

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 08/20/2025
NAME OF PROVIDER OR SUPPLIER Guardian Angels Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and document review, the facility failed to ensure supply and administration of ordered medications for 3 of 3 resident (R1, R2, and R3) reviewed for pharmacy services. Findings include: R1 R1's Face Sheet dated 3/9/25, identified R1 had diagnoses of lower back pain, arthritis, and pain in left hip. R1's care plan revised on 3/16/25, identified R1 had chronic pain and instructed staff to administer medications per provider orders. R1's medication administration record (MAR) dated 8/2025, identified R1 had orders for oxycodone (a prescription medicine used to treat moderate to severe pain) 10mg twice daily for pain. The MAR lacked documentation R1 received ordered medications on 8/9/25 at 8:00 p.m., through 8/11/25 at 8:00 a.m. R1's progress note dated 8/8/25 at 8:43 p.m., identified R1's medical provider (MD)-A was called on 8/8/25 at 5:00 p.m., regarding R1's oxycodone 10mg pain medication needing a new order. MD-A indicated he would take care of it. On 8/9/25 at 6:12 a.m., a progress note identified R1's oxycodone never arrived from the pharmacy. On 8/10/25 at 10:45 p.m., a progress note identified MD-A was faxed regarding R1's oxycodone. Pharmacy was called and stated MD-A never sent new orders to pharmacy. On 8/11/25 at 7:19 a.m., a progress note identified oxycodone 10mg dose was not on cart and MD-A was notified. R2 R2's care plan dated 3/26/25, identified R2 had potential for pain and instructed staff to administer medications per orders. R2's Face Sheet dated 5/23/25, identified R2 had diagnoses of polyneuropathy (nervous system disorder that can cause symptoms of numbness, burning, and pain in multiple areas of the body), polymyalgia rheumatica (inflammatory disorder causing muscle pain around shoulders and hips), and lower back pain. R2's MAR dated 8/2025, identified R2 had orders for hydromorphone (a prescription medicine used to treat moderate to severe pain) 1mg (milligram) three times a day for pain. The MAR lacked documentation R2 received the ordered medications on 8/10/25 at 8:00 a.m. through 8/13/25 at 8:00 a.m. R2's progress note dated 8/10/25 at 9:02 a.m., identified R2's hydromorphone was not administered, was ordered, and staff waited for delivery. On 8/11/25 at 7:14 p.m., a progress note identified R2's hydromorphone was not given, and facility continued to wait for pharmacy to deliver the medication. On 8/12/25 at 12:29 p.m., a progress note identified R2 was out of scheduled hydromorphone. Pharmacy had stated the order appeared to be discontinued, but facility had no record of the medication being discontinued, facility needed to provide pharmacy with a new order or confirm the medication was discontinued. On 8/12/25 at 12:48 p.m., a progress note identified MD-A was called and preferred to be sent a fax in regards to R2's out of stock pain medication. On 8/13/25 at 9:07 a.m., a progress note identified pharmacy was called and stated they were awaiting MD-A's response to a refill request for R2's hydromorphone. R3 R3's Face Sheet dated 6/24/25, identified R3 had diagnoses of surgical amputation of right toes and gout (form of arthritis that causes severe pain). R3's care plan dated 7/1/25, identified R3 had potential for pain due to right toe amputation and instructed staff to administer pain medications per orders. R3's MAR dated 8/2025, identified R3 had orders for hydromorphone 2mg every four hours as needed for pain. R3 did not received ordered medications on 8/12/25. R3's progress note dated 8/12/25 at 11:44 a.m., identified R3 had no hydromorphone at the facility, MD-B was called and left a message to advise on R3's pain medication. On 8/12/25 at 1:48 p.m., a progress note identified a nurse from MD-B's office called the facility and stated a new order was sent to pharmacy on 8/11/25. Facility called pharmacy but pharmacy phone was not working. On 8/13/25 at 9:02 a.m., a progress note identified the pharmacy received new orders for R3's hydromorphone and would be delivering the medication as soon as possible. During an interview on 8/19/25 at 11:31 a.m., R1 stated she had not received her pain medication in the past due to not having any in the facility. During an interview on 8/20/25 at 7:48 a.m., licensed practical nurse (LPN)-A stated R1 had ran out of pain medications twice. At times, the providers did not reply to our requests for new pain medication prescriptions and residents would run out of their pain medications. During an interview on 8/20/25 at 9:53 a.m., R3 stated he did run out of his pain medications and the facility told him they would keep a better eye on his medication to ensure he did not run out again. During an interview on 8/20/25 at 12:10 p.m., registered nurse (RN)-A stated she did not believe the facility received medications for residents in a timely manner. RN-A called MD-A about R1 running out of her pain medication and MD-A stated not to call him just fax. RN-A explained to MD-A that not getting pain medications in a timely manner was an issue. During an interview on 8/20/25 at 12:34 p.m., the director of nursing stated the facility had a system issue when it came to pharmacy services and physician's responses. As a result, the medications not received timely at the facility for residents. During an interview on 8/20/25 at 1:22 p.m. MD-A stated the pharmacy would not</p>		