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	03/19/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a comprehensive bowel and bladder assessment and develop an individualized incontinence care plan with goals and interventions to maintain or improve continence status for 1 of 3 (R6) reviewed for urinary incontinence.Findings include:R6's diagnoses list dated 3/18/26 included surgical aftercare for right hip fracture, type 2 diabetes, repeated falls and dementia.R6's admission Minimum Data Set, dated [DATE] indicated R6 had moderate cognitive impairment. R6 was frequently incontinent of bladder and needed maximum assistance from staff for transfers and toileting hygiene. The urinary incontinence care area assessment indicated urinary incontinence would be addressed in the care plan with the overall objectives to include improvement and avoid complications.R6's bladder and bowel incontinence assessment dated [DATE] identified R6 did not have an indwelling catheter and did not have a urostomy. The following sections were not assessed or left blank: Incontinence symptoms, onset of incontinence, pattern of incontinence, bowel movement pattern, relevant physical factors, cognitive/emotional/communication status, current medication that may affect incontinence, overflow incontinence, physician order obtained for post-void residual, types of incontinence and care plan review. R6's care plan dated 2/27/26 identified R6 required assistance from one staff with a manual stand aid for transfers and toileting. The care plan did not address urinary incontinence that identified individualized goals and interventions that would maintain and/or improve incontinence.R6's urinary continence documentation from 2/28/26 through 3/18/26 identified R6 was incontinent of bladder fifty-one times and continent of bladder ten times.The nursing assistant care sheet for R6 had no information in the bowel and bladder column.On 3/18/2026 at 12:16 p.m., R6 was observed in his room sitting in a wheelchair with the call light within reach. Incontinent products were observed in the bathroom. During an interview, R6 stated he needed staff assistance to go to the bathroom. He wore an incontinent product and did not like when it was wet. R6 would use his call light to get help from staff to go to the bathroom or to change the incontinent product.During an interview on 3/18/2026 at 12:32 p.m., licensed practical nurse (LPN)-A stated assessments that need to be completed by the floor nurse would pop up on the treatment administration record (TAR). The floor nurse would complete and sign the assessment. Information would be gathered from the resident, report from the hospital nurse, and family members, if needed. LPN-A did not know who looked at the assessments after they were completed or who entered the information into the care plan. LPN-A stated toileting and incontinence information would be found on the resident's Kardex. LPN-A reviewed R6's Kardex and stated it did not indicate whether R6 was continent or incontinent of bladder and did not include a urinary toileting plan. During an interview on 3/18/2026 at 2:36 p.m., nursing assistant (NA)-A stated a resident's toileting information would be found on the Kardex or NA care sheet. Every resident was either checked for incontinence or offered to be taken to the toilet every two to three hours or as indicated on the Kardex.During an interview on 3/19/2026 at 2:08 p.m., NA-B stated R6's Kardex did not include a specific toileting plan. NA-B received information in report that R6 liked to sit on the toilet, but he was always incontinent of urine. R6 did not use his call light to request toileting so he (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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was offered the opportunity to use the bathroom every 2-3 hours. During an interview on 3/19/2026 at 2:18 p.m., NA-C stated all residents are offered to go to the bathroom or checked for incontinence every two-three hours, as requested, and/or as indicated on the resident's Kardex.During an interview on 3/19/2026 at 4:34 p.m., the director of nursing (DON) stated a comprehensive bladder assessment was completed on admission to the facility, and a care plan focus would trigger if a resident was incontinent and individualized interventions would be added. DON further stated R6's comprehensive bladder assessment did not have all portions completed and the care plan did not address urinary incontinence nor was there a urinary toileting plan. The goal for an individualized toileting plan was for a resident to return to or maintain the continence level they were at prior to being at the hospital.The Bowel and Bladder Assessment policy dated April 2025 indicated all residents will receive a comprehensive bowel and bladder assessment upon admission, with ongoing reassessment and individualized interventions. Findings from the assessment must be used to develop an individualized bowel and bladder program and update the resident's comprehensive care plan. Care plans must include toileting schedules (prompted, timed, or scheduled voiding), bowel program (routine, medications, diet) and incontinence products and skin care, hydration and nutrition interventions, mobility and transfer assistance and monitoring parameters.