Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 29, 2025

Administrator
Guardian Angels Health & Rehab Center
1500 EAST THIRD AVENUE
HIBBING, MN 55746

RE: CCN: 245239
Cycle Start Date: August 20, 2025

Dear Administrator:

On September 26, 2025, the Minnesota Department of Health 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.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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September 29, 2025

Administrator
Guardian Angels Health & Rehab Center
1500 EAST THIRD AVENUE
HIBBING, MN 55746

Re: Reinspection Results
Event ID: 1D469D-H2

Dear Administrator:

On 09/26/2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on 08/20/2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 5, 2025

Administrator
Guardian Angels Health & Rehab Center
1500 EAST THIRD AVENUE
HIBBING, MN 55746

RE: CCN:245239
Cycle Start Date: August 20, 2025

Dear Administrator:

On August 20, 2025, a survey was completed at your facility by the Minnesota Departments of Health 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 November 20, 2025, (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 February 20, 2026, (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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Electronically delivered

September 5, 2025

Administrator
Guardian Angels Health & Rehab Center
1500 EAST THIRD AVENUE
HIBBING, MN 55746

Re: State Nursing Home Licensing Orders
Event ID: 1D469D-H1

Dear Administrator:

The above facility survey was completed on 08/20/2025 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 one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The 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 number and the corresponding text of 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 that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors' findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Angels Health & Rehab Center	**1500 EAST THIRD AVENUE , HIBBING, Minnesota, 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
F0000	INITIAL COMMENTS On 8/19/25 through 8/20/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52392580C (2593771) H52392580C (2593809) H52392363C (2590203) with a deficiency cited at F755. H52392362C (2590229) with a deficiency cited at F755. H52392283C (2583290) with a deficiency cited at F755. 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. 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.	F0000		09/18/2025
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F0755	DON and/or designee will implement corrective action for residents affected by this practice R1, R2, R3: R1’s medication oxycodone was ordered and staff educated on oxycodone in the Emergency Kit at all times. Narc book to be screened every Tuesday by licensed nursing staff to ensure that medications are ordered timely. R2’s medication hydromorphone was ordered and 6 – 1mg tablets of hydromorphone added to the Emergency Kit. Staff educated on updates to the EKIT. Narc book to be	09/18/2025

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0755 SS = E	Continued from page 1 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure supply and administration of ordered medications for 3 of 3 resident (R1, R2, and R3) reviewed for pharmacy services. Findings include: R1 R1's Face Sheet dated 3/9/25, identified R1 had diagnoses of lower back pain, arthritis, and pain in left hip. R1's care plan revised on 3/16/25, identified R1 had chronic pain and instructed staff to administer medications per provider orders. R1's medication administration record (MAR) dated 8/2025, identified R1 had orders for oxycodone (a prescription medicine used to treat moderate to severe	F0755	Continued from page 1 screened every Tuesday by licensed nursing staff to ensure that medications are ordered timely. R3's medication hydromorphone was ordered and 6 – 1mg tablets of hydromorphone added to the Emergency Kit. Staff educated on updates to the EKIT. Narc book to be screened every Tuesday by licensed nursing staff to ensure that medications are ordered timely. Discussion with DON, providers (MD-A and MD-B), and Thrifty White Pharmacy on importance of responding to faxes in a timely manner and filling prescriptions timely. Thrifty White Pharmacy agreed to re-vamping the Emergency Kit kept at Guardian Angels Health and Rehabilitation Center to include 6 tablets of 1mg hydromorphone. All residents who have orders for narcotic pain medications have the potential to be impacted by this practice. Thrifty White Pharmacy agreed to re-vamping the Emergency Kit kept at Guardian Angels Health and Rehabilitation Center to include 6 tablets of 1mg hydromorphone. All residents have the potential to be impacted by this practice. All residents who have orders for narcotic pain medication were audited to ensure they currently have their medication onsite. DON and/or designee will implement measures to ensure this practice does not reoccur including: The Emergency Kit Procedures, Pain Management Policy, and Ordering and Receiving Medications policies reviewed with no updates needed. All licensed nurses will be educated on the Emergency Kit Procedures Policy and Pain Management Policy, along with the EKIT updates. Random audits of narcotic pain medication counts are being completed, that narcotic pain medications are being ordered and delivered in a timely manner, and that residents have pain management reports as controlled will be completed by DON and/or designee starting 9/15/25, 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Angels Health & Rehab Center	1500 EAST THIRD AVENUE , HIBBING, Minnesota, 55746

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F0755 SS = E	Continued from page 2 pain) 10mg twice daily for pain. The MAR lacked documentation R1 received ordered medications on 8/9/25 at 8:00 p.m., through 8/11/25 at 8:00 a.m. R1's progress note dated 8/8/25 at 8:43 p.m., identified R1's medical provider (MD)-A was called on 8/8/25 at 5:00 p.m., regarding R1's oxycodone 10mg pain medication needing a new order. MD-A indicated he would take care of it. On 8/9/25 at 6:12 a.m., a progress note identified R1's oxycodone never arrived from the pharmacy. On 8/10/25 at 10:45 p.m., a progress note identified MD-A was faxed regarding R1's oxycodone. Pharmacy was called and stated MD-A never sent new orders to pharmacy. On 8/11/25 at 7:19 a.m., a progress note identified oxycodone 10mg dose was not on cart and MD-A was notified. R2 R2's care plan dated 3/26/25, identified R2 had potential for pain and instructed staff to administer medications per orders. R2's Face Sheet dated 5/23/25, identified R2 had diagnoses of polyneuropathy (nervous system disorder that can cause symptoms of numbness, burning, and pain in multiple areas of the body), polymyalgia rheumatica (inflammatory disorder causing muscle pain around shoulders and hips), and lower back pain. R2's MAR dated 8/2025, identified R2 had orders for hydromorphone (a prescription medicine used to treat moderate to severe pain) 1mg (milligram) three times a day for pain. The MAR lacked documentation R2 received the ordered medications on 8/10/25 at 8:00 a.m. through 8/13/25 at 8:00 a.m. R2's progress note dated 8/10/25 at 9:02 a.m., identified R2's hydromorphone was not administered, was ordered, and staff waited for delivery. On 8/11/25 at 7:14 p.m., a progress note identified R2's hydromorphone was not given, and facility continued to wait for pharmacy to deliver the medication. On 8/12/25 at 12:29 p.m., a progress note identified R2 was out of scheduled hydromorphone. Pharmacy had stated the order appeared to be discontinued, but facility had no record of the medication being discontinued, facility needed to provide pharmacy with a new order or confirm the	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0755 SS = E	Continued from page 3 medication was discontinued. On 8/12/25 at 12:48 p.m., a progress note identified MD-A was called and preferred to be sent a fax in regards to R2's out of stock pain medication. On 8/13/25 at 9:07 a.m., a progress note identified pharmacy was called and stated they were awaiting MD-A's response to a refill request for R2's hydromorphone. R3 R3's Face Sheet dated 6/24/25, identified R3 had diagnoses of surgical amputation of right toes and gout (form of arthritis that causes severe pain). R3's care plan dated 7/1/25, identified R3 had potential for pain due to right toe amputation and instructed staff to administer pain medications per orders. R3's MAR dated 8/2025, identified R3 had orders for hydromorphone 2mg every four hours as needed for pain. R3 did not received ordered medications on 8/12/25. R3's progress note dated 8/12/25 at 11:44 a.m., identified R3 had no hydromorphone at the facility, MD-B was called and left a message to advise on R3's pain medication. On 8/12/25 at 1:48 p.m., a progress note identified a nurse from MD-B's office called the facility and stated a new order was sent to pharmacy on 8/11/25. Facility called pharmacy but pharmacy phone was not working. On 8/13/25 at 9:02 a.m., a progress note identified the pharmacy received new orders for R3's hydromorphone and would be delivering the medication as soon as possible. During an interview on 8/19/25 at 11:31 a.m., R1 stated she had not received her pain medication in the past due to not having any in the facility. During an interview on 8/20/25 at 7:48 a.m., licensed practical nurse (LPN)-A stated R1 had ran out of pain medications twice. At times, the providers did not reply to our requests for new pain medication prescriptions and residents would run out of their pain medications.	F0755		

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F0755 SS = E	Continued from page 4 During an interview on 8/20/25 at 9:53 a.m., R3 stated he did run out of his pain medications and the facility told him they would keep a better eye on his medication to ensure he did not run out again. During an interview on 8/20/25 at 12:10 p.m., registered nurse (RN)-A stated she did not believe the facility received medications for residents in a timely manner. RN-A called MD-A about R1 running out of her pain medication and MD-A stated not to call him just fax. RN-A explained to MD-A that not getting pain medications in a timely manner was an issue. During an interview on 8/20/25 at 12:34 p.m., the director of nursing stated the facility had a system issue when it came to pharmacy services and physician's responses. As a result, the medications not received timely at the facility for residents. During an interview on 8/20/25 at 1:22 p.m., MD-A stated the pharmacy would not accept verbal orders for pain medications, so residents were running out of their pain medications at the facility. During an interview on 8/20/25 at 1:32 p.m., the consultant pharmacist stated the pharmacy could only take verbal orders for narcotics if it was an emergency. Pharmacy did not receive timely faxed orders and as a result, residents were running out of pain medications. During an interview on 8/20/25 at 2:35 p.m., the administrator stated it was expected that residents had their order medications and were given the medications per orders. The facility planned to work on a solution with the pharmacy and MD-A to ensure residents did not run out of their medications in the future. The facility policy Ordering and Receiving Medications undated, indicated reorder medications three to five days in advance of need to assure an adequate supply was on hand. When reordering medications that require special processing (such as Schedule II controlled substances), order at least seven days in advance of need.	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Angels Health & Rehab Center	**1500 EAST THIRD AVENUE , HIBBING, Minnesota, 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
20000	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 8/19/25 through 8/20/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		09/18/2025

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Angels Health & Rehab Center	**1500 EAST THIRD AVENUE , HIBBING, Minnesota, 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
20000	Continued from page 1 The following complaints were reviewed: H52392580C (2593771) H52392580C (2593809) H52392363C (2590203) with a licensing order issued at 1550. H52392362C (2590229) with a licensing order issued at 1550. H52392283C (2583290) with a licensing order issued at 1550. 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 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
21550	Adminiatration of Medications; Pharmacy Serv.	21550	corrected	09/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/20/2025**

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21550	Continued from page 2 CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure supply and administration of ordered medications for 3 of 3 resident (R1, R2, and R3) reviewed for pharmacy services. Findings include: R1 R1's Face Sheet dated 3/9/25, identified R1 had diagnoses of lower back pain, arthritis, and pain in left hip. R1's care plan revised on 3/16/25, identified R1 had chronic pain and instructed staff to administer medications per provider orders. R1's medication administration record (MAR) dated 8/2025, identified R1 had orders for oxycodone (a prescription medicine used to treat moderate to severe pain) 10mg twice daily for pain. The MAR lacked documentation R1 received ordered medications on 8/9/25 at 8:00 p.m., through 8/11/25 at 8:00 a.m. R1's progress note dated 8/8/25 at 8:43 p.m., identified R1's medical provider (MD)-A was called on 8/8/25 at 5:00 p.m., regarding R1's oxycodone 10mg pain medication needing a new order. MD-A indicated he would take care of it. On 8/9/25 at 6:12 a.m., a progress note identified R1's oxycodone never arrived from the pharmacy. On 8/10/25 at 10:45 p.m., a progress note identified MD-A was faxed regarding R1's oxycodone. Pharmacy was called and stated MD-A never sent new orders to pharmacy. On 8/11/25 at 7:19 a.m., a progress note identified oxycodone 10mg dose was not on cart and MD-A was notified. R2	21550		

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21550	Continued from page 3 R2's care plan dated 3/26/25, identified R2 had potential for pain and instructed staff to administer medications per orders. R2's Face Sheet dated 5/23/25, identified R2 had diagnoses of polyneuropathy (nervous system disorder that can cause symptoms of numbness, burning, and pain in multiple areas of the body), polymyalgia rheumatica (inflammatory disorder causing muscle pain around shoulders and hips), and lower back pain. R2's MAR dated 8/2025, identified R2 had orders for hydromorphone (a prescription medicine used to treat moderate to severe pain) 1mg (milligram) three times a day for pain. The MAR lacked documentation R2 received the ordered medications on 8/10/25 at 8:00 a.m. through 8/13/25 at 8:00 a.m. R2's progress note dated 8/10/25 at 9:02 a.m., identified R2's hydromorphone was not administered, was ordered, and staff waited for delivery. On 8/11/25 at 7:14 p.m., a progress note identified R2's hydromorphone was not given, and facility continued to wait for pharmacy to deliver the medication. On 8/12/25 at 12:29 p.m., a progress note identified R2 was out of scheduled hydromorphone. Pharmacy had stated the order appeared to be discontinued, but facility had no record of the medication being discontinued, facility needed to provide pharmacy with a new order or confirm the medication was discontinued. On 8/12/25 at 12:48 p.m., a progress note identified MD-A was called and preferred to be sent a fax in regards to R2's out of stock pain medication. On 8/13/25 at 9:07 a.m., a progress note identified pharmacy was called and stated they were awaiting MD-A's response to a refill request for R2's hydromorphone. R3 R3's Face Sheet dated 6/24/25, identified R3 had diagnoses of surgical amputation of right toes and gout (form of arthritis that causes severe pain). R3's care plan dated 7/1/25, identified R3 had potential for pain due to right toe amputation and instructed staff to administer pain medications per orders.	21550		

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21550	Continued from page 4 R3's MAR dated 8/2025, identified R3 had orders for hydromorphone 2mg every four hours as needed for pain. R3 did not received ordered medications on 8/12/25. R3's progress note dated 8/12/25 at 11:44 a.m., identified R3 had no hydromorphone at the facility, MD-B was called and left a message to advise on R3's pain medication. On 8/12/25 at 1:48 p.m., a progress note identified a nurse from MD-B's office called the facility and stated a new order was sent to pharmacy on 8/11/25. Facility called pharmacy but pharmacy phone was not working. On 8/13/25 at 9:02 a.m., a progress note identified the pharmacy received new orders for R3's hydromorphone and would be delivering the medication as soon as possible. During an interview on 8/19/25 at 11:31 a.m., R1 stated she had not received her pain medication in the past due to not having any in the facility. During an interview on 8/20/25 at 7:48 a.m., licensed practical nurse (LPN)-A stated R1 had ran out of pain medications twice. At times, the providers did not reply to our requests for new pain medication prescriptions and residents would run out of their pain medications. During an interview on 8/20/25 at 9:53 a.m., R3 stated he did run out of his pain medications and the facility told him they would keep a better eye on his medication to ensure he did not run out again. During an interview on 8/20/25 at 12:10 p.m., registered nurse (RN)-A stated she did not believe the facility received medications for residents in a timely manner. RN-A called MD-A about R1 running out of her pain medication and MD-A stated not to call him just fax. RN-A explained to MD-A that not getting pain medications in a timely manner was an issue. During an interview on 8/20/25 at 12:34 p.m., the director of nursing stated the facility had a system issue when it came to pharmacy services and physician's responses. As a result, the medications not received timely at the facility for residents.	21550		

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21550	Continued from page 5 During an interview on 8/20/25 at 1:22 p.m., MD-A stated the pharmacy would not accept verbal orders for pain medications, so residents were running out of their pain medications at the facility. During an interview on 8/20/25 at 1:32 p.m., the consultant pharmacist stated the pharmacy could only take verbal orders for narcotics if it was an emergency. Pharmacy did not receive timely faxed orders and as a result, residents were running out of pain medications. During an interview on 8/20/25 at 2:35 p.m., the administrator stated it was expected that residents had their order medications and were given the medications per orders. The facility planned to work on a solution with the pharmacy and MD-A to ensure residents did not run out of their medications in the future. The facility policy Ordering and Receiving Medications undated, indicated reorder medications three to five days in advance of need to assure an adequate supply was on hand. When reordering medications that require special processing (such as Schedule II controlled substances), order at least seven days in advance of need. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication was ordered, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the disposition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21550		