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	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Angels Care Center	400 Evans Avenue Elk River, MN 55330

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a dignified living existence for 3 of 3 residents (R1, R2, and R3) reviewed for call lights. Staff responded timely to the residents when the residents pressed their all lights for assistance; however, the staff would turn off the call light not providing services. This practice resulted in R1 and R2 soiling themselves and R3, a non-weight bearing resident attempted to transfer herself to the bathroom.Findings include: R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) of 15 indicating she was cognitively intact. R1 required substantial assistance with toileting hygiene, lower body dressing, personal hygiene, rolling from side to side in bed, transferring from a sitting to lying position and transferring from bed to chair. R1 was frequently incontinent of urine and stool and was not on a toileting program. R1's diagnoses included Type 2 Diabetes, cellulitis (a bacterial infection that enters the skin) of the right lower limb, morbid obesity, and lymphedema (swelling most often in the arm or leg caused by a lymphatic system blockage). R1's care plan report dated 7/10/25 indicated to make sure R1's call light was within reach and encourage her to use it for assistance as needed. R1 required prompt response to all requests for assistance. R1 used incontinent briefs, and staff was to change as needed and clean peri-area with each incontinent episode. R1's toileting need was one hand assistance from staff with a raised toilet set to assist with a safe transfer to the toilet. R1's call light detailed activity reported dated 9/8/25 at 3:30 a.m. indicated R1 pressed her call light. The call light response time was six minutes and fifty-nine seconds. R1's call light was again pressed on 9/8/25 at 6:05 a.m. and the response time was six minutes and sixteen seconds. Upon observation and interview on 9/8/25 at 11:55 a.m. R1 stated she pressed her call light around 4:00 a.m. and requested to use the bathroom. The light was answered and turned off. R1 soiled herself of urine in her brief waiting for the staff member to return. She fell asleep for a few hours and woke-up around 5:30 a.m. She waited for the morning shift to be on duty and pressed her light again at 6:05 a.m. stating she knew the a.m. staff would assist her. R1 was diabetic, her skin was a big concern. A few weeks ago, R1 developed a rash on her left thigh region just below her buttocks that was bleeding from sitting in soiled incontinent briefs. R1 was able to notify the staff when she needed to use the bathroom. She wore incontinent briefs for dribbling of urine and for when staff did assist her, and she soiled herself. She stated she was [AGE] years old, and she felt like she was [AGE] years old when she wet herself because of staff not assisting her timely. R1's skin was observed and revealed the inside of her left thigh under her buttocks was a macerated area (skin breakdown due to prolonged exposure to moisture). The area was approximately 12 centimeters in length x 4 centimeters in height. The area was covered with a barrier cream. There were no open areas and no bleeding was observed. R1's incontinent brief was dry. Upon interview on 9/8/25 at 12:15 p.m. nursing assistant (NA)-A stated R1 did turn her light on right away at the beginning of the shift and mentioned to her that in the night she requested to use the bathroom, and no staff member returned. R1's brief was soaked with urine. R1 was able to press her call light and request the use of the bathroom. NA-A stated she often found other residents soiled in the morning. NA-A stated her practice was to turn off a residents light when she answered it and would return when able to keep the call lights appear under 10 minutes. She hoped she never forgot about a resident with that practice. R2's MDS report dated 9/4/25 was in process at the time of the survey. R2's Care Plan Report dated 9/4/25 indicated R2 transferred with the assistance of two staff members. R2 did not walk. Staff was to ensure R2's call light was within reach and encourage R2 to use it for assistance. The resident required prompt responses to all requests for assistance. R2's face sheet dated 9/4/25 indicted R2's pertinent diagnoses were fracture of the left femur (hip), Type 2 Diabetes, and coronary artery disease. R2's BIMs score assessment dated [DATE] indicated R2 had a score of 15 indicating she was cognitively intact. R2's Functional Status Tracking dated 9/7/25 indicated R2 required maximum assistance with lower body dressing, rolling from side to side in bed, transferring from bed to chair and toileting hygiene. Upon observation and interview on 9/8/25 at 1:06 p.m. R2 was wheeling herself in a wheelchair to the bathroom. R2 had a boot cast on her left foot. R2 stated she was not supposed to transfer herself, but she was able to. She was aware she was not to bear weight on her left foot. R2 stated she transferred herself to the toilet because in only the few days she had been at the facility staff members would answer call light and not return for a long time. She had not soiled herself and would be horrified if she did. She stated she will have to transfer herself when she returned home, so may as well start in the facility. Upon interview on 9/9/25 at