Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 22, 2024

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

RE: CCN: 245239
Cycle Start Date: February 9, 2024

Dear Administrator:

On March 21, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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Electronically delivered

March 22, 2024

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

Re: Reinspection Results
Event ID: HZHZ12

Dear Administrator:

On March 21, 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 February 9, 2024. At this time these correction orders were found corrected.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 15, 2024

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

RE: CCN: 245239
Cycle Start Date: February 9, 2024

Dear Administrator:

On February 9, 2024, a 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.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 9, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 9, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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 02/09/2024

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 On 2/7/24 through 2/9/24, 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: H52399565C (MN00096700) with a deficiency issued at F688. H52399490C (MN00100463) H52399567C (MN00099958) H52396247C (MN00097177) H52399566C (MN00096701) 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 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		3/13/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 02/23/2024

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 688	Continued From page 1 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure an ordered range of motion (ROM) program was provided consistently for 4 of 4 resident (R3, R5, R6, and R7) reviewed for positioning and mobility. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/27/23 indicated R3 had dementia with severe cognitive impairment, and required extensive assistance for bed mobility and transfers. R3's care plan revised 1/30/24 indicated R3 had a need for restorative intervention of an ambulation program of 200 feet with each walk. R3's Restorative Nursing Program form dated 6/1/22 indicated R3 would walk 200 feet daily with walker, gait belt, and stand by assist from staff. R3's Restorative Ambulation Record from 12/7/23 to 2/7/24, indicated ambulation was proved to R3 ten times, on 12/11/23, 12/12/23, 12/30/23, 1/3/24, 1/4/24, 1/5/24, 1/8/24, 1/13/24, 1/19/24, and 1/28/24.	F 688	Guardian Angels will ensure that residents that enter the facility will receive range of motion/ ambulation services to maintain function. DON and/or designee will implement corrective action for resident affected by this practice: R3, R5, R6, R7 will be reviewed again for ROM/ambulation restorative programming. Care plan will be updated with any changes. Nursing staff will be educated with any changes. All residents on ROM/ambulation programs have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The Restorative Nursing Program policy was reviewed, with no updates needed. All residents currently on a restorative program(s) will be reviewed to ensure the restorative program(s) remain appropriate. Care plan will be updated	

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F 688	Continued From page 2 R5's significant change MDS dated 1/8/24 indicated R5 was cognitively intact, needed partial/moderate assistance with walking, needed extensive assistance with bed mobility, and limited assistance with transfers. R5's Diagnosis List undated, indicated R5 had muscle weakness, abnormalities of gait and mobility, and history of a transient cerebral ischemic attack (stroke). R5's care plan revised 1/9/24, indicated R5 had a need for restorative intervention of an ambulation program of 150 feet with walker, gait belt, and assist of one staff. R5's Restorative Nursing Program form dated 9/6/23, indicated R5 would walk 50-200 feet with walker and physical assist of staff at least once daily. R5's Restorative Ambulation Record from 12/7/23 to 2/7/24, indicated ambulation was provide to R5 twice, on 1/8/24 and 1/14/24. R6's significant change MDS dated 12/19/23, indicated R6 had schizophrenia with mild cognitive impairment and muscle weakness, and needed supervision/touching assistance with walking. R6's care plan revised 2/9/24, indicated R6 had a need for restorative intervention of an ambulation program of 150 feet with walker and assist of one staff. R6's Restorative Nursing Program form undated indicated R6 would walk 150 feet with walker and stand by assist of staff once daily.	F 688	with any changes. Nursing staff will be educated with any changes. Nursing staff will be re-educated by DON and/or designee regarding ROM/ambulation restorative program completion. All nursing staff will be educated on the Restorative Nursing Program policy. Random audits on completion of restorative care will be completed by DON and/or designee starting 3-4-24, three times a week for three weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 3/13/24	

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F 688	Continued From page 3 R6's Restorative Ambulation Records from 12/7/23 to 2/7/24, indicated ambulation was provided to R6 eight times, on 1/4/24, 1/6/24, 1/7/24, 1/8/24, 1/11/24, 1/13/24, 1/14/24, and 1/20/24. R7's significant change MDS dated 11/28/23, indicated R7 had lymphedema (swelling in the legs), osteoarthritis, was cognitively intact, and needed partial/moderate assistance with walking. R7's care plan revised 2/8/24, indicated R7 had a need for restorative intervention of an ambulation program of walking with walker and assist of one staff daily. R7's Restorative Nursing Program form dated 12/13/23, indicated R7 would walk up to 40 feet with walker and contact guard assist of staff once daily. R7's Restorative Ambulation Record from 12/13/23 to 2/7/24, indicated ambulation was provided to R6 nine times, on 12/11/23, 12/13/23, 12/22/23, 12/28/23, 12/31/23, 1/1/24, 1/8/24, 1/11/24, and 1/13/24. On 2/7/24 at 11:31 p.m., nursing assistant (NA)-A stated she was unable to walk residents on restorative programs because she had 14 residents and was unable to get ambulation completed. On 2/7/24 at 12:20 p.m., NA-B stated restorative programs were not getting done because of all the other care tasks that needed to be completed for 24 residents and only 2 aides to assist. NA-B stated the facility does not have enough staff to	F 688		

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F 688	Continued From page 4	F 688		

complete walking programs.

On 2/8/24 at 8:58 a.m., NA-C stated, "If we don't have enough staff here, we are unable to get restorative done and that would be the case a lot of the time."

On 2/9/24 at 8:04 a.m., occupational therapist (OT)-A stated, "We would put residents on restorative programs to maintain function. If the program is not being completed this could cause a decline in function." OT-A stated R3, R5, R6, and R7 were currently on a restorative walking program.

On 2/9/24 at 8:25 a.m., family member (FM)-A stated R3 was on a walking program and should be walked daily. FM-A was not sure if it was being completed by the facility.

On 2/9/24 at 8:37 a.m., R5 stated she was unable to walk herself because she had fallen in the past. R5 stated she would ask staff to walk her, and they would tell her they don't have time or make excuses as to why they were unable to assist her to walk. R5 stated she had not walked in the last three days, and thought she was walked one to three times a week.

On 2/9/24 at 8:48 a.m., NA-D stated some days restorative nursing gets done, but the case load was so high they often don't get to it. NA-D stated R5 was unable to get her walk yesterday because her workload was too high.

On 2/9/24 at 8:53 a.m., licensed practical nurse (LPN)-A stated it restorative programs being completed were dependent on the staff workload.

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F 688	Continued From page 5 On 2/9/24 at 8:56 a.m., registered nurse (RN)-A stated in the last few weeks restorative programs had not been getting done. RN-A stated staff on the floor state the reason was they do not have enough staff to complete the restorative programs. On 2/9/24 at 10:24 a.m., R7 stated she wouldn't be able to walk herself as she would be to very unsteady. R7 stated the walking program was not getting done, and it has been an issue for along time. On 2/9/24 at 10:46 a.m., NA-E stated when it was busy, the NAs don't have the help needed, so restorative nursing does not get done. On 2/9/24 at 11:01 a.m., the director of nursing (DON) stated it was expected restorative programs were completed per the care plan daily by the staff. The DON stated, "I am not able to give a reason as to why it is not getting done, but there is now a plan in place moving forward to ensure restorative programs are completed." The facility Restorative policy dated 4/6/20 directed the facility will have a restorative nursing program that promotes a residents' ability to achieve and/or maintain their optimal function, in accordance with the resident's comprehensive assessment and person-centered plan of care.	F 688		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 15, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: HZHZ11

Dear Administrator:

The above facility was surveyed on February 7, 2024 through February 9, 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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.

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

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

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Please 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00858	A. BUILDING: ______ B. WING ______	C 02/09/2024

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2 000	Initial Comments	2 000		

*****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 2/7/24 through 2/9/24, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders

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2 000	Continued From page 1	2 000		

and identify the date when they will be completed.

The following complaints were reviewed:
H52399565C (MN00096700) with a licensing order issued at 4658.0525 Subp 2.A.
H52399490C (MN00100463)
H52399567C (MN00099958)
H52396247C (MN00097177)
H52399566C (MN00096701)

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

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	00858	A. BUILDING: ______ B. WING ______	C 02/09/2024

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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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota 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		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure an ordered range of motion (ROM) program was provided consistently for 4 of 4 resident (R3, R5, R6, and R7) reviewed for positioning and mobility.	2 890	corrected	3/13/24

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2 890	Continued From page 3	2 890		

Findings include:

R3's quarterly Minimum Data Set (MDS) dated 12/27/23 indicated R3 had dementia with severe cognitive impairment, and required extensive assistance for bed mobility and transfers.

R3's care plan revised 1/30/24 indicated R3 had a need for restorative intervention of an ambulation program of 200 feet with each walk.

R3's Restorative Nursing Program form dated 6/1/22 indicated R3 would walk 200 feet daily with walker, gait belt, and stand by assist from staff.

R3's Restorative Ambulation Record from 12/7/23 to 2/7/24, indicated ambulation was proved to R3 ten times, on 12/11/23, 12/12/23, 12/30/23, 1/3/24, 1/4/24, 1/5/24, 1/8/24, 1/13/24, 1/19/24, and 1/28/24.

R5's significant change MDS dated 1/8/24 indicated R5 was cognitively intact, needed partial/moderate assistance with walking, needed extensive assistance with bed mobility, and limited assistance with transfers.

R5's Diagnosis List undated, indicated R5 had muscle weakness, abnormalities of gait and mobility, and history of a transient cerebral ischemic attack (stroke).

R5's care plan revised 1/9/24, indicated R5 had a need for restorative intervention of an ambulation program of 150 feet with walker, gait belt, and assist of one staff.

R5's Restorative Nursing Program form dated 9/6/23, indicated R5 would walk 50-200 feet with

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2 890	Continued From page 4 walker and physical assist of staff at least once daily. R5's Restorative Ambulation Record from 12/7/23 to 2/7/24, indicated ambulation was provide to R5 twice, on 1/8/24 and 1/14/24. R6's significant change MDS dated 12/19/23, indicated R6 had schizophrenia with mild cognitive impairment and muscle weakness, and needed supervision/touching assistance with walking. R6's care plan revised 2/9/24, indicated R6 had a need for restorative intervention of an ambulation program of 150 feet with walker and assist of one staff. R6's Restorative Nursing Program form undated indicated R6 would walk 150 feet with walker and stand by assist of staff once daily. R6's Restorative Ambulation Records from 12/7/23 to 2/7/24, indicated ambulation was provided to R6 eight times, on 1/4/24, 1/6/24, 1/7/24, 1/8/24, 1/11/24, 1/13/24, 1/14/24, and 1/20/24. R7's significant change MDS dated 11/28/23, indicated R7 had lymphedema (swelling in the legs), osteoarthritis, was cognitively intact, and needed partial/moderate assistance with walking. R7's care plan revised 2/8/24, indicated R7 had a need for restorative intervention of an ambulation program of walking with walker and assist of one staff daily. R7's Restorative Nursing Program form dated 12/13/23, indicated R7 would walk up to 40 feet	2 890		

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2 890	Continued From page 5	2 890		

with walker and contact guard assist of staff once daily.

R7's Restorative Ambulation Record from 12/13/23 to 2/7/24, indicated ambulation was provided to R6 nine times, on 12/11/23, 12/13/23, 12/22/23, 12/28/23, 12/31/23, 1/1/24, 1/8/24, 1/11/24, and 1/13/24.

On 2/7/24 at 11:31 p.m., nursing assistant (NA)-A stated she was unable to walk residents on restorative programs because she had 14 residents and was unable to get ambulation completed.

On 2/7/24 at 12:20 p.m., NA-B stated restorative programs were not getting done because of all the other care tasks that needed to be completed for 24 residents and only 2 aides to assist. NA-B stated the facility does not have enough staff to complete walking programs.

On 2/8/24 at 8:58 a.m., NA-C stated, "If we don't have enough staff here, we are unable to get restorative done and that would be the case a lot of the time."

On 2/9/24 at 8:04 a.m., occupational therapist (OT)-A stated, "We would put residents on restorative programs to maintain function. If the program is not being completed this could cause a decline in function." OT-A stated R3, R5, R6, and R7 were currently on a restorative walking program.

On 2/9/24 at 8:25 a.m., family member (FM)-A stated R3 was on a walking program and should be walked daily. FM-A was not sure if it was being completed by the facility.

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2 890	Continued From page 6 On 2/9/24 at 8:37 a.m., R5 stated she was unable to walk herself because she had fallen in the past. R5 stated she would ask staff to walk her, and they would tell her they don't have time or make excuses as to why they were unable to assist her to walk. R5 stated she had not walked in the last three days, and thought she was walked one to three times a week. On 2/9/24 at 8:48 a.m., NA-D stated some days restorative nursing gets done, but the case load was so high they often don't get to it. NA-D stated R5 was unable to get her walk yesterday because her workload was too high. On 2/9/24 at 8:53 a.m., licensed practical nurse (LPN)-A stated it restorative programs being completed were dependent on the staff workload. On 2/9/24 at 8:56 a.m., registered nurse (RN)-A stated in the last few weeks restorative programs had not been getting done. RN-A stated staff on the floor state the reason was they do not have enough staff to complete the restorative programs. On 2/9/24 at 10:24 a.m., R7 stated she wouldn't be able to walk herself as she would be to very unsteady. R7 stated the walking program was not getting done, and it has been an issue for along time. On 2/9/24 at 10:46 a.m., NA-E stated when it was busy, the NAs don't have the help needed, so restorative nursing does not get done. On 2/9/24 at 11:01 a.m., the director of nursing (DON) stated it was expected restorative programs were completed per the care plan daily by the staff. The DON stated, "I am not able to	2 890		

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give a reason as to why it is not getting done, but there is now a plan in place moving forward to ensure restorative programs are completed."

The facility Restorative policy dated 4/6/20 directed the facility will have a restorative nursing program that promotes a residents' ability to achieve and/or maintain their optimal function, in accordance with the resident's comprehensive assessment and person-centered plan of care.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could review applicable policies on ensuring restorative programs are attempted and completed timely; then educate direct care staff and audit to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days