Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 13, 2023

Administrator
Annandale Care Center
500 Park Street East
Annandale, MN 55302

RE: CCN: 245364
Cycle Start Date: July 26, 2023

Dear Administrator:

On August 21, 2023, we notified you a remedy was imposed. On October 3, 2023, the Minnesota Department(s) 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 September 29, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 26, 2023, did not go into effect. (42 CFR 488.417 (b))

In our letter of August 21, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 26, 2023, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 29, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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August 21, 2023

Administrator
Annandale Care Center
500 Park Street East
Annandale, MN 55302

RE: CCN: 245364
Cycle Start Date: July 26, 2023

Dear Administrator:

On July 26, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 26, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 26, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / 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/ltc_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 electronic 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

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER	500 PARK STREET EAST ANNANDALE, MN 55302

(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
E 000	Initial Comments On 7/24/23-7/26/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/24/23-7/26/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. 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 with NO deficiencies cited: H53643805C MN93621 and H53643804C MN 93626. 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 substantial compliance with the regulations has been attained.	F 000		
F 790	Routine/Emergency Dental Srvcs in SNFs	F 790		9/29/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/30/2023

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.

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F 790 SS=D	Continued From page 1 CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental	F 790		

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F 790	Continued From page 2 services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow up with the dental provider after a dental evaluation was completed, and a need for a treatment had been identified for 1 of 1 residents (R25) reviewed for dental concerns. Findings include: R25's Face Sheet identified multiple diagnoses, which included diabetes mellitus (a disease which affects how the body uses blood sugar (glucose), nausea with vomiting, gastroparesis (a condition where the stomach muscles can't move food normally through the digestive tract), and gastro-esophageal reflux disease (a condition that causes acid reflux and heartburn) with esophagitis (inflammation of the esophagus). R25's care plan, edited 7/10/23, identified R25 was on a regular diet with thin liquids and regular textures, with foods cut for resident. The care plan also identified R25 was independent with hygiene and grooming, with staff assistance provided as needed. During interview on 7/24/23 at 6:16 p.m., R25 stated she had a partial denture in place, as well as broken teeth present. R25 stated she had seen a dentist for evaluation since admission, and although she was unaware of the specific work needed, stated there was a recommendation for further dental work. A review of the Consult section in R25's electronic medical record lacked indication of any dental	F 790	How corrective action will be accomplished for the residents found to be affected: HealthDrive was contacted to obtain treatment plan for R25. Recommendations were reviewed with R25. Treatment plan was declined and family stated they are following up with outside provider. How the facility will identify other residents having the potential to be affected by same practice: We will audit all resident charts for outside provider visit notes to ensure that any treatment plans recommended have been followed up on or completed. A progress note will be put in resident chart to indicate audit was completed. What measures will be put into place, or systemic changes made to ensure deficient practice will not recur. Reviewed process with Healthdrive, our in-house rounding ancillary provider to establish a system that includes sending after visit summaries and treatment plans to the facility designated staff. Their current process was to send the follow up letter directly to the resident or their responsible party and not to the facility staff. A shared document will be created that lists the resident and which provider was seen along with any follow-up that is required. The RN case manager or	

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F 790	Continued From page 3 visits completed. On 7/26/23 at 1:06 p.m. registered nurse (RN)-B was consulted regarding any history of dental consults for R25. At 1:39 p.m. RN-B provided documentation of a dental consult which had been completed on 12/8/22. The document identified R25 had active dental disease and a treatment plan was to be developed once radiographs (x-rays) were reviewed. RN-B stated she was unsure of the time frame when the reports should have been received, however, stated the recommendations should have been received prior to this. RN-B stated follow through on dental recommendations was important for prevention of other dental issues. On 7/26/23 at 2:45 p.m. the director of nursing (DON) stated follow up should have been in place to track consultation visit notes of those consultations completed to ensure the appropriate follow up was received. The facility policy, reviewed 9/17, titled Consultation Tracking Records, identified nursing was to track all appointments each resident had and were to record them in the progress notes in the Automated record. The policy lacked indication as to the process of obtaining the progress notes following consultation, and the process of coordination of recommended treatment.	F 790	designee will be required to follow up and sign off on the document that is was completed. A note will also be put into their electronic medical record indicating that the treatment plan was followed up on. How facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur. The Director or Designee will audit shared document and resident charts monthly x3 months, then quarterly x3 quarterly and annually thereafter.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883		9/29/23

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F 883	Continued From page 4 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

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F 883	Continued From page 5 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R26 and R35) were offered, or received, the pneumococcal vaccine (PCV20) in accordance with the Centers for Disease Control (CDC) recommendations. Findings include: The CDC's PneumoRecs VaxAdvisor identified: "Based on shared clinical decision-making, decide whether to administer one dose of PCV20 at least 5 years after the last pneumococcal vaccine dose" and patients age 19-64 with the risk factor of diabetes mellitus are recommended to have "one dose of PCV15 or PCV20 at least 1 year after their last dose of PPSV23". The CDC's Pneumococcal Vaccine Timing for Adults, dated 3/15/23, identified: "Together with the patient, vaccine providers may choose to administer PCV20 to adults 65 years and older who have already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of 65 years old".	F 883	How corrective action will be accomplished for the residents found to be affected: R26 and R35 were offered the PCV20 per CDC guidelines. R35 accepted and has been administered. R26 accepted and awaiting PCP orders. How the facility will identify other residents having the potential to be affected by same practice: An audit will be completed of all residents in facility to identify if there are others who are eligible for the updated pneumococcal immunization. For those that are identified as being eligible they will be offered the vaccine and their electronic record will be updated to reflect whether accepted or declined and when the vaccine was administered if accepted. What measures will be put into place, or systemic changes made to ensure deficient practice will not recur: The Infection Preventionist or designee will review vaccination records to	

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F 883	Continued From page 6 R26's Resident Face Sheet, identified she was 80 years old, and had multiple diagnoses, which included Type 2 diabetes mellitus, pulmonary nodule (a growth which may be cancerous or non-cancerous), and malignant pleural effusion (a condition where fluid with cancer cells accumulates in the space between lungs and the chest wall). R26 had no allergies to vaccines or contraindications to the PCV20 vaccine listed. R26's immunization report identified she had previously received the PPSV23 on 3/25/13, and the PCV13 on 9/23/15. R26's medical record lacked evidence the recommended PCV20 vaccination was offered or received. R35's Resident Face Sheet, identified she was 80 years old. R35's diagnoses included chronic respiratory failure with hypoxia, other forms of dyspnea, chronic obstructive pulmonary disease, and obstructive sleep apnea. R35 had no allergies or contraindications to the PCV20 vaccine listed. R35's immunization report identified she had previously received the PCV13 on 3/30/17 and the PPSV23 on 11/1/02 and 3/5/10. R35's medical record lacked evidence the recommended PCV20 vaccine was offered or received. When interviewed on 7/26/23 at 10:02 a.m. the infection preventionist, registered nurse (RN)-A, stated although she was aware of the requirement to offer the PCV-20 to residents upon their admission to the facility, she was unaware of the need to develop a plan to audit the records of those currently residing in the facility. RN-B stated she was using the recommendations as outlined by CDC from 4/1/22. RN-A stated it was important to be aware of current recommendations for residents in long	F 883	determine if the resident is eligible or past due for any vaccines including pneumococcal. Resident vaccine records will also be reviewed annually during their comprehensive assessment to ensure they are up to date with vaccine recommendations. The facility policy will be updated as to how vaccination recommendations were to be determined or what processes were to be used. How facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur: The Director or Designee will audit shared document and resident charts monthly x3 months, then quarterly x3 quarterly and annually thereafter.	

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F 883	Continued From page 7 term care as "They are at such high risk of severe illness or death." The facility policy, Vaccinations and Immunizations, last reviewed on 10/2022, directed upon admission a nurse reviewed the residents vaccination history to determine the need for vaccinations. Under the title Procedure, the policy went on to identify for the pneumococcal vaccine the facility staff was to follow the recommendations from MDH (Minnesota Department of Health)/CDC r/t (related to) timing of PCV13, PCV15, PCV20, and/or PPSV23. The policy went on to direct the staff if additional pneumococcal vaccine was indicated after admission, the RN was to proceed with providing the resident the risk versus benefits using the most current vaccination information. The policy lacked identification as to how vaccination recommendation were to be determined or what processes were to be used.	F 883		

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	245364	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/27/2023**

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ANNANDALE CARE CENTER	**500 PARK STREET EAST** **ANNANDALE, MN 55302**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/27/2023. At the time of this survey, Annandale Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 08/30/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER	**500 PARK STREET EAST** **ANNANDALE, MN 55302**

(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
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Annandale Care Center is a 1-story building with no basement. The building was constructed at 5 different times. The original building was constructed in 1982 and was determined to be of Type II(000) construction. In 1986 , an addition was constructed to the north and was determined to be of Type II(000) construction. In 1990 an addition was constructed at the front entrance and was determined to be of Type II(000) construction. In 2004 and addition was constructed to the ends of A and B wings and was	K 000		

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K 000	Continued From page 2 determined to be of Type II(000) construction. In 2008 an addition was added to the northwest corner of the facility and was determined to be of type II(000) construction. The facility was surveyed as one building. The facility has a capacity of 45 beds and had a census of 40 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K 321		9/29/23

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K 321	Continued From page 3 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/27/2023 at 10:25 AM, it was revealed by observation that the door to storage room 144 was propped open with a wooden wedge. An interview with the Administrator and Director of Maintenance verified this deficient finding at the time of discovery.	K 321	Description of correction action taken or planned to correct deficiency: The storage room door (144) was closed and wedge removed. What measures will be put into place, or systemic changes made to ensure deficient practice will not recur. Education provided to all staff on the requirement to have doors to storage rooms closed at all times. Sign posted on door to keep door closed at all times. How facility will monitor future performance to ensure solutions are sustained: An audit will be completed monthly x 3 months, then quarterly x 3 quarters to ensure that doors to hazardous areas are kept closed at all times. Results will be brought to QAPI committee Who is responsible for corrective actions: Maintenance Director or designee	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance	K 324		9/29/23

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K 324	Continued From page 4 with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/27/2023 at 10:17 AM, it was revealed by observation that the stove in the activities room did not have a lockout device installed. When	K 324	Description of correction action taken or planned to correct deficiency: Lockout device will be installed on stove in activity room What measures will be put into place, or systemic changes made to ensure deficient practice will not recur. Staff will be educated on requirement to have a lockout device on any stove that is accessible to residents. How facility will monitor future	

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K 324	Continued From page 5 asked staff members stated that they use the stove to bake. An interview with the Administrator and Director of Maintenance verified this deficient finding at the time of discovery.	K 324	performance to ensure solutions are sustained: An audit will be completed monthly x 3 months, then quarterly x 3 quarters to ensure that all stoves that are used in resident areas have the proper lock on them for safety. Results will be brought to QAPI committee Who is responsible for corrective actions: Maintenance Director or designee	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 372	Description of correction action taken or planned to correct deficiency: Penetrations in the smoke barrier will be caulked per code What measures will be put into place, or systemic changes made to ensure deficient practice will not recur.	9/29/23

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K 372	Continued From page 6 1. On 07/27/2023 at 09:49 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors 108A/108B by the front entrance. 2. On 07/27/2023 at 09:53 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier door 155A near room B6 caused by a black pipe. 3. On 07/27/2023 at 09:56 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors near the mechanical room caused by a white low-voltage wire. An interview with the Administrator and Director of Maintenance verified these deficient findings at the time of discovery.	K 372	Maintenance Director or designee will ensure that contractors or others that are installing new lines are aware of requirement to seal the penetration areas between smoke barriers. Maint. Director or designee will audit after each time work is performed. How facility will monitor future performance to ensure solutions are sustained: Audit of smoke barriers will be conducted annually and after completion of any work that may penetrate the smoke barrier. Results will be brought to QAPI committee Who is responsible for corrective actions: Maintenance Director or designee	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 511	Description of correction action taken or	9/29/23

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K 511	Continued From page 7 facility failed to maintain electrical equipment per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/27/2023 at 10:18 AM, it was revealed by observation that the electrical panel near the staff lounge was unlocked. 2. On 07/27/2023 at 10:35 AM, it was revealed by observation that the electrical panel "F" near the front door was unlocked. An interview with the Administrator and Director of Maintenance verified these deficient findings at the time of discovery.	K 511	planned to correct deficiency: Electrical panels were locked, new lock ordered for panel that lock is inoperative. What measures will be put into place, or systemic changes made to ensure deficient practice will not recur. Maintenance Director or designee will ensure that electrical panels are locked at all times when not directly in use. Education given to staff who have access to panels. How facility will monitor future performance to ensure solutions are sustained: Audit of electrical panels will be conducted monthly x3, quarterly x 3 quarters and as need. Results will be brought to QAPI committee Who is responsible for corrective actions: Maintenance Director or designee	