sure if it was before or after R1 was transferred to and from the bathroom. During an interview on 5/14/24, at 3:39 p.m. nurse manager (RN)-A stated nursing staff were expected to help and answer resident call lights in other rooms besides those assigned to them. RN-A stated prior to each shift worked, staff were expected to read and review the resident Kardex to verify their care and how they transferred, because changes occurred frequently on the transitional care unit (TCU). RN-A stated the Kardex was considered the road map on how to care for residents and was important to know to ensure accommodation of needs and safety. During a follow up interview on 5/15/24, at 12:06	F 689			

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F 689	Continued From page 10 p.m. RN-A stated R1 was impulsive and a high risk for falls. RN-A verified R1 never indicated she was uncomfortable with male caregivers and, if that were the case, NA-A could have called another staff on the walkie to assist R1. RN-A indicated NA-A left R1 alone in the bathroom, she fell, and sustained a fractured right hip. RN-A verified all staff were expected to work together to verify the education was received, no date was determined to assure all staff were educated on this incident, expectation would have been prior to their next shift worked. RN-A stated it had been more than a week, a questionnaire regarding this incident was placed on a clip board at the nurse's station and staff filled them, placed them face down, and were collected periodically. RN-A verified NA-D and NA-E were educated early this morning, unsure as to what time. During an interview on 5/15/24, at 8:30 a.m. family member (FM) stated R1 was ok with having all (including male) staff in the bathroom with her because she was afraid of falling. FM also stated R1 had fallen many times and required assistance while in the bathroom. FM indicated R1 most likely would not ask staff to step out of bathroom. FM verified "without a doubt" R1 was very determined to go home and knew she would try to get up by herself once she could bear weight. During an interview on 5/15/24, at 8:45 a.m. physical therapist (PT) stated R1 had some cognitive deficits especially with memory. PT stated R1 was reassessed on 5/13/24, after she returned from hospital and was manual assist of one but required max assistance of two, unable to pivot. PT recommended the manual stand with one be used to assist R1. PT stated staff were	F 689			

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F 689	Continued From page 11 expected to stay in the bathroom with R1 since she had fallen once. PT indicated R1 was not cognitively intact had already demonstrated that self-transferring leads to a fall, and now required one to two staff and the manual stand lift, to stand up. During an interview on 5/15/24, at 9:17 a.m. occupational therapist (OT) stated R1 was forgetful, distractible, impaired cognition with poor decision making and does not always stop to think about what the consequences are, and therefore was a high risk for falls. OT stated R1 required assistance with peri cares and dressing. OT stated R1 required assistance of two but always a possibility to get up by herself out of the chair especially if she had to go to the bathroom. OT stated since R1 had fallen in bathroom the expectation for staff would be stay with her in the bathroom to help minimize fall risk. OT verified R1 required transfers with the manual stand lift and assistance of one, difficult to stand up by self without assistance, but would be possible. During an interview on 5/15/24, at 10:36 a.m. director of nursing (DON) stated R1 was a high risk for falls, had at least three falls at home, admitted to nursing home with a lower leg/ankle fracture and walking boot. DON stated R1 used a wheelchair and wanted to be more independent. DON verified staff were expected to review each resident's transfers on transfer sheet, care plan, and Kardex prior to assisting them. DON also verified R1 had decreased mobility and had an intervention to not leave alone in bathroom. DON stated NA-A admitted he was aware of this intervention, R1 felt embarrassed to have him in the bathroom with her. DON stated had been identified R1 has had many falls, a fall risk, and	F 689			

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F 689	Continued From page 12 the bathroom had hard surfaces, tile, toilet, and sink that are all very hard to fall onto and should have not been left alone in the bathroom. DON stated daily reminders were given to staff to ensure care plan interventions were being implemented and staff were expected to follow the plan of care for each resident. DON stated the floor nursing managers were responsible for education and the education for this incident needed more attention. DON indicated house wide education should have been done and was not completed in entirety and was resumed yesterday 5/14/24. DON stated all nursing staff should have received the education prior to the next day worked. During a telephone interview on 5/16/24, at 11:20 a.m. NA-A stated on 5/6/24, he answered R1's call light, she requested assistance to get ready for bed. NA-A verified he handed her a gown (night clothes) while she was in the bathroom, and asked him to step out while she changed clothes. NA-A exited the bathroom, left the door ajar (cracked open), and waited in the bedroom. NA-A indicated R1 did not want him to see her body, he encouraged independence, and once she was ready planned on assisting to bed. NA-A also stated R1 was not on the toilet rather positioned in the wheelchair in front of the bathroom sink for approximately three minutes and then shouted out for help. NA-A stated it happened all so quickly, R1 sat on the floor next to the wheelchair faced the sink and held onto the wheelchair arm with her one hand. NA-A indicated R1 had bruises on her knee and hand and notified the staff nurse right away. NA-A stated he had taken R1 to the bathroom many times such as three to four times a shift prior to this incident, cracked the door so he could hear	F 689			

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F 689	Continued From page 13 her, and left her alone in the bathroom to provide privacy. NA-A verified was aware of R1's care plan and intervention do not leave alone in bathroom. NA-A stated R1 had tried to self-transfer in the past but privacy was important. NA-A indicated if he had been in the bathroom with her, tried to stand up he could have intervened, offered to help, and possibly prevented a fall. Facility policy titled Fall Management Protocol dated April 2024, identified all residents who were assessed as being at high risk for falls will be identified and individualized fall precautions will be developed for that resident. Preventive measures shall have been taken to decrease the number of falls whenever possible. Potential and actual risks for falls will be placed on the resident care plan along with identified individualized interventions. Facility policy titled Care Plans - Comprehensive/Baseline/Discharge dated 9/2023, identified care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Facility policy titled Care Plan/Kardex Development/Use, dated 5/16/24, identified a plan of care will be developed and individualized based on comprehensive and subsequent assessments performed for each resident aimed at directing resident care/needs by all members of the interdisciplinary team. The Kardex is developed directly as a subset of the resident plan of care including specific information for the NA providing direct care to the resident. The Kardex will be reviewed daily by nursing staff prior to providing care for the resident.	F 689			

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F 689	Continued From page 14 The IJ which began on 5/6/24, was removed on 5/16/24, when the facility successfully implemented a removal plan which included: All nursing staff on duty will be trained on the current Kardex/Care Plan and interventions for R1 by 12:00 p.m. on 5/16/2024. All nursing staff not on duty will be trained at the start of their next shift, prior to beginning duties on unit. All nursing staff on duty on 5/16/2024 will be trained by 12:00 p.m. on the procedures for Kardex/care plans with emphasis placed on the need to regularly and comprehensively review these documents to ensure that appropriate care is provided. Nursing staff not on duty will be trained on the same at the start of their next shift, prior to beginning duties on the unit. The policy and procedure for resident care plans has been reviewed/revised. On 5/16/24, between 9:30 a.m. and 3:30 p.m. interviews with DON, nursing staff and management verified training procedure for Kardex/care plans and need to regularly review those documents to ensure appropriate care was provided to help prevent falls. The facility had a plan in place and check off system to assure all staff would be educated prior to working their next shift.	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
June 4, 2024

Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

RE: CCN: 245012
Cycle Start Date: May 16, 2024

Dear Administrator:

On May 16, 2024, survey was completed at your facility by the Minnesota Department of Health 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 16, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 19, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 19, 2024, (42 CFR 488.417 (b)). They will also notify the

State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 19, 2024, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 16, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

Midtown Square

3333 Division Street, Suite 212

Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 16, 2024 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00611	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2024
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330		
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/14/24, through 5/16/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

05/29/24

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H50123645C (MN00103145). H50123646C (MN00103147) with a licensing order issued at 830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota	2 000			

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2 000	Continued From page 2 Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care planned supervision to prevent falls for 1 of 3 residents (R1) reviewed for accidents. Findings include: R1's admission Minimum Data Set (MDS) dated	2 830	Corrected.		6/7/24

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2 830	Continued From page 3 4/27/24, identified intact cognition and no behaviors. R1 required substantial to maximal assistance for toileting hygiene and was dependent on staff to safely stand from a sitting position, and all transfers. R1 was frequently incontinent of bowel and bladder. R1's medical diagnoses included hypertension (HTN), atrial fibrillation (AFIB) (abnormal rapid heart rhythm), fracture with multiple trauma, renal failure, obstructive uropathy (flow of urine is blocked), arthritis, depression, past history of falls, and recent surgery for fracture repair. R1 received diuretics (increases urine output), anticoagulant (thins the blood), and insulin. R1's Care Area Assessment (CAA) dated 4/27/24, identified R1 had hearing and vision impairment, confusion, disorientation, forgetfulness, complications of immobility such as contractures and incontinence. R1 had functional limitation in range of motion, increased risk for falls, shortness of breath upon exertion, and history of pain. R1's Saint Louis University Mental Status (SLUMS) (detects mild cognition impairment and dementia) dated 4/23/24, identified a score of 19/30 and indicated dementia. R1's Fall Risk Assessment dated 4/21/24, identified a fall with fracture occurred within six months prior to admission, weakness, gait impairment, and impairment of one side of lower extremity. R1's Fall Risk Assessment dated 5/14/24, identified lack of safety and awareness due to new environment, impairment of both lower sides of extremities, wore a walking boot, weakness, and gait impairment. R1 had pre-admission fall	2 830			

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2 830	Continued From page 4 which resulted in left foot fracture and recent fall at the facility which resulted in right hip fracture. R1 required manual stand assist (MSA) with assist of one per therapy. Staff were not to leave R1 alone unattended in bathroom. R1's care plan last updated 4/24/24, identified R1 had mobility and activities of daily living deficits due to previous left lower leg fracture, did not walk, required assist of one to stand, and transferred with walking boot on. Staff were directed to anticipate needs. R1 had a history of repeated falls. Staff were instructed to not leave R1 alone in the bathroom, fall risk. Review of R1's care plan dated 4/24/24, lacked evidence R1 preferred female care givers or was modest in the bathroom. R1's Kardex undated, identified transfer with assist of one, manual stand with walking boot. "Need To Know" section included: "DO NOT LEAVE ALONE in Bathroom, Fall Risk!!! Resident does not walk." R1's progress note dated 5/6/2024, at 11:55 p.m. identified at 10:00 p.m. nursing assistant (NA) reported to nurse R1 had fallen on right side while she was being assisted in bathroom. R1 reported she stood up off toilet by herself and then suddenly she was on her right side. R1 sustained a two-inch laceration to left forearm actively bleeding, two skin tears two centimeters (cm) circular shape on right knee, and two circular shape skin tears above right knee. R1 rated right hip/leg pain at 8/10 and was unable to move right leg. No bruising or bleeding noted. On call triage provider notified with new orders to be sent to emergency department. R1 was hesitant to go, refused at first, but then decided was best to be	2 830			

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2 830	Continued From page 5 seen right away. Emergency medical system (EMS) transferred R1 at approximately 11:00 p.m. to local hospital. R1's x-ray of pelvis dated 5/7/24, identified intertrochanteric (hip) fracture. R1's hospital discharge dated 5/11/24, identified principal diagnosis closed intertrochanteric (IT) fracture of the right femur with routine healing. R1 had a recent ankle fracture on 4/2/24. Per report, R1 had a witnessed fall at her nursing home facility while transferring to the toilet. R1 was on Coumadin, imaging revealed a right IT fracture, right psoas (deep within the body near the pelvis and spine) muscle and iliacus (triangle shaped muscle located in pelvic bone) muscle hematoma (an abnormal pooling of blood under the skin that resulted from broken or ruptured blood vessels). T6 and T7 and sacral fractures. R1 demonstrated profound anemia, hgb 5.2. at admission due to trauma and received three units of blood (packed red blood cells) transfusions. R1 had a right hip intramedullary (IM) (a rod placed into the hollow center of the femur/bone) surgical procedure on 5/8/24. R1's facility incident/fall risk management report dated 5/6/24, identified R1 had been assisted to the bathroom and then fell in bathroom onto her right side. R1 sustained a right trochanter fracture, laceration of left forearm and right forearm, and skin tear of right knee. R1's hemoglobin (measures amount of oxygen carried in the red blood cells to the body's organs) 5.2 grams per deciliter (gm/dl) (normal range for woman 11.6 to 15 gm/dl) was extremely low. Contributing factor identified as NA having left R1 unattended in the bathroom, impulsivity, and history of repeated falls.	2 830			

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2 830	Continued From page 6 Review of State Agency report dated 5/7/24, indicated on 5/6/24, at approximately 11:00 p.m. NA-A reported to licensed practical nurse (LPN)-A that R1, while being assisted in bathroom, stood up off the toilet by herself and then suddenly was on her right side. R1 had right hip/leg pain of 8/10 and unable to move leg. R1 was transferred to local hospital via EMS. Per R1's care plan and Kardex was not to be left unattended in the bathroom. Upon initial incident interview, LPN-A's perspective was R1 was not left unattended in the bathroom. On 5/7/24, at 5:00 p.m. NA-A was interviewed again by director of nursing (DON) and indicated R1 asked him to step out of the bathroom because she felt embarrassed. NA-A stepped outside the door, did not see what happened, and heard R1 fall, and quickly entered the bathroom. NA-A presumed she stood up by the sink to brush her teeth and then fell. NA-A failed to follow R1's care plan and was suspended from work until investigation was completed. NA-A stated he understood R1 was care planned to have staff stay in the bathroom with R1 as a fall intervention and it was listed on the Kardex. Review of facility investigation five-day report dated 5/13/24, identified R1's care plan was correct, up to date, and indicated staff were instructed to not leave R1 unattended in bathroom alone. NA-A admitted he left the bathroom, felt R1 was embarrassed, did not supervise through the open door. Later when NA-A was interviewed, he corrected his story indicating he brought R1 to bathroom, was asked to step out by the resident, he exited bathroom, closed door, stood outside of door and heard R1 fall onto the floor. NA-A confirmed during interview he was aware R1 was not to be left	2 830			

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2 830	Continued From page 7 alone in bathroom. Report identified facility wide nursing education would be given. Review of a handwritten document provided by nurse manager (RN)-A on 5/15/24, identified nine staff had documented they worked directly with R1 under the cares section in PCC from 5/11/24, through 5/14/24. -5/11/24 NA-F -5/12/24 NA-G, NA-H, NA-I -5/13/24 NA-J, NA-K, NA-L -5/14/24 NA-E and NA-M Review of facility "On the Spot Education" on 5/15/24, revealed seven out of nine staff provided direct care for R1 and had not received the required re-education related to supervision after R1 had fallen in bathroom and fractured her right hip on 5/6/24, and prior to her return to facility on 5/11/24. During an interview on 5/14/24, at 9:00 a.m., R1 stated she fell at home, had surgery to repair left lower leg and shattered parts of left foot, adding, a walking boot was worn to protect the foot. R1 stated she had a fall at the facility in the bathroom not too long ago. R1 indicated she required assistance in the bathroom and was aware she was not to be left in there alone. R1 also stated she had fallen many times in bathroom prior to admission to nursing home and felt comfortable having a male in there with her. R1 indicated she did not ask NA-A to leave the bathroom the night that she fell, and she was unsure if the door was closed or open. R1 stated she informed NA-A she planned on using the toilet since she was already in the bathroom. R1 verified she stood up from toilet, in front of her wheelchair, pivoted to sit down, and then fell to the floor. R1 shared that the feeling was awful to be in the bathroom alone	2 830			

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2 830	Continued From page 8 after the fall but once NA-A found her, he hollered for help. R1 indicated when her right leg was moved, she yelled out a lot and they took her to the hospital. During an observation on 5/14/24, at 11:05 a.m. R1 sat in wheelchair in her room. NA-D and NA-E entered R1's room and assisted her to the bathroom using the mechanical stand lift machine. NA-D and NA-E were observed to lower R1 onto the toilet and then proceeded to exit the bathroom and closed the door. NA-D and NA-E stood in the bedroom and conversed with R1's daughter for approximately seven minutes. After approximately four minutes NA-E asked R1 while door was still closed if she needed help. R1 responded no. Seven minutes had passed and then NA-E and NA-D opened the door and R1 remained sitting on toilet. Once R1 was finished using the bathroom, NA-D and NA-E assisted R1 back to her bedroom using the mechanical stand lift. During observation facility staff failed to follow care planned intervention to stay in the bathroom with R1 for safety. During interview on 5/14/24, at 2:00 p.m. NA-E stated R1's short term memory was not the best. NA-E stated R1 needed assistance of at least one in bathroom to get on and off toilet. NA-E stated prior to working with residents today she had reviewed Kardex but was unaware R1 was not to be left alone in the bathroom. NA-E stated she did not stay with R1 in the bathroom earlier today when she was in the bathroom, closed the door, and waited in the bedroom. NA-E stated had seen R1 become impulsive, get up on her own when with her. NA-E indicated would have been important to remain in the bathroom for safety to avoid falls. NA-E stated had not received education since her fall or prior to assisting her to	2 830			

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2 830	Continued From page 9 the bathroom today. Follow up interview on 5/14/24, at 2:40 p.m. NA-E stated later today she was approached by management and read a training document, and signed to acknowledge she received the education regarding R1 who should not be left alone in bathroom. During an interview on 5/14/24, at 2:43 p.m. NA-D stated R1 required assist of one to two and a manual stand lift to transfer, depending on her strength that day. NA-D verified she had looked at R1's Kardex and transfer sheet prior to the start of the shift. NA-D stated R1 could be in the bathroom alone, with door closed but was not sure and wished the Kardex was posted in the room so that staff would know for sure. NA-D indicated she felt uncomfortable when they left R1 in the bathroom alone earlier, was not aware at that time she was not to be left alone and probably should have opened the bathroom door but chose not to and relied on the other NA. NA-D verified she had received and signed a document of "On the Spot Training" today, but was not sure if it was before or after R1 was transferred to and from the bathroom. During an interview on 5/14/24, at 3:39 p.m. nurse manager (RN)-A stated nursing staff were expected to help and answer resident call lights in other rooms besides those assigned to them. RN-A stated prior to each shift worked, staff were expected to read and review the resident Kardex to verify their care and how they transferred, because changes occurred frequently on the transitional care unit (TCU). RN-A stated the Kardex was considered the road map on how to care for residents and was important to know to ensure accommodation of needs and safety.	2 830			

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2 830	Continued From page 10 During a follow up interview on 5/15/24, at 12:06 p.m. RN-A stated R1 was impulsive and a high risk for falls. RN-A verified R1 never indicated she was uncomfortable with male caregivers and, if that were the case, NA-A could have called another staff on the walkie to assist R1. RN-A indicated NA-A left R1 alone in the bathroom, she fell, and sustained a fractured right hip. RN-A verified all staff were expected to work together to verify the education was received, no date was determined to assure all staff were educated on this incident, expectation would have been prior to their next shift worked. RN-A stated it had been more than a week, a questionnaire regarding this incident was placed on a clip board at the nurse's station and staff filled them, placed them face down, and were collected periodically. RN-A verified NA-D and NA-E were educated early this morning, unsure as to what time. During an interview on 5/15/24, at 8:30 a.m. family member (FM) stated R1 was ok with having all (including male) staff in the bathroom with her because she was afraid of falling. FM also stated R1 had fallen many times and required assistance while in the bathroom. FM indicated R1 most likely would not ask staff to step out of bathroom. FM verified "without a doubt" R1 was very determined to go home and knew she would try to get up by herself once she could bear weight. During an interview on 5/15/24, at 8:45 a.m. physical therapist (PT) stated R1 had some cognitive deficits especially with memory. PT stated R1 was reassessed on 5/13/24, after she returned from hospital and was manual assist of one but required max assistance of two, unable to pivot. PT recommended the manual stand with	2 830			

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2 830	Continued From page 11 one be used to assist R1. PT stated staff were expected to stay in the bathroom with R1 since she had fallen once. PT indicated R1 was not cognitively intact had already demonstrated that self-transferring leads to a fall, and now required one to two staff and the manual stand lift, to stand up. During an interview on 5/15/24, at 9:17 a.m. occupational therapist (OT) stated R1 was forgetful, distractible, impaired cognition with poor decision making and does not always stop to think about what the consequences are, and therefore was a high risk for falls. OT stated R1 required assistance with peri cares and dressing. OT stated R1 required assistance of two but always a possibility to get up by herself out of the chair especially if she had to go to the bathroom. OT stated since R1 had fallen in bathroom the expectation for staff would be stay with her in the bathroom to help minimize fall risk. OT verified R1 required transfers with the manual stand lift and assistance of one, difficult to stand up by self without assistance, but would be possible. During an interview on 5/15/24, at 10:36 a.m. director of nursing (DON) stated R1 was a high risk for falls, had at least three falls at home, admitted to nursing home with a lower leg/ankle fracture and walking boot. DON stated R1 used a wheelchair and wanted to be more independent. DON verified staff were expected to review each resident's transfers on transfer sheet, care plan, and Kardex prior to assisting them. DON also verified R1 had decreased mobility and had an intervention to not leave alone in bathroom. DON stated NA-A admitted he was aware of this intervention, R1 felt embarrassed to have him in the bathroom with her. DON stated had been identified R1 has had many falls, a fall risk, and	2 830			

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2 830	Continued From page 12 the bathroom had hard surfaces, tile, toilet, and sink that are all very hard to fall onto and should have not been left alone in the bathroom. DON stated daily reminders were given to staff to ensure care plan interventions were being implemented and staff were expected to follow the plan of care for each resident. DON stated the floor nursing managers were responsible for education and the education for this incident needed more attention. DON indicated house wide education should have been done and was not completed in entirety and was resumed yesterday 5/14/24. DON stated all nursing staff should have received the education prior to the next day worked. During a telephone interview on 5/16/24, at 11:20 a.m. NA-A stated on 5/6/24, he answered R1's call light, she requested assistance to get ready for bed. NA-A verified he handed her a gown (night clothes) while she was in the bathroom, and asked him to step out while she changed clothes. NA-A exited the bathroom, left the door ajar (cracked open), and waited in the bedroom. NA-A indicated R1 did not want him to see her body, he encouraged independence, and once she was ready planned on assisting to bed. NA-A also stated R1 was not on the toilet rather positioned in the wheelchair in front of the bathroom sink for approximately three minutes and then shouted out for help. NA-A stated it happened all so quickly, R1 sat on the floor next to the wheelchair faced the sink and held onto the wheelchair arm with her one hand. NA-A indicated R1 had bruises on her knee and hand and notified the staff nurse right away. NA-A stated he had taken R1 to the bathroom many times such as three to four times a shift prior to this incident, cracked the door so he could hear her, and left her alone in the bathroom to provide	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00611	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2024
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330		
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2 830	Continued From page 13 privacy. NA-A verified was aware of R1's care plan and intervention do not leave alone in bathroom. NA-A stated R1 had tried to self-transfer in the past but privacy was important. NA-A indicated if he had been in the bathroom with her, tried to stand up he could have intervened, offered to help, and possibly prevented a fall. Facility policy titled Fall Management Protocol dated April 2024, identified all residents who were assessed as being at high risk for falls will be identified and individualized fall precautions will be developed for that resident. Preventive measures shall have been taken to decrease the number of falls whenever possible. Potential and actual risks for falls will be placed on the resident care plan along with identified individualized interventions. Facility policy titled Care Plans - Comprehensive/Baseline/Discharge dated 9/2023, identified care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Facility policy titled Care Plan/Kardex Development/Use, dated 5/16/24, identified a plan of care will be developed and individualized based on comprehensive and subsequent assessments performed for each resident aimed at directing resident care/needs by all members of the interdisciplinary team. The Kardex is developed directly as a subset of the resident plan of care including specific information for the NA providing direct care to the resident. The Kardex will be reviewed daily by nursing staff prior to providing care for the resident. SUGGESTED METHOD FOR CORRECTION:	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00611	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2024
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EVANS AVENUE ELK RIVER, MN 55330		
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2 830	Continued From page 14 The director of nursing or designee could direct staff to comprehensively assess and implement interventions to ensure residents are provided care in a manner to promote their highest well-being. A monitoring program could be established in order to assure ongoing assessment and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830			