DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 26, 2022

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

RE: CCN: 245239
Cycle Start Date: June 30, 2022

Dear Administrator:

On September 8, 2022, the Minnesota Departments of Health and Public Safety, 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
July 18, 2022

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

RE: CCN: 245239
Cycle Start Date: June 30, 2022

Dear Administrator:

On June 30, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that 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:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 September 30, 2022 (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 December 30, 2022 (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.

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 06/30/2022

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
E 000	Initial Comments On 6/27/22, to 6/30/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 6/27/22, to 6/30/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED H52392907C (MN00084505) and H52392677C (MN00083351), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be SUBSTANTIATED: H52392908C (MN00084547), with a deficiency cited at (F600). The following complaints were found to be UNSUBSTANTIATED: H5239091C(MN00079890) and H52392678C (MN00083786). The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 07/27/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING _____ B. WING _____	C 06/30/2022

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	Continued From page 1 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 substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess safety with self-administration of medication for 1 of 1 residents (R50) observed to have medications left in their room unsupervised by staff after staff set-up. R50's annual Minimum Data Set (MDS) dated 6/6/22, indicated R50 was cognitively intact and required assistance with activities of daily living (ADL's). On 6/27/22, at 6:41 p.m. R50 was observed lying in bed in her room with no staff present, and there were two gummy chews and six pills in a medication cup on R50's bedside table. On 6/28/22, at 9:25 a.m. R50 was observed lying in her bed with no staff present, and there was an	F 554	F554 Resident Self- Admin Meds-Clinically Appropriate. DON and/or designee will implement corrective action for resident affected by this practice (R50): R50 will be reviewed again for self-administration of medications LPN-A was re-educated by DON on regarding self-administration of medications policy. All residents 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 Self-Administration of Medication by Residents policy was reviewed, with no updates needed. All licensed nursing staff and TMA□s will	8/24/22

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 06/30/2022

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 554	Continued From page 2 empty tube of triamcinolone cream on a table in R50's room. R50 stated staff had put the cream on her buttocks earlier in the morning. On 6/29/22, at 7:18 a.m. R50 was observed lying in bed with no staff present, and there was one medium sized white pill in a medication cup on R50's bedside table and an empty tube of triamcinolone cream on a table in the same spot as the previous day. R50's medical record lacked a current self-administration of medication assessment. On 6/29/22, at 7:33 a.m. licensed practical nurse (LPN)-A entered R50's room. R50 stated the night nurse left a pill at 6 a.m and she had just taken it. R50 stated the nurses sometimes left pills for her to take on her own unsupervised. R50 stated the tube of cream was taken by the aides earlier in the morning. LPN-A stated staff are allowed to leave medications with a resident only if they have a self-administration of medications order and R50 did not have an order. During interview on 6/30/22, at 8:47 a.m. registered nurse (RN)-A stated a self-administration of medication order means staff could leave medications for the resident to take on their own and staff would check back 30 minutes later to be sure the resident took the medications. If a resident did not have an assessment and an order then staff would watch the resident swallow the medication. RN-A stated R50's last assessment was on 7/27/20, which identified the resident was unable to take medications unsupervised. R50 should have been assessed annually since then and did not have a current self-administration of medications	F 554	be educated on the Self-Administration of Medication Policy. Random audits on appropriate administering of medications per residents self-administration assessment will be completed by DON and/or designee starting 8/17/22, 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: 8/24/22	

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 06/30/2022

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 554	Continued From page 3 assessment. RN-A further stated she did not feel comfortable with staff leaving medications for R50 to take unsupervised, and staff were expected to stay with R50 and observe the resident taking medications. The risks of leaving medications with a resident not assessed to take them on their own included the resident could drop the medications and not take the needed dose, or another resident could take the medication. During interview on 6/30/22, at 4:19 p.m. the director of nursing (DON) stated self-administration of medications was defined as staff would set-up medications for a resident, the resident would take the medications without supervision, and staff would check back to be sure the resident took the medications. Nursing would assess the resident to determine if they were able to take their medications unsupervised, the medical provider would need to agree and write an order and then it would be added to the residents care plan. The DON stated R50 was not reliable to take her own medications and it was her expectation staff would supervise R50while taking her medications. The facility's Self-Administration of Medications by Residents policy, reviewed 1/8/18, indicated any resident that wished to self-administer medication would be assessed for their ability to safely do so. If the resident was clinically appropriate interventions would be put into place.	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse	F 578		8/24/22

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 06/30/2022

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 578	Continued From page 4 to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 578		

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 06/30/2022

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 578	Continued From page 5 Based on interview and document review, the facility failed to ensure the advance directive for emergency care and treatment was accurately reflected in all areas of the medical record for 1 of 1 residents (R53) reviewed for advance directives. Findings included: R53's quarterly Minimum Data Set (MDS) dated 6/9/22, identified moderate cognitive impairment. Diagnoses included stroke and hemiplegia/hemiparesis (paralysis or weakness of one side of body). R53's Provider Orders for Life-Sustaining Treatment (POLST) dated 5/17/21, indicated in the event she had no pulse and was not breathing the facility would start chest compressions only. R53's care plan dated 1/28/22, indicated her advanced directive preferences of chest compression only be honored. R53's Face Sheet printed on 6/30/22, indicated R53 was as a full code. Full code would include use of intubation (sticking a tube in your throat), use of an advanced airway, mechanical ventilations, chest compressions, defibrilation (shocking of the heart), and transfer to the hospital and/or intensive care unit. This was more than the resident preference on the POLST of "chest compressions only". R53's electronic medical record (EMR) header dated 6/30/22 identified R53 as a full code. During an interview on 6/30/22, at 8:51 a.m. licensed practical nurse (LPN)-B stated if R53	F 578	F578 Advanced Directives DON and/or designee will implement corrective action for resident affected by this practice (R53) R53 POLST will be reviewed again and updated to clearly reflect the resident□s code status All residents have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: DON reviewed the Cardiopulmonary Resuscitation and Advance Care Planning policies, with no updates needed. All facility resident POLST will be reviewed to ensure clear instructions between the POLST and within Yardi EHR and updated as needed by the nurse unit managers and DON. Education will be provided by the DON and/or designee to nurse unit managers on proper documentation of resident POLST and to clearly reflect the resident□s code status within Yardi EHR. Review of the resident code status was added to Social Services care conference checklist for review quarterly and to compare with Yardi EHR. Nurse Unit Manager will be responsible for making any necessary updates. Random audits monitoring of residents POLST to ensure clarity on the Yardi EHR will be completed by the DON and/or designee starting 8/17/22, three times a week for two weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as	

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 06/30/2022

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 578	Continued From page 6 was found not breathing and no pulse she would check either the header on the EMR or R53's POLST. During an interview on 6/30/22, at 8:56 a.m. registered nurse (RN)-B stated R53's POLST indicated "chest compression only" and the header in the EMR indicated "full code". She stated if R53 had no pulse and was not breathing and the nurse on checked the EMR header instead of the POLST, R53 would be treated as a full code. According to R53's POLST that was not her wishes. During an interview on 6/30/22, at 2:55 p.m. RN-C stated they would check the POLST for a resident's advanced directive wishes. During an interview on 6/30/22, at 2:57 p.m. LPN-E stated she would check the POLST for a resident's advance directive wishes. During an interview on 6/30/22, at 3:14 p.m. RN-A stated if she was needing to find the code status quickly, she would access the R53's chart and look directly at the POLST. During an interview on 6/30/22, at 3:51 p.m. family member (FM)-C, who was also the power of attorney, stated R53 wishes were for chest compression only. FM-C stated, "Mom did not want to be hooked up to any machine, or have any tubes placed". FM-C would be upset if the facility did not follow R53's wishes. During an interview on 6/30/22, at 5:08 p.m. the director of nursing (DON) stated if a staff member was quickly trying to find R53's code stated and checked the face sheet or the EMR header, they	F 578	needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completed Date: 8/24/22	

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 06/30/2022

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 578	Continued From page 7 would have received incorrect information regarding R53's advanced directive and her wishes would not be honored. The facility's Advance Care Planning policy dated 2/19/18, indicated resident's POLST/advanced directive would be accurately documented in the EMR, including the medical orders and plan of care.	F 578		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585		8/24/22

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 06/30/2022

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 585	Continued From page 8 to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by	F 585		

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 06/30/2022

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 585	Continued From page 9 anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a grievance concern regardin missing clothing was acted upon in a timely manner for 1 of 1 residents (R9) reviewed who had voiced complaints of missing clothes to staff. Findings include: R9's Resident Face Sheet printed 6/30/22, indicated R9 had diagnoses of Intervertebral disc degeneration, lumbosacral region and muscle	F 585	F585 Grievances Social Services Director or Designee will direct the corrective action for residents affected by this practice R9 will be re-interviewed for determination of loss items All residents have the potential to be affected by this practice	

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 06/30/2022

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 585	Continued From page 10 weakness. R9's quarterly Minimum Data Set MDS) dated 3/3/22, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R14 had intact cognition. On 6/27/22, at 6:30 p.m. R9 stated approximately four weeks ago a pair of pants was missing when laundry returned her washed clothing to her. R9 stated she reported the missing pants to laundry staff. R9 stated the laundry staff looked around her room but the pants were not found. R9 stated after that she never heard anymore about it and the pants were not found. On 6/30/22, at 12:33 p.m. housekeeping and laundry aide (HLA)-A stated three weeks ago R9 had reported she had a pair of blue jeans that were missing. HLA-A stated she looked all over R9's room and laundry but could not find the missing jeans. HLA-A stated when missing clothing could not be found she would write it in a book in laundry to let people know to look for it. HLA-A stated she would notify other laundry staff and the environmental services director of the missing items. HLA-A stated she did not have to notify anybody else about missing clothing items or fill out any special forms about missing clothing items. HLA-A stated she followed her normal process with R9's missing jeans. On 06/30/22, at 12:40 p.m. social services designee (SSD)-A stated when clothing was reported missing there was a missing item form that was filled out after it was reported to her. SSD-A stated she would talk with the resident and then look in their room to see if the lost items were there. SSD-A stated she would let laundry	F 585	All facility staff will be trained on the missing items reporting process Social Services Director and/or Designee will monitor corrective actions with missing items reports during care conferences beginning 8/17/22 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 08/24/22	

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 06/30/2022

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 585	Continued From page 11 know items are missing, if they were not already aware. SSD-A stated if the clothing was lost for more than three weeks she would talk with family to see if they had more of the same item or talk withinterdisciplinary team (IDT) about reimbursement for the item. SSD-A stated she had a log where she documented all missing item reports. SSD-A reviewed the missing item log and stated R9's missing pants were not on the log and SSD-A did not remember if she received notification of R9's missing pants. On 6/30/2022, at 1:03 p.m. the environmental services director (ESD) stated he did not remember receiving notice about R9's missing pants three weeks ago. The ESD stated all missing clothing item reports should be reported to him and SSD-A. ESD-C stated all staff were educated on the process to report missing clothing items. On 6/30/2022, 3:11 p.m. the administrator stated all missing items should be reported on the missing items report sheets and then reported to social services who ensures the missing item policy was performed correctly. The administrator stated his expectation was staff would report all missing items to the social worker. The facility policy Resident Concerns dated 1/7/19, indicated resident concerns related to personal belongings and missing items would be reported to the social service department. The person who received the concern would complete the top of the Concern Form with date, name of resident vocalizing concern, name taking report and details of concern. The Policy indicated after information was obtained it would be given to the person responsible for follow up.	F 585		

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 06/30/2022

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 585	Continued From page 12 The facility policy Lost Clothing/Missing Items Policy dated 9/12/06, indicated any missing items had to be reported to the social services department by way of a Missing Item Report. The policy indicated the staff member the resident first reported the loss to would report the loss to their supervisor and then immediately fill out the Missing Item Report form.	F 585		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review facility failed to prevent physical abuse and develop and consistently implement interventions to ensure the prevention of further physical abuse for 1 of 5 residents (R14), reviewed for abuse. Findings Include: R14's Resident Face Sheet printed 6/30/22,	F 600	F600 Freedom from Abuse, Neglect, and Exploitation Guardian Angel□s will develop and consistently implement interventions for resident to resident altercations to ensure the prevention of abuse. Social Services Director and/or Designee	8/24/22

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 06/30/2022

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 600	Continued From page 13 indicated R14 had diagnoses of macular degeneration. R14's quarterly Minimum Data Set (MDS) dated 4/27/22, indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R14 was moderately impaired. R14's Service Plan (care plan), last modified on 6/13/22, lacked any changes to care related to R14's being safe from R26 and the potential consequenes. R26's Resident Face Sheet printed 6/30/22, at 4:30 p.m. indicated diagnoses of dementia without behavioral disturbances, and macular degeneration. R26's significant change Minimum Data Set (MDS) dated 6/9/22, indicated a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R26 was moderately impaired. R26's Service Plan (care plan), last motified on 6/29/22, indicated interventions for behaviors included one on one while awake and out of room. R14's progress note dated 6/15/22, at 12:38 p.m. by registered nurse (RN)-C indicated R26 entered R14's room and began going through R14's clothing. R14 told R26 that the clothing belonged to her; and R26 proceeded to "slap" R14 on the arm. R26's progress note dated 6/19/22, at 9:56 p.m. by licensed practical nurse (LPN)-C indicated R26 was entering other resident's rooms and having increased behaviors. The progress note	F 600	will direct the corrective action for residents affected by this practice. Resident # 14 will be re-interviewed All residents have the potential to be affected by this practice. All facility staff will be trained on the implementation of interventions for resident to resident altercations to ensure the prevention of further abuse. Social Services Director and/or Designee will monitor corrective actions is established and implemented after resident to resident altercations. Audits will be completed by the SSD and/or designee starting 8/17/22, three times a week for two weeks, two times a week for two weeks, and weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 08/24/22	

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 06/30/2022

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 600	Continued From page 14 indicated R14 was afraid of R26 and she was staying in her room to avoid R26. R14's progress notes dated 6/23/22, at 12:15 p.m. by RN-C indicated R26 was sitting in front of R14's room. R14 tried to enter her room and R26 proceeded to kick R14 in the shin. The progress note further indicated care plan was followed. R26's progress note dated 6/27/22, at 8:23 p.m. by RN-C indicated R26 had been placed on one on one status unless in her own room and asleep. During a continuous observation on 6/28/22, beginning at 1:59 p.m. R26 was observed entering the nursing unit accompanied by activity staff (AS)-A ; they entered the commons area and AS-A placed wash clothes on the table in front of R26 to fold. R26 began folding the wash clothes and the activity staff walked away from R26 and walked off the unit and did not return. No other staff were in the area when R26 was left unattended. One other resident was sitting at the same rectangle table as R26, on the opposite end. --at 2:23 p.m a staff person walked up to R26 and talked with her for approxamitely five minutes; then staff member walked away from R26 and left the unit. Right after the staff walked away R26 proceeded to wheel around the unit on her own. There were no staff in the commons area while R26 was wheeling herself around the unit. On 6/30/22, at 8:30 a.m. R26 was observed wheeling herself down the hallway from her room without staff around her. R26 was observed stopping in front of R14's room and looking in the room at R14. R26 then rolled down to the nurse manger's office and had a conversation with	F 600		

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 06/30/2022

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 600	Continued From page 15 somebody in office. After approximately five minutes R26 rolled away from the nursing office without staff and left the unit. On 6/27/22, at 3:44 p.m. R14 stated R26 had kicked her in the shin "last week". R14 proceeded to lift her left pants leg and revealed a bruise with swelling to the inner part of the left shin area. R14 stated " that is where she kicked me". R14 stated R26 was in her doorway and R14 was just trying to get in her room. R14 stated a few days before the kick happened R26 "slapped" her on the arm. R14 stated R26 was in R14's room going through the clothes in her closet. When R14 told R26 the clothes belonged to her, R26 began swearing " you son of a b---h, I own everything, I own this building" and slapped R14. On 6/28/22, at 3:49 p.m. R14 stated she was still afraid of R26. R14 stated she thought R26 could do it again but "what am I suppose to do?". R14 stated she went to activities because there were lots of staff around during group activites. R14 stated she just tried to stay away from R26. R14 stated the only thing they have done for her was to place the stop sign on her door and to leave it up all the time. On 6/29/22, at 8:50 a.m. family member (FM)-A stated he had been made aware of the slapping and kick by R26 towards R14 by R14 and by staff. FM-A stated when he had talked with R14 "yesterday afternoon" (6/28/22), R14 had vocalized still having fear of R26 but was trying to not let it get to her. FM-A stated the facility was using the stop sign to protect R14 but was unaware of any other actions implemented to treat R14's mental health or R14's continued fear of R26.	F 600		

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 06/30/2022

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 600	Continued From page 16 On 6/30/2022, at 12:49 p.m. LPN-D stated R26 was on one on one staffing at that time. LPN-D stated the activity department, therapies and chaplin were assisting in the 1 on 1 observation status. LPN-D stated the only way staff know R26 was one on one was to observe and see if staff members were around R26 when nursing staff are not in a different resident room. LPN-D stated other than that staff are not sure when R26 had somebody watching her and when not. On 6/29/22, at 1:05 p.m. RN-C stated R26 was still on one on one care at that time. RN-C stated R14 had also told RN-C that she was still afraid of R26. RN-C stated when R14 told him R14 was still afraid of R26, he had responded to not be afraid because they were keeping an eye on R26. RN-C stated the facility was using the stop sign on R14's door but R14 was alert and oriented so R14 needed to remove herself from the situation if R26 got close again. RN-C stated there were no other interventions in place to address R14's psychosocial concerns related to being afraid of R26. On 6/30/22, at 3:56 p.m. the director of nursing (DON) stated R26 was still on one-on-ones in regards to staff working with R26 for safety. The DON stated the intervention for R14 to feel safe from R26 was the stop sign placed across the front of R14's doorway to her room. The DON stated there were other interventions that could have been done to assist R14 with her psychosocial concerns but they were dealing with R26 directly. The facility's Maltreatment Prohibition policy revised 10/18/21, indicated the purpose was to	F 600		

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 06/30/2022

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 600	Continued From page 17 provide a safe environment for residents served in the care center by preventing, identifying, investigating, protecting and reporting Maltreatment (abuse, neglect and financial exploitation) of vulnerable adults.	F 600		
F 688 SS=D	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 §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 observation, interview, and document review, the facility failed to ensure staff offered the walking program as recommended by physical therapy to maintain mobility for 2 of 3 residents (R207, R28) reviewed for ambulation program. Findings include: R207's Face Sheet printed on 6/30/22, indicated	F 688	F688 Prevent decrease in ROM/Mobility Guardian Angels will ensure that residents that enter the facility will receive range of motion/ ambulation services to maintain mobility. DON and/or designee will implement corrective action for resident affected by this practice R28 and R207 will be reviewed again for	8/24/22

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 06/30/2022

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 688	Continued From page 18 R207 was admitted on 6/15/22, with diagnoses which included multiple fractures of ribs on her left side, osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down), idiopathic peripheral autonomic neuropathy (damage to the peripheral nerves that affect the feet with numbness, tingling, and burning sensation), and spondylosis with radiculopathy of the lumbar region (degeneration of the vertebrae and disks of the lower back). R207's admission Minimum Data Set (MDS) dated 6/20/22, indicated R207 was cognitively intact and required limited assistance with walking in the corridor and extensive assistance with locomotion on the unit. R207's service plan/care plan initiated on 6/15/22, indicated R207 was at risk for a decline in ambulation related to rib fractures and pain. Interventions included ambulation with nursing; assistance of one and a front wheel walker in the a.m. and p.m. (200 feet to tolerance). R207's Therapy Recommendations dated 6/21/22, indicated R207 was on a restorative program for walking with a goal of ambulating independently using a walker. Instructions were for nursing to begin walking with R207 in the hallway on the unit with a front wheel walker 200 feet to tolerance. R207 required contact guard assistance (the assisting person has one or two hands on resident for balance). On 6/27/22, at 6:29 p.m. R207 stated she was supposed to walk with nursing twice a day, she went on to say "they don't get around to it." On 6/29/22, at 12:20 p.m. nursing assistant	F 688	walking/restorative programming NAR□s on unit re-educated by DON and/or designee on regarding restorative ambulation program completion. All residents 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 care policy was reviewed, with no updates needed. All nursing staff will be educated on the restorative Care Policy. Random audits on completion of restorative care will be completed by DON and/or designee starting 8/17/22, 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: 8/24/22	

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 06/30/2022

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 688	Continued From page 19 (NA)-A stated she had not been walking with R207 because she thought therapy was working with her on walking. On 6/29/22, at 12:40 p.m. NA-B stated "I can tell you right now ambulation doesn't get done, it's very hard to get everything done." NA-B went on to state there wasn't enough help and R207 wasn't getting walked by nursing. On 6/29/22, at 12:53 p.m. licensed practical nurse (LPN)-A stated the NAs had not reported to her that walks were not getting done. LPN-A went on to state they could use more staff; usually there were just two staff because someone would get pulled to go somewhere else that was short because of a call in. On 6/29/22, at 1:41 p.m. occupational therapist (OT)-D stated the goal for R207 was for nursing to walk with her twice a day. R207's goal was to return home, and the restorative program provided by nursing was in addition to what the therapy staff were providing. On 6/30/22, at 2:56 p.m. registered nurse (RN)-D stated R207 did not get her walk on the evening shift of 6/29/22, due to not enough help. R28's Face Sheet printed on 6/30/22, indicated R28's diagnoses included cerebral infarction, muscle weakness, vascular dementia, and hemiplegia (paralysis of one side of the body) affecting left non-dominant side. R28's significant change MDS dated 5/11/22, indicated R28 was severely cognitively impaired and required limited assistance to walk in the corridor and significant assistance for locomotion	F 688		

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 06/30/2022

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 688	Continued From page 20 on the unit. R28's service plan/care plan initiated on 3/2/22, indicated R28 was at risk for a decline in ambulation. R28's goal was to maintain his ability to walk at least 200 feet daily. Interventions included walking with an assist of one, with front wheeled walker, and wheel chair to follow behind two times a day. R28's Therapy Recommendations dated 2/8/22, indicated R28 was on a restorative program for walking with goals of walking to and from the bathroom and walking in the hallway with front wheeled walker and wheelchair behind to and from meals. On 6/27/22, at 7:11 p.m. family member (FM)-A stated R28 was supposed to walk twice a day with staff. FM-A stated staff were supposed to walk with him to the dining room for meals, but this wasn't happening because there wasn't enough help. On 6/30/22, at 10:46 a.m. RN-A stated she did not walk R28 to the dining room for breakfast because she had just gotten him out of the shower and was running late. On 6/30/22, at 12:43 p.m. NA-C stated it was sometimes difficult to get all the tasks done because there was not enough help. NA-C stated on 6/29/22, on the evening shift they were not able to get the walks done for R28 or R207. On 6/30/22, at 3:16 p.m. RN-A stated the walks were not occurring when there was lack of staff. On 6/30/22, at 4:40 p.m. the director of nursing	F 688		

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 06/30/2022

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 688	Continued From page 21 (DON) and the administrator stated maintaining and/or improving a resident's ability to walk was important for the resident's well-being. The administrator stated they were working hard to fill positions, hire the right people, and retain them. The DON verified it was important for residents to get their scheduled walks so they could maintain or improve their functional mobility in ambulation. Documentation of walks for R207 and R28 over the past month were requested but not provided. The facility policy titled Restorative Nursing Program Policy undated, indicated the purpose of the program was to enable residents to achieve and/or maintain their highest practicable level of function with minimal assistance. To maintain or improve residents' functional abilities in mobility/ambulation. The policy indicated staff would document the activity and report any non-participation or changes in the resident's condition.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain respiratory	F 695	F695 Respiratory Care DON and/or designee will implement	8/24/22

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 06/30/2022

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 695	Continued From page 22 equipment per manufacturer's recommendation for 1 of 2 resident (R42) who required a continuous positive airway pressure (CPAP- a type of ventilator that is used to treat sleep apnea) Findings included: R42's comprehensive Minimum Data Set (MDS) dated 5/23/22, indicated R42 had severe cognitive impairment. R42's diagnoses included obstructive sleep apnea. R42's MDS indicated he received oxygen therapy and used a non-invasive mechanical ventilator (CPAP). R42's care plan dated 5/23/22, indicated R42 had difficulty with sleep and required the use of sleep aids/devices. The care plan did not identify the sleep aids/devices used and it also lacked any instruction or frequency for cleaning of the CPAP. R42's medical record lacked any instruction or frequency for cleaning of the CPAP. R42's progress note dated 5/23/22, indicated a diagnosis of obstructive sleep apnea and R42 required use of a CPAP with oxygen nightly. During an interview on 6/30/22, at 1:24 p.m. nursing assistant (NA)-D stated did not ever clean or care for the CPAP and was unsure if it was cleaned. During an interview on 6/30/22, at 1:26 p.m. licensed practical nurse (LPN)-B stated there were not orders for cleaning or maintenance of the CPAP. She rinsed out the mask and the	F 695	corrective action for resident affected by this practice (R42): R42 CPAP will be cleaned and the care plan will include frequency of cleaning All residents with respiratory care 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 CPAP policy was reviewed, with no updates needed. All licensed nursing staff will be educated on the care of CPAP/ respiratory care equipment cleaning and charting on the completion of cleaning Random audits on the frequent cleaning of CPAPs and the care plans containing cleaning procedures for respiratory equipment will be completed by DON and/or designee starting 8/17/22, 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: 8/24/22	

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 06/30/2022

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 695	Continued From page 23	F 695		

tubing every day but did not chart it and did not know if it was done on the days she was not working. LPN-B also stated the CPAP had an integrated humidifier and the humidifier was supposed to be cleaned weekly by evenings or overnights. LPN-B could not indicate if it had ever been cleaned because there wasn't any charting on when, or if, it was done.

During an interview on 6/30/22, at 2:09 p.m. the assistant director of nursing (ADON) stated the facility had a policy on cleaning and maintenance of CPAP and she would expect the cleaning and care of the CPAP to be charted. The ADON stated it was not charted for R42 and she could not say if it had been cleaned.

During an interview on 6/30/22, at 5:06 p.m. the director of nursing (DON) stated R42 should have had orders placed in his chart for cleaning and care of the CPAP and a place on the treatment plan for nursing to chart when it was done. R42 did not have orders for cleaning or care of the CPAP in his chart and there wasn't any charting of when, or if, it was done. The DON stated she would expect orders placed in the chart for cleaning and care and staff would be charting when it was done.

The CPAP manufacturer's instructions indicated cleaning of the CPAP should be done weekly. There should also be regular cleaning of the tubing and assembly, water tub and mask to receive optimal therapy and to prevent the growth of germs that can adversely affect the wearer's health.

The facility's CPAP/BiPAP policy dated 7/20/21, indicated daily cleaning and care included wiping

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 06/30/2022

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 695	Continued From page 24 the portion of the mask that meet the skin with a damp cloth, emptying remaining water from humidifier chamber, fill the chamber with warm soapy water and shake vigorously and then rinse the chamber and let air dry. Weekly cleaning included removing the chin strap and washing the head gear in standard laundry detergent, baby shampoo or plain dish soap, air dry head gear, wash mask and tubing in a mixture of warm wart and a small amount of liquid dish detergent of baby shampoo, would then rinse thoroughly and air dry.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		8/24/22

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 06/30/2022

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 725	Continued From page 25 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient staff was available for 2 of 3 residents (R28, R207) reviewed for restorative nursing program for ambulation and for one to one staff coverage 1 of 5 (R14) reviewed for abuse. This had the potential to affect residents with restorative nursing programs and residents assigned as one to one. Findings include: See F600: Based on observation, interview and record review facility failed to prevent physical abuse and develop and consistently implement interventions to ensure the prevention of further physical abuse for 1 of 5 residents (R14), reviewed for abuse. See F688: Based on observation, interview, and document review, the facility failed to ensure staff implemented the walking program as recommended by physical therapy to maintain mobility for 2 of 2 residents (R207, R28) reviewed for ambulation program. RESTORATIVE PROGRAMS On 6/27/22, at 6:29 p.m. R207 stated she was supposed to walk with nursing twice a day, she went on to say "they don't get around to it." On 6/27/22, at 7:11 p.m. family member (FM)-B	F 725	F725 Sufficient Nursing Staff DON and/or designee will implement corrective action for resident affected by this practice (R14, R28, and R207): R28 and R207 will be reviewed again for walking/restorative programming. R #14 and R 26 safety interventions will be reviewed. Sufficient staffing for any 1:1 interventions will be implemented All residents 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 care policy and safety intervention processes were reviewed, with no updates needed. Licensed staff will be re-educated regarding completing resident care planned restorative ambulation and safety interventions for resident to resident altercations as implemented. Random audits on completion of care planned restorative programming and compliance of 1:1 safety interventions will be completed by DON and/or designee starting 8/17/22, 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	

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 06/30/2022

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 725	Continued From page 26 stated R28 was supposed to walk twice a day with staff. FM-B stated staff were supposed to walk with him to the dining room for meals, but this wasn't happening because there wasn't enough help. On 6/29/22, at 12:20 p.m. nursing assistant (NA)-A stated she had not been walking with R207 because she thought therapy was working with her on walking. On 6/29/22, at 12:40 p.m. NA-B stated "I can tell you right now ambulation doesn't get done, it's very hard to get everything done." NA-B went on to state there wasn't enough help and R207 wasn't getting walked by nursing. On 6/29/22, at 12:53 p.m. licensed practical nurse (LPN)-A stated the NAs had not reported to her that walks were not getting done. LPN-A went on to state, they could use more staff, she stated usually there were just two staff because someone would get pulled to go somewhere else that was short because of a call in. On 6/29/22, at 1:41 p.m. occupational therapist (OT)-D stated the goal for R207 was for nursing to walk with her twice a day. R207's goal was to return home, the restorative program provided by nursing was in addition to what the therapy staff were providing. On 6/30/22, at 10:46 a.m. RN-A stated she did not walk R28 to the dining room for breakfast because she had just gotten him out of the shower and was running late. On 6/30/22, at 12:43 p.m. NA-C stated it was sometimes difficult to get all the tasks done	F 725	for ongoing monitoring. Completion Date: 8/24/22	

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 06/30/2022

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 725	Continued From page 27	F 725		

because there was not enough help. NA-C stated on 6/29/22, on the evening shift they were not able to get the walks done for R28 or R207.

On 6/30/22, at 2:56 p.m. registered nurse (RN)-D stated R207 did not get her walk on the evening shift of 6/29/22, due to not enough help.

On 6/30/22, at 3:16 p.m. RN-A stated the walks were not occurring when there was lack of staff.

SAFETY INTERVENTIONS

On 6/27/22, at 3:44 p.m. R14 stated R26 had kicked her in the shin "last week". R14 proceeded to lift her left pants leg and revealed a bruise with swelling to the inner part of the left shin area. R14 stated " that is where she kicked me". R14 stated R26 was in R14's doorway and R14 was just trying to get in her room. R14 stated a few days before the kick happened R26 slapped R14 on the arm. R14 stated R26 was in R14's room going through the clothes in her closet. When R14 told R26 the clothes belonged to R14, R26 began swearing " you son of a b---h, I own everything, I own this building" and slapped R14.

On 6/28/22, at 3:49 p.m. R14 stated she was still afraid of R26. R14 stated she thought R26 could do it again but "what am I suppose to do". R14 stated she went to activities because there were lots of staff around during group activities. R14 stated she just tried to stay away from R26. R14 stated the only thing they have done for me is to place the stop sign on my door and said to leave it up all the time.

On 6/29/22, at 8:50 a.m. FM-A stated he had

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 06/30/2022

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 725	Continued From page 28 been made aware of the slapping and kick by R26 towards R14 by R14 and staff. FM-A stated when he had talked with R14 "yesterday afternoon" (6/28/22), R14 had vocalized still having fear of R26 but was trying to not let it get to R14. FM-A stated the facility was using the stop sign to protect R14 but was unaware of any other actions performed to treat R14's mental health and R14's continual fear of R26. 06/30/2022 12:49 PM LPN-D stated R26 was 1 on 1 observation at that time. LPN-D stated that activity department, therapies and chaplain were assisting in the one-on-one observation status. R26 stated the only way staff knew R26 was one-to-ones was to observe and see if staff members were around R26 when nursing staff were not in a different resident room. LPN-D stated other than that staff were not sure when the resident had somebody watching them and when not. On 6/29/22, at 1:05 p.m. RN-C stated R26 was still on one on one care at that time. RN-C stated R14 had also told RN-C that she was still afraid of R26. RN-C stated when R14 told him R14 was still afraid of R26, he had responded to not be afraid because they were keeping an eye on R26. RN-C stated the facility was using the stop sign on R14's door but R14 was alert and oriented so R14 needed to remove herself from the situation if R26 got close again. RN-C stated there were no other interventions in place to address R14's psychosocial concerns related to being afraid of R26. On 6/30/22, at 3:56 p.m. director of nursing (DON) stated R26 was still one-on-ones in regards to staff working with resident for safety.	F 725		

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 06/30/2022

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 725	Continued From page 29 DON stated the only intervention for R14 to feel safe from R26 was the stop sign placed across the front of R14's doorway to her room. The DON stated there were other interventions that could have been done to assist R14 with her psychosocial concerns but they were dealing with R26 directly. On 6/30/22, at 4:40 p.m. the administrator stated they were working hard to fill positions, hire the right people, and retain them. The DON verified it was important for residents to get their scheduled walks so they could maintain or improve their functional mobility in ambulation. The Facility Assessment revised on 2/1/22, indicated the facility would support residents' needs for mobility by supporting the resident's independence in doing as much of activities by himself/herself. In addition, the facility would support residents' behavioral healthcare needs such as dealing with anxiety, dementia, memory care, care for depression, trauma/post traumatic stress disorder, psychiatric diagnoses, intellectual or developmental disabilities. Therapy services were listed as care that would be provided. Restorative programs were also listed as nursing services that were available to residents.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2022**

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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/29/2022. At the time of this survey, Guardian Angels Care Health & Rehab Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 07/27/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2022**

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
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Guardian Angels Health and Rehab Center, is a 1-story building with a small partial basement. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1968, 1973, & 1991 additions were constructed to the building that was determined to be of Type II(111) construction. In 1990 a Type V (111) administrative wing (nonresident use area) was constructed. In 2006 a 1-story building with a partial basement was added that was determined to be of Type II(111) constructed. In 2011 another	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2022**

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
K 000	Continued From page 2 wing was constructed that is a one story building with a small partial mechanical basement that was determined to be of Type II(000). The building is fully sprinklered throughout and also has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 59 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed properly maintain enclosed stairways used for exits and smoke proof enclosures in accordance with NFPA 101 (2012), Life Safety Code, section 7.1.3.2.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 225	K225 Stairway and Smoke Proof Enclosure 1. All storage items have been removed from the exit stairwell enclosure in the Merryview wing, lower level under the stair case. 2. Audits of exit stairwells will be completed monthly by ESD or designee. 3. All Maintenance staff will be educated on storage under stairwells.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2022**

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
K 225	Continued From page 3 On 06/29/2022, between 10:00am and 1:30pm, it was revealed that storage was found in the exit stairwell enclosure in the Mary View Wing, lower-level under stair case of this facility. This deficient practice was verified by the Environmental Service Director at the time of discovery.	K 225	4. Environmental Services Director and/or designee will implement corrective action 5. Completion Date: 8/24/22	
K 291 SS=B	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to maintain emergency lighting system per NFPA 101 (2012 edition), Life Safety Code sections 19.2.9.1 and 7.9.1.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/29/2022 between 10:00AM and 1:30PM, it was revealed by observation that the battery operated emergency lighting in the Wells Woodland Wing, near west exit, failed to operate when tested. An interview with the Environmental Serviced Director verified this deficient finding at the time of discovery. THIS DEFICIENCY WAS CORRECTED BEFORE THE EXIT OF THE SURVEY	K 291	K291 Emergency Lighting 1. This deficiency was corrected with battery replacement immediately 2. Audits of emergency lighting will occur monthly by the ESD or designee 3. All Maintenance staff will be educated on emergency lighting 4. Environmental Services Director and/or designee will implement corrective action. 5. Completion Date: 8/24/22	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2022**

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
K 291	Continued From page 4 CONDUCTED ON JUNE 29, 2022.	K 291		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety	K 321	K321 Hazardous Areas 1. Storage rooms 405 and 406 will have self-closing devices installed on the doors.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2022**

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
K 321	Continued From page 5 Code, sections 19.3.2.1.2, 19.3.2.1.3, and 7.2.1.8.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 06/29/2022 between 10:00 AM and 1:30 PM, it was revealed by observation that residents room had been converted into combustible storage rooms. Rooms 405, 406 did not have a self-closing device on the doors. 2. On 06/29/2022 between 10:00am and 1:30pm, it was revealed by observation that soiled utility room self-closer failed to completely close and latch room, on Home Acers Wing. An interview with the Environment Service Director verified this deficient finding at the time of discovery.	K 321	The soiled utility room self-closer will be replaced to ensure complete closure and latching. 2. Audits of storage rooms will be completed monthly by ESD or designee. 3. All Maintenance staff will be educated on self-closing devices for storage rooms. . 4. Environmental Services Director and/or designee will implement corrective action 5. Completion Date: 8/24/22	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and	K 351		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2022**

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
K 351	Continued From page 6 sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.5.6.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/29/2022 between 10:00am and 1:30pm, it was revealed by observation that supplies were stored within 18 inches of sprinkler system in storage room located Mary View Wing. An interview with the Environment Service Director verified this deficient finding at the time of discovery.	K 351	K351 Sprinkler Installation 1. All supplies in the storage room located in the Merryview wing have been placed below 18 inches of the sprinkler system. 2. Audits of storage room items remaining below 18 inches of the sprinkler system will be completed monthly by ESD or designee. 3. All Maintenance staff will be educated on storing items below 18 inches of the sprinkler system. 4. Environmental Services Director and/or designee will implement corrective action 5. Completion Date: 8/24/22	