November 2, 2021

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

RE: CCN: 245239

Cycle Start Date: October 27, 2021

Dear Administrator

On October 27, 2021, a survey was completed at your facility by the Minnesota Department of Health to investigate a complaint 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. The investigation resulted in no deficiencies being issued.

Also at the time of the investigation, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, found no violations of these rules promulgated under Minnesota Statute section 144.653 and/or Minnesota Statute section 144A.10.

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. Electronically attached is your copy of the Federal Form CMS-2567 stating that no violations were noted at the time of this investigation.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С .
		245239	B. WING		· · · · · · · · · · · · · · · · · · ·	10/	27/2021
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHARDI	AN ANGELS HEALTH	9 DELIAD CENTED		1:	500 EAST THIRD AVENUE		
GUARDIA	AN ANGELS REALIR	& REHAD CENTER		Н	IBBING, MN 55746		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREFIX		(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP	RIATE	DATE
					DEFICIENCY)		
			1				
E 000	Initial Comments		ΕC	00			
	A COVID-19 Focus	sed Infection Control survey					
		10/27/21, at your facility by the					
		nent of Health to determine					
		nergency Preparedness					
		3(b)(6). The facility was in full					
	compliance.	(L)(C)					
	Because you are er	nrolled in ePOC, your					
		uired at the bottom of the first					
	page of the CMS-2	567 form.					
F 000	INITIAL COMMENT	ΓS	F C	00			
	On 10/27/21 a sta	ndard abbreviated survey was					
		acility to conduct a complaint					
		dition, a Focused Infection					
		also completed. Your facility					
		compliance with 42 CFR Part					
		for Long Term Care Facilities.					
	, ,	3					
		laint was found to be					
	UNSUBSTANTIATE	ED: H5339090C (MN77772).					
		ed in ePOC and therefore a					
		uired at the bottom of the first					
		567 form. Although no plan of					
	correction is require						
	acknowledge receip	ot of the electronic documents.					
			1				

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

PRINTED: 11/02/2021 FORM APPROVED

Minnesota Department of Health

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00858	B. WING		C 10/27/2021			
NAME OF	DDU/IDED OD SLIDDI IED		INDRESS CITY (STATE ZID CODE	10/21/2021			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE								
GUARDIAN ANGELS HEALTH & REHAB CENTI HIBBING, MN 55746								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE			
2 000	Initial Comments		2 000					
	****ATTENTION*****							
	NH LICENSING CORRECTION ORDER							
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.						
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all erule provided at the tagule number indicated below. It is several items, failure to the items will be considered a Lack of compliance upon any item of multi-part rule will the tem aring the initial inspection was						
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.						
	at your facility by su Department of Heal	rs: nplaint survey was conducted urveyors from the Minnesota lth (MDH). Your facility was be with the MN State						
	The following comp	plaint was found to be						

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
20050		B. WING			C 10/27/2021		
		00858			10/2	7/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4500 EAST THIRD AVENUE							
GUARDIAN ANGELS HEALTH & REHAB CENTI HIBBING, MN 55746							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE		
2 000	Continued From pa	ge 1	2 000				
	UNSUBSTANTIATE	ED: H5239090C (MN77772).					
	The Minnesota Dep documenting the St Orders using Feder The facility is enroll signature is not req page of state form. is required, it is required,	partment of Health is ate Licensing Correction					

Minnesota Department of Health