



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 17, 2023

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

RE: CCN: 245239
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 25, 2023, we notified you a remedy was imposed. On September 14, 2023, October 16, 2023 and November 15, 2023 the Minnesota Departments of Health and Public Safety 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 3, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 9, 2023 be discontinued as of November 3, 2023. (42 CFR 488.417 (b))

In our letter of August 25, 2023, 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 September 9, 2023. 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 17, 2023

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

Re: Reinspection Results
Event ID: 6UY912

Dear Administrator:

On November 15, 2023 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 September 25, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 25, 2023

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

RE: CCN: 245239
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 25, 2023, we informed you of imposed enforcement remedies.

On September 25, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 9, 2023, will remain in effect.

This Department continues to recommend 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 September 9, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 9, 2023.

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.

As we notified you in our letter of August 25, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years

An equal opportunity employer.

from September 9, 2023.

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us

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 - Health Regulation Division 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 February 3, 2024 (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

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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/ltr_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

Guardian Angels Health & Rehab Center

October 25, 2023

Page 5

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,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 000	INITIAL COMMENTS On 9/21/23 through 9/25/23, 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. H52395643C (MN00096953) with a deficiency issued at F580, F684, and 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.	F 000			
F 580 SS=D	Notify of Changes (Injury/Degrade/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580			11/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/02/2023

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.

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023	
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 580	Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician and resident			F 580	F580- Notify of Changes DON and/or designee will implement		

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 580	Continued From page 2 representative were timely notified of a change of condition for 1 of 3 residents (R1) who had a status change resulting in a delay of medical diagnoses and treatment. Findings include R1's Face Sheet identified R1 had the following diagnosis: Parkinson's disease R1's quarterly Minimum Data Set (MDS) dated 6/28/23 identifies R1 to have had moderate cognitive impairment. Required assist of one for bed mobility, dressing, toilet use and assist of two for transferring. R1's care plan dated 1/30/22, identified R1 required assist to safely transfer from one surface to another and staff were to monitor for changes in abilities. R1's progress note dated 9/8/23 at 11:23 a.m., included "R1 weak, not eating, drooling, eyes glassed over, and left side of mouth drooping. No responding to questions. Resident appears to have possible stroke. Called MD and gave verbal orders to send to emergency room (ER). Family present signed bed hold. Ambulance called resident transported to Hibbing Fairview Range Medical Center. [FM-A] is going to ER [emergency room]." During an interview on 9/21/23 at 3:07 p.m., nursing assistant (NA)-A stated she had cared for R1 for over a year. The morning of 9/8/23, she had noticed R1 "had a big change", "something was wrong" and he was "way off". NA-A recalled being in R1's room between 5:30-5:45 a.m. on 9/8/23 to provide morning cares. R1 was not	F 580	corrective action for resident affected by this practice (R1) LPN-B was re-educated by DON/designee on notification of changes and significant change assessments. All residents have the potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: The Notification of Significant Change policy, and Significant Change of Status Assessment policy were reviewed, with no updates needed. All licensed nursing staff will be educated on the Notification of Significant Changes and Significant Change of Status Assessment policies to update medical provider and resident/resident's representative of changes noted and changes in treatment recommended by the medical provider. Random audits beginning on 11-3-23 will be completed by DON and/or designee, 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. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 11-3-23		

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 580	Continued From page 3 speaking clearly, would not stand, and was not following instructions. NA-A was concerned about balance, so the mechanical lift was used to get R1 out of bed. During the transfer R1 could not figure out how to use his legs, he wasn't following directions to keep his feet flat on the lift's foot support, and was not holding onto the lift. NA-A stated she had to use excessive strength to transfer R1 safely. Once R1 was seated in his wheelchair, NA-A noticed R1 was drooling throughout cares and he was not participating like normal. She completed his cares around 6:15 a.m. There was not a nurse on R1's unit so NA-A did not report R1's changes and waited until the day shift NA's started at 6:30 a.m. NA-A stated she did not notify LPN-A (night shift nurse), but thought LPN-A may have heard her giving report to NA-B and NA-C. During an interview on 9/21/23 at 3:15p.m., LPN-A indicated she recalled NA-A reporting R1 was not standing well, but nothing more specific. LPN-A stated after she heard report, she did not ask NA-A further questions, check on R1, or complete a comprehensive assessment. She did not think much of R1's change in ability to stand was concerning because his general health was declining. LPN-A stated her shift ended at 7:00 a.m. Review of R1's record from 9/8/23, identified after NA-A had identified and reported R1's condition at shift change, there were no recorded vital signs and no assessments or monitoring of R1's condition. Additionally, not evident the physician or R1's resident representative (family member (FM-A) was notified of the change in condition. During interview on 9/21/23 at 12:45 p.m., FM-A	F 580			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 580	Continued From page 4 stated on 9/8/23 she arrived at facility at 9:30 a.m. to visit R1. Upon arrival she immediately noticed something was wrong with R1; he was drooling, favoring his left side, and difficulty with swallowing. FM-A reported an NA (name not known) had told her R1 was up earlier than normal and required the use of a mechanical lift. FM-A found LPN-B at 10:00 a.m. and told her she was concerned he was favoring his left side and drooling. LPN-B attempted to give him tylenol and was not able to swallow. LPN-B responded to the situation by telling FM-A "let me know if he gets any worse." FM-A explained around 10:15 a.m. she was pushing R1 out of the dining room when LPN-B asked her "Do you want me to call the paramedics?" and FM-A responded "Yes please!". Email communication on 9/8/23 at 9:45 a.m., from FM-A to assistant director of nursing (ADON), activities director (AD)-A and registered nurse (RN)-A stated "I'm wondering who got him up this morning. And how he was doing... I got here past 9:30 a.m....conversing is a little difficult. He seems quite out of it." During interview on 9/21/23 at 4:39 p.m. LPN-B stated on 9/8/23, her shift started at 6:30 a.m. and was responsible for R1. LPN-B indicated she had not received any reports of concerns during shift report or from any day shift NAs about R1. LPN-B explained her first interaction was around 9:00 a.m., but did not recall anything specific about the interaction. LPN-B stated around 10:00 a.m. FM-A was with her voicing concerns about R1's condition; LPN-B attempted to administer pain medication however R1 was not swallowing and not himself. He was also not focusing and drooling. LPN-B indicated she did not complete	F 580			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023	
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 580	Continued From page 5 an assessment, obtain vital signs, or notify the physician, but instead completed a couple of more tasks. She then went back to the dining room and offered FM-A to send R1 to the hospital (LPN-B could not remember the time). FM-A wanted R1 sent to the hospital so LPN-B notified the physician who gave an order to send R1 to the hospital. ADON was the one that called the paramedics. LPN-B stated she felt the most important thing to do was to get R1 to the hospital, so she did not complete a neurological assessment or vital signs at any time During interview on 9/22/23 at 8:39 a.m., ADON recalled witnessing LPN-B running down the hallway on 9/8/23 around brunch time. LPN-B reported to her, R1 was drooling, not eating, and not really responsive. She had not heard anything about R1's condition change prior. ADON went to R1 and FM-A, upon arrival she attempted to talk to R1, however wasn't responsive, eyes were glazed over and drooling. ADON informed FM-A plan to send R1 to hospital. ADON called 9-1-1 around "10:30 a.m.-10:45ish." ADON explained NA's were supposed to notify a nurse, a nurse on the cart or DON if any concerns arise with change of condition. Review of R1's record from 9/8/23, identified a hand written MD verbal order to send to the emergency room due to signs and symptoms of a stroke, however did not identify the time of the order. Hibbing fire department pre hospital care report dated 9/8/23, identified the facility was received at 11:03 a.m. and arrived on scene at 11:05 a.m. R1 was positive for BEFAST stroke assessment. (assessment for sudden loss of balance, eyes,			F 580			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 580	Continued From page 6 face, uneven smile, arm weakness, speech). Facility staff did not report to medics R1's condition as reported by NA-A nor that staff had not had contact with R1 until after 9:00 a.m. Instead, the report identified staff reported R1 appeared sleepier than normal upon waking up at 8:00 a.m., however showed altered mental status, slurred speech, and weakness that started at approximately 9:30 a.m. Emergency Department Hospital records dated 9/8/23 identified R1's arrival time of 11:33 a.m. via emergency ambulance. Notes indicated the hospital was unclear of R1's well known time with a questionable onset of symptoms discovery time. R1 presented to the ED with face/arm/leg weakness, speech difficulty, not following commands. Stroke code was activated at 11:28 a.m., stroke provider first response 11:30 a.m, a head CT was read by doctor at 11:43 a.m., and stroke code was not deescalated due to a bleed. Imaging findings of 2.6 cm left thalamic intraparenchymal hemorrhage. During interview on 9/22/23 at 10:06 a.m., medical doctor (MD)-A indicated the facility notified her of the condition change on 9/8/23, however could not recall the time. She was not aware of the concerns that was noticed and reported by NA-A early that morning, nor facility nursing had not completed any type of assessment or monitored R1. MD-A stated she expected to be called immediately for any concern with change of condition especially if there were signs and symptoms of a stroke including change in mental status, speech, neuromuscular response, change in transfer status, and change with normal functional ability. MD stated R1's current condition was poor and	F 580			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 580	Continued From page 7 considering comfort measures versus placing a feeding tube. There had not been improvement in the last several days. MD indicated it was important to act fast regardless of the outcome and style of stroke as facility staff would not be able to identify the source without scans. Policy and procedure for notification of significant changes dated 1/7/19 identifies the facility will immediately inform the resident, consult with the physician, and notify the resident representative when the resident has a significant change. The purpose of the policy is to provide guidance to staff on when and who to notify of a significant change in a residents status. Significant change: a change in residents status, a need to alter treatment, an accident that results in injury, or a decision to transfer or discharge the individual receiving services from the care center. Immediately: as soon as practicable; acknowledging the need to stabilize an individual receiving services' condition. The charge nurse will immediately (as indicated by the change of condition) inform the resident, consult with the physician, and notify the resident representative for the following significant change situations: "An accident involving the resident which results in injury and has the potential for requiring physician intervention. "A deterioration in health, mental health, or psychosocial status in either life-threatening conditions or clinical complications. However, ongoing chronic conditions related to due to underlying disease process will be discussed at the care conference with the resident and or resident representative and when the condition deteriorates to meet criteria of a significant change, resident and/ or	F 580			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 580	Continued From page 8 representative will be notified. "A need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment: or "A decision to transfer to another provider or discharge the resident from the care center without primary physician involvement "Death of resident In the case of sudden illness or accident, the designated resident representative or family member, as appropriate will be notified of significant changes in the residents health status because the resident may not be able to notify them personally.	F 580			
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess, monitor and respond to signs of stroke like symptoms for 1 of 3 residents (R1) reviewed for change of condition. The facility's failures caused an excessive delay of medical diagnoses, management, and treatment of R1's condition which resulted in actual harm to R1. Findings include	F 684	F684 Quality of Care DON or designee will implement corrective action for residents affected by this practice (R1) R1 will be monitored for change of condition. All residents have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including:		11/3/23

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 684	Continued From page 9 R1's Face Sheet identified R1 had diagnosis of Parkinson's disease R1's quarterly Minimum Data Set (MDS) dated 6/28/23 identified R1 had moderate cognitive impairment. Required assist of one for bed mobility, dressing, toilet use, and assist of two for transferring. R1's care plan dated 1/30/22, identified R1 required assist to safely transfer from one surface to another and staff were to monitor for changes in abilities. R1's medication administration record (MAR) dated 9/8/23 identified R1's medications were administered at 5:31 a.m. and 9:03 a.m. and a tylenol dose at 10:00:37 a.m. Email communication on 9/8/23 at 9:45 a.m., from family member (FM)-A to assistant director of nursing (ADON), activities director (AD)-A and registered nurse (RN)-A stated "I'm wondering who got him up this morning. And how he was doing. I got here past 9:30 a.m.. No hearing aids in. No dentures in. He claims he slept well. But other than that conversing is a little difficult. He seems quite out of it." R1's progress note dated 9/8/23 at 11:23 a.m., included "R1 weak, not eating, drooling, eyes glassed over, and left side of mouth drooping. No responding to questions. Resident appears to have possible stroke. Called MD and gave verbal orders to send to emergency room (ER). Family present signed bed hold. Ambulance called resident transported to Hibbing Fairview Range Medical Center. [FM-A] is going to ER."	F 684	The Notification of Significant Change policy, and Significant Change of Status Assessment policy were reviewed, with no updates needed. All nursing staff will be educated on monitoring, assessing, and reporting change of condition process. Nursing education will include signs and symptoms of stroke and review of Stop and Watch tool to be completed by the NAR. The NAR will complete this tool and promptly bring changes noted to the nurse on the floor. Nurse on the floor will promptly assess resident and utilize SBAR to update medical provider and resident/residents representative of changes noted and changes in treatment recommended by the medical provider. Random audits beginning on 11-3-23 for change of condition will be completed by DON and/or designee three times a week for two weeks, then two times a week for two weeks, and then weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completion Date: 11-3-23		

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 684	Continued From page 10 During an interview on 9/21/23 at 3:15p.m., licensed practical nurse (LPN)-A stated she worked the night shift on 9/7/23 into 9/8/23. LPN-A reported providing medication to R1 at around 5:00 a.m. R1 was able to swallow, sit on the edge of the bed, and followed commands. R1 was not talkative but that was not abnormal for him. During an interview on 9/21/23 at 3:07 p.m., nursing assistant (NA)-A stated she had cared for R1 for over a year. The morning of 9/8/23, she had noticed R1 "had a big change", "something was wrong" and he was "way off". NA-A recalled being in R1's room between 5:30-5:45 a.m. on 9/8/23 to provide morning cares. R1 was not speaking clearly, would not stand, and was not following instructions. NA-A was concerned about balance, so the mechanical lift was used to get R1 out of bed. During the transfer R1 could not figure out how to use his legs, he wasn't following directions to keep his feet flat on the lift's foot support, and was not holding onto the lift. NA-A stated she had to use excessive strength to transfer R1 safely. Once R1 was seated in his wheelchair, NA-A noticed R1 was drooling throughout cares and he was not participating like normal. She completed his cares around 6:15 a.m. There was not a nurse on R1's unit so NA-A did not report R1's changes and waited until the day shift NA's started at 6:30 a.m. NA-A stated she told NA-B and NA-C "something was wrong", R1's legs were not working, was not sure what was going on, and they should use two assist to transfer. NA-A stated she did not notify LPN-A (night shift nurse), but thought LPN-A may have heard her giving report to NA-B and NA-C. NA-A stated she did not believe the NA's took her seriously and she should have immediately	F 684			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 684	Continued From page 11 reported the changes to the nurse. During interview on 9/21/23 at 2:38 p.m., NA-B recalled receiving report from NA-A and was instructed to "look out for him and monitor him because he wasn't doing too well" NA-B also indicated in report from NA-A there was a near fall while getting R1 up and NA-A had expressed transfer concerns. NA-B explained after getting report she did not go in and check on R1 until around 9:40 a.m. when FM-A asked her about R1's condition and asked her why staff were not checking on him. NA-B was not sure if other NA's provided any cares or contact with R1. NA-B indicated if there was a change in a resident it should be reported to a nurse right away if possible. However, sometimes she would make a note to herself then report to other NA's at the end of her shift. NA-A indicated she was supposed to check on residents every two hours, however that morning she unable to check on R1 because she was busy getting other residents up for the day. During interview on 9/25/23 at 10:08 a.m., RN-B indicated staff are to report to a nurse right away on any change of condition including weakness on one side and difficulty speaking. NA's were to tell nurses immediately if there were any concerns or changes. NAs should always communicate with the nurse prior to the end of their shift and should not only report to other nursing assistants. RN-B stated NAs were supposed to fill out the Early warning tool that identified the changes and given to a nurse, nurse manager, or the DON to complete an assessment. RN-B reviewed submitted tools, she stated there was not a tool completed for R1.	F 684			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 684	Continued From page 12 During an interview on 9/21/23 at 3:15p.m., LPN-A indicated that it was mandatory to get report from NAs at end of the shift. She recalled NA-A reporting R1 was not standing well, but nothing more specific. LPN-A stated after she heard report, she did not ask NA-A further questions, check on R1, or complete a comprehensive assessment. She did not think much of R1's change in ability to stand was concerning because his general health was declining. LPN-A stated her shift ended at 7:00 a.m. Review of R1's record from 9/8/23, identified after NA-A had identified and reported R1's condition at shift change, there were no recorded vital signs and no assessments or monitoring of R1's condition to determine his need for emergency medical treatment. Additionally not evident the physician was notified of the change in condition. During interview on 9/21/23 at 1:23 p.m., NA-C stated on 9/8/23, her shift started at 6:30 a.m. NA-C reported she was familiar with R1; he was an assist of one with a transfer belt, could brush his own teeth, shave himself, he was able to talk and make needs known, and he knew how to use the call light. It would be abnormal if he could not participate in or complete those tasks. NA-C recalled receiving report that day for R1, but did not provide cares or engage with R1. NA-C indicated FM-A asked her how R1 was doing, but told FM-A she was not the person who got R1 up for the day and did not know how he was. NA-C explained the first time she saw R1 was around 10:00 a.m. to get his brunch order and he was not able to understand, he was drooling, and was not normal. NA-C recalled R1's gaze being off and R1 was unable to look at her despite R1 being	F 684			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 684	Continued From page 13 directly in front of her. NA-C stated there was not a nurse scheduled on R1's unit that morning, she could not get a hold of LPN-B on the phone so she walked around and found her just after 10:30 a.m. During interview on 9/21/23 at 4:39 p.m. LPN-B stated on 9/8/23, her shift started at 6:30 a.m. and was responsible for R1. LPN-B indicated she had not received any reports of concerns during shift report or from any day shift NAs about R1. LPN-B explained her first interaction was around 9:00 a.m., but did not recall anything specific about the interaction. LPN-B stated around 10:00 a.m. FM-A was with her voicing concerns about R1's condition; LPN-B attempted to administer pain medication however R1 was not swallowing and not himself. He was also not focusing and drooling. LPN-B indicated she did not complete an assessment, obtain vital signs, or notify the physician, but instead completed a couple of more tasks. She then went back to the dining room and offered FM-A to send R1 to the hospital (LPN-B could not remember the time). FM-A wanted R1 sent to the hospital so LPN-B notified the physician who gave an order to send R1 to the hospital. ADON was the one that called the paramedics. LPN-B stated she felt the most important thing to do was to get R1 to the hospital, so she did not complete a neurological assessment or vital signs at any time. During interview on 9/21/23 at 12:45 p.m., FM-A stated on 9/8/23 she arrived at facility at 9:30 a.m. to visit R1. Upon arrival she immediately noticed something was wrong with R1; he was drooling, favoring his left side, and difficulty with swallowing. FM-A reported an NA (name not known) had told her R1 was up earlier than	F 684			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 684	Continued From page 14 normal and required the use of a mechanical lift. FM-A found LPN-B at 10:00 a.m. and told her she was concerned he was favoring his left side and drooling. LPN-B attempted to give him tylenol and was not able to swallow. LPN-B responded to the situation by telling FM-A "let me know if he gets any worse." FM-A explained around 10:15 a.m. she was pushing R1 out of the dining room when LPN-B asked her "Do you want me to call the paramedics?" and FM-A responded "Yes please!". FM-A expressed concerns with her own observations of staff's lack of identification, monitoring, taking vital signs and lack of urgency. FM-A was not informed of any condition changes prior to arriving at the facility. Review of R1's record from 9/8/23, identified after LPN-B was made aware of R1's changes, there were no recorded vital signs, no assessments or monitoring of R1's condition in order to determine need for emergency medical management. During interview on 9/22/23 at 8:39 a.m., ADON recalled witnessing LPN-B running down the hallway on 9/8/23 around brunch time. LPN-B reported to her, R1 was drooling, not eating, and not really responsive. She had not heard anything about R1's condition change prior. ADON went to R1 and FM-A, upon arrival she attempted to talk to R1, however wasn't responsive, eyes were glazed over and drooling. ADON informed FM-A plan to send R1 to hospital. ADON called 9-1-1 around "10:30 a.m.-10:45ish." ADON stated she did not do a neurological assessment or obtain vital signs. ADON explained NA's were supposed to notify a nurse, a nurse on the cart or DON if any concerns arise with change of condition. ADON indicated it was not appropriate for staff to be on shift for three hours and not have contact	F 684			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 684	Continued From page 15 with residents they are responsible for. ADON reported an internal investigation was not completed. Review of R1's record from 9/8/23, identified after ADON had been notified of R1's change in condition R1's record continued to reflect no recorded vital signs and no assessments or monitoring of R1's condition to determine the need for emergency medical treatment. Hibbing fire department pre-hospital care report identified on 9/8/23, the facility's call was received at 11:03 a.m. with response action of emergent (immediate response). Paramedics arrived on scene and R1 was seated in wheelchair in common area. R1 was sitting slumped leaning to the left side, neglecting right side, alert to painful stimuli with incomprehensible speech, and not able to follow commands. Staff stated to paramedics R1's normal mental status was alert and oriented with clear speech. The report identified staff reported R1 appeared sleepier than normal upon waking up at 8:00 a.m., however showed altered mental status, slurred speech, and weakness that started at approximately 9:30 a.m. R1 was positive for BEFAST stroke assessment. (assessment for sudden loss of balance, eyes, face, uneven smile, arm weakness, speech). The report identified the ambulance left the facility at 11:21 a.m. Emergency Department Hospital records dated 9/8/23 identified the ambulance arrived at the hospital at 11:33 a.m. The provider attempted to call the care facility about 15 times to ensure R1 was not on blood thinning medication but was only transferred to voicemail despite using the emergency line. Notes indicated it was unknown	F 684			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 684	Continued From page 16 the last time R1 was at base line due to not being able to get a hold of facility and the time of discovery or onset of symptoms is 8:00 a.m., however questionable. R1 presented with face/arm/leg weakness, speech difficulty, not following commands. All deficits were still present in ED upon provider exam. Stroke code was activated at 11:28 a.m., stroke provider first response 11:30 a.m., unknown last normal, questionable time of discovery, head CT was read by doctor at 11:43 a.m., and stroke code was not deescalated due to a bleed. Imaging findings of 2.6 cm left thalamic intraparenchymal hemorrhage (a brain bleed). During interview on 9/22/23 at 10:06 a.m., medical doctor (MD)-A indicated the facility notified her of the condition change on 9/8/23, however could not recall the time. She was not aware of the concerns that was noticed and reported by NA-A early that morning, nor facility nursing had not completed any type of assessment or monitored R1. MD-A stated she expected to be called immediately for any concern with change of condition especially if there were signs and symptoms of a stroke including change in mental status, speech, neuromuscular response, change in transfer status, and change with normal functional ability. MD-A would expect neurological assessments to be initiated right away, blood pressure to be completed and monitored. If assessments were not completed stroke signs and symptoms could progress without awareness. MD stated R1's current condition was poor and considering comfort measures versus placing a feeding tube. There had not been improvement in the last several days. MD-A indicated R1's type of stroke was hemorrhagic, therefore even with earlier	F 684			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 684	Continued From page 17 identification likely would not have changed the outcome. However, it was important to act fast regardless because facility staff would not be able to identify the type of stroke without further imaging scans and testing. During interview on 9/25/23 at 11:06 a.m. ADON indicated staff should find a nurse and speak directly with them with any change of condition. The receiving nurse should do an assessment and complete vitals to monitor for any changes outside of the residents baseline. Depending on the assessment the resident should be sent in to the hospital or closely monitored. ADON indicated early warning tool was a tool nursing assistants to communicate resident status changes, however not aware if it was fully implemented. ADON was not aware if one was completed for R1. Early warning tool "stop and watch" . If you have identified an important change while caring for a resident today, please circle the change and discuss it with the charge nurse before the end of your shift. Seems different then usual Talks or communicates less then usual Overall needs more help than usual Participated in activities less than usual Ate less than usual (not because of dislike of food) N Drank less than usual Weight change Agitated or nervous more than usual Tired, weak, confused, or drowsy Change in skin color or condition Help with walking, transferring toileting more then usual	F 684			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 684	Continued From page 18	F 684			
F 755 SS=D	A policy and procedure for quality care was requested and not received. 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(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §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:	F 755			11/3/23

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023	
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 755	Continued From page 19 Based on interview and record review the facility failed to ensure anti-Parkinson's medication was administered with in accordance with manufacturer's recommendations, and physician orders to prevent or reduce the risk of adverse side effects. Additionally failed to identify, report, and analyze medication errors in accordance with facility policy and standards of practice for 3 of 3 (R1, R2, R3) residents who received anti-Parkinson's medications. Findings include R1's Face Sheet identifies R1 had diagnoses that included Parkinson's disease. R1's quarterly Minimum Data Set (MDS) dated 6/28/23 identified R1 had moderate cognitive impairment. R1 required assist of one for bed, mobility, dressing, toilet use, and assist of two for transferring. R1's physicians orders included -Ferrous sulfate oral tablet (iron) to be given in the afternoon every day at 4:00 p.m. (start date 5/4/23) -Sinemet (carbidopa-levodopa) 25-100 milligrams (mg) five times per day every day at 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 8:00 p.m. (start date 4/19/22) -Carbidopa-Levodopa to be given at prescribed times without exception. Please try to give medication on time without variation to avoid wearing off, interaction with other medications, and side effects. No changes to medication timing (start date 9/7/23) The Federal Drug Administration manufacturer's recommendations for Sinemet			F 755	F755- Pharmacy Services DON and/or designee will implement corrective action for resident affected by this practice (R1, R2, and R3) R1, R2, and R3 medication administration times reviewed All residents have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: DON reviewed the Medication Administration and Medication Error Policies, with no updates needed. All residents who take Anti-Parkinson medications orders were reviewed. Resident's taking Iron and Anti-Parkinson medications are not scheduled at the same time. Education will be provided by the DON and/or designee to all Nurses and TMAs regarding SINEMET and the importance of taking this medication at the same time every day. Education provided that when Iron is administered at the same time as SINEMET, it reduces the efficiency of the medication. Iron and SINEMET should not be given at the same time. Paper forms were created for all residents taking SINEMET. Staff will use these forms as a reminder at the beginning of the shift that they have medications to administer that are time sensitive. Staff will document on paper logs the time that they administer SINEMET. These forms will be turned into the DON for review. Random audits beginning on 11-3-23 for monitoring of residents receiving SINEMET to ensure the time sensitive		

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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	
F 755	Continued From page 20 (carbidopa-levodopa) on record (https://www.accessdata.fda.gov/drugsatfda_docs/label/2008/017555s069lbl.pdf) included: The patient should be informed that SINEMET is an immediate-release formulation of carbidop-levodopa that is designed to begin release of ingredients within 30 minutes. It is important that SINEMET be taken at regular intervals according to the schedule outlined by the physician. The patient should be cautioned not to change the prescribed dosage regimen...Patients should be advised that sometimes a 'wearing-off ' effect may occur at the end of the dosing interval. The physician should be notified if such response poses a problem to lifestyle. R1's face to face encounter note dated 8/17/23 identified family member (FM)-A had brought concerns to medical doctor's (MD) attention regarding the importance of timely administration of Parkinson's medication. The note indicated R1 experienced intermittent confusion that clears between episodes MD had reiterated concerns to staff to ensure iron and Sinemet (carbidopa-Levodopa) are not administered together and within the appropriate time windows. Anemia was mild and occurring over the last several months. R1's time variance report from 4/1/23 to 9/25/23 identified 330 carbidopa-Levodopa administration variances outside of one hour scheduled administration time and 50 over three hours with the longest time variance of 4 hours and 35 minutes on 8/11/23. This report did not identify irregular intervals of administration. R1's medication administration record (MAR)	F 755	medication is being administered at appropriate times to give the desired therapeutic effect to the resident will be completed by the DON and/or designee for three times a week for two weeks, two times a week for two weeks, and weekly thereafter. Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Completed Date: 11-3-23		

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023	
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 755	Continued From page 21 between 8/27/23 through 9/25/23 included physician orders for carbidopa-Levodopa with dosing times of 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 8:00 p.m. The MAR identified Multiple doses that were not administered according to physician orders nor in accordance with facility policy that indicated medication could be administered one hour before or after the scheduled time. Further identified doses were not administered at consistent regular intervals according to manufacturer's recommendations. MAR included the following examples of administration time variances and irregular intervals for carbidopa-Levodopa: -On 8/27/23, scheduled doses administered at 1:38 p.m. then 6:43 p.m. -On 8/28/23, 10:00 a.m. scheduled dose was administered at 7:50 a.m., 2:00 p.m. dose was administered at 1:44 p.m., 6:00 p.m. dose was administered at 5:42 p.m. followed by a dose at 6:48 p.m. -On 8/29/23, doses were administered at 4:26 a.m., 10:11 a.m., 12:13 p.m., and doses scheduled for 6:00 and 8:00 p.m. were administered at 8:14 p.m. -On 8/30/23, doses were administered at 4:28 p.m. and 10:11 a.m. -On 8/31/23, 8:00 p.m. scheduled dose was not administered until 9:38 p.m. -On 9/2/23, scheduled doses were administered at 5:37 a.m., 7:34 a.m., 1:28 p.m., 6:20 p.m., and 6:55 p.m. -On 9/3/23 scheduled doses were administered at 6:24 a.m., 7:43 a.m., 12:03 p.m., 4:40 p.m., and 6:52 p.m. -On 9/4/23, scheduled doses were administered at 5:39 a.m., 7:45 a.m., and 1:35 p.m. -On 9/6/23, scheduled doses were administered at 9:21 a.m., 11:13 am., and 5:54 p.m.			F 755			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 755	Continued From page 22 -On 9/7/23, scheduled doses were administered at 5:37 a.m., 10:54 a.m. 12:03 p.m., 5:07 p.m. and 8:33 p.m. R1 was not in the facility between 9/8/23 to 9/22. -On 9/25/23, scheduled doses were administered at 10:35 a.m. then at 12:08 p.m. R1's Ferrous sulfate (iron) administration history from 8/27/23 to 9/26/23 identified R1 was provided ferrous sulfate at the same time as carbidopa-Levodopa on 8/29/23, 9/3/23, and 9/6/23 and within two hours on 8/28/23, 8/30/23, 9/1/23, 9/2/23, 9/4/23, and 9/7/23. No medication error reports were provided by the facility. During interview on 9/21/23 at 12:45 p.m., FM-A reported concerns regarding medication administration and staff were not receptive to importance of getting the medication on time including doses too close, too far apart, or double doses. It was also concerning carbidopa-Levodopa and iron were being administered together. FM-A stated R1's MD had expressed concerns to her that the facility was not following orders for the dosage times of the medication and as a result was affecting R1's physical ability, quality of life, and safety. The MD had reiterated the importance of timely administration. FM-A indicated she had notified the facility on several occasions but did not feel the facility was taking her concerns seriously. In a subsequent interview on 9/22/23, at 1:19 p.m. FM-A stated when R1's medications were not administered at the ordered times, R1 experienced increased weakness, increased shakiness, variability, and inconsistencies with ability to perform daily tasks. FM-A reported	F 755			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 755	Continued From page 23 concerns of R1 being provided carbidopa-Levodopa after R1 was in bed for the night or after falling asleep and feels it was an ineffective use of medications, because the purpose was to improve function and symptoms of Parkinson's while awake. During interview on 9/22/23 at 12:39 p.m., licensed practical nurse (LPN)-C stated carbidopa-Levodopa was the most important medication to give on time due to the risk of wearing off, the risk for increased symptoms, and need for appropriate spacing at the four-hour mark. Anything outside of the four-hour scheduled time dose would need to have a reasoning as to why the medication was provided late or early and an update to the doctor. LPN-C stated communication was key and letting the oncoming shift nurse know if a carbidopa-Levodopa medication was provided late or early so appropriate spacing could continue. During interview on 9/22/23 at 8:39 a.m. assistant director of nursing (ADON) stated awareness of some medication concerns with R1 including carbidopa-Levodopa and Iron being administered together. ADON reported completing a medication chart review and identified some medications were given too early and some were given too late. ADON indicated it was not okay to give carbidopa-Levodopa three hours past the scheduled time and would be too late. ADON stated the facility reached out to the pharmacist on 9/1/23 and received a pharmacist review on 9/7/23. During a subsequent interview on 9/25/23, at 11:06 a.m. ADON indicated that carbidopa-Levodopa and iron should be given 1-2 hours from each other per the recommendation	F 755			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023	
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 755	Continued From page 24 of the pharmacist. Pharmacy review letter, undated identified medication concerns from FM-A of medication administration including carbidopa-Levodopa and Iron. Letter indicated Sinemet package insert (carbidopa-Levodopa) and iron was recommended to be separated by 1-2 hours. Pharmacist indicated facilities medication window of an hour (on each side) to allow for the facility to be flexible and care of their patients in a safe and timely manner and was doing their best to administer the medications. During interview on 9/21/23 at 4:14 p.m., Pharmacist (P)-A confirmed R1 was taking and prescribed Iron (ferrous sulfate), and carbidopa-Levodopa. P-A stated iron and carbidopa-Levodopa are recommended to be taken two hours apart for proper absorption. During interview on 9/22/23 at 4:09 p.m., Pharmacist (P)-B indicated administering carbidopa-Levodopa two to three hours from scheduled dosage times was too late. It was recommended to take carbidopa-Levodopa four hours at the closest time between administration. Administering carbidopa-Levodopa too close together could increase side effects such as nausea, vomiting, and upset stomach. Additionally, administering carbidopa-Levodopa too far apart could cause wearing off which would increase Parkinson's side effects such as involuntary movements, chewing, gnawing, twisting, bobbing of the head, and shaking of hands and feet. (P)-B stated it was not recommended to vary times of this medication and it was important for staff to pay attention and administer based off previous dosage times and			F 755			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 755	Continued From page 25 adjust the administration so that it was to not be administered too early or too far apart. (P)-B indicated if this medication was consistently administered outside the recommended time frame and staff were to be "willy nilly" regarding the administration it would be cause for concern. R2's Face Sheet identified R1 had diagnoses that included neurocognitive disorder with Lewy bodies. R2's quarterly MDS dated 07/06/23 identified R2 had severe cognitive impairment. Required assist of two people for bed mobility, transferring, toilet use, and assist of one for dressing. R2's physician orders included carbidopa-Levodopa 25-100 mg three times per day every day at 8:00 a.m., 12:00 p.m., and 4:00 p.m. (start date 3/16/23) R2's August and September 2023 medication administration records identified physician orders for carbidopa-Levodopa with scheduled administration times of 8:00 a.m. 12:00 p.m, 4:00 p.m. The MAR identified Multiple doses that were not administered according to physician orders nor in accordance with facility policy that indicated medication could be administered one hour before or after the scheduled time. Further identified doses were not administered at consistent regular intervals according to manufacturer's recommendations. The MAR included the following examples of administration time variances and irregular intervals for carbidopa-Levodopa: -On 8/28/23, 4:00 p.m. scheduled dose was administered at 9:21 p.m. (previous dose given at 12:07 p.m.)	F 755			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 755	Continued From page 26 -On 9/1/23, both 8:00 a.m. and 12:00 p.m. doses were administered at 12:35 p.m., then at 3:19 p.m. -On 9/2/23, doses were administered at 9:20 a.m., 1:05 p.m., and 8:02 p.m. -On 9/3/23, doses were administered at 7:41 a.m. 11:33 a.m., and 9:19 p.m. -On 9/6/23, doses were administered at 8:00 a.m., 12:12 p.m., and 6:08 p.m. -On 9/7/23, doses were administered at 7:10 a.m., 11:12 p.m., and 2:20 p.m. -On 9/10/23, doses were administered at 7:39 a.m., 12:54 p.m., and 3:39 p.m. -On 9/11/23, doses were administered at 7:51 a.m., 11:57 p.m., and 2:13 p.m. -On 9/14/23, doses were administered at 9:22 a.m., 2:53 p.m., and 5:10 p.m. -On 9/15/23, doses were administered at 10:01 a.m., 12:21 p.m., and 3:18 p.m. -On 9/18/23, doses were administered at 8:01 a.m., 11:53 a.m., and 9:57 p.m. -On 9/23/23, doses were administered at 10:00 a.m., 11:57 a.m., and 2:28 p.m. -On 9/24/23, doses were administered at 10:06 a.m., 12:12 p.m., and 5:36 p.m. No medication error reports were provided by the facility. During interview on 9/25/23 at 12:04 p.m., FM-B indicated did not always know when R2 received the carbidopa-Levodopa but understood it to be an important medication to take timely and would be concerned if R2 was not receiving it timely. FM-B reported being in the facility and R2 not receiving the 12:00 p.m. dose prior to leaving in the afternoon. FM-A indicated nursing staff have asked FM-A when R2 was due to receive medication and does not feel that was	F 755			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 755	Continued From page 27 appropriate. R3's Face Sheet identified R1 had diagnoses that included Parkinson's disease. R3's quarterly MDS dated 8/25/23 identified R3 had moderate cognitive impairment. Required assist of one for bed mobility, dressing, toileting, and no assistance for transferring. R3's orders dated 2/1/22 instruct carbidopa-Levodopa 25-100 mg to be administered four times per day every day at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. R3's progress note dated 9/19/23, indicated R3 had Parkinson's disease with a significant tremor and now developing increasing cognitive issues. R3's August and September 2023 medication administration records identified physician orders for carbidopa-Levodopa with scheduled administration times of 8:00 a.m. 12:00 p.m, 4:00 p.m., and 8:00 p.m. The MAR identified Multiple doses that were not administered according to physician orders nor in accordance with facility policy that indicated medication could be administered one hour before or after the scheduled time. Further identified doses were not administered at consistent regular intervals according to manufacturer's recommendations. The MAR included the following examples of administration time variances and irregular intervals for carbidopa-Levodopa: -On 8/27/23, doses were administered at 9:31 a.m. and then at 11:55 a.m. -On 8/30/23, doses were administered at 8:27 a.m., 11:22 a.m., 5:07 p.m., and 8:47 p.m. -On 9/1/23, doses were administered at 9:19	F 755			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 755	Continued From page 28 a.m., 1:49 p.m., 3:42 p.m. -On 9/3/23, doses were administered at 11:37 a.m., and the 4:00 and 8:00 p.m. doses administered together at 8:09 p.m. -On 9/4/23, doses were administered at 11:36 a.m., 2:22 p.m., and 8:00 p.m. -On 9/6/23, doses were administered at 8:50 a.m., 12:16 p.m., 6:21 p.m., and 9:00 p.m. -On 9/7/23, doses were administered at 2:50 p.m. then at 6:05 p.m. -On 9/15/23, doses were administered at 3:49 p.m. then at 5:58 p.m. -On 9/16/23, doses were administered at 4:39 p.m. then at 9:49 p.m. -On 9/17/23, doses scheduled for 4:00 p.m. and 8:00 p.m. were both administered at 9:59 p.m. -On 9/18/23, doses were administered at 5:22 p.m. then at 10:23 p.m. -On 9/24/23, doses scheduled for 4:00 p.m. and 8:00 p.m. were administered at 5:43 p.m. and 5:55 p.m. -On 9/25/23, doses were administered at 9:14 a.m. then again at 10:43 p.m. No medication error reports were provided by the facility. During a return call interview on 9/27/23 at 8:31 a.m., MD-B indicated that anything outside of two hours would be a concern for administration of carbidopa-Levodopa as it's a short acting drug and essential for optimal function. MD-B would be concerned if R3 was not receiving carbidopa-Levodopa within two hours as R3 had a very serious tremor and very little manual dexterity (hand movement) that could impact transfers, function, and safety within the facility. MD-B indicated that there are residents that administration time was vital for	F 755			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 755	Continued From page 29 carbidopa-Levodopa, and if it was improperly administered, they would be unable to function. MD-B indicated that anything outside of four hours should be considered a medication error, and the expectation was for residents to be given medication on time and appropriate amounts in accordance with the order. During interview on 9/22/23 at 3:34 p.m., Administrator and ADON indicated the facility had not had any medication errors in the last 30 days. Late administration or variances causing irregular intervals of the dosage would not be considered a medication error. Further indicated the facility would only consider a medication error unless there were adverse side effects. Policy titled Medication administration dated 8/7/23, indicates the facility will ensure all medications will administered safely according to current standards of practice and regulatory requirement. The purpose to provide guidance to nursing staff on administering medication. 1. Procedure a. Check the electronic medical record (eMAR), not stop or hold orders, verify resident, medication, dose, time and route. b. BE SURE THE ACT OF SWALLOWING IS OBSERVED. c. The nursing staff documents the medications prepared, then upon ingestion documents the administration. d. If the resident refused the medication or unable to take the medication document the refusal in the eMAR and explain the reason why the medication was not given e. If a resident is currently out of the care center at the time of medication administration and has not taken their medication with them, the licensed	F 755			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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
F 755	Continued From page 30 staff member will document in the eMAR f. If a resident is currently out of the care center at time of the medication administration and has taken their medications with them. The nursing staff member will document in the eMAR g. DO NOT LEAVE MEDICATIONS WITH RESIDENTS. For residents who have been assessed as able or wanting to self - administer their medications, see policy on self- administration of medications 2. Miscellaneous a. Medication errors must be reported immediately to the charge nurse and/or the Director of Nursing. b. Physicians will be notified of medication errors, if a significant medication error (one that puts a resident's health in jeopardy) occurs the physician will be notified immediately for further treatment orders. 3. Medication pass times a. Medication pass times will include general timeframes to accommodate resident's wake/sleep cycle, preferences, and not to interfere with residents quality of life, as able. b. A specific time will be scheduled for orders the provider indicated to administer at a certain time. Determining Medication Errors Timing Errors Count a wrong time error if the medication is administered 60 or more minutes earlier or later than its scheduled time of administration, but only if that wrong time error can cause the resident discomfort or jeopardize the resident's health and safety. Counting a medication with a long half- life as a wrong time error when it is 15 minutes late is improper because the medication has a long half-life (beyond 24 hours) and 15 minutes has no significant impact on the resident. The same is true for many other wrong time errors.	F 755			

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

PRINTED: 11/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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	
F 755	Continued From page 31 The adjustment of the medication administration times, to meet the individual needs and preferences of residents, must be considered in a nursing home. However, medication administration scheduling must still consider physician prescription, manufacture's guidelines, and the types of medication, including time-critical medications. Some medications require administration within a narrow window of time to ensure resident safety or achieve a therapeutic effect while other medications are not affected by a more flexible schedule.	F 755			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 25, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 6UY911

Dear Administrator:

The above facility was surveyed on September 21, 2023 through September 25, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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,



Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
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 9/21/23 through 9/25/23, 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	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

11/02/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed. H52395643C (MN00096953) with a licensing order issued at 0265, 0830, and 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 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	2 000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 000	Continued From page 2 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.	2 000			
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265			11/3/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician and resident representative were timely notified of a change of condition for 1 of 3 residents (R1) who had a status change resulting in a delay of medical diagnoses and treatment. Findings include R1's Face Sheet identified R1 had the following diagnosis: Parkinson's disease R1's quarterly Minimum Data Set (MDS) dated 6/28/23 identifies R1 to have had moderate cognitive impairment. Required assist of one for bed mobility, dressing, toilet use and assist of two for transferring. R1's care plan dated 1/30/22, identified R1 required assist to safely transfer from one surface to another and staff were to monitor for changes in abilities. R1's progress note dated 9/8/23 at 11:23 a.m., included "R1 weak, not eating, drooling, eyes glassed over, and left side of mouth drooping. No responding to questions. Resident appears to have possible stroke. Called MD and gave verbal orders to send to emergency room (ER). Family present signed bed hold. Ambulance called resident transported to Hibbing Fairview Range Medical Center. [FM-A] is going to ER	2 265	Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 265	Continued From page 4 [emergency room]." During an interview on 9/21/23 at 3:07 p.m., nursing assistant (NA)-A stated she had cared for R1 for over a year. The morning of 9/8/23, she had noticed R1 "had a big change", "something was wrong" and he was "way off". NA-A recalled being in R1's room between 5:30-5:45 a.m. on 9/8/23 to provide morning cares. R1 was not speaking clearly, would not stand, and was not following instructions. NA-A was concerned about balance, so the mechanical lift was used to get R1 out of bed. During the transfer R1 could not figure out how to use his legs, he wasn't following directions to keep his feet flat on the lift's foot support, and was not holding onto the lift. NA-A stated she had to use excessive strength to transfer R1 safely. Once R1 was seated in his wheelchair, NA-A noticed R1 was drooling throughout cares and he was not participating like normal. She completed his cares around 6:15 a.m. There was not a nurse on R1's unit so NA-A did not report R1's changes and waited until the day shift NA's started at 6:30 a.m. NA-A stated she did not notify LPN-A (night shift nurse), but thought LPN-A may have heard her giving report to NA-B and NA-C. During an interview on 9/21/23 at 3:15p.m., LPN-A indicated she recalled NA-A reporting R1 was not standing well, but nothing more specific. LPN-A stated after she heard report, she did not ask NA-A further questions, check on R1, or complete a comprehensive assessment. She did not think much of R1's change in ability to stand was concerning because his general health was declining. LPN-A stated her shift ended at 7:00 a.m. Review of R1's record from 9/8/23, identified after	2 265			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 265	Continued From page 5 NA-A had identified and reported R1's condition at shift change, there were no recorded vital signs and no assessments or monitoring of R1's condition. Additionally, not evident the physician or R1's resident representative (family member (FM-A) was notified of the change in condition. During interview on 9/21/23 at 12:45 p.m., FM-A stated on 9/8/23 she arrived at facility at 9:30 a.m. to visit R1. Upon arrival she immediately noticed something was wrong with R1; he was drooling, favoring his left side, and difficulty with swallowing. FM-A reported an NA (name not known) had told her R1 was up earlier than normal and required the use of a mechanical lift. FM-A found LPN-B at 10:00 a.m. and told her she was concerned he was favoring his left side and drooling. LPN-B attempted to give him tylenol and was not able to swallow. LPN-B responded to the situation by telling FM-A "let me know if he gets any worse." FM-A explained around 10:15 a.m. she was pushing R1 out of the dining room when LPN-B asked her "Do you want me to call the paramedics?" and FM-A responded "Yes please!". Email communication on 9/8/23 at 9:45 a.m., from FM-A to assistant director of nursing (ADON), activities director (AD)-A and registered nurse (RN)-A stated "I'm wondering who got him up this morning. And how he was doing... I got here past 9:30 a.m....conversing is a little difficult. He seems quite out of it." During interview on 9/21/23 at 4:39 p.m. LPN-B stated on 9/8/23, her shift started at 6:30 a.m. and was responsible for R1. LPN-B indicated she had not received any reports of concerns during shift report or from any day shift NAs about R1. LPN-B explained her first interaction was around	2 265			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 265	Continued From page 6 9:00 a.m., but did not recall anything specific about the interaction. LPN-B stated around 10:00 a.m. FM-A was with her voicing concerns about R1's condition; LPN-B attempted to administer pain medication however R1 was not swallowing and not himself. He was also not focusing and drooling. LPN-B indicated she did not complete an assessment, obtain vital signs, or notify the physician, but instead completed a couple of more tasks. She then went back to the dining room and offered FM-A to send R1 to the hospital (LPN-B could not remember the time). FM-A wanted R1 sent to the hospital so LPN-B notified the physician who gave an order to send R1 to the hospital. ADON was the one that called the paramedics. LPN-B stated she felt the most important thing to do was to get R1 to the hospital, so she did not complete a neurological assessment or vital signs at any time During interview on 9/22/23 at 8:39 a.m., ADON recalled witnessing LPN-B running down the hallway on 9/8/23 around brunch time. LPN-B reported to her, R1 was drooling, not eating, and not really responsive. She had not heard anything about R1's condition change prior. ADON went to R1 and FM-A, upon arrival she attempted to talk to R1, however wasn't responsive, eyes were glazed over and drooling. ADON informed FM-A plan to send R1 to hospital. ADON called 9-1-1 around "10:30 a.m.-10:45ish." ADON explained NA's were supposed to notify a nurse, a nurse on the cart or DON if any concerns arise with change of condition. Review of R1's record from 9/8/23, identified a hand written MD verbal order to send to the emergency room due to signs and symptoms of a stroke, however did not identify the time of the order.	2 265			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE	
2 265	Continued From page 7 Hibbing fire department pre hospital care report dated 9/8/23, identified the facility was received at 11:03 a.m. and arrived on scene at 11:05 a.m. R1 was positive for BEFAST stroke assessment. (assessment for sudden loss of balance, eyes, face, uneven smile, arm weakness, speech). Facility staff did not report to medics R1's condition as reported by NA-A nor that staff had not had contact with R1 until after 9:00 a.m. Instead, the report identified staff reported R1 appeared sleepier than normal upon waking up at 8:00 a.m., however showed altered mental status, slurred speech, and weakness that started at approximately 9:30 a.m. Emergency Department Hospital records dated 9/8/23 identified R1's arrival time of 11:33 a.m. via emergency ambulance. Notes indicated the hospital was unclear of R1's well known time with a questionable onset of symptoms discovery time. R1 presented to the ED with face/arm/leg weakness, speech difficulty, not following commands. Stroke code was activated at 11:28 a.m., stroke provider first response 11:30 a.m, a head CT was read by doctor at 11:43 a.m., and stroke code was not deescalated due to a bleed. Imaging findings of 2.6 cm left thalamic intraparenchymal hemorrhage. During interview on 9/22/23 at 10:06 a.m., medical doctor (MD)-A indicated the facility notified her of the condition change on 9/8/23, however could not recall the time. She was not aware of the concerns that was noticed and reported by NA-A early that morning, nor facility nursing had not completed any type of assessment or monitored R1. MD-A stated she expected to be called immediately for any concern with change of condition especially if	2 265			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 265	Continued From page 8 there were signs and symptoms of a stroke including change in mental status, speech, neuromuscular response, change in transfer status, and change with normal functional ability. MD stated R1's current condition was poor and considering comfort measures versus placing a feeding tube. There had not been improvement in the last several days. MD indicated it was important to act fast regardless of the outcome and style of stroke as facility staff would not be able to identify the source without scans. Policy and procedure for notification of significant changes dated 1/7/19 identifies the facility will immediately inform the resident, consult with the physician, and notify the resident representative when the resident has a significant change. The purpose of the policy is to provide guidance to staff on when and who to notify of a significant change in a residents status. Significant change: a change in residents status, a need to alter treatment, an accident that results in injury, or a decision to transfer or discharge the individual receiving services from the care center. Immediately: as soon as practicable; acknowledging the need to stabilize an individual receiving services' condition. The charge nurse will immediately (as indicated by the change of condition) inform the resident, consult with the physician, and notify the resident representative for the following significant change situations: "An accident involving the resident which results in injury and has the potential for requiring physician intervention. "A deterioration in health, mental health, or psychosocial status in either life-threatening conditions or clinical complications. However, ongoing chronic conditions related to due to underlying disease process will be	2 265			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 265	Continued From page 9 discussed at the care conference with the resident and or resident representative and when the condition deteriorates to meet criteria of a significant change, resident and/ or representative will be notified. "A need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment: or "A decision to transfer to another provider or discharge the resident from the care center without primary physician involvement "Death of resident In the case of sudden illness or accident, the designated resident representative or family member, as appropriate will be notified of significant changes in the residents health status because the resident may not be able to notify them personally. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on notification on change of condition. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents are assessed and monitored for change of condition, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 265			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and	2 830			11/3/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 830	Continued From page 10 plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess, monitor and respond to signs of stroke like symptoms for 1 of 3 residents (R1) reviewed for change of condition. The facility's failures caused an excessive delay of medical diagnoses, management, and treatment of R1's condition which resulted in actual harm to R1. Findings include R1's Face Sheet identified R1 had diagnosis of Parkinson's disease R1's quarterly Minimum Data Set (MDS) dated 6/28/23 identified R1 had moderate cognitive impairment. Required assist of one for bed mobility, dressing, toilet use, and assist of two for transferring. R1's care plan dated 1/30/22, identified R1 required assist to safely transfer from one surface to another and staff were to monitor for changes in abilities. R1's medication administration record (MAR) dated 9/8/23 identified R1's medications were administered at 5:31 a.m. and 9:03 a.m. and a	2 830	Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 830	Continued From page 11 tylenol dose at 10:00:37 a.m. Email communication on 9/8/23 at 9:45 a.m., from family member (FM)-A to assistant director of nursing (ADON), activities director (AD)-A and registered nurse (RN)-A stated "I'm wondering who got him up this morning. And how he was doing. I got here past 9:30 a.m.. No hearing aids in. No dentures in. He claims he slept well. But other than that conversing is a little difficult. He seems quite out of it." R1's progress note dated 9/8/23 at 11:23 a.m., included "R1 weak, not eating, drooling, eyes glassed over, and left side of mouth drooping. No responding to questions. Resident appears to have possible stroke. Called MD and gave verbal orders to send to emergency room (ER). Family present signed bed hold. Ambulance called resident transported to Hibbing Fairview Range Medical Center. [FM-A] is going to ER." During an interview on 9/21/23 at 3:15p.m., licensed practical nurse (LPN)-A stated she worked the night shift on 9/7/23 into 9/8/23. LPN-A reported providing medication to R1 at around 5:00 a.m. R1 was able to swallow, sit on the edge of the bed, and followed commands. R1 was not talkative but that was not abnormal for him. During an interview on 9/21/23 at 3:07 p.m., nursing assistant (NA)-A stated she had cared for R1 for over a year. The morning of 9/8/23, she had noticed R1 "had a big change", "something was wrong" and he was "way off". NA-A recalled being in R1's room between 5:30-5:45 a.m. on 9/8/23 to provide morning cares. R1 was not speaking clearly, would not stand, and was not following instructions. NA-A was concerned about	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 830	Continued From page 12 balance, so the mechanical lift was used to get R1 out of bed. During the transfer R1 could not figure out how to use his legs, he wasn't following directions to keep his feet flat on the lift's foot support, and was not holding onto the lift. NA-A stated she had to use excessive strength to transfer R1 safely. Once R1 was seated in his wheelchair, NA-A noticed R1 was drooling throughout cares and he was not participating like normal. She completed his cares around 6:15 a.m. There was not a nurse on R1's unit so NA-A did not report R1's changes and waited until the day shift NA's started at 6:30 a.m. NA-A stated she told NA-B and NA-C "something was wrong", R1's legs were not working, was not sure what was going on, and they should use two assist to transfer. NA-A stated she did not notify LPN-A (night shift nurse), but thought LPN-A may have heard her giving report to NA-B and NA-C. NA-A stated she did not believe the NA's took her seriously and she should have immediately reported the changes to the nurse. During interview on 9/21/23 at 2:38 p.m., NA-B recalled receiving report from NA-A and was instructed to "look out for him and monitor him because he wasn't doing too well" NA-B also indicated in report from NA-A there was a near fall while getting R1 up and NA-A had expressed transfer concerns. NA-B explained after getting report she did not go in and check on R1 until around 9:40 a.m. when FM-A asked her about R1's condition and asked her why staff were not checking on him. NA-B was not sure if other NA's provided any cares or contact with R1. NA-B indicated if there was a change in a resident it should be reported to a nurse right away if possible. However, sometimes she would make a note to herself then report to other NA's at the end of her shift. NA-A indicated she was	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 830	Continued From page 13 supposed to check on residents every two hours, however that morning she unable to check on R1 because she was busy getting other residents up for the day. During interview on 9/25/23 at 10:08 a.m., RN-B indicated staff are to report to a nurse right away on any change of condition including weakness on one side and difficulty speaking. NA's were to tell nurses immediately if there were any concerns or changes. NAs should always communicate with the nurse prior to the end of their shift and should not only report to other nursing assistants. RN-B stated NAs were supposed to fill out the Early warning tool that identified the changes and given to a nurse, nurse manager, or the DON to complete an assessment. RN-B reviewed submitted tools, she stated there was not a tool completed for R1. During an interview on 9/21/23 at 3:15p.m., LPN-A indicated that it was mandatory to get report from NAs at end of the shift. She recalled NA-A reporting R1 was not standing well, but nothing more specific. LPN-A stated after she heard report, she did not ask NA-A further questions, check on R1, or complete a comprehensive assessment. She did not think much of R1's change in ability to stand was concerning because his general health was declining. LPN-A stated her shift ended at 7:00 a.m. Review of R1's record from 9/8/23, identified after NA-A had identified and reported R1's condition at shift change, there were no recorded vital signs and no assessments or monitoring of R1's condition to determine his need for emergency medical treatment. Additionally not evident the physician was notified of the change in condition.	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 830	Continued From page 14 During interview on 9/21/23 at 1:23 p.m., NA-C stated on 9/8/23, her shift started at 6:30 a.m. NA-C reported she was familiar with R1; he was an assist of one with a transfer belt, could brush his own teeth, shave himself, he was able to talk and make needs known, and he knew how to use the call light. It would be abnormal if he could not participate in or complete those tasks. NA-C recalled receiving report that day for R1, but did not provide cares or engage with R1. NA-C indicated FM-A asked her how R1 was doing, but told FM-A she was not the person who got R1 up for the day and did not know how he was. NA-C explained the first time she saw R1 was around 10:00 a.m. to get his brunch order and he was not able to understand, he was drooling, and was not normal. NA-C recalled R1's gaze being off and R1 was unable to look at her despite R1 being directly in front of her. NA-C stated there was not a nurse scheduled on R1's unit that morning, she could not get a hold of LPN-B on the phone so she walked around and found her just after 10:30 a.m. During interview on 9/21/23 at 4:39 p.m. LPN-B stated on 9/8/23, her shift started at 6:30 a.m. and was responsible for R1. LPN-B indicated she had not received any reports of concerns during shift report or from any day shift NAs about R1. LPN-B explained her first interaction was around 9:00 a.m., but did not recall anything specific about the interaction. LPN-B stated around 10:00 a.m. FM-A was with her voicing concerns about R1's condition; LPN-B attempted to administer pain medication however R1 was not swallowing and not himself. He was also not focusing and drooling. LPN-B indicated she did not complete an assessment, obtain vital signs, or notify the physician, but instead completed a couple of	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 830	Continued From page 15 more tasks. She then went back to the dining room and offered FM-A to send R1 to the hospital (LPN-B could not remember the time). FM-A wanted R1 sent to the hospital so LPN-B notified the physician who gave an order to send R1 to the hospital. ADON was the one that called the paramedics. LPN-B stated she felt the most important thing to do was to get R1 to the hospital, so she did not complete a neurological assessment or vital signs at any time. During interview on 9/21/23 at 12:45 p.m., FM-A stated on 9/8/23 she arrived at facility at 9:30 a.m. to visit R1. Upon arrival she immediately noticed something was wrong with R1; he was drooling, favoring his left side, and difficulty with swallowing. FM-A reported an NA (name not known) had told her R1 was up earlier than normal and required the use of a mechanical lift. FM-A found LPN-B at 10:00 a.m. and told her she was concerned he was favoring his left side and drooling. LPN-B attempted to give him tylenol and was not able to swallow. LPN-B responded to the situation by telling FM-A "let me know if he gets any worse." FM-A explained around 10:15 a.m. she was pushing R1 out of the dining room when LPN-B asked her "Do you want me to call the paramedics?" and FM-A responded "Yes please!". FM-A expressed concerns with her own observations of staff's lack of identification, monitoring, taking vital signs and lack of urgency. FM-A was not informed of any condition changes prior to arriving at the facility. Review of R1's record from 9/8/23, identified after LPN-B was made aware of R1's changes, there were no recorded vital signs, no assessments or monitoring of R1's condition in order to determine need for emergency medical management.	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 830	Continued From page 16 During interview on 9/22/23 at 8:39 a.m., ADON recalled witnessing LPN-B running down the hallway on 9/8/23 around brunch time. LPN-B reported to her, R1 was drooling, not eating, and not really responsive. She had not heard anything about R1's condition change prior. ADON went to R1 and FM-A, upon arrival she attempted to talk to R1, however wasn't responsive, eyes were glazed over and drooling. ADON informed FM-A plan to send R1 to hospital. ADON called 9-1-1 around "10:30 a.m.-10:45ish." ADON stated she did not do a neurological assessment or obtain vital signs. ADON explained NA's were supposed to notify a nurse, a nurse on the cart or DON if any concerns arise with change of condition. ADON indicated it was not appropriate for staff to be on shift for three hours and not have contact with residents they are responsible for. ADON reported an internal investigation was not completed. Review of R1's record from 9/8/23, identified after ADON had been notified of R1's change in condition R1's record continued to reflect no recorded vital signs and no assessments or monitoring of R1's condition to determine the need for emergency medical treatment. Hibbing fire department pre-hospital care report identified on 9/8/23, the facility's call was received at 11:03 a.m. with response action of emergent (immediate response). Paramedics arrived on scene and R1 was seated in wheelchair in common area. R1 was sitting slumped leaning to the left side, neglecting right side, alert to painful stimuli with incomprehensible speech, and not able to follow commands. Staff stated to paramedics R1's normal mental status was alert and oriented with clear speech. The report identified staff reported R1 appeared sleepier	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 830	Continued From page 17 than normal upon waking up at 8:00 a.m., however showed altered mental status, slurred speech, and weakness that started at approximately 9:30 a.m. R1 was positive for BEFAST stroke assessment. (assessment for sudden loss of balance, eyes, face, uneven smile, arm weakness, speech). The report identified the ambulance left the facility at 11:21 a.m. Emergency Department Hospital records dated 9/8/23 identified the ambulance arrived at the hospital at 11:33 a.m. The provider attempted to call the care facility about 15 times to ensure R1 was not on blood thinning medication but was only transferred to voicemail despite using the emergency line. Notes indicated it was unknown the last time R1 was at base line due to not being able to get a hold of facility and the time of discovery or onset of symptoms is 8:00 a.m., however questionable. R1 presented with face/arm/leg weakness, speech difficulty, not following commands. All deficits were still present in ED upon provider exam. Stroke code was activated at 11:28 a.m., stroke provider first response 11:30 a.m., unknown last normal, questionable time of discovery, head CT was read by doctor at 11:43 a.m., and stroke code was not deescalated due to a bleed. Imaging findings of 2.6 cm left thalamic intraparenchymal hemorrhage (a brain bleed). During interview on 9/22/23 at 10:06 a.m., medical doctor (MD)-A indicated the facility notified her of the condition change on 9/8/23, however could not recall the time. She was not aware of the concerns that was noticed and reported by NA-A early that morning, nor facility nursing had not completed any type of assessment or monitored R1. MD-A stated she expected to be called immediately for any	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 830	Continued From page 18 concern with change of condition especially if there were signs and symptoms of a stroke including change in mental status, speech, neuromuscular response, change in transfer status, and change with normal functional ability. MD-A would expect neurological assessments to be initiated right away, blood pressure to be completed and monitored. If assessments were not completed stroke signs and symptoms could progress without awareness. MD stated R1's current condition was poor and considering comfort measures versus placing a feeding tube. There had not been improvement in the last several days. MD-A indicated R1's type of stroke was hemorrhagic, therefore even with earlier identification likely would not have changed the outcome. However, it was important to act fast regardless because facility staff would not be able to identify the type of stroke without further imaging scans and testing. During interview on 9/25/23 at 11:06 a.m. ADON indicated staff should find a nurse and speak directly with them with any change of condition. The receiving nurse should do an assessment and complete vitals to monitor for any changes outside of the residents baseline. Depending on the assessment the resident should be sent in to the hospital or closely monitored. ADON indicated early warning tool was a tool nursing assistants to communicate resident status changes, however not aware if it was fully implemented. ADON was not aware if one was completed for R1. Early warning tool "stop and watch" . If you have identified an important change while caring for a resident today, please circle the change and discuss it with the charge nurse before the end of your shift. Seems different then usual	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
2 830	Continued From page 19 Talks or communicates less than usual Overall needs more help than usual Participated in activities less than usual Ate less than usual (not because of dislike of food) N Drank less than usual Weight change Agitated or nervous more than usual Tired, weak, confused, or drowsy Change in skin color or condition Help with walking, transferring toileting more than usual A policy and procedure for quality care was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to significant change in condition assessments, including identification of when a significant change in condition has occurred and collection of required information. The DON or designee could educate nursing staff on signs and symptoms of stroke and notification of change protocols. The DON or designee could then review and auditing system to ensure staff are communicating and appropriately documenting changes. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830			
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy	21550			11/3/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
21550	Continued From page 20 services. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure anti-Parkinson's medication was administered with in accordance with manufacturer's recommendations, and physician orders to prevent or reduce the risk of adverse side effects. Additionally failed to identify, report, and analyze medication errors in accordance with facility policy and standards of practice for 3 of 3 (R1, R2, R3) residents who received anti-Parkinson's medications. Findings include R1's Face Sheet identifies R1 had diagnoses that included Parkinson's disease. R1's quarterly Minimum Data Set (MDS) dated 6/28/23 identified R1 had moderate cognitive impairment. R1 required assist of one for bed, mobility, dressing, toilet use, and assist of two for transferring. R1's physicians orders included -Ferrous sulfate oral tablet (iron) to be given in the afternoon every day at 4:00 p.m. (start date 5/4/23) -Sinemet (carbidopa-levodopa) 25-100 milligrams (mg) five times per day every day at 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 8:00 p.m. (start date 4/19/22) -Carbidopa-Levodopa to be given at prescribed times without exception. Please try to give medication on time without variation to avoid wearing off, interaction with other medications,	21550	Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
21550	Continued From page 21 and side effects. No changes to medication timing (start date 9/7/23) The Federal Drug Administration manufacturer's recommendations for Sinemet (carbidopa-levodopa) on record (https://www.accessdata.fda.gov/drugsatfda_docs/label/2008/017555s069lbl.pdf) included: The patient should be informed that SINEMET is an immediate-release formulation of carbidop-levodopa that is designed to begin release of ingredients within 30 minutes. It is important that SINEMET be taken at regular intervals according to the schedule outlined by the physician. The patient should be cautioned not to change the prescribed dosage regimen...Patients should be advised that sometimes a 'wearing-off' effect may occur at the end of the dosing interval. The physician should be notified if such response poses a problem to lifestyle. R1's face to face encounter note dated 8/17/23 identified family member (FM)-A had brought concerns to medical doctor's (MD) attention regarding the importance of timely administration of Parkinson's medication. The note indicated R1 experienced intermittent confusion that clears between episodes MD had reiterated concerns to staff to ensure iron and Sinemet (carbidopa-Levodopa) are not administered together and within the appropriate time windows. Anemia was mild and occurring over the last several months. R1's time variance report from 4/1/23 to 9/25/23 identified 330 carbidopa-Levodopa administration variances outside of one hour scheduled administration time and 50 over three hours with the longest time variance of 4 hours and 35	21550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
21550	Continued From page 22 minutes on 8/11/23. This report did not identify irregular intervals of administration. R1's medication administration record (MAR) between 8/27/23 through 9/25/23 included physician orders for carbidopa-Levodopa with dosing times of 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 8:00 p.m. The MAR identified Multiple doses that were not administered according to physician orders nor in accordance with facility policy that indicated medication could be administered one hour before or after the scheduled time. Further identified doses were not administered at consistent regular intervals according to manufacturer's recommendations. MAR included the following examples of administration time variances and irregular intervals for carbidopa-Levodopa: -On 8/27/23, scheduled doses administered at 1:38 p.m. then 6:43 p.m. -On 8/28/23, 10:00 a.m. scheduled dose was administered at 7:50 a.m., 2:00 p.m. dose was administered at 1:44 p.m., 6:00 p.m. dose was administered at 5:42 p.m. followed by a dose at 6:48 p.m. -On 8/29/23, doses were administered at 4:26 a.m., 10:11 a.m., 12:13 p.m., and doses scheduled for 6:00 and 8:00 p.m. were administered at 8:14 p.m. -On 8/30/23, doses were administered at 4:28 p.m. and 10:11 a.m. -On 8/31/23, 8:00 p.m. scheduled dose was not administered until 9:38 p.m. -On 9/2/23, scheduled doses were administered at 5:37 a.m., 7:34 a.m., 1:28 p.m., 6:20 p.m., and 6:55 p.m. -On 9/3/23 scheduled doses were administered at 6:24 a.m., 7:43 a.m., 12:03 p.m., 4:40 p.m., and 6:52 p.m. -On 9/4/23, scheduled doses were administered	21550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
21550	Continued From page 23 at 5:39 a.m., 7:45 a.m., and 1:35 p.m. -On 9/6/23, scheduled doses were administered at 9:21 a.m., 11:13 am., and 5:54 p.m. -On 9/7/23, scheduled doses were administered at 5:37 a.m., 10:54 a.m. 12:03 p.m., 5:07 p.m. and 8:33 p.m. R1 was not in the facility between 9/8/23 to 9/22. -On 9/25/23, scheduled doses were administered at 10:35 a.m. then at 12:08 p.m. R1's Ferrous sulfate (iron) administration history from 8/27/23 to 9/26/23 identified R1 was provided ferrous sulfate at the same time as carbidopa-Levodopa on 8/29/23, 9/3/23, and 9/6/23 and within two hours on 8/28/23, 8/30/23, 9/1/23, 9/2/23, 9/4/23, and 9/7/23. No medication error reports were provided by the facility. During interview on 9/21/23 at 12:45 p.m., FM-A reported concerns regarding medication administration and staff were not receptive to importance of getting the medication on time including doses too close, too far apart, or double doses. It was also concerning carbidopa-Levodopa and iron were being administered together. FM-A stated R1's MD had expressed concerns to her that the facility was not following orders for the dosage times of the medication and as a result was affecting R1's physical ability, quality of life, and safety. The MD had reiterated the importance of timely administration. FM-A indicated she had notified the facility on several occasions but did not feel the facility was taking her concerns seriously. In a subsequent interview on 9/22/23, at 1:19 p.m. FM-A stated when R1's medications were not administered at the ordered times, R1 experienced increased weakness, increased	21550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
21550	Continued From page 24 shakiness, variability, and inconsistencies with ability to perform daily tasks. FM-A reported concerns of R1 being provided carbidopa-Levodopa after R1 was in bed for the night or after falling asleep and feels it was an ineffective use of medications, because the purpose was to improve function and symptoms of Parkinson's while awake. During interview on 9/22/23 at 12:39 p.m., licensed practical nurse (LPN)-C stated carbidopa-Levodopa was the most important medication to give on time due to the risk of wearing off, the risk for increased symptoms, and need for appropriate spacing at the four-hour mark. Anything outside of the four-hour scheduled time dose would need to have a reasoning as to why the medication was provided late or early and an update to the doctor. LPN-C stated communication was key and letting the oncoming shift nurse know if a carbidopa-Levodopa medication was provided late or early so appropriate spacing could continue. During interview on 9/22/23 at 8:39 a.m. assistant director of nursing (ADON) stated awareness of some medication concerns with R1 including carbidopa-Levodopa and Iron being administered together. ADON reported completing a medication chart review and identified some medications were given too early and some were given too late. ADON indicated it was not okay to give carbidopa-Levodopa three hours past the scheduled time and would be too late. ADON stated the facility reached out to the pharmacist on 9/1/23 and received a pharmacist review on 9/7/23. During a subsequent interview on 9/25/23, at 11:06 a.m. ADON indicated that carbidopa-Levodopa and iron should be given 1-2	21550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
21550	Continued From page 25 hours from each other per the recommendation of the pharmacist. Pharmacy review letter, undated identified medication concerns from FM-A of medication administration including carbidopa-Levodopa and Iron. Letter indicated Sinemet package insert (carbidopa-Levodopa) and iron was recommended to be separated by 1-2 hours. Pharmacist indicated facilities medication window of an hour (on each side) to allow for the facility to be flexible and care of their patients in a safe and timely manner and was doing their best to administer the medications. During interview on 9/21/23 at 4:14 p.m., Pharmacist (P)-A confirmed R1 was taking and prescribed Iron (ferrous sulfate), and carbidopa-Levodopa. P-A stated iron and carbidopa-Levodopa are recommended to be taken two hours apart for proper absorption. During interview on 9/22/23 at 4:09 p.m., Pharmacist (P)-B indicated administering carbidopa-Levodopa two to three hours from scheduled dosage times was too late. It was recommended to take carbidopa-Levodopa four hours at the closest time between administration. Administering carbidopa-Levodopa too close together could increase side effects such as nausea, vomiting, and upset stomach. Additionally, administering carbidopa-Levodopa too far apart could cause wearing off which would increase Parkinson's side effects such as involuntary movements, chewing, gnawing, twisting, bobbing of the head, and shaking of hands and feet. (P)-B stated it was not recommended to vary times of this medication and it was important for staff to pay attention and administer based off previous dosage times and	21550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
21550	Continued From page 26 adjust the administration so that it was to not be administered too early or too far apart. (P)-B indicated if this medication was consistently administered outside the recommended time frame and staff were to be "willy nilly" regarding the administration it would be cause for concern. R2's Face Sheet identified R1 had diagnoses that included neurocognitive disorder with Lewy bodies. R2's quarterly MDS dated 07/06/23 identified R2 had severe cognitive impairment. Required assist of two people for bed mobility, transferring, toilet use, and assist of one for dressing. R2's physician orders included carbidopa-Levodopa 25-100 mg three times per day every day at 8:00 a.m., 12:00 p.m., and 4:00 p.m. (start date 3/16/23) R2's August and September 2023 medication administration records identified physician orders for carbidopa-Levodopa with scheduled administration times of 8:00 a.m. 12:00 p.m, 4:00 p.m. The MAR identified Multiple doses that were not administered according to physician orders nor in accordance with facility policy that indicated medication could be administered one hour before or after the scheduled time. Further identified doses were not administered at consistent regular intervals according to manufacturer's recommendations. The MAR included the following examples of administration time variances and irregular intervals for carbidopa-Levodopa: -On 8/28/23, 4:00 p.m. scheduled dose was administered at 9:21 p.m. (previous dose given at 12:07 p.m.) -On 9/1/23, both 8:00 a.m. and 12:00 p.m. doses	21550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
21550	Continued From page 27 were administered at 12:35 p.m., then at 3:19 p.m. -On 9/2/23, doses were administered at 9:20 a.m., 1:05 p.m., and 8:02 p.m. -On 9/3/23, doses were administered at 7:41 a.m. 11:33 a.m., and 9:19 p.m. -On 9/6/23, doses were administered at 8:00 a.m., 12:12 p.m., and 6:08 p.m. -On 9/7/23, doses were administered at 7:10 a.m., 11:12 p.m., and 2:20 p.m. -On 9/10/23, doses were administered at 7:39 a.m., 12:54 p.m., and 3:39 p.m. -On 9/11/23, doses were administered at 7:51 a.m., 11:57 p.m., and 2:13 p.m. -On 9/14/23, doses were administered at 9:22 a.m., 2:53 p.m., and 5:10 p.m. -On 9/15/23, doses were administered at 10:01 a.m., 12:21 p.m., and 3:18 p.m. -On 9/18/23, doses were administered at 8:01 a.m., 11:53 a.m., and 9:57 p.m. -On 9/23/23, doses were administered at 10:00 a.m., 11:57 a.m., and 2:28 p.m. -On 9/24/23, doses were administered at 10:06 a.m., 12:12 p.m., and 5:36 p.m. No medication error reports were provided by the facility. During interview on 9/25/23 at 12:04 p.m., FM-B indicated did not always know when R2 received the carbidopa-Levodopa but understood it to be an important medication to take timely and would be concerned if R2 was not receiving it timely. FM-B reported being in the facility and R2 not receiving the 12:00 p.m. dose prior to leaving in the afternoon. FM-A indicated nursing staff have asked FM-A when R2 was due to receive medication and does not feel that was appropriate.	21550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
21550	Continued From page 28 R3's Face Sheet identified R1 had diagnoses that included Parkinson's disease. R3's quarterly MDS dated 8/25/23 identified R3 had moderate cognitive impairment. Required assist of one for bed mobility, dressing, toileting, and no assistance for transferring. R3's orders dated 2/1/22 instruct carbidopa-Levodopa 25-100 mg to be administered four times per day every day at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. R3's progress note dated 9/19/23, indicated R3 had Parkinson's disease with a significant tremor and now developing increasing cognitive issues. R3's August and September 2023 medication administration records identified physician orders for carbidopa-Levodopa with scheduled administration times of 8:00 a.m. 12:00 p.m, 4:00 p.m., and 8:00 p.m. The MAR identified Multiple doses that were not administered according to physician orders nor in accordance with facility policy that indicated medication could be administered one hour before or after the scheduled time. Further identified doses were not administered at consistent regular intervals according to manufacturer's recommendations. The MAR included the following examples of administration time variances and irregular intervals for carbidopa-Levodopa: -On 8/27/23, doses were administered at 9:31 a.m. and then at 11:55 a.m. -On 8/30/23, doses were administered at 8:27 a.m., 11:22 a.m., 5:07 p.m., and 8:47 p.m. -On 9/1/23, doses were administered at 9:19 a.m., 1:49 p.m., 3:42 p.m. -On 9/3/23, doses were administered at 11:37 a.m., and the 4:00 and 8:00 p.m. doses	21550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
21550	Continued From page 29 administered together at 8:09 p.m. -On 9/4/23, doses were administered at 11:36 a.m., 2:22 p.m., and 8:00 p.m. -On 9/6/23, doses were administered at 8:50 a.m., 12:16 p.m., 6:21 p.m., and 9:00 p.m. -On 9/7/23, doses were administered at 2:50 p.m. then at 6:05 p.m. -On 9/15/23, doses were administered at 3:49 p.m. then at 5:58 p.m. -On 9/16/23, doses were administered at 4:39 p.m. then at 9:49 p.m. -On 9/17/23, doses scheduled for 4:00 p.m. and 8:00 p.m. were both administered at 9:59 p.m. -On 9/18/23, doses were administered at 5:22 p.m. then at 10:23 p.m. -On 9/24/23, doses scheduled for 4:00 p.m. and 8:00 p.m. were administered at 5:43 p.m. and 5:55 p.m. -On 9/25/23, doses were administered at 9:14 a.m. then again at 10:43 p.m. No medication error reports were provided by the facility. During a return call interview on 9/27/23 at 8:31 a.m., MD-B indicated that anything outside of two hours would be a concern for administration of carbidopa-Levodopa as it's a short acting drug and essential for optimal function. MD-B would be concerned if R3 was not receiving carbidopa-Levodopa within two hours as R3 had a very serious tremor and very little manual dexterity (hand movement) that could impact transfers, function, and safety within the facility. MD-B indicated that there are residents that administration time was vital for carbidopa-Levodopa, and if it was improperly administered, they would be unable to function. MD-B indicated that anything outside of four hours should be considered a medication error,	21550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
21550	Continued From page 30 and the expectation was for residents to be given medication on time and appropriate amounts in accordance with the order. During interview on 9/22/23 at 3:34 p.m., Administrator and ADON indicated the facility had not had any medication errors in the last 30 days. Late administration or variances causing irregular intervals of the dosage would not be considered a medication error. Further indicated the facility would only consider a medication error unless there were adverse side effects. Policy titled Medication administration dated 8/7/23, indicates the facility will ensure all medications will administered safely according to current standards of practice and regulatory requirement. The purpose to provide guidance to nursing staff on administering medication. 1. Procedure a. Check the electronic medical record (eMAR), not stop or hold orders, verify resident, medication, dose, time and route. b. BE SURE THE ACT OF SWALLOWING IS OBSERVED. c. The nursing staff documents the medications prepared, then upon ingestion documents the administration. d. If the resident refused the medication or unable to take the medication document the refusal in the eMAR and explain the reason why the medication was not given e. If a resident is currently out of the care center at the time of medication administration and has not taken their medication with them, the licensed staff member will document in the eMAR f. If a resident is currently out of the care center at time of the medication administration and has taken their medications with them. The nursing staff member will document in the eMAR	21550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE
21550	Continued From page 31 g. DO NOT LEAVE MEDICATIONS WITH RESIDENTS. For residents when have been assessed as able or wanting to self - administer their medications, see policy on self-administration of medications 2. Miscellaneous a. Medication errors must be reported immediately to the charge nurse and/or the Director of Nursing. b. Physicians will be notified of medication errors, if a significant medication error (one that puts a residents health in jeopardy) occurs the physician will be notified immediately for further treatment orders. 3. Medication pass times a. Medication pass times will include general timeframes to accommodate resident's wake/sleep cycle, preferences, and not to interfere with residents quality of life, as able. b. A specific time will be schedule for orders the provider indicated to administer at a certain time. Determining Medication Errors Timing Errors Count a wrong time error if the medication is administered 60 or more minutes earlier or later than its scheduled time of administration, but only if that wrong time error can cause the resident discomfort or jeopardize the residents health and safety. Counting a medication with a long half- life as a wrong time error when it is 15 minutes late is improper because the medication has a long half-life (beyond 24 hours) and 15 minutes has no significant impact on the resident. The same is true for many other wrong time errors. The adjustment of the medication administration times, to meet the individual needs and preferences of residents, must be considered in a nursing home. However, medication administration scheduling must still consider physician prescription, manufacture's guidelines,	21550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2023
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS HEALTH & REHAB CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 EAST THIRD AVENUE HIBBING, MN 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) COMPLETE DATE	
21550	Continued From page 32 and the types of medication, including time-critical medications. Some medications require administration within a narrow window of time to ensure resident safety or achieve a therapeutic effect while other medications are not affected by a more flexible schedule. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on medication administration. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents are being provided medication in accordance to physicians order, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21550			