STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Angels Health & Rehab Center	1500 East Third Avenue Hibbing, MN 55746

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790 Based on interview and document review, the facility failed to ensure pain management was provided according to the residents' goals and preferences for 1 of 3 residents (R1) reviewed for pain management. This deficient practice caused actual harm for R1, who experienced unmanaged severe pain, disturbed sleep and needed two doses of his narcotic medication to receive pain control. The facility implemented immediate corrective action, prior to the survey and was issued at past non-compliance. Findings include: R1's Face Sheet dated 10/15/24, identified R1 had diagnoses of chronic pain syndrome. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 was cognitively intact, had pain, and used as needed pain medications. R1's care plan dated 10/24/24 indicated R1 was at risk for pain, and directed staff to administer medications as ordered. Non-pharmacological interventions were identified to apply cold or heat to area of R1's pain or offer to repositioning. R1's Provider Orders dated 10/15/24 indicated orders for hydrocodone-acetaminophen (narcotic pain medication) 10-325 milligrams (mg) one tablet to be given as needed every six hours for pain. R1's electronic Medication Administration Record (eMAR) dated 10/25/24 through 11/11/24,since admission, R1 received pain medication at least once daily, and all but one day he had a dose between 3:00 p.m. and 9:30 p.m. He only received two doses of hydrocodone- acetaminophen 10-325 mg at 9:59 a.m. and 11:12 p. m. on 11/3/24. R1's call light log for 11/3/24 indicated R1 put his call light on at 6:11 p.m., 7:10 p.m., 7:36 p.m., 8:30 p.m., 8:43 p.m., 10:16 p.m., and 11:08 p.m. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 11/12/24 at 9:21 a.m., R1 stated on the evening of 11/3/24, it took the nurse five hours to bring him his pain medications. He had left sided flank pain (from a previous kidney donation surgery), and put his call light on to ask for pain medication. Nursing assistant (NA)-A answered his call light, and told him she was going to let the nurse know he was requesting pain medication. The pain continued to get worse and worse, it felt like someone was ripping my left side open, it was off the charts and was at a 13/10 pain level (a pain scale from 0 to 10 describes pain intensity; 0 meaning no pain, 1-3 meaning mild pain, 4-6 meaning moderate pain, and 7-10 meaning severe pain). He couldn't sleep because of the pain, so he kept putting on the call light, and everyone kept saying they had told the nurse. He kept pushing the call light until a nurse came in during the night and gave him pain medications. It took him until the morning of 11/4/24 to get his pain managed, he did not sleep well that night. On 11/12/24 at 10:23 a.m., RN-A stated on 11/3/24 at around 11:00 p.m., R1 had his call light on and she had answered it. R1 told her he had been waiting for his pain medications for over five hours. He told her he had asked for a pain pill around 6:00 p.m. and still hadn't received any medication. R1 told her his pain was off the charts and terrible. He rated his pain a 13/10 and he was upset. She gave him his pain medication around 11:05 p.m. The next morning around 6:00 a.m. she went to check on him again, he was still having pain of 10/10, so she gave him another dose of pain medication. On 11/12/24 at 10:54 a.m., NA-A stated on the evening of 11/3/24 she took care of R1. She went into his room three different times that evening due to answer his call light. The first time he asked for pain medications, and she went and told licensed practical nurse (LPN)-A. LPN-A stated, Ok. The second time NA-A went into R1's room, he stated he had been waiting an hour and a half for his pain medication. She told him the nurse had been told, and should be coming in with his pain meds soon. The third time she answered his call light, R1 told her he was still waiting for his pain medication, and it had been over two hours. She told him again LPN-A should be coming soon. She only told LPN-A the first time R1 requested pain medication, and did not go and tell LPN-A the other two times she had answered the call light. On 11/12/24 at 11:21 a.m., LPN-B stated on the evening of 11/3/24 he had answered R1's call light twice. The first time he answered R1's call light was between 7:00 p.m. and 8:00 p.m. R1 told him he needed a pain pill, and had already requested pain medication, but still hadn't received it. R1 was upset that he was still waiting. He went and told LPN-A R1 was requesting pain medication, and she stated she had to look to see if R1 could have anything yet. On 11/12/24 at 12:34 p.m., the director of nursing (DON) stated staff should follow provider orders and the care plans when a resident need or requested anything. On 11/12/24 at 12:53 p.m., R1's medical provider stated if R1 was having high pain levels and his pain was not under control, even though the pain was not life threatening, he would have concerns with the affect the pain could have on R1's quality of life. On 11/12/24 at 1:43 p.m., LPN-A stated she couldn't remember if anyone told her R1 needed pain medications on 11/3/24. Someone could have told her R1 needed pain medications, but she might not have heard them because she was busy. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Although two separate individuals communicated to LPN-A that R1 request pain medication, he did not received it until five hours later. He identified his pain continued to get and worse, it felt like someone was ripping his left side open, and his pain was off the charts rating it a 13/10 pain level scale. Also, R1 had to take two doses of his narcotic pain medication which he had not done historically to get his pain under control on 11/3 to 11/4/24. The facility policy Pain Management dated 11/6/24 directed the facility will provide care and services that will recognize and manage resident's pain to support his or her highest practicable level of well-being. The deficient practice was corrected on 11/6/24, after the facility implemented a plan that included the following actions: Facility investigation was coordinated with interviews of staff and residents on unit. Pain management policy was reviewed on 11/6/24. Staff was educated on the pain management policy and expectations if a resident was in pain on 11/6/24. Audits monitoring pain management practices started on 11/6/24. LPN-A was provided education for pain management, resident rights, and customer service. The corrective actions were verified through observation, interviews and document review.