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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: CJ65

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00951

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245364**
2.STATE VENDOR OR MEDICAID NO.
(L2) **244742800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANNANDALE CARE CENTER**
(L4) **500 PARK STREET EAST**
(L5) **ANNANDALE, MN** (L6) **55302**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 09/11/2013 (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, HFE NEII 09/11/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 02/11/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/06/2013
(L33)

DETERMINATION APPROVAL

On July 19, 2013, Surveyors representing the Centers of Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) to determine if the facility was in compliance with Federal requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On September 11, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the FMS, completed on July 19, 2013. Based on this visit, it was determined that the facility had corrected the deficiencies issued pursuant to the FMS completed on July 19, 2013, as of July 23, 2013. As a result of the PCR findings, Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective October 19, 2013 did not go into effect. The facility is no longer subject to a loss of NATCEP.

Please refer to CMS 2567B.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5364 February 11, 2014

Ms. Debra Reitmeier, Administrator
Annandale Care Center
500 Park Street East
Annandale, Minnesota 55302

Dear Ms. Reitmeier:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 10, 2013, the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

November 16, 2013

Ms. Debra Reitmeier, Administrator
Annandale Care Center
500 Park Street East
Annandale, Minnesota 55302

RE: Project Number S5364026

Dear Ms. Reitmeier:

On July 19, 2013, Surveyors representing the Centers of Medicare adn Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) at your facility to determine if your facility was in compliance with Federal requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found the most deficiency a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On September 11, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the FMS, completed on July 19, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to the FMS completed on July 19, 2013, as of July 23, 2013. As a result of the PCR findings, this Department recommended to the CMS Region V office the following actions related to the remedies outlined in their letter of July 24, 2013.

The CMS Region V office concurs and has authorized this Department to notify you that the remedies outlined in their letter dated July 24, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245364	A. Building B. Wing	9/11/2013

Name of Facility	Street Address, City, State, Zip Code
ANNANDALE CARE CENTER	500 PARK STREET EAST ANNANDALE, MN 55302

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0441** Reg. # **483.65** LSC	**07/23/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/mm	11/25/13	29245	09/11/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/19/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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 _____	07/19/2013

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
F 000	INITIAL COMMENTS A health comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on July 19, 2013, following a Minnesota Department of Health survey on June 26, 2013. Survey dates: July 15, 2013 to July 19, 2013 Survey Census: 51 Medicare: 8 Medicaid: 23 Other: 20 Total: 51 Sample Size: Stage 1: 30 Stage 2: 31	F 000	RECEIVED AUG 13 2013 CMS-V-DS&C CMS approved per Mary A. 7/24	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	**1) How corrective action will be accomplished for those residents found to be affected:** LPN #1 was re-trained on infection control guidelines relating to medication and tube feeding administration and both are administered to residents according to infection control standards.	7/23/13

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

Administrator/President 8/6/13

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 _____ B. WING _____	07/19/2013

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
F 441	Continued From page 1 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to: 1) ensure that proper handwashing and gloving were performed during the medication pass for five residents (R49,R84,R46,R10,R9), 2) ensure that the gastrostomy tube syringe piston was placed on a clean area during the checking of the gastrostomy tube placement for one resident (R31) in the Stage 2 sample of 31. Findings include: 1. The following were observations of failure to perform hand hygiene during medication pass:	F 441	**2) How to identify other residents having the potential to be affected by the same practice** An audit was completed on nurses during medication administration and infection control guidelines are being followed by nursing staff. All RN, LPN and TMA scheduled staff were educated and re-trained on the revised Administration of Medications and Treatments and the Tube Feedings Policies and Procedures. **3)Measures put into place or systemic changes made to ensure practice will not recur** The Administration of Medications and the Tube Feeding policies were revised to include additional infection control guidelines relating to medication pass and to the use of syringes and all RN, LPN and TMA scheduled staff was re-trained on the revised policies. **4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system.** Corrective action was completed on July 23, 2013.	

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 _____	07/19/2013

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

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F 441	Continued From page 2 A. On 7/18/13 at approximately 8:46am, LPN1 was observed administering R49's medications outside the Adminsitrator's office. After she gave the medication LPN1 went back to the medication cart and pulled R84's inhaler and proceeded to give the inhaler to R84 without performing hand hygiene. B. On 7/18/13 at approximately 9:09am, LPN1 was observed passing medications in hallway A. LPN1 entered R46's room, gave R46 her medications and took R46's pulse. LPN1 then exited the room without washing or sanitizing her hands before proceeding to prepare R10's medications. C. On 7/18/13 at approximately 9:23am, LPN1 was observed entering R10's room, where R10 was still sleeping and touched R10's right foot for approximately 45 seconds to wake her up. After touching R10's foot LPN1 was observed giving R10's medication without performing any hand hygiene then exited the room before proceeding to prepare R9's medications. D. On 7/18/13 at approximately 9:29am, LPN1 was observed administering R9's medication without washing or sanitizing her hands before and after medication administration. 2. Observation during a medication pass on 7/18/13 at approximately 10am, LPN1 was observed to check the placement of R31's gastrostomy. During the procedure, LPN1 removed the piston from the syringe, used the syringe to check the placement. After removing the piston from the syringe, LPN 1 placed the piston portion of the syringe onto a blanket	F 441	An RN will audit one LPN or TMA staff weekly for four weeks for proper Administration of Medication procedures, including hand washing and tube feeding infection control. Audits will continue every month for one quarter and the results of the audits will be added to the Quality of Life Subcommittee agenda to be evaluated by the team. The Quality of Life Subcommittee will determine when final compliance is indicated.	

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 _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 441	Continued From page 3 covering R31's lap. A barrier was not in place between the piston and blanket. Following the completion of the procedure, LPN1 removed the piston from R31's lap, took it to R31's bathroom, rinsed it with tap water, placed the wet piston into the syringe and placed it in a plastic bag which was located on an intravenous pole. On 7/18/13 at approximately 10:25am, the Director of Nursing (DON) stated that she expected the nurses to wash or use the hand sanitizer during medication pass. The DON stressed that the nurses should wash their hands before and after medication pass and in between residents. In an interview on 7/18/13 at approximately 10:38am, LPN1 was asked about the medication pass process. LPN1 stated that she would normally sanitize only when administering eye drops and use gloves when administering g-tube medications. LPN1 further stated that "I do not believe we do handwashing or sanitizing in between residents with oral medications." Record review of the facility's policy and procedure titled "Administration of Medications and Treatments" with a revision date of 1/13 revealed that, "When medications are administered by nursing staff, the following procedures will be followed: 1. Wash hands before and after administration of medication."	F 441		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: CJ65

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00951

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245364**
2.STATE VENDOR OR MEDICAID NO.
(L2) **244742800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANNANDALE CARE CENTER**
(L4) **500 PARK STREET EAST**
(L5) **ANNANDALE, MN** (L6) **55302**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/26/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers:
* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. Post Certification Revisit to follow. Please refer to the Life Safety Code CMS 2567 along with the facility's plan of correction.

17. SURVEYOR SIGNATURE — Date :
Timothy Rhonemus, HFE NEII — 07/16/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist — 08/03/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 8/6/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3090

July 2, 2013

Ms. Debra Reitmeier, Administrator
Annandale Care Center
500 Park Street East
Annandale, Minnesota 55302

RE: Project Number S5364024

Dear Ms. Reitmeier:

On June 26, 2013, a standard 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 4, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

If an acceptable PoC 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).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 September 26, 2013 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 December 26, 2013 (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.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

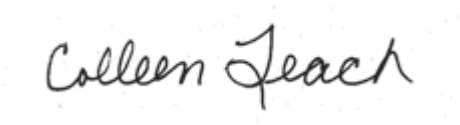
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

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 _____	**06/25/2013**

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	INITIAL COMMENTS	K 000	RECEIVED JUL 16 [illegible] MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Annandale Care Center Building 1 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 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

DC: 08.05.2013

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

Ext: 06.26.2013

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

POC rk
7-16-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7/11/13

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 _____	**06/25/2013**

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 By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us 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 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. Because the original building and the 2004 and 2008 additions are of different construction years, the facility was surveyed as two buildings. The building is automatic sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 47 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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 _____	**06/25/2013**

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 029 SS=D	Continued From page 2 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection for 2 of 3 soiled utility rooms located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practices could affect residents, staff and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include: On facility tour between 12:30 PM to 3:30 PM on 06/25/2013, observation revealed that the storage room that is over 50 square feet in area that is located next to the kitchen is not equipped with a self-closing device. This deficient practice was confirmed by the Director of Maintenance (SP).	K 029	K 029 The storage room that is next to the kitchen is now equipped with a self-closing device. The completion date was July 10, 2013. The Director of Maintenance is responsible for the correction and will oversee all future structural changes that involve door installations to assure compliance with this requirement.	7/10/13
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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 _____	**06/25/2013**

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

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K 147 SS=D	Continued From page 3 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility had several electrical appliances found not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect all residents, staff and visitors. Findings include: On facility tour between 12:30 PM to 3:30 PM on 06/25/2013, observations revealed that the facility failed to limit the use of extension cords in the facility by using an extension cord to power the fish aquarium that is located in the dayroom. This deficient practice was confirmed by the Director of Maintenance (SP).	K 147	K 147 The extension cord that was used in the dayroom to power the fish aquarium was removed and an additional power source was hard-wired in on July 10, 2013. The Maintenance Director will continue to have oversight responsibility in regards to the limited use of extension cords in the facility.	7/10/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING 02 - BUILDING 0202 B. WING _____	06/25/2013

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	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Annandale Care Center Building 2 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Annandale Care Center Building 2 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Annandale Care Center building 2 is a 1-story building with no basement. In 2004 an addition was constructed to the ends of A and B wings of building 1 and was determined to be of Type II(000) construction. In 2008 an addition was added to the northwest corner of building 1 and was determined to be of type II(000) construction. The building is fully sprinklered and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire	K 000	7-16-13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kyle Putman — TITLE: Administrator — (X6) DATE: 7/11/13

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 **02 - BUILDING 0202** B. WING _____	**06/25/2013**

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

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K 000	Continued From page 1 department notification. Because the 2004 and 2008 additions are of new construction the additions were surveyed under the same building. The facility has a capacity of 60 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) are MET.	K 000		