DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 10, 2021

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

RE: CCN: 245012
Cycle Start Date: October 8, 2021

Dear Administrator:

On October 25, 2021, we notified you a remedy was imposed. On November 4, 2021 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 2, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 9, 2021 did not go into effect. (42 CFR 488.417 (b))

As we notified you in our letter of October 25, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 8, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically Submitted

October 25, 2021

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

RE: CCN: 245012
Cycle Start Date: October 8, 2021

Dear Administrator:

On October 8, 2021, survey was completed at your facility by the Minnesota Department 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.

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

REMOVAL OF IMMEDIATE JEOPARDY

On October 8, 2021, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 9, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our

recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 9, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 9, 2021, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 8, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

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

quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Guardian Angels Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 8, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 8, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fike-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE ELK RIVER, MN 55330**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/5/21, through 10/8/21, a standard abbreviated survey was conducted at your facility. 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 complaint was found to be SUBSTANTIATED: H5012064C (MN00077279, MN00077311, MN00077313), with a deficiency cited at F600. The survey resulted in an Immediate Jeopardy (IJ) at F600 when R1 was heard screaming in her room when alone with nursing assistant (NA)-A. NA-A exited R1's room, did not respond to her screaming, and R1 was found bleeding with newly identified injuries to her elbow and forehead. The administrator and director of nursing (DON) were notified of the IJ on 10/7/21, at 1:32 p.m. The IJ was removed on 10/8/21, at 2:25 p.m. but non-compliance remained at the lower scope and severity of D - isolated scope and severity, which indicated no actual harm with the potential for more than minimal harm, that is not IJ. The above findings constituted substandard quality of care, and an extended survey was conducted on 10/8/21. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/01/2021

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=J	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 interview and document review, the facility failed to ensure 1 of 2 allegations of abuse were reported to the state agency (SA) immediately, but not later than two hours, and 1 of 3 residents (R1) was subsequently free from physical abuse. This deficient practice resulted in an immediate jeopardy (IJ) for R1 who was noted to suffer physical injuries after an interaction with facility staff. The IJ began on 10/1/21, at 7:46 p.m. when R1 was heard screaming in her room when alone with nursing assistant (NA)-A. NA-A exited R1's	F 600	This plan of correction is being submitted as requirement of participation in Medicare/Medicaid program, and does not indicate that we agree with the citation. It is the goal of Guardian Angels Care Center to maintain the safety of all residents, including R1. This includes prevention of abuse and neglect from staff, visitors, and other residents. R1 and other residents being cared for by NA-A had the potential for abuse and	11/2/21

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F 600	Continued From page 2 room, did not respond to her screaming, and R1 was found bleeding with newly identified injuries to her elbow and forehead. The administrator and director of nursing (DON) were notified of the IJ on 10/7/21, at 1:32 p.m. The IJ was removed on 10/8/21, at 2:25 p.m. but non-compliance remained at the lower scope and severity of D - isolated scope and severity, which indicated no actual harm with the potential for more than minimal harm, that is not IJ. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/24/21, indicated R1 had a severe cognitive impairment and diagnoses which included Alzheimer's disease, falls, and delusions. R1 required extensive assistance with transfers and grooming. A facility Discussion/Coaching form dated 3/31/21, indicated NA-A received coaching related to an allegation of rough care / going too fast during resident cares. There was no documented follow-up with NA-A. During an interview on 10/5/21, at 5:59 p.m. family member (F)-A reported she visited R1 on 8/24/21, and noted R1 was anxious and fearful. R1 was holding her arms close to her body and asked family not to leave because someone at the facility had hurt her and she was scared. F-A stated R1 verbalized a, "Black male nurse threw her down on the bed roughly." F-A reported the allegation of abuse to a facility social worker and nurse manager on 8/25/21. R1 was placed on a buddy system (two caregivers) and female caregivers only, if possible. F-A stated since the alleged abuse on 8/24/21, R1 had increased	F 600	neglect by the alleged perpetrator. On 10/1/2021 R1 was identified as having sustained injuries to her forehead and her right elbow as described in the POC. Immediately upon identification of injuries, LPN-A and RN-A removed NA-A from the resident care area and summoned police. Police arrived at the facility in the described timeline in POC and placed NA-A under arrest pending investigation of the incident. NAR- A was suspended and has not worked at the facility since the incident. Effective 10/1/2021 staff training was initiated for all staff on substance abuse in the workplace. On 10/7/21 additional staff training was added on abuse prevention and reporting to ensure deficient practice will not recur. Facility will ensure that all staff complete abuse training prior to start of next scheduled shift. The Director of Nursing will consultant with Administrator to ensure timely reporting of all allegations of abuse or neglect. All VA reports will be reviewed at QAA/QAPI. Date of correction: 11/2/2021	

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F 600	Continued From page 3	F 600		

anxiety and tearfulness. Further, prior 8/24/21, R1 did not differentiate staff, however, had subsequently made comments reflecting she did not want a African American males working with her.

During an interview on 10/6/21, at 12:37 p.m. registered nurse (RN)-B confirmed, approximately one month ago, a complaint was received from R1's family regarding an allegation of abuse on 8/25/21. The facility investigated the allegation which included interviewing residents and staff. Further, R1's care plan was changed to reflect only female caregivers, when possible, and implemented a, "buddy system." RN-B stated the allegation of abuse was not reported to the state agency SA as, "nothing had happened." RN-B was unable to provide documentation of the investigation.

During an interview on 10/6/21, at 1:18 p.m. social worker (SW)-A stated the facility interviewed staff and residents regarding a complaint received on 8/25/21, for R1. SW-A was unsure what the complaint involved or why an investigation was conducted. SW-A stated, "I was told to ask residents if they felt safe at the facility and about their cares" by RN-A.

The above noted incident was not reported to the SA.

A Nursing Home Incident Report (NHIR) dated 10/1/21, at 9:54 p.m. indicated on 10/1/21, at 7:55 p.m. R1 was heard calling for help and a staff-person entered R1's room. R1 was seated in a wheelchair and was noted to be bleeding from her forehead and right elbow. R1 had a 1.8 centimeter (cm.) by 2 cm. laceration on her

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F 600	Continued From page 4	F 600		

forehead and two lacerations to her right elbow which measured 1.3 cm. by 0.7 cm. and 1.5 cm. by 1 cm. The NHIR indicated R1 verbalized, "that short black man came up from behind me and picked me up and threw me on the floor." The alleged perpetrator, nursing assistant (NA)-A, was immediately removed from the floor, asked to provide a written statement, and told to leave pending investigation. Law enforcement arrived prior to NA-A leaving the facility and interviewed NA-A. Law enforcement requested NA-A's clothing as the officer felt there was, "blood on his [NA-A] clothes. NA-A was arrested.

Camera footage dated 10/1/21, revealed:
- 7:41 p.m. NA-B exited R1's room.
- 7:45 p.m. the rear handles of R1's wheelchair became visible at R1's door entrance. R1 was unable to be seen at this time.
- 7:46:01 p.m. NA-A, an African American male with a stocky build, was visualized wearing a royal blue uniform. NA-A pushed the above noted wheelchair inside R1's room.
- 7:46:10 p.m. R1 was heard screaming.
- 7:46:32 p.m. NA-A exited R1's room and screaming was still audile. NA-A walked to and entered a supply room. Subsequently, NA-A exited the supply room and entered a resident room across the hall from R1. NA-A walked by R1's room as she continued to scream.
- 7:48 p.m. R1 was visualized self-propelling her wheelchair outside of her room and licensed practical nurse (LPN)-A responded to R1 who continued to scream. R1 verbalized, "That black man in the blue clothes did this."
- At 7:51 p.m. NA-A was visualized looking out a doorway, in a room across the hall from R1, towards staff attending to R1.
- At 7:55 p.m. R1 verbalized, "A black man

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F 600	Continued From page 5	F 600		

pushed me over" to LPN-A and RN-A who were providing medical aide to R1.
- 8:07 p.m. law enforcement were visualized arriving at the facility.

A progress note dated 10/1/21, at 8:29 p.m. indicated R1 had an abrasion to her forehead and elbow. Further, blood was noted on R1's clothing when assessed by nursing staff. R1's medical record lacked indication R1 had the previously noted injuries prior to this medical record entry.

During an interview on 10/5/21, at 2:51 p.m. NA-A denied entering R1's room, contrary to camera footage, on 10/1/21. Further NA-A denied consuming alcohol, being intoxicated while at work, or coming into contact with blood on 10/1/2.

During an interview on 10/5/21, at 3:33 p.m. LPN-A reported NA-A was difficult to work with, at times, as he was disrespectful of authority. LPN-A, who worked evening shift on 10/1/21, sated she saw R1 going back-and-forth to her room throughout her shift and R1 had no blood on her forehead or arm. LPN-A stated she attended to R1 after she heard R1 screaming and observed blood on R1's forehead and R1's right arm. LPN-A cleaned R1 and noted R1 had two skin tears to her right elbow. R1 also had a bruise to the right side of her forehead which measured 1.8 cm. by 2 cm. LPN-A stated herself and registered nurse (RN)-A informed NA-A he was suspected of abuse (due to R1's allegation), however, NA-A continued to want to work on the floor. NA-A was informed NA-A law enforcement was called. LPN-A stated she did not observe blood on NA-A uniform, prior to him being suspected of abuse, and noticed it after law enforcement pointed it out.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE ELK RIVER, MN 55330**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6	F 600		

During an interview on 10/5/21, at 3:57 p.m. RN-A, who worked evening shift on 10/1/21, stated she observed R1 leave the dining room after supper and did not see blood on R1 at this time. RN-A stated NA-A denied he worked with R1 on 10/1/21. Further, RN-A did not notice blood on NA-A's uniform, prior to him being suspected of abuse, and noticed it after law enforcement pointed it out. RN-A stated NA-A had defiant behaviors with supervision.

During an interview on 10/5/21, at 4:45 p.m. NA-B stated at approximately 6:00 p.m. on 10/1/21, she completed evening cares with R1 and assisted R1 to bed. R1 got up at approximately 7:00 p.m. and was put back to bed by her. At 7:33 p.m., R1 requested NA-B to lay out clothing for church and R1 was again assisted back to bed. NA-B stated, "She [R1] had no bleeding or bruising" and was in good spirits at that time.

During an interview on 10/6/21, at 2:12 p.m. the DON denied having knowledge of a complaint received from R1's family or an investigation being completed regarding allegations of abuse on 8/25/21. It was expected staff report any allegations of abuse to the DON or administrator immediately. Further, the facility needed to file a report to the state agency within two hours.

During an interview on 10/6/21, at 2:29 p.m. the administrator stated all reports of abuse should be reported immediately to the DON and the administrator. The administrator denied having knowledge of any allegations of abuse, regarding R1, prior to 10/1/21. Further, the administrator was not aware an internal investigation was conducted regarding the previous allegation of

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F 600	Continued From page 7 abuse for R1. During an interview on 10/8/21, at 10:52 a.m. law enforcement officer (LE)-A stated he was called to the facility on 10/1/21, regarding an allegation of abuse of a vulnerable adult [R1]. LE-A stated he observed blood on NA-A's uniform around his waist and shoes. Further, the smell of alcohol was noted on NA-A's breath. NA-A was escorted out of the facility and taken to jail. Further, NA-A's blood alcohol level was taken and resulted at 0.16 (consistent with alcohol intoxication). NA-A remained in jail until 10/3/21, and was criminally charged with a gross misdemeanor of assaulting a vulnerable adult on 10/8/21. The facility Abuse Prevention Policy and Procedure revised 1/15, indicated abuse was the willful infliction or injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Anyone who has information concerning an incident or alleged abuse or neglect of a resident or suspects that a resident has sustained an injury not reasonably explained by the resident's medical history, resident, report, witnessed resident or staff actions should report it immediately. The IJ which began on 10/1/21, at 7:46 p.m. was removed on 10/8/21, at 2:25 p.m. when it was verified through interview and document review facility implemented a systemic removal plan which included: - NA-A was suspended and the facility began an investigation on 10/1/21. - The facility Abuse Prevention Policy and Procedure was reviewed on 10/7/21. - The facility provided education to all staff who were working regarding abuse prevention and	F 600		

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F 600	Continued From page 8 reporting on 10/8/21. - All facility staff, who had not worked, were notified abuse prevention and reporting training must be completed prior to their next scheduled shift.	F 600		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 25, 2021

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

Re: Event ID: DE3611

Dear Administrator:

The above facility survey was completed on October 8, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/5/21, through 10/8/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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

Electronically Signed | 11/01/21

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5012064C (MN77279, MN77311, MN77313). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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