#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: L7J8

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AC	GENCY	I	Facility ID: 00951
MEDICARE/MEDICAID PROVIDER     (L1)		3. NAME AND AD (L3) ANNANDAI (L4) 500 PARK S' (L5) ANNANDAI	LE CARE CENTE TREET EAST		(L6)	55302	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF C	WNERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR' 05 HHA	Y 09 ESRD	<u>02</u> (L7)	) 22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other omplaint
6. DATE OF SURVEY <b>07</b> .  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Othe	(L10) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds	60 (L18) 60 (L17)	X A. In Complia  Program Re Compliance 1. A  B. Not in Com	quirements		2. Tecl3. 24 H4. 7-D	hnical Personnel Hour RN ay RN (Rural SNF) Safety Code A*	Following Requirements:	cices Limit
14. LIC CERTIFIED BED BREAKDON  18 SNF 18/19 SN  60  (L37) (L38)		ICF (L42)	IID (L43)		1861 (e) (1) or		(L15)	
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICABLE S	HOW LTC CANCELI	LATION DATE):					
17. SURVEYOR SIGNATURE  Timothy Rhonem	us, HFE NE II	Date :	07/06/2017			vey agency app	PROVAL Ogram Specialis	Date: 6t 07/25/2017
	PART II - TO	BE COMPLETE	D RV HCFA RI	(L19)				(L20)
DETERMINATION OF ELIGIBILE  _X1. Facility is Eligible to 2. Facility is not Eligible	TY Participate	20. COM	MPLIANCE WITH C		21. 1. 2.	Statement of Financia	al Solvency (HCFA-2572) terest Disclosure Stmt (HCFA	A-1513)
22. ORIGINAL DATE  OF PARTICIPATION  11/01/1986  (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEME ENDING DATI (L25)					L30) FARY eet Health/Safety feet Agreement
25. LTC EXTENSION DATE: (L27)	ALTERNATIVI     A. Suspension of     B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involu 04-Other Reason	ntary Termination for Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C	CARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION ( 06/30/2017	OF APPROVAL DAT	ΓΕ (L33)		27/2017 Co. ATION APPROV	VAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245364 July 26, 2017

Ms. Debra Reitmeier, Administrator Annandale Care Center 500 Park Street East Annandale, MN 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 June 9, 2017 the above facility is certified for or recommended 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.

Annandale Care Center July 26, 2017 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697





#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 26, 2017

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

RE: Project Number S5364029

Dear Ms. Reitmeier:

On May 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 4, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 12, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 4, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 9, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 4, 2017, effective June 9, 2017 and therefore remedies outlined in our letter to you dated May 18, 2017, 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File

	POST-CERTIFICATION REVISIT REPORT										
	R / SUPPLIER /		MULTIPLE CON	STRUCTIO	N					DATE C	F REVISIT
245364	CATION NUMBE	R ' Y1	A. Building B. Wing						Y2	7/6/20 <sup>-</sup>	17 <sub>Y3</sub>
NAME OF	FACILITY					1	r ADDRESS, C		, ZIP CODE		
ANNANE	DALE CARE CE	ENTER				1	RK STREET E <i>A</i> DALE, MN 553				
						AMMAN	DALL, MIN 555		the description of the second		
program, corrected provision	to show those and the	deficie such co ne iden	ncies previously prective action v	reported ovas accom	the Medicare, M on the CMS-256 plished. Each d usly shown on tl	37, Staten deficiency	nent of Defici should be fu	encies and Illy identifie	Plan of Correct d using either th	tion, that ne regula	have been ation or LSC
ITE	VI		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0282		Correction	ID Prefix	F0309		Correction	ID Prefix	F0315		Correction
Reg.#	483.21(b)(3)(ii)		Completed	Reg. #	483.24, 483.25(k)	)(I)	Completed	Reg.#	483.25(e)(1)-(3)		Completed
LSC			06/09/2017	LSC			05/12/2017	LSC			06/05/2017
ID Prefix	F0318		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	483.25(c)(2)(3)		Completed	Reg.#			Completed	Reg.#			Completed
LSC			06/09/2017	LSC				LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #			Completed	Reg.#			Completed
LSC				LSC	- Most			LSC		è	
ID Prefix		-	Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #			Completed	Reg.#			Completed
LSC				LSC				LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #			Completed	Reg.#			Completed
LSC			_	LSC				LSC		-	
REVIEW STATE A		REVIE (INITIA	WED BY ALS)	DATE	SIGNATI	URE OF S	SURVEYOR	>		DATE 7	-6-17
REVIEW CMS RO		REVIE (INITIA	WED BY ALS)	DATE	TITLE	+FE	Nwie	Eval	I	DATE	-6-17
FOLLOW 5/4/2017	VUP TO SURVE	Y COMP	LETED ON		CK FOR ANY UN ORRECTED DEF					YE	s 🗆 no

#### POST-CERTIFICATION REVISIT REPORT

		_	
MULTIPLE CONSTRUCTION  A Building 01 - MAIN BUILDING 01		DATE OF REVISI	T
3. Wing	Y	6/12/2017	Y3
		_	<u> </u>
	STREET ADDRESS, CITY, STATE, ZIP CODE		
	500 PARK STREET EAST		
	ANNANDALE, MN 55302		
alified State surveyor for the Medicare M	ledicaid and/or Clinical Laboratory Improvemen	nt Amendments	
3	. Building 01 - MAIN BUILDING 01 . Wing	. Building 01 - MAIN BUILDING 01 . Wing  STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302	Building 01 - MAIN BUILDING 01 . Wing  STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST

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).

ITE Y4		<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0341	05/02/2017	LSC	K0345	05/01/2017	LSC	K0353		06/06/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0374	05/02/2017	LSC	K0712	05/01/2017	LSC	K0920		05/08/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #			Completed
LSC	K0923	05/30/2017	LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC	-		
REVIEWS		REVIEWED BY (INITIALS)	DATE	SIGNATUR	E OF SURVEYOR			DATE	
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 5/1/2017		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO						s 🗆 NO	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 26, 2017

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

Re: Reinspection Results - Project Number S5364029

Dear Ms. Reitmeier:

On July 6, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 4, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File

#### STATE FORM: REVISIT REPORT MULTIPLE CONSTRUCTION DATE OF REVISIT PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER A. Building 7/6/2017 00951 B. Wing STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF FACILITY 500 PARK STREET EAST ANNANDALE CARE CENTER ANNANDALE, MN 55302 This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE ITEM DATE ITEM DATE Y5 Y5 Y4 Y5 Y4 **Y4** ID Prefix 20565 Correction ID Prefix 20830 Correction ID Prefix 20895 Correction MN Rule 4658.0520 MN Rule 4658.0525 MN Rule 4658.0405 Completed Reg. # Completed Reg. # Reg. # Completed Subp. 2.B Subp. 3 Subp. 1 05/12/2017 06/05/2017 06/09/2017 LSC LSC LSC **ID Prefix** Correction **ID Prefix** Correction ID Prefix 20910 Correction MN Rule 4658.0525 Completed Completed Reg.# Reg. # Completed Reg. # Subp. 5 A.B LSC 06/09/2017 LSC LSC **ID Prefix** Correction **ID Prefix** Correction **ID Prefix** Correction Completed Completed Reg. # Completed Reg. # Reg. # LSC LSC LSC **ID Prefix ID Prefix** Correction **ID Prefix** Correction Correction Reg.# Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix** Correction **ID Prefix** Correction **ID Prefix** Correction Completed Completed Reg. # Completed Reg. # Reg. # LSC LSC LSC REVIEWED BY **REVIEWED BY** DATE SIGNATURE OF SURVEYOR STATE AGENCY (INITIALS) DATE **REVIEWED BY** DATE **REVIEWED BY** CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON

Page 1 of 1

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

**EVENT ID:** 

L7J812

YES NO

5/4/2017

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: L7J8

#### ${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

	PAKI	1 - TO BE COM	PLETED BY I	HE STATI	E SURVEY AGENCY	Facility ID: 00951	
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245364		3. NAME AND ADD (L3) ANNANDAL				4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification	
2.STATE VENDOR OR MEDICAID NO.		(L4) 500 PARK ST	TREET EAST			3. Termination 4. CHOW	
(L2) <b>244742800</b>		(L5) ANNANDAL	E, MN		(L6) <b>55302</b>	5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSH	ПР	7. PROVIDER/SUF	PPLIER CATEGOR	Y	<u>02</u> (L7)	7. On-Site Visit 9. Other	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint	
6. DATE OF SURVEY <b>05/04/2017</b>	(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:				
From (a):		X A. In Complian	nce With		And/Or Approved Waivers Of The	Following Requirements:	
To (b):		Program Re	-		2. Technical Personnel	6. Scope of Services Limit	
		Compliance	Based On:		3. 24 Hour RN	7. Medical Director	
12 Total Equility Dada	<b>60</b> (L18)	_X_1. A	acceptable POC		4. 7-Day RN (Rural SNF)	8. Patient Room Size	
•					5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	<b>60</b> (L17)	1	pliance with Progran and/or Applied Waiv		* Code: A1*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN		1			15. FACILITY MEETS		_
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
60	19 5111	ici	пр		1801 (e) (1) 01 1801 (j) (1).	(2.3)	
	(7.40)						
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARKS (IF A	APPLICABLE S	SHOW LTC CANCELL	LATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:	
Michelle Thompson, H	FE NE I		05/30/2017	(L19)	Kate JohnsTon, Pr	ogram Specialist 06/27/2017	20)
PA	RT II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY		20. COM	IPLIANCE WITH C	TIVIL	21. 1. Statement of Financi	ial Solvency (HCFA-2572)	
1. Facility is Eligible to Participate		RIGH	HTS ACT:		<ol> <li>Ownership/Control I</li> <li>Both of the Above :</li> </ol>	Interest Disclosure Stmt (HCFA-1513)	
2. Facility is not Eligible					5. Both of the Above .		
2. Facility is not English	(L21)						
22. ORIGINAL DATE 23.	LTC AGREEM	ENT 2	24. LTC AGREEME	ENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DATI	Е	VOLUNTARY 00	INVOLUNTARY	
11/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Meet Agreement	
		E SANCTIONS			03-Risk of Involuntary Termination	OTHER	
	A. Suspension				04-Other Reason for Withdrawal	07-Provider Status Change	
			(L44)			00-Active	
(L27)	B. Rescind Sus	pension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
		03001					
(I	L28)			(L31)			
31. RO RECEIPT OF CMS-1539	27	. DETERMINATION (	OF APPROVAL DAT	re	Posted 06/20/2017 Cc		
		. DETERMINATION	JI AITKOVALDA		Posted 06/30/2017 Co.		
(I	.32)			(L33)	DETERMINATION APPRO	VAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 18, 2017

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

RE: Project Number S5364029

Dear Ms. Reitmeier:

On May 4, 2017, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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>Electronic 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;

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

<u>Informal Dispute Resolution</u> - 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
St. Cloud A Survey Team
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
brenda.fischer@state.mn.us

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 June 13, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 13, 2017 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

Failure to submit an acceptable ePoC 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 ePoC 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 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, 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 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.

#### 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 August 4, 2017 (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 November 4, 2017 (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 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: 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

Email: kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

PRINTED: 05/30/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245364	B. WING		C <b>05/04/2017</b>	
	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302	, 00/0 1/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
F 000	INITIAL COMMENT	-S	F 000			
	completed by surved Department of Heat Center was found to the regulations at 4 requirements for Lot The facility's plan or as your allegation of Department's acceptant of the bottom of the form. Your electron be used as verificated.	·				
F 282 SS=E	on-site revisit of you validate that substa regulations has bee your verification. 483.21(b)(3)(ii) SEF	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN	F 282		6/9/17	
		ive Care Plans led or arranged by the facility, omprehensive care plan,				
	care. This REQUIREMENT by: Based on observate review, the facility for interventions as directly for the second se	qualified persons in ch resident's written plan of NT is not met as evidenced ion, interview and document ailed to implement care plan ected for 5 of 5 residents 5, and R36) who received		F282 SERVICES BY QAULIFIED PERSON/PER CARE PLAN  1) How corrective action will be		
ABORATORY	   DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE	

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

**Electronically Signed** 

05/26/2017

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245364	B. WING		C 05/04	/2017
PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/01	72017
			500 PARK STREET EAST		
DALE CARE CENTER			ANNANDALE, MN 55302		
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	) BE	(X5) COMPLETION DATE
282 Continued From page 1		F 282	2		
This had the potent identified as received program.  Findings include:  R38's facesheet (unally Alzheimer's demendences and Cook Cook Cook Cook Cook Cook Cook Coo	ndated) had diagnoses of tia with behaviors, major ntractures of muscle, multiple		be affected: The RN reassessed Resident R3's restorative nursing needs and discontinued the program due to a increase in behaviors; the care pla updated to reflect current status.  Resident R18 is currently working physical therapy; when completed,	n n was with	
Minimum Data Set indicated the reside impaired, was total of daily living (ADLs had functional limits upper extremities wwist and hand. Thidentified no restoral implemented.	(MDS), dated 4/14/2017, ent was severely cognitively ly dependant with all activities s). The MDS identified R38 ations in ROM on one side of which included shoulder, elbow, e restorative nursing section ative programs were		Resident R67 is currently working occupational therapy and will have shoulder ROM program upon com with restorative nursing 3-5 times/v	with a pletion week.	
4/21/17), indicated nursing rehab prog The facility indicate was to receive, "Ns to 3-5 x/wk has with PROM [passive rar times a week]. Con ROM. Wash left had During observation nursing assistant re R38's to provide RO on his back and wrocloth around his lef ROM of R38's shou continued to provide	that "R38 participates in a ram to prevent contractures." d in the care plan that R38 g [nursing] rehab program: up n ROM, LE [lower extremities] age of motion] 3/-5x/wk [3 to 5 nplete bilateral upper extremity nd."  s on 05/03/2017 at 9:10 a.m., ehabilitation (Rehab)-A entered DM. Rehab-A positioned R38 apped a warm moist wash thand. Rehab-A completed alder, elbow, and hand. She e ROM to R38's left leg, knee		occupational therapy and will have upper ROM program with restoratinursing 3-5 times/week upon comparts. Resident 15 had restorative nursinureds reassessed and the ROM puill be discontinued due to an antichealth decline with hospice status. plan interventions have been update reflect current status.  2) How to identify other residents in the potential to be affected by the spractice:	an ve pletion.  g rogram cipated Care ted to naving same	
	PROVIDER OR SUPPLIER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa range of motion (Re This had the potent identified as receivi program.  Findings include:  R38's facesheet (un Alzheimer's demen depression and Co sites. R38's Signific Minimum Data Set indicated the reside impaired, was totall of daily living (ADLs had functional limits upper extremities w wrist and hand. Th identified no restora implemented.  Review of R38's ca 4/21/17), indicated nursing rehab prog The facility indicate was to receive, "Ns to 3-5 x/wk has with PROM [passive rar times a week]. Con ROM. Wash left ha  During observation nursing assistant re R38's to provide R0 on his back and wra cloth around his lef ROM of R38's shou continued to provid	PROVIDER OR SUPPLIER  DALE CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1 range of motion (ROM) from restorative nursing. This had the potential to effect 28 residents identified as receiving a restorative nursing program.  Findings include:  R38's facesheet (undated) had diagnoses of Alzheimer's dementia with behaviors, major depression and Contractures of muscle, multiple sites. R38's Significant Change in Status Minimum Data Set (MDS), dated 4/14/2017, indicated the resident was severely cognitively impaired, was totally dependant with all activities of daily living (ADLs). The MDS identified R38 had functional limitations in ROM on one side of upper extremities which included shoulder, elbow, wrist and hand. The restorative nursing section identified no restorative programs were	PROVIDER OR SUPPLIER  DALE CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1 range of motion (ROM) from restorative nursing. 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The facility indicated in the care plan that R38 was to receive, "Nsg [nursing] rehab program: up to 3-5 x/wk has with ROM, LE [lower extremities] PROM [passive range of motion] 3/-5x/wk [3 to 5 times a week]. Complete bilateral upper extremity ROM. Wash left hand."  During observations on 05/03/2017 at 9:10 a.m., nursing assistant rehabilitation (Rehab)-A entered R38's to provide ROM. Rehab-A positioned R38 on his back and wrapped a warm moist wash cloth around his left hand. Rehab-A completed ROM of R38's shoulder, elbow, and hand. She continued to provide ROM to R38's left leg, knee	PROVIDER OR SUPPLIER  245364  B. WING  STREET ADRESS, CITY, STATE, ZIP CODE  500 PARK STREET EAST ANNANDALE, MN 55302  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFOIGENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1 range of motion (ROM) from restorative nursing. 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WING  STREET ADDRESS, CITY, STATE, ZIP CODE  500 PARK STREET EAST ANNANDALE, MN 55302  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  Continued From page 1  range of motion (ROM) from restorative nursing. This had the potential to effect 28 residents identified as receiving a restorative nursing program.  Findings include:  R38's facesheet (undated) had diagnoses of Alzheimer's dementia with behaviors, major depression and Contractures of muscle, multiple sites. R38's Significant Change in Status  Minimum Data Set (MDS), dated 4/14/2017, indicated the resident was severely cognitively impaired, was totally dependant with all activities of daily living (ADLs). The MDS identified R38 had functional limitations in ROM on one side of upper extremities which included shoulder, elbow, wrist and hand. The restorative nursing section identified no restorative programs were implemented.  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Rehab-A positioned R38 on his back and warpped a warm moist wash cloth around his left hand. Rehab-A completed ROM of R38's sho

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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and finished with R hand.  Review of R38's metools from March to Attachment C ident May 1-3, 2017 - red April 1-30, 2017 - red April 1-30, 2017 - red April 1-31, 2017 - with one treatment another "O etc)  During interview on Rehab-A stated the rehabilitation staff who not scheduled as defined the facility's identified because does not get always reviewed the ROM March to May 2017 not met for R38 as  During an interview B care manager red the Rehab RN revieweek (on Fridays), concerns with the red unaware that R38 red times a week for the red and the red	onthly ROM data collection of May 2017 entitled: iffied the following frequency: decived 2 treatments eceived only 4 treatments with das "AG" (agitated) received only 7 treatments documented as "AG" and " (MD appointment, visitor, or S/3/17, at 11:52 a.m., are were two nursing work alternating days, and are irect care nursing assistants. The two have been pulled to exercise group daily. Rehab-A of the heavy work load ROM as get completed. Rehab-A data collection tool from and the ROM frequency was identified by the care plan.  Toon 5/3/17 at 1:59 p.m., Wing gistered nurse (RN)-B stated lews with the rehab staff once a to see if there are changes or esidents. RN-B stated she was had not received ROM 3-5 e months of March and April	F 282	rehab staff and audits were compleall residents in the restorative nursing program on 5/19/17 and 5/26/17 to monitor that care plan interventions carried out by staff.  3) Measures put into place or systechanges made to ensure practice werecur:  The structure of the restorative nursing program was revised to include the addition of an activity exercise progfor those unable to meet the criteria participation for the Fit 4 life class. Additional nursing hours have been dedicated to the restorative nursing program to assure compliance with planned goals.  The restorative nursing program and policies and procedures have been revised and staffed trained on the changes. Weekly rehab meetings to review individual resident goals and compliance with the program will continue.  4) How to monitor performance to a solutions are sustained, that correct achieved and sustained; implement evaluated and integrated into QA sy An RN will audit the implementation care planned interventions weekly for weeks then monthly for three month the correction date. The results will discussed monthly at the Quality of	are mic vill not sing ram of care d care d so l assure tion is ted, vstem. of the or four ns after l be	
R18's facesheet (u	ndated) had the diagnoses of		committee and the committee will determine when compliance is indic	cated.	
	PROVIDER OR SUPPLIER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa and finished with R hand.  Review of R38's me tools from March to Attachment C ident  May 1-3, 2017 - rec April 1-30, 2017 - rec April 1-30, 2017 - rec March 1-31, 2017 - with one treatment another "O etc)  During interview on Rehab-A stated the rehabilitation staff v not scheduled as d However, at times is cover direct care po to lead the facility's identified because of to lead the facility's identified because of to lead the ROM March to May 2017 not met for R38 as  During an interview B care manager rec the Rehab RN review B care manager rec the	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2 and finished with R38's right shoulder, arm and hand.  Review of R38's monthly ROM data collection tools from March to May 2017 entitled: Attachment C identified the following frequency:  May 1-3, 2017 - received 2 treatments April 1-30, 2017 - received only 4 treatments with the 5th documented as "AG" (agitated) March 1-31, 2017 - received only 7 treatments with one treatment documented as "AG" and another "O" (MD appointment, visitor,	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2 and finished with R38's right shoulder, arm and hand.  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During an interview on 5/3/17 at 1:59 p.m., Wing B care manager registered nurse (RN)-B stated the Rehab RN reviews with the rehab staff once a week (on Fridays), to see if there are changes or concerns with the residents. RN-B stated she was unaware that R38 had not received ROM 3-5 times a week for the months of March and April 2017, as identified by the care plan.	PROVIDER OR SUPPLIER  245364  245364  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY WILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2 and finished with R38's right shoulder, arm and hand.  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During an interview on 5/3/17 at 1:59 p.m., Wing B care manager registered nurse (RN)-B stated the Rehab RN reviews with the reshab staff once a week (on Fridays), to see if there are changes or concerns with the residents. RN-B stated she was unaware that R38 had not received ROM 3-5 times a week for the months of March and April 2017, as identified by the care plan.	A BUILDING  245384  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNADALE, MN 55302  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSG IDENTIFYING INFORMATION)  Continued From page 2 and finished with R38's right shoulder, arm and hand.  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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245364	B. WING				C <b>04/2017</b>
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F 282	dementia with Lewy attack (TIA) and sle MDS, dated 3/15/17 cognitively impaired ADLs and had no furthe restorative nursing R18's care plan, up "[R18] participates imaintain current abability to do ADLs." "bilateral LE ROM pback) X [times] 20 in direction 3-5 times extremity] ROM proceed Review of the montentitled: Attachmen indicated that R18 in frequency:  May 1-3, 2017 - reconstituted appointment, visit of the sth documented appointment, visit of the stream of two oth appointment, visit of the standard transmitted and two oth appointment, visit of the standard transmitted and two oth appointment, visit of the standard transmitted and two oth appointment, visit of the standard transmitted and two oth appointment, visit of the standard transmitted and two oth appointment, visit of the standard transmitted and two oth appointment, visit of the standard transmitted and two oth appointment, visit of the standard transmitted and two oth appointment, visit of the standard transmitted and transmitted and transmitted and transmitted and transmitted and transmitted and transmitted	Bodies, transient ischemic rep disorder. R18's quarterly 7, indicated they were severely 8 and totally dependant with all unctional limitations in ROM. Sing section identified had not occurred.  dated 4/24/17, indicated, in a nursing rehab program to ility and to prevent decline in Rehab nursing to perform program in supine (on R18's reps [repetitions] each wk [weekly], and "UE [upper regram" 3-5 times a week.  hly ROM data collection tools, to C (last revised 3/08), received ROM for the following received only 4 treatments with das "O" (MD sitor, etc) received only 6 treatments documented as "I" (illness) hers documented as "I" (illness) hers documented as "O" (MD sitor, etc).  5/4/2017 at 11:20 a.m., the finursing (ADON) reviewed the intool, and stated R18 was ments. R18's care plan for	F 2	282	5) The date each deficiency will be corrected:  Correction date: June 9, 2017		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
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F 282	resident had arthritic quarterly MDS of 3 was cognitively into one to two to compincluding. The MDS limitations in range extremities of shour There was no indicate restorative nursing.  During interview on reported increased right shoulder, hip, pain medications for are completed with trained by therapy", completed on an axing she stated her, "She since coming to the had some limitation right hand and held body.  R67's care plan, up resident was to par program which con balance-transfer exfor Tuesday and The plan also identified.	s in multiple sites. R67's  1/14/17 identified the resident ct, required staff assistance of lete activities of daily living identified R67 had functional of motion bilateral upper lder, elbow, wrist and hand. ation R67 received any  5/3/17, at 11:07 a.m. R67 pain and discomfort in her and thigh but dislikes taking or this. R67 stated exercises by an "Aide who has been however these are not frequency. The exercises are verage of one time per week. coulders are definitively worse" a facility. Per observation R67 as with opening and closing her her right shoulder close to her  addated 3/15/17, identified ticipate in the Fit 4 Life sisted of stretches, tercises and strength training nursday programs. The care R67 had shoulder ogram 3 to 5 times per week	F 2	82		
	titled: Attachment C					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  DALE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 500 PARK STREET EAST ANNANDALE, MN 55302		/O4/2017
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F 282	April 1-30, 2017 - re the frequency of "3" "O" representing O' etc) with no addition indicated "A" (in an entry indicated "R" March 1-31, 2017 - with the frequency 9 entries identified information, and 1 oparticipation in anot February 1-28, 201 "O" with no addition identified as "A", and LOA (leave of absedurary 1-31, 2017 received 15 minute was identified as "A" (illness), and 3 entrollectives of the comparticipation in classes indicated "A/R".  During interview on Rehab-A stated R64 Life, on Tuesday stated R67 had con participation in classes exercise/stretch proweek, Rehab-A stated R64 Life, on Tuesday stated R67 had con participation in classes exercises when unable to return at exercises as directed R36's undated Res	eceived only 1 treatments at 0", five entries were denoted ther (MD appointment, visitor, nal information, 1 entry other activity), and another refused.  received only 3 treatments of 20-30-20, with an additional as "O", with no additional entry identified as "A" for ther activity.  7-2 entries are identified as nal information, 1 entry was not one noted resident was on ence).  7-1 entry identified resident s of 1:1 interaction, 1 entry x", 2 entries indicated "I" ries indicated "O".  117-2 entries identified R67 s of 1:1 therapy, 6 entries no additional explanation, 1 dent was "A", and 1 entry  15/3/17, at 12:06 p.m.  7 comes to exercise class, Fit and Thursdays. Rehab-A	F 2	82		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED	
		245364	B. WING			C / <b>04/2017</b>
	PROVIDER OR SUPPLIER  DALE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 500 PARK STREET EAST ANNANDALE, MN 55302	<b>.</b>	
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F 282	impacted. R36's quidentified resident himpairment and recistaff to complete All any functional limits. R36's care plan, edwas to be evaluated occupational theraptoning. The care play recommendations on Nursing was instructing was instructing was instructed at the end of flexion and abducting forearm suspiration flexion/extension, a fingers) flexion/extension flexion/extension flexion and abducting forearm suspiration flexion from January to March January to January to March January Janua	parterly MDS of 1/31/17 rad moderate cognitive reived assistance of one to two DL's. The MDS did not identify ration in ROM.  rited on 12/7/16, identified R36 rited by physical therapy and rited by therapy and rected staff to follow retailined by therapy. Rehab rited by OT to assist R36 with rity repetitions with prolonged rity movement for shoulder ron, elbow flexion/extension, ronation, wrist rited full fist (all rision 3-5 x week." R36 was rit 4 Life class.  ry document Attachment C rity document attachment cereived 1 treatment.  received 1 treatment. received only 7 treatments at received 1 treatment.	F 2	82		

AND DUAN OF CODDECTION INDESTRUCTION NUMBER.		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 500 PARK STREET EAST ANNANDALE, MN 55302	•	00/0 1/2011
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F 282	January 1-31, 2017 treatment with a fread and one noted incide During interview on Rehab-A stated RS participant in the Fi willing to complete receive a hamstring and PROM (passivupper extremity. Reactive participant in exercises were not	age 7 Ilness) was indicated. 7-received 5 episodes of equency of "15" 1:1 minutes, dent where resident refused.  a 5/3/17, at 12:06 p.m.  36 has been an active t 4 Life program and has been the program. R36 was to g stretch with standing frame, e range of motion) to right ehab-A stated R36 was an exercise group so the PROM completed due to prioritizing ag tasks to be completed.	F 2	82		
	diagnosis of arthriti 3/18/17 indicated athe need for extensistaff to complete Alfunctional impairmed. R15's care plan, rewas to receive bilativith nursing rehabito maintain current. In review of the modecember 2016 the R15 received ROM program as follows. December 1-31, 2015 1:1 (one to one) January 1-31, 2017 of 15 1:1 minutes.	onthly rehabilitation logs from ru February 2017 identified I bilateral shoulder exercise :				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302		<u> </u>	
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F 309 SS=D	notation of "O".  During interview on Rehab-A stated the exercises because  During interview on director of nursing (Rehab Nursing was frequency recomme was currently re-eval A policy, titled Care 12/02, identified that the deliverance of odocumentation was of care.  483.24, 483.25(k)(I) FOR HIGHEST WE 483.24 Quality of life upplies to all care a residents. Each residents. Each residents. Each residents. Each residents of attain or practicable physical well-being, consiste comprehensive ass 483.25 Quality of care is a applies to all treatmer facility residents. Bassessment of a residents received that residents received the exercises of a residents assessment of a residents received the exercises of a residents received the exercises of the exe	of 15 1:1 minutes, and one  5/3/17, at 12:06 p.m. y were unable to complete of limited time.  5/4/17, at 12:20 p.m. the (DON) stated she was aware on the being completed at the ended by therapy. The facility aluating the process.  Planning Process, dated at the care plan was to direct care provided and or reflective of following the plan  PROVIDE CARE/SERVICES ELL BEING  e undamental principle that and services provided to facility sident must receive and the ethe necessary care and or maintain the highest I, mental, and psychosocial ent with the resident's sessment and plan of care.	F2			5/12/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	X3) DATE SURVEY COMPLETED		
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F 309	practice, the complicate plan, and the but not limited to the but not limited to the but not limited to the complete provided to resident consistent with protite comprehensive and the residents' (I) Dialysis. The fact residents who requiservices, consistent of practice, the concare plan, and the preferences. This REQUIREMED by:  Based on observative review, the facility fan outside psychiat recommendations reviewed who receservices.  Findings include:  R51's quarterly Mir 2/25/17, identified frequired extensive of daily living (ADLS R51 displayed symmers of the preference of daily living (ADLS R51 displayed symmers of daily living the protition of the preference of daily living (ADLS R51 displayed symmers of daily living the protition of the preference of daily living the protition of the protition of the protition of the protition of the province of the protition of the protition of the protition of the protition of the province of the protition of the protition of the province of the protition of the province of the protition of the province of the protition of the protition of the province of the protition of the province of the protition of	rehensive person-centered residents' choices, including e following:	F 309	F309 Provide care/ services for the highest well being  1) How corrective action will be accomplished for those residents for the beaffected: Annandale Care Center coordinate care and recommendations of outs providers. R51's primary care provider review addressed the psychology recommendations on 5/4/17.  2) How to identify other residents he the potential to be affected by the sepractice:  A facility wide audit for those with psychology services was completed found in compliance with the coord	ound to s the ide ed and aving ame

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F 309	her arms and neck. hurt, "Awful bad," a  R51's care plan dat depression and was medication. The ca "Worries and rumin body/medical proble attempt gradual downen indicated and update the physicial lacked any interventidentified R51 was services.  R51's Associated Control Note dated 3/31/17 adjustment and perbeen working with the from some family rewas identified to, " about the same with and sweating," and Further, the note id Recommendations report sadness and benefit from Cymba pain and depression her reports of sadnedeferred to her PCF R51's following phy 4/4/17, identified R5 depression with an "Assessment [and] each diagnosis R5 "Moderate episode"	ith nearly constant tremors of R51 stated her contractures	F 30	of care.  3) Measures put into place of changes made to ensure practicur:  A new process was impleme 5/4/17 to have psychology not distributed to the care planning review and follow-up. The Psychology and procedure updated and communicated with the care planning review and follow-up. The Psychology and procedure updated and communicated with the care planning review and follow-up. The Psychology and procedure updated and communicated with the care planning review and procedure updated and communicated with the care planning and procedure updated and sustained; implementations are sustained, that achieved and sustained; implementations are sustained; implementations are sustained, that achieved and sustained; implementations are sustained. The results will audit all of psychology progress notes for and randomly thereafter. The results will be discussed at the Assurance meeting who will when compliance is indicated.	entice will not ented on one of the or 4 weeks e audit ne Quality determine			

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F 309	patch (narcotic dura R51 was, "Stable," regimen for depress reference or dictation psychologist' recome Cymbalta to R51's identified in the 3/3'.  R51's medical recome any evidence R51's considered the psychologistered the psychologistered the psychologistered the psychologistered the psychologistered the psychologistered any experience of the psychologistered the psychologistered the psychologistered and psychologistered the psychologistered and practitioner and practitioner. The psychologistered and practitioner. The psychologistered psychologistered and practitioner. The psychologistered and practitioner adding addressed because RN-A stated the recome psychologistered and psychologistered a	ased R51's ordered Fentanyl agesic patch) and identified on her current medication sion. There was no identified on addressing the mendation to consider adding medication regimen as 1/17 note.  In discovery and lacked aphysician had addressed or chologist's recommendation. The physician orders dated orders or trial dosing of an 5/4/17, at 8:36 a.m. nursing ated R51's mood, "hasn't really st months. NA-A stated R51 odes of crying, "Every once in grunable to care for herself or 5/4/17, at 12:04 p.m.  N)-A stated R51 had a history had her narcotic medication are result. RN-A stated R51 ersonal "stuff," going on in her 51's mood was good. At 12:41 he had reviewed R51's spoke to R51's nurse sychologist's recommendation Cymbalta had not been as someone missed it. Further, commendations should have	F3	09			

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F 309	charts. Notes with reviewed by the prin scheduled resident	sent to the facility for resident recommendations are mary physician at the next visit."  CATHETER, PREVENT UTI,	F3	309 315			6/5/17
SS=D	(e) Incontinence. (1) The facility must continent of bladder receives services a continence unless hor becomes such that o maintain. (2) For a resident without the resident's continence unless had becomes such that on the resident without the resident's continence.	t ensure that resident who is and bowel on admission assistance to maintain his or her clinical condition is nat continence is not possible th urinary incontinence, based amprehensive assessment, the					
	indwelling catheter resident's clinical cocatheterization was  (ii) A resident who estindwelling catheter is assessed for remass possible unless to demonstrates that coand	nters the facility without an is not catheterized unless the condition demonstrates that necessary; enters the facility with an or subsequently receives one loval of the catheter as soon the resident's clinical condition catheterization is necessary					
	receives appropriat prevent urinary trac continence to the ex- (3) For a resident w	is incontinent of bladder e treatment and services to t infections and to restore extent possible.  with fecal incontinence, based emprehensive assessment, the					

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F 315	facility must ensure incontinent of bowe treatment and servi bowel function as p This REQUIREMEN by: Based on observat review, the facility for reassess a change residents (R39) review. Findings include: R39's admission M 12/28/16, indicated cognitively impaired she needed total as had occasional incomposed of incontinuous assessment (CAA) had urinary urgency occasional dribbling mobility impairment Assessment dated continent of bowel afor toileting during the tanight every four history (lists episod continence of urine identified she was in R39's quarterly MD needed extensive a was frequently incomore episodes). R Assessment dated incontinent of urine The assessment furing the same of the sam	that a resident who is I receives appropriate ces to restore as much normal	F 31	F315 No catheter, prevent bladder  1) How corrective action will accomplished for those reside be affected: A comprehensive assessme completed for R39 and accuthe continence status and to the resident. The care planto reflect the resident's currenthis was communicated to stransp.  2) How to identify other residented by practice: All residents who have bower incontinence were reassessed accuracy. Residents will continue to has comprehensive Bowel & Bladassessment completed per the policy and procedure on admit quarterly, annually and with a change in status. The information reflected on each residents of indicate individualized continuation indicate individualized continuation.	I be dents found to nt was irately reflects ileting plan of was updated ent needs and taff caring for dents having by the same el and bladder ed for ave a dder the revised nission, a significant nation will be care plan to	

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F 315	Point Of Care Historindicated she was in with various times of R39's care plan dat on a will call toiletin dribbling of urine, a products.  During interview 5/2 nurse (RN)-B stated had an increase in urinary tract infection antibiotic on 3/26/1 sure if R39 still had During interview 5/5 she works the day sweek R39 was incomposite the works of the works o	ry dated 3/23/17 to 3/30/17, necontinent of urine 11 times over the day.  ed 1/12/17, indicated she was g plan related to occasional and wore an incontinence  2/17, at 3:06 p.m. registered d she thought the reason R39 incontinence was related to a sin and was started on a r. RN-B stated she was not problems with incontinence.  2/17, at 3:30 p.m. NA-C stated shift and about 2-3 times a ntinent of urine. She got R39 d she was incontinence of a urine.	F 3	315	,	will not on the and wel and assure ction is ted, ystem. der nts onths y by the results uality of	
	she has to use the When he works nig incontinent and was a.m.  During interview 5/practical nurse (LPI shift and R39 was uwhen she gets up in During interview 5/3 she works the day at night and this ma	2/17, at 3:26 p.m. licensed N)-A stated works on the day usually incontinent of urine			determine when compliance is indicated as in		

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION  NG	COM	E SURVEY IPLETED
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F315  Continued From page 15 usually wet when she wakes up, but during the day she will tell us when she needs to use the bathroom.  During observation 5/3/17, at 7:20 a.m. R39 was in the bathroom voiding in the toilet with NA-D assisting her.  During interview 5/3/17, at 10:56 a.m. RN-B stated she did not realize (R39) had an increase with urinary incontinence, and they needed to reassess R39's bladder function, and develop a new plan that was more specific to her needs.  The facilities Bladder and Bowel Policy and Procedure revised 2/15, indicated "It is the policy that the facility will ensure that each resident that is incontinent of bladder and/or bowel function as possible through use of appropriate treatment and services. It is the policy to also identify risk factors and assess resident who are continent of bladder and bowel for the purpose of maintaining current function."					500 PARK STREET EAST		<u> </u>
usually wet when she wakes up, but during the day she will tell us when she needs to use the bathroom.  During observation 5/3/17, at 7:20 a.m. R39 was in the bathroom voiding in the toilet with NA-D assisting her.  During interview 5/3/17, at 10:56 a.m. RN-B stated she did not realize (R39) had an increase with urinary incontinence, and they needed to reassess R39's bladder function, and develop a new plan that was more specific to her needs.  The facilities Bladder and Bowel Policy and Procedure revised 2/15, indicated "It is the policy that the facility will ensure that each resident that is incontinent of bladder and/or bowel is identified and assessed, given the opportunity to achieve continence or restore as much normal bladder and/or bowel function as possible through use of appropriate treatment and services. It is the policy to also identify risk factors and assess resident who are continent of bladder and bowel for the purpose of maintaining current function."	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	(X5) COMPLETION DATE
the appropriate toileting or bladder/bowel retraining program as assessed. This is care planned and staff are informed of the plan.	F 318	usually wet when sl day she will tell us we bathroom.  During observation in the bathroom voi assisting her.  During interview 5/3 stated she did not rwith urinary inconting reassess R39's blanew plan that was reasonable that the facilities Bladder Procedure revised that the facility will be is incontinent of bland assessed, give continence or restonand/or bowel functionally to also identificated the purpose of resident who are conformed to the purpose of retraining program planned and staff at 483.25(c)(2)(3) INCO DECREASE IN RACCO Mobility.	be wakes up, but during the when she needs to use the she needs to use the 5/3/17, at 7:20 a.m. R39 was ding in the toilet with NA-D 8/17, at 10:56 a.m. RN-B ealize (R39) had an increase nence, and they needed to dder function, and develop a more specific to her needs.  Be and Bowel Policy and 2/15, indicated "It is the policy ensure that each resident that dder and/or bowel is identified in the opportunity to achieve re as much normal bladder on as possible through use of ent and services. It is the far factors and assess ontinent of bladder and bowel naintaining current function." Indicated the RN determines eting or bladder/bowel as assessed. This is care re informed of the plan. CREASE/PREVENT NGE OF MOTION	F 3			6/9/17

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(3) A approto m prace mober This by: Bass reviet nurs direct and Find R38 Alzh depremult Minital indictions of data had upper wrist iden Duri nurs R38 on h cloth ROM contand	opriate service aintain or improticable indeperility is demonst REQUIREMEI ed on observation, the facility fing programs for the facility from the facility for the facilit	imited mobility receives s, equipment, and assistance ove mobility with the maximum idence unless a reduction in rably unavoidable.  NT is not met as evidenced tion, interview and document ailed to provide restorative or range of motion (ROM) as esidents (R38, R18, R67, R36 for ROM services.  Indated) had the diagnoses of tia with behaviors, major intractures of muscle on as Significant Change in Status (MDS), dated 4/14/2017, ent was severely cognitively by dependant with all activities actions in ROM on one side of which included shoulder, elbow, e restorative nursing section active programs occurred.  Son 05/03/2017 at 9:10 a.m., enabilitation (Rehab)-A entered DM. Rehab-A positioned R38 apped a warm moist wash thand. Rehab-A completed alder, elbow, and hand. She er ROM to R38's left leg, knee the same on the right side, 38's right shoulder, arm and	F 3	F318 Increase/ Preverange of motion  1) How corrective active accomplished for those be affected: Resident R38 had rest needs reassessed and plan updated to reflect Resident R18 is currer physical therapy and control interventions will be up completed to reflect current occupational therapy a interventions will be up completed to reflect current occupational therapy a interventions will be up completed to reflect current occupational therapy a interventions will be up completed to reflect current occupational therapy a interventions will be up completed to reflect current occupational therapy a interventions will be up completed to reflect current occupational therapy a interventions will be up completed to reflect current occupational therapy a interventions will be up completed to reflect current occupational therapy a interventions will be up completed to reflect current occupational therapy a interventions will be up completed to reflect current occupational therapy a intervention will be up completed to reflect current occupational therapy a intervention will be up completed to reflect current occupational therapy a intervention will be up completed to reflect current occupational therapy a intervention will be up completed to reflect current occupational therapy a intervention will be up completed to reflect current occupational therapy a intervention will be up completed to reflect current occupational therapy a intervention will be up completed to reflect current occupational therapy a intervention will be up completed to reflect current occupation will	on will be e residents found to orative nursing I the individual care current status. In the individual care plan in the individual care current needs. In the individual care current status.	

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	PROVIDER OR SUPPLIER  DALE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302	1 30/	<i>,,</i>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 318	After completion of a.m., Rehab-A, star ROM, pull away an occurred, you stop occurring or move usually calms him.  In review of R38's ITherapy Discharge indicated: "Please of left] hand and ROM arms and hands 3-R38's Rehab Vision Information, , dated "please completed (range of motion pr 3-5x/wk."  R38's care plan (lathat "R38 participate to prevent contraction the care plan that F [nursing] rehab pro ROM, LE [lower ex range of motion] 3/Complete bilateral left hand."  Review of R38's metools from March to Attachment C identification and the standard for the st	the ROM on 05/03/17 at 9:45 ted R38 could be resistive to d strike out. When this and explain what was to a different extremity, which Rehab Visions Occupational Information, dated 2/24/17, complete washing and drying M (range of motion) on [both] 5x/week (time per week)." In as Physical Therapy Discharge 16/8/16, the orders indicated: [both] [lower extremities] ROM ogram in a supine (on back) at reviewed 4/21/17), indicated es in a nursing rehab program ures." The facility indicated in R38 was to receive, "Nsg gram: up to 3-5 x/wk has with tremities] PROM [passive -5x/wk [3 to 5 times a week]. upper extremity ROM. Wash onthly ROM data collection May 2017 entitled:	F 318	and RN to evaluate current prog care plan interventions for each in restorative nursing. A meeting team was held on May 24th whe residents program was evaluated overall structure of the restorative program was revised.  3) Measures put into place or synchanges made to ensure practice recur. The restorative nursing program policies and procedures have be revised and staffed trained on the changes. Weekly rehab meeting continue and any changes will be on the individual care plan.  4) How to monitor performance is solutions are sustained, that corrections are sustained; implemental evaluated and integrated into QA. An RN will audit the implemental care planned interventions week weeks then monthly for three most the correction date. The results discussed monthly at the Quality committee and the committee with determine when compliance is in	resident g with the re each d and the e nursing stemic e will not and en e gs will e updated o assure rection is ented, a system. ion of the ly for four onths after will be of Life ll	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245364	B. WING			C <b>04/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302	, 55,	- · · - · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 318	Rehab-A stated the rehabilitation staff vanot scheduled as de However, at times to cover direct care pot to lead the facility's stated if resident's a visitors, or refuses, reschedule their reload. Rehab-A state nursing rehab are stopped to from March to frequency of ROM R38.  During an interview Wing care manage stated the Rehab Reprogression with the week (on Fridays), any of the residents unaware that R38 of a week for the monomorphism occupational theraplast quarterly screen oticeable change the resident fluctual behavior and cogni	5/3/17, at 11:52 a.m., are were two nursing work alternating days, and are irect care nursing assistants. The two have been pulled to obsitions along with rehab and exercise group daily. Rehab-A are out to appointments, have it is difficult to reproach and or hab because of heavy case and residents who receive scheduled by the therapy en 3-5 times each week for iewed the ROM data collection May 2017 and identified the was not being completed for an on 5/3/17 at 1:59 p.m., the B r, registered nurse (RN)-B RN reviews resident e rehabilitation staff once a for changes and concerns with a RN-B stated she was the of March and April 2017.  5/4/17 at 9:01 a.m., the obst (OTR)-A, stated during the n on 2/24/17, there was no in R38's ROM. OTR-A stated ted day to day because of tion. They expect the nursing ROM exercises 3-5 times a	F 31	,		
	2 2 1 2 2 1 1 2 1 1 2 1 1 2 1 2 1 2 1 2					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245364	B. WING		05/04/2017		
NAME OF PROVIDER OR SUPPLIER  ANNANDALE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302	, 33.3		
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	HOULD BE COMPLETION		
F 318	with Lewy Bodies, tand sleep disorder. 3/15/17, identified stotally dependent with functional limitation nursing section of tance and the functional limitation nursing section of tance and the functional limitation nursing section of tance and tance are and tance and tance and tance are and tance and tance and tance are and tance and	the diagnoses of dementia ransient ischemic attack (TIA) R18's quarterly MDS, dated severe cognitive impaired, with all ADLs and had no in ROM. The restorative he MDS identified restorative descurred.  Rehab Visions Occupational Information, dated 11/19/16, complete [upper extremity] tion) program", on 4/13/17: upper extremity] ROM ROM FMP (functional am) for further information." on 5/4/17 at 9:01 a.m., the post (OTR)-A stated her for treatments completed 3-5 or R18.  ions Physical Therapy ion, dated 6/08/16, the orders completed [both] [lower range of motion program in a	F 318	3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245364	B. WING			C / <b>04/2017</b>	
NAME OF PROVIDER OR SUPPLIER  ANNANDALE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLÉTION		
F 318	May 1-3, 2017 - red April 1-30, 2017 - red April 1-30, 2017 - red the 5th documented appointment, vi March 1-31, 2017 - with one treatment and two oth appointment, visitor  During interview on assistant director of ROM data collection missing ROM treatment An interview on 5/4 stated the last quaridentified no noticed R18 fluctuated from behavior and cogni rehab to complete to week as they have  R67's Resident Factoresident had arthritit quarterly MDS of 30 cognitively intact are to two staff to complication of bilatera shoulder, elbow, we indication R67 rece  R67's care plan, up resident was to par program which con balance-transfer ex	teived 1 treatment eceived only 4 treatments with das "O" (MD isitor, etc) received only 6 treatments documented as "I" (illness) ners documented as "O" (MD r, etc)  5/4/2017 at 11:20 a.m., the f nursing (ADON) reviewed the n tool, and stated R18 was ments.  /17 at 9:01 a.m., OTR-A, terly OT screen on 4/13/17, able decline in R18's ROM. In day to day because of tion. They expect nursing ROM exercises 3-5 times a directed for R18.  ce Sheet, undated, identified in multiple sites. R67's in multiple sites. R67's in the required assistance of one olete ADL's. The MDS functional limitations in range all upper extremities of its and hand. There was no ived any restorative nursing.	F 318				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245364	B. WING _			C / <b>04/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 318	plan also identified exercise/stretch prowith Nursing Rehated. The OT Evaluation 9/21/16, identified with upper body dretwo to complete low program was devel shoulder exercise/sper week.  During interview on reported increased right shoulder, hip, pain medications for are completed with trained by therapy", completed with any completed on an as She stated her, "She since coming to the had some limitation right hand and held body.  Review of the facilities.	R67 had shoulder ogram 3 to 5 times per week	F 31	8		
		bilateral shoulder exercise				
	the frequency of "30" representing O etc) with no addition indicated "A" (in an entry indicated "R."	eceived only 1 treatments at 0", five entries were denoted ther (MD appointment, visitor, nal information, 1 entry other activity), and another				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245364	B. WING				C <b>04/2017</b>
	PROVIDER OR SUPPLIER  DALE CARE CENTER			500	PARK STREET EAST NANDALE, MN 55302	1 30/	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 318	with the frequency of the pertial section of the participation in and the participation in and February 1-28, 201 "O" with no addition identified as "A", and LOA (leave of absedurary 1-31, 2017 received 15 minute was identified as "A" (illness), and 3 entropecember 1-31, 20 received 15 minute identified "O", with reflect indicated "A/R".  During interview on Rehab-A stated R64 Life, on Tuesday stated R67 had comparticipation in class exercise/stretch proweek, Rehab-A stated R64 Life, on Tuesday stated R67 had comparticipation in class exercises. Rehab-A more pain when comparticipation in class exercises. Rehab-A more pain when comparticipation. NA-A seperform in bed as the exercises are to be severcises are to be	of 20-30-20, with an additional as "O", with no additional entry identified as "A" for ther activity.  7-2 entries are identified as all information, 1 entry was ad one noted resident was on nce).  -1 entry identified resident so of 1:1 interaction, 1 entry as indicated "I" ies indicated "O".  17-2 entries indicated "I" ies indicated "O".  17-2 entries identified R67 so of 1:1 therapy, 6 entries no additional explanation, 1 dent was "A", and 1 entry  5/3/17, at 12:06 p.m.  7 comes to exercise class, Fit and Thursdays. Rehab-A	F3	18			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245364	B. WING _		05	C / <b>04/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 500 PARK STREET EAST ANNANDALE, MN 55302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 318	does have limitation mobility is uncomformation has placed her on a worked with R67 relimitations and computing interview on OTR-A stated R67 ROM, both active a complete independing assistance-passive for rehab nursing to ROM with table top present during this	therapist (DPT)-A stated R67 ns related to arthritis and ortable. Occupational therapy a ROM program and has egarding her shoulder of the respective of the	F3	18		
	R36 had arthritis w impacted. R36's quidentified resident himpairment and recistaff to complete Al any functional limits. R36's Rehab Vision discharge instruction rehab nursing was upper extremity RC the end of movement completed 3 to 5 till Life class.  R36's care plan, last the resident participrogram to maintain	ident Face Sheet identified ith difficulty with multiple joints uarterly MDS of 1/31/17 and moderate cognitive seived assistance of one to two DL's. The MDS did not identify ation in ROM.  In occupational therapy ons, dated 11/25/16, identified to assist resident with right DM with prolonged stretch at ent. This routine was to be mes week and attend the Fit 4 at updated 2/6/17, identified pates in nursing rehab in current ability and prevent e care plan directed Rehab				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245364	B. WING			C <b>05/04/2017</b>
_	PROVIDER OR SUPPLIER  DALE CARE CENTER			STREET ADDRESS, CITY, STAT 500 PARK STREET EAST ANNANDALE, MN 55302		00/04/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD B TO THE APPROPRI	
F 318	Nursing to "comple prolonged stretch a shoulder flexion and flexion/extension, for wrist flexion/extensingers) flexion/extensingers) flexion/extensingers) flexion/extensingers) flexion/extensingers) flexion/extensingers) flexion/extensingers) flexion/extensingers) flexion/extension to attend the Fand Updated physical dated 4/2/17, identification assist R36 perform bilaterally 3 to 5 timesecond hold.  In review of the montal to the frequency of "10 entries were denoted appointment, visitor information, 1 entry activity), and 1 entry activity).	te 5 reps [repetitions] with tend of movement for dabduction, elbow brearm suspiration/pronation, ion, and full fist (all nsion 3-5 x week." R36 was it 4 Life class.  all therapy information sheet, fied rehab nursing was to hamstring stretching es a week 5 times with a 30 and the nursing as follows:  weived 1 treatments at D" 1:1 (one to one) minutes, 5 and "O" representing Other (MD re, etc) with no additional indicated "A" (in another	FS	318		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
	245364		B. WING		0.5	C <b>05/04/2017</b>		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 500 PARK STREET EAST ANNANDALE, MN 55302	<u> </u>	70 172011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 318	participant in the Fi willing to complete receive a hamstring and PROM (passiv upper extremity. Reactive participant in exercises were not prioritizing other Recompleted.	age 25 36 has been an active t 4 Life program and has been the program. R36 was to g stretch with standing frame, e range of motion) to right ehab-A stated R36 was an exercise group so the PROM completed at times due to ehab Nursing tasks to be	F3	18				
	stated R36 had bee recommended to re repetitions with pro movement for shou elbow flexion/exten suspiration/pronatic full fist (all fingers)f OTR-A stated reha	en evaluated and eceive "right upper extremity longed stretch at the end of allder flexion and abduction,						
	diagnosis of arthriti 3/18/17 indicated a the need for extens staff to complete Al	ident Face Sheet identified a s. R15's quarterly MDS of severe cognitive deficit and sive assistance of one to two DL's. The MDS identified no ent of range of motion or any						
	dated 9/8/16, idention of 2 and use of the note directed rehability and lower extremity RO R15's care plan, reparticipation in the	by evaluation information, fied R15 received assistance Medi-Lift with transfers. The paides to complete bilateral M 3 to 5 times a week.  Viewed on 3/20/17, identified rehab nursing program to bility. The care plan outlined the						

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245364	B. WING _		05	C / <b>04/2017</b>
	PROVIDER OR SUPPLIER  DALE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 500 PARK STREET EAST ANNANDALE, MN 55302		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 318	In review of the modecember 2016 thr R15 received ROM program as follows  December 1-31, 2015 1:1 (one to one) January 1-31, 2017 of 15 1:1 minutes February 1-28, 201 with the frequency notation of "O".  During interview on Rehab-A stated the exercises as direct During interview on stated R15 was se extremity ROM wit week to maintain furchanges in his function of the company of	ram to assist with bilateral M 3 to 5 times per week.  Inthly rehabilitation logs from ru February 2017 identified bilateral shoulder exercise:  If 6 - received 8 treatments of minutes If - received only 7 treatments If - received only 5 treatments If - received only 6 treatments If - received only 7 treatments If - received only 7 treatments If - received only 8 treatments If - received 8 treatments of minutes If - received 9 treatments		8		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED  C  05/04/2017	
245364						
	NAME OF PROVIDER OR SUPPLIER  ANNANDALE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIF 500 PARK STREET EAST ANNANDALE, MN 55302		0 1/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 318	Program Nursing, the Policy statemen directed toward the residents, restorationand independence, style, prevention of	abilitation and Restorative reviewed 5/12. identified under at, first bullet: "Nursing care is conservation of abilities of an of optimal levels of function, adaptation to an altered life	F3	18		

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PRINTED: 06/12/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 245364 05/01/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 500 PARK STREET EAST ANNANDALE CARE CENTER ANNANDALE, MN 55302 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PRÉFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS **FIRE SAFETY** 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. 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. 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 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 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** ( K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or

Electronically Signed

(X6) DATE

06/07/2017

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  IG 01 - MAIN BUILDING 01		MPLETED
		245364	B. WING _			/01/2017
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUFOLLOWING INF  1. A description of to correct the defication of the correct of the facility of the correct of	estate.mn.us and an@state.mn.us  ORRECTION FOR EACH IST INCLUDE ALL OF THE FORMATION:  f what has been, or will be, done				
	facility has a fire a detection in the c	building.  Itomatic sprinkler protected. The alarm system with smoke orridors and spaces open to the nonitored for automatic fire				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLETED
		245364	B. WING	<del></del>	05/	01/2017
	PROVIDER OR SUPPLIER  DALE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	capacity of 60 beds time of the survey.  The requirement at NOT MET as evide	tion. The facility has a and had a census of 51 at 42 CFR, Subpart 483.70(a) is need by:	KO			5/2/17
K 341 SS=C	NFPA 101 Fire Alarm System - Installation		К3	41		5/2/1/
	Based on observa facility failed to inst accordance with NI (2012) section 19.3 National Fire Alarm This deficient pract the alarm system to during a fire event	s not met as evidenced by: tions and staff interview the all the smoke detection in FPA 101 Life Safety Code 6.4.1, 9.6.1.3 and NFPA 72 Code (2010) section 17.7.4.1. ice could affect the ability of a sound in a timely manner which would affect all residents ed amount of staff and visitors.		K341 The smoke detector in observed to be too close to the diffuser. On 5/2/2017 we move smoke detector in B23 one spa from the HVAC diffuser. In the will be looking for the 36" sepa anytime ceiling work is done. Tof Maintenance is responsible correction and for preventing reoccurrence.	HVAC d the 1 ace over future we ration The Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245364	B. WING		5/01/2017
	PROVIDER OR SUPPLIER  DALE CARE CENTER		5	TREET ADDRESS, CITY, STATE, ZIP CODE = 00 PARK STREET EAST NNANDALE, MN 55302	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 341	on 05/01/2017, obs	petween 1:15 PM to 4:30 PM ervations and staff interview	K 341		
	HVAC diffuser by ro This deficient cond Facility Maintenance	tion was confirmed by the	K 345		5/1/17
	A fire alarm system accordance with ar with the requirement Electric Code, and and Signaling Code	- Testing and Maintenance is tested and maintained in approved program complying approved program complying of NFPA 70, National NFPA 72, National Fire Alarm e. Records of system enance and testing are readily and NFPA 25			
	Based on docume the Facility failed to Alarm System in ac National Electric Co Fire Alarm and Sign	s not met as evidenced by: ntation review and interview, test and maintain the Fire cordance with NFPA 70, ode, and NFPA 72, National naling Code. The deficient et all residents, visitors and		K345 The fire alarm panel was showing that 1 detector by the nurses station was dirty. On 5/1/2017, the detector was removed and cleaned with compressed air, reinstalled and the fire alarm trouble code cleared. The Director of Maintenance is responsible for the correction and for preventing	
	A fire alarm system accordance with ar with the requirement	- Testing and Maintenance is tested and maintained in approved program complying hts of NFPA 70, National NFPA 72, National Fire Alarm		reoccurrence.	

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	COMPLETED		
		245364	B. WING _		05/0	01/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 353	acceptance, mainter available.  9.7.5, 9.7.7, 9.7.8, Findings include: On the facility tour on 05/01/2017, obstanding in Trouble Stacility maintenance because of a dirty standing process of a dirty	e. Records of system enance and testing are readily and NFPA 72.  between 1:15 PM to 4:30 PM servations revealed the Fire Status." When interviewed the edirector it was stated it smoke detector.  riewed revealed that the DACT sted during these times:  17 First and Third shift rd shift rd Shift Fourth quarter lition was confirmed by the exercise Director.  er System - Maintenance and Maintenance and Testing r and standpipe systems are and maintained in accordance and maintaine	K 34			6/6/17
		-				

Event ID: L7J821

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245364	B. WING		05/01/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 374	any non-required of system.  9.7.5, 9.7.7, 9.7.8, at This STANDARD is Based on observatifacility failed to test system in accordant Code (NFPA 101) at The standard for tesprinkler systems. cause the sprinkler properly and allow a could affect all of the undetermined amount of the system of the systems. The standard for tesprinkler systems. The standard for the systems. The standard for the systems in the standard for the systems. The standard for the systems in the standard for the systems in the syst	AS information on coverage for partial automatic sprinkler and NFPA 25 so not met as evidenced by: sion and staff interview, the and maintain the sprinkler ice with the 2012 Life Safety and NFPA 25 section 5.2.1.1.2. sting and maintenance of This deficient condition could system not to function for the spread of fire. This is 60 residents and an unit of staff and visitors.	K 353	K353 Documentation on the springers showed they had been inspetiwice in the last 12 months; 5/2/20 11/05/2016 on each of the 2 risers Simplex Grinnell, the facility's contispertion and testing on June 6th Simplex Grinnell also completed the year maintenance on both risers in to place them both onto the same quarterly inspection schedule. The Director of Maintenance is responsible correction and for preventing reoccurrence.	ected 16, and racted , 2017. ne 5 n order	5/2/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G <b>01 - Main Building 01</b>		SURVEY PLETED
		245364	B. WING		05/0	1/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 500 PARK STREET EAST ANNANDALE, MN 55302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 374	automatic-closing, are not required to egress travel. Doo clear width of 32 in doors. 19.3.7.6, 19.3.7.8, This STANDARD Based on observate facility failed to materier doors in action Code (NFPA 101) 101.8.5.4.1 and NID Doors and Other Codition, section 6.3 could allow the trasmoke compartment corridors untenable	do not require latching, and swing in the direction of ropening provides a minimum inches for swinging or horizontal 19.3.7.9 is not met as evidenced by: ation and staff interview the intain 2 of the three smoke cordance with the Life Safety 2012 edition section FPA 80 the Standard for Fire Opening Protective's, 2010 8.1.7. This deficient practice insfer of smoke from one ent to another making the and an undetermined amount	K 37	K374 On 5/2/2017, the doc the smoke barrier doors of A Wing were adjusted by reset closers to ensure the gap be barriers did not exceed 1/8 ir barrier doors will be inspecte and coinciding with the fire d that no more than 1/8 inch ga The Director of Maintenance responsible for the correction preventing reoccurrence.	Wing and B ting the tween the nch. Smoke d quarterly rills to ensure ap is present. is	
K 712 SS=F	on 05/01/2017, ob revealed the door in the smoke barrie exceeded 1/8 inch.  This deficient cond Facility Maintenan NFPA 101 Fire Drills  Fire Drills  Fire drills include to signal and simulate conditions. Fire drills	dition was confirmed by the ce Director.	K 71	2		5/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G <b>01 - Main Building 01</b>	(X3) DATE SURVEY COMPLETED	
		245364	B. WING		05/01/	2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE C	(X5) OMPLETION DATE
K 712	and is aware that or routine. Responsible conducting drills is persons who are of Where drills are conducting drills are conducting and instead of audible 18.7.1.4 through 1 19.7.1.7  This STANDARD Based on record of acility failed to product a safe and emergency, which an undetermined a Findings include:  During the facility of 5/01/2017, documentation 4) Second quarter documentation 4) Second shift this documentation 5) Third Shift third	staff is familiar with procedures drills are part of established bility for planning and assigned only to competent qualified to exercise leadership. Inducted between 9:00 PM and announcement may be used alarms.  8.7.1.7, 19.7.1.4 through is not met as evidenced by: review and staff interview the ovide documentation of fire drills on each shift as required by the NFPA 101) 2012 edition, and 19.7.1.7. This deficient uce the ability of staff to differ the ability of staff to differ the alimitation of staff and visitors.  documentation review on mentation reviewed revealed anot performed or incomplete staff.  First shift Third shift improper	K 71:	K712 All staff were trained on the facility's fire procedure on 5-1-17. Additional fire drills were conducted each shift during the month of May Future fire Drills were added to the facility's scheduled maintenance sprogram and will be monitored month the Safety Director and Safety Contractor of Maintenance is responsible for the correction and preventing reoccurrence.	ed on y. e software onthly by mmittee.	
	This deficient cond	dition was confirmed by the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION 1 - MAIN BUILDING 01		SURVEY PLETED
		245364	B. WING		05/0	1/2017
NAME OF PROVIDER OR SUPPLIER  ANNANDALE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 920	Electrical Equipme Extension Cords Power strips in a proper strips in a proper patient-care-related (PCREE) assemble by qualified person 10.2.3.6. Power strong not be used for electronics), except rooms that do not on the PCREE meet UL 1 strips for non-PCR (outside of vicinity) care rooms, power standards. All power procedure for fixed extension cords us immediately upon which it was install 10.2.4. 10.2.3.6 (NFPA 99) (NFPA 70), 590.3 (IThis STANDARD Based on observation facility failed to ensign connection was in edition of NFPA 99.	ce Director. al Equipment - Power Cords  nt - Power Cords and atient care vicinity are only	K 712 K 920	K920 1) On 5/1/2017, the were removed from the two rand the coffee pot was removed premises so that only one out needed at each location.  2) On 5/8/2017, an external premises are the control of the co	efrigerators ved from the tlet was	5/8/17

NAME OF PROVIDER OR SUPPLIER  ANNANDALE CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  SOD PARK STREET EAST  ANNANDALE, MN 55302  PROVIDERS TREET LADDRESS, CITY, STATE, ZIP CODE  SOD PARK STREET EAST  ANNANDALE, MN 55302  PROVIDERS TABLE OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  K 920  Continued From page 9  Findings include:  On the facility four between 1:15 PM to 4:30 PM on 05/01/2017, observations and staff interview revealed:  1) 2 refrigerators, 1 microwave and a coffee pot in the maintenance shop plugged into a power strip and not directly into a wall outlet.  2) 1 Extension cord plugged in the copy room and going into the ceiling to plug in the nurse call display.  This deficient condition was confirmed by the Facility Maintenance Director.  K 923 NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.  >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	' '	6 01 - MAIN BUILDING 01	COMF	PLETED
ANNANDALE CARE CENTER    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG)   PREFIX TAG			245364	B. WING		05/0	1/2017
RECEX TAG  K 920 Continued From page 9  Findings include:  On the facility tour between 1:15 PM to 4:30 PM on 05/01/2017, observations and staff interview revealed:  1) 2 refrigerators, 1 microwave and a coffee pot in the maintenance shop plugged into a power strip and not directly into a wall outlet.  2) 1 Extension cord plugged in the copy room and going into the ceiling to plug in the nurse call display.  This deficient condition was confirmed by the Facility Maintenance Director.  K 923  SS=C  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.  >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non-or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if					500 PARK STREET EAST		
responsible for the correction and for preventing reoccurrence.  On the facility tour between 1:15 PM to 4:30 PM on 05/01/2017, observations and staff interview revealed:  1) 2 refrigerators, 1 microwave and a coffee pot in the maintenance shop plugged into a power strip and not directly into a wall outlet.  2) 1 Extension cord plugged in the copy room and going into the ceiling to plug in the nurse call display.  This deficient condition was confirmed by the Facility Maintenance Director.  K 923  S=C Container Storag  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.  >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	COMPLETION
sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923	Findings include:  On the facility tour on 05/01/2017, obsrevealed:  1) 2 refrigerators, 1 in the maintenance strip and not direct.  2) 1 Extension cord going into the ceilindisplay.  This deficient cond Facility Maintenance NFPA 101 Gas Equipment - Organization of Container Storag.  Gas Equipment - Organization of Container Storage Iocations a ventilated in accord 5.1.3.3.3.  >300 but <3,000 construction of Storage Iocations a ventilated in accord 5.1.3.3.3.  >300 but <3,000 construction of Storage Iocations a ventilated in accord 5.1.3.3.3.  >300 but <3,000 construction of Storage Iocations a ventilated in accord 5.1.3.3.3.	between 1:15 PM to 4:30 PM servations and staff interview  I microwave and a coffee pot shop plugged into a power ly into a wall outlet.  If plugged in the copy room and ig to plug in the nurse call sition was confirmed by the see Director.  Lipment - Cylinder and  Cylinder and Container Storage wal to 3,000 cubic feet are designed, constructed, and dance with 5.1.3.3.2 and with flammables, and are mbustibles by 20 feet (5 feet if losed in a cabinet of instruction having a minimum on rating.  to 300 cubic feet compartment, individual		responsible for the correction and preventing reoccurrence.	for	5/30/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	IPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 01</b>	COMP	LETED
		245364	B. WING _		05/0	1/2017
	PROVIDER OR SUPPLIER  DALE CARE CENTER	· ·		STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 923	or equal to 300 cub stored in an enclos handled with preca A precautionary sig each door or gate of where the sign inclumination minimum "CAUTIO STORED WITHIN Storage is planned of which they are recylinders. When faintegral pressure gronsidered empty is are marked to avoid in the open are prosidered empty in the standard encould affect of the could affect all of the could encould e	aggregate volume of less than ic feet are not required to be ure. Cylinders must be utions as specified in 11.6.2. In readable from 5 feet is on of a cylinder storage room, udes the wording as a N: OXIDIZING GAS(ES) NO SMOKING." so cylinders are used in order eceived from the supplier. It is segregated from full incility employs cylinders with auge, a threshold pressure is established. Empty cylinders id confusion. Cylinders stored tected from weather. It is, 11.3.4, 11.6.5 (NFPA 99) is not met as evidenced by: it ion and staff interview the re oxygen tanks in accordance of the an oxygen filled atmosphere is pread of fire. This condition in the 60 residents and an unit of staff and visitors.  In the supplier is the supplier in the supplier is condition in the supplier is condition. In the supplier is condition in the supplier is condition in the supplier is condition. In the supplier is condition in the supplier is condition in the supplier is condition. In the supplier is condition in the supplier is condition in the supplier is condition.	K 93	K923 On 05/30/2017, the extra bottles in the Oxygen storage roor removed from the storage area. Was installed to show FULL BOTT AREA and EMPTY BOTTLE ARE. Segregation will be maintained by bottle storage racks. The Director Maintenance is responsible for the correction and for preventing reoccurrence.	m were Signage LE A. use of of	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 18, 2017

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5364029

Dear Ms. Reitmeier:

The above facility was surveyed on May 1, 2017 through May 4, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

Annandale Care Center May 18, 2017 Page 2

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338 or brenda.fischer@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please 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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

Email: kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

PRINTED: 05/30/2017 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X2) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00951	B. WING		05/0	; 4/2017	
ANNANDALE CARE CENTER 500 PAR			DRESS, CITY, S STREET EA ALE, MN 55		,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	*****	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and mumber and mum	nether a violation has been					
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.					
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/26/17 **Electronically Signed** 

TITLE

STATE FORM 6899 L7J811 If continuation sheet 1 of 29

PRINTED: 05/30/2017 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00951	B. WING		05/0	)4/ <b>2017</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
ANNANI	ANNANDALE CARE CENTER 500 PAR ANNAND					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Heal you electronically. Is necessary for State enter the word "corn text. You must then State licensure proceed prior to el Minnesota Department's staff, the following correct Please indicate in your and identify the date. Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department federal software in the State of Column entitled "ID statute/rule out of column entitled "ID statute/r	th orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic ress, under the heading edate your orders will be rectronically submitting to the rent of Health.  4th, 2017 surveyors of this visited the above provider and tion orders are issued. Our electronic plan of nave reviewed these orders, when they will be completed.  The ent of Health is documenting Correction Orders using gnumbers have been of a state statutes/rules for umber appears in the far left Prefix Tag." The state ompliance is listed in the nt of Deficiencies" column of Comply" portion of the sis column also includes the naviolation of the state statute. "This Rule is not met as wing the surveyors findings wethod of Correction and rection.  RD THE HEADING OF THE I WHICH STATES, NOF CORRECTION." THIS ERAL DEFICIENCIES ONLY.	2 000			

6899

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET (X3) DATE SU COMPLET (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) DATE SU COMPLET (X6) DATE SU COMPLET					
		00951	B. WING		05/0	) 4/2017
NAME OF I	PROVIDER OR SUPPLIER		DDESS CITY S	STATE, ZIP CODE	1 03/0	7/2017
			STREET EA	*		
ANNAND	PALE CARE CENTER		ALE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			6/9/17
		omprehensive plan of care personnel involved in the				
	by: Based on observati review, the facility fa interventions as dire (R38, R18, R67, R1 range of motion (R0 This had the potent	ent is not met as evidenced on, interview and document ailed to implement care plan ected for 5 of 5 residents (5, and R36) who received DM) from restorative nursing. ial to effect 28 residents ng a restorative nursing		Corrected		
	Findings include:					
	Alzheimer's dement depression and Cor sites. R38's Signific Minimum Data Set indicated the reside impaired, was totall of daily living (ADLs had functional limita upper extremities w wrist and hand. The	ndated) had diagnoses of tia with behaviors, major ntractures of muscle, multiple ant Change in Status (MDS), dated 4/14/2017, and was severely cognitively by dependant with all activities at tions in ROM on one side of which included shoulder, elbow, a restorative nursing section at ive programs were				

Minnesota Department of Health

STATE FORM 6899 L7J811 If continuation sheet 3 of 29

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			, 50. <del>1</del> 5		С	
		00951	B. WING			4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANNAND	OALE CARE CENTER		STREET EA ALE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 3	2 565			
	implemented.					
	4/21/17), indicated nursing rehab programmers are to receive, "Ns to 3-5 x/wk has with PROM [passive rartimes a week]. Com ROM. Wash left has During observations nursing assistant re R38's to provide ROM on his back and wracloth around his left ROM of R38's should continued to provid and foot, repeating	re plan (last reviewed that "R38 participates in a ram to prevent contractures." d in the care plan that R38 g [nursing] rehab program: up n ROM, LE [lower extremities] age of motion] 3/-5x/wk [3 to 5 nplete bilateral upper extremity nd."  s on 05/03/2017 at 9:10 a.m., ehabilitation (Rehab)-A entered DM. Rehab-A positioned R38 apped a warm moist wash thand. Rehab-A completed alder, elbow, and hand. She e ROM to R38's left leg, knee the same on the right side, 38's right shoulder, arm and				
	tools from March to	onthly ROM data collection May 2017 entitled: ified the following frequency:				
	the 5th documented March 1-31, 2017 - with one treatment	eceived only 4 treatments with				
	Rehab-A stated the rehabilitation staff v not scheduled as di However, at times t	5/3/17, at 11:52 a.m., re were two nursing work alternating days, and are irect care nursing assistants. The two have been pulled to ositions along with rehab and				

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STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			, 50.25 10			;
		00951	B. WING			4/2017
NAME OF PROVID	ER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
I ANNANDALE CARE CENTER			STREET EA LE, MN 55			
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
to lead identification of the identification	tified because of anot get always weed the ROM of the to May 2017 met for R38 as ang an interview re manager regarded. (on Fridays), terns with the reware that R38 has a week for the reward that R38 has a week for the restorative nursing so care plan, up as care plan plan plan plan plan plan plan plan	ge 4  exercise group daily. Rehab-A of the heavy work load ROM is get completed. Rehab-A data collection tool from and the ROM frequency was identified by the care plan.  on 5/3/17 at 1:59 p.m., Wing gistered nurse (RN)-B stated ews with the rehab staff once a to see if there are changes or esidents. RN-B stated she was lad not received ROM 3-5 e months of March and April by the care plan.  Indated) had the diagnoses of the Bodies, transient ischemic lep disorder. R18's quarterly the gistered they were severely thank totally dependant with all functional limitations in ROM. Sing section identified thad not occurred.  Indated 4/24/17, indicated, In a nursing rehab program to ility and to prevent decline in Rehab nursing to perform forogram in supine (on R18's reps [repetitions] each wk [weekly], and "UE [upper foram" 3-5 times a week.  In the program of the section tools, the C (last revised 3/08), the received ROM for the following	2 565			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		С	
		00951	B. WING		_	4/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ANNAND	ALE CARE CENTER		STREET EA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	the 5th documented visitor, etc) March 1-31, 2017 - with one treatment and two others doc appointment, visitor	received only 4 treatments with d as "O" (MD appointment, received only 6 treatments documented as "I" (illness) umented as "O" (MD r, etc)				
	assistant director of ROM data collection	5/4/2017 at 11:20 a.m., the f nursing (ADON) reviewed the n tool, and stated R18 was ments. R18's care plan for g implemented.				
	resident had arthriti quarterly MDS of 3 was cognitively inta one to two to comp including. The MDS limitations in range extremities of should	se Sheet, undated, identified is in multiple sites. R67's /14/17 identified the resident ct, required staff assistance of lete activities of daily living identified R67 had functional of motion bilateral upper lder, elbow, wrist and hand ation R67 received any				
	reported increased right shoulder, hip, pain medications for are completed with trained by therapy", completed with any completed on an avecompleted on a some limitation and avecompleted on a some limitation are are avecompleted on a some limitation and avecompleted on an avecompleted on a supplication of avecompleted on a supplication on a supplication of avecompleted on an avecompleted on a supplication of avecompleted on a supplication of a supplica	5/3/17, at 11:07 a.m. R67 pain and discomfort in her and thigh but dislikes taking or this. R67 stated exercises by an "Aide who has been however these are not frequency. The exercises are verage of one time per week. oulders are definitively worse" a facility. Per observation R67 is with opening and closing her her right shoulder close to her				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. BOILBING.			;
		00951	B. WING	·····	05/0	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ANNANI	DALE CARE CENTER		STREET EA ALE, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	R67's care plan, up resident was to par program which con balance-transfer ex for Tuesday and The plan also identified exercise/stretch prowith Nursing Rehabilities. Attachment CR67 received ROM program at the following the frequency of "30" "O" representing Oretc) with no addition indicated "A" (in an entry indicated "R" March 1-31, 2017 with the frequency of 9 entries identified information, and 1 expanding the participation in another participation in another participation in another participation in addition identified as "A", and LOA (leave of absection of the participation in another	dated 3/15/17, identified ticipate in the Fit 4 Life sisted of stretches, ercises and strength training tursday programs. The care R67 had shoulder ogram 3 to 5 times per week o program.  The care R67 had shoulder ogram 3 to 5 times per week o program.  The care R67 had shoulder ogram 3 to 5 times per week of program.  The care R67 had shoulder ogram 3 to 5 times per week of program.  The collection tools, and indicated of the collection tools, indicated only 1 treatments at D'', five entries were denoted the collection, 1 entry other activity), and another refused.  The collection tools, indicated only 3 treatments of 20-30-20, with an additional entry identified as "A" for the activity.  The collection tools, indicated as "A" for the activity.  The collection tools, indicated only 3 treatments of 20-30-20, with an additional entry identified as "A" for the activity.  The collection tools, indicated as and information, 1 entry was and one noted resident was on once).  The other collection tools, indicated "I"	2 565			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				C		
		00951	B. WING		05/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ANNANE	ALE CARE CENTER		STREET EA			
	OUR MAR DV OTA		ALE, MN 55		211	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 7	2 565			
	Rehab-A stated R6 4 Life, on Tuesday stated R67 had corparticipation in clas exercise/stretch proweek, Rehab-A stather exercises when unable to return at exercises as directed.  R36's undated Res R36 had arthritis wiimpacted. R36's quidentified resident himpairment and records.	s and was to receive shoulder ogram three to five times a sed if R67 was not ready for they arrived, they were a later time to complete ed by the care plan.  ident Face Sheet identified th difficulty with multiple joints parterly MDS of 1/31/17 and moderate cognitive eived assistance of one to two DL's. The MDS did not identify				
	was to be evaluated occupational theraptoning. The care play recommendations of Nursing was instructing was instructed at the end of the facility of the facil	nd full fist (all nsion 3-5 x week." R36 was				

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STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			7. BOILDING.		С	
		00951	B. WING			4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANNANI	DALE CARE CENTER		STREET EA ALE, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	May 1-3, 2017 - rec April 1-30, 2017 - rec the frequency of "10 entries were denote appointment, visitor information, 1 entry activity), and 1 entr March 1-31, 2017 - with the frequency additional 2 entries therapy. February 1-28, 201 treatment with the frand two dates "I" (il January 1-31, 2017 treatment with a freand one noted incided to the participant in the Fi willing to complete receive a hamstring and PROM (passivupper extremity. Reactive participant in exercises were not prioritizing other Recompleted.  R15's undated Residiagnosis of arthriti 3/18/17 indicated at the need for extens staff to complete Alfunctional impairments.	ceived 1 treatment. eceived only 7 treatments at 0" 1:1 (one to one) minutes, 5 ed "O" representing Other (MD r, etc) with no additional r indicated "A" (in another	2 565			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00951	B. WING		05/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ANNAND	ALE CARE CENTER		STREET EA LE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 9	2 565			
	with nursing rehab to maintain current	program 3 to 5 times per week ability.				
	In review of the monthly rehabilitation logs from December 2016 thru February 2017 identified R15 received ROM bilateral shoulder exercise program as follows:					
	15 1:1 (one to one) January 1-31, 2017 of 15 1:1 minutes February 1-28, 201	16 - received 8 treatments of minutes - received only 7 treatments 7 - received only 5 treatments of 15 1:1 minutes, and one				
	Rehab-A stated the	5/3/17, at 12:06 p.m. y were unable to complete fied in the care plan because				
	director of nursing ( Rehab Nursing was	5/4/17, at 12:20 p.m. the (DON) stated she was aware a not being completed on the nmended and the facility was ing the process.				
	12/02, identified that the deliverance of contracts	Planning Process , dated at the care plan was to direct care provided and reflective of following the plan				
	The director of nurs inservice staff on fo	THOD OF CORRECTION: sing (DON) or designee could illowing the individualized plan o ensure compliance.				
	TIME PERIOD FOR	R CORRECTION: Twenty-one				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(3) DATE SURVEY COMPLETED	
		00951	B. WING	·····	05/0	)4/ <b>2017</b>
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE AST		
AMMANL	ALL CANE CENTEN	ANNANDA	ALE, MN 55	302		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 10	2 565			
	(21) days.					
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			5/18/17
	receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				
	by: Based on observati review, the facility fa an outside psychiat recommendations f	on, interview and document ailed to coordinate care with ry service and act on their or 1 of 1 residents (R51) ved outside psychiatry		Corrected		
	Findings include:					
	2/25/17, identified F required extensive a of daily living (ADLs R51 displayed symplements) "Feeling tired or have	imum Data Set (MDS) dated R51 had intact cognition and assistance with her activities b). Further, the MDS identified otoms of depression including, ving little energy," nearly pain, "Almost constantly."				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00951	B. WING	<del></del>	05/0	)4/ <b>2017</b>
	NAME OF PROVIDER OR SUPPLIER  ANNANDALE CARE CENTER  STREET AD  500 PARK ANNAND					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	During observation was seated in an elhallway. R51 had vlower extremities wher arms and neck. hurt, "Awful bad," at R51's care plan dat depression and was medication. The care "Worries and rumin body/medical proble attempt gradual dos when indicated and update the physicial lacked any intervenidentified R51 was a services.  R51's Associated Contentified R51 was a services.  R51's following with the same with and sweating," and Further, the note identified to, " about the same with and sweating," and benefit from Cymba pain and depression her reports of sadned deferred to her PCF R51's following physical sales and benefit from with any "Assessment [and]	on 5/1/17, at 6:03 p.m. R51 ectric wheelchair in the risible contractures on her ith nearly constant tremors of R51 stated her contractures at times.  ed 2/28/17, identified R51 had as taking antidepressant are plan identified R51, ates over changes in ems," and directed staff to be reductions of medications monitor R51's status and an as needed. The care plan tions or dictation which being seen by psychology	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
			A. BUILDING:	A. BUILDING:		С	
		00951	B. WING			)4/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ANNANE	ALE CARE CENTER		STREET EA				
(VA) ID	CLIMMA DV CTA	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECT	ION	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ige 12	2 830				
	"Moderate episode disorder," and, "Chi The physician increpatch (narcotic dura R51 was, "Stable," regimen for depres reference or dictation psychologist' recommoderate of Cymbalta to R51's identified in the 3/3 R51's medical recommon evidence R51's considered the psychurther, R51's sign	of recurrent major depressive ronic pain of both extremities." eased R51's ordered Fentanyl agesic patch) and identified on her current medication sion. There was no identified on addressing the mendation to consider adding medication regimen as					
	When interviewed on 5/4/17, at 8:36 a.m. nursing assistant (NA)-A stated R51's mood, "hasn't really changed," in the past months. NA-A stated R51 still does have episodes of crying, "Every once in awhile," about being unable to care for herself or return to her home.						
	registered nurse (R of pain and recently dosing increased a also had, a lot of pelife; however, felt R p.m. RN-A stated s medical record and practitioner. The period to consider adding addressed because RN-A stated the reception been looked at and	is 5/4/17, at 12:04 p.m. in 5/4/17, at 12:04 p.m. in 5/4/17, at 12:04 p.m. in 1/4 had her narcotic medication is a result. RN-A stated R51 ersonal "stuff," going on in her 51's mood was good. At 12:41 he had reviewed R51's a spoke to R51's nurse sychologist's recommendation Cymbalta had not been in a someone missed it. Further, commendations should have addressed.  In the first product of the first produc					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			A. BUILDING:	·	С		
		00951	B. WING	····		)4/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
ANNAND	ANNANDALE CARE CENTER  500 PAR ANNAND						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	"Dictated notes are charts. Notes with reviewed by the prinscheduled resident SUGGESTED MET The director of nursinservice nursing st psychiatry recommetimely; then audit to TIME PERIOD FOR (21) days.	procedure which included, sent to the facility for resident recommendations are mary physician at the next visit."  THOD OF CORRECTION: sing (DON) or designee could raff regarding making sure endations are acted upon ensure compliance.  R CORRECTION: Twenty-one	2 830			0/0/47	
2 895	Motion  Subp. 2. Range of that is directed town through positioning implemented and not comprehensive rest of nursing services development of a not provides that:  B. a resident with receives appropriate increase range of not decrease in range of the comprehensive	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which  h a limited range of motion the treatment and services to notion and to prevent further of motion.  ent is not met as evidenced ion, interview and document ailed to provide restorative or range of motion (ROM) as	2 895	Corrected		6/9/17	

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING			
		00951	b. WING	· · · · · · · · · · · · · · · · · · ·	05/0	4/2017
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ANNAND	OALE CARE CENTER		STREET EA ALE, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	Continued From pa	ige 14	2 895			
	•	esidents (R38, R18, R67, R36				
	Findings include:					
	Alzheimer's demen depression and cor multiple sites. R38's Minimum Data Set indicated the reside impaired, was totall of daily living (ADLs had functional limits upper extremities wwrist and hand. Thidentified no restoral During observation nursing assistant re R38's to provide R0 on his back and wrocloth around his lef ROM of R38's shou continued to provid and foot, repeating	ndated) had the diagnoses of tia with behaviors, major intractures of muscle on significant Change in Status (MDS), dated 4/14/2017, ent was severely cognitively by dependant with all activities in the MDS identified R38 ations in ROM on one side of which included shoulder, elbow, he restorative nursing section active programs occurred.  Is on 05/03/2017 at 9:10 a.m., ehabilitation (Rehab)-A entered DM. Rehab-A positioned R38 apped a warm moist wash thand. Rehab-A completed alder, elbow, and hand. She e ROM to R38's left leg, knee the same on the right side, 38's right shoulder, arm and				
	a.m., Rehab-A, star ROM, pull away an occurred, you stop	the ROM on 05/03/17 at 9:45 ted R38 could be resistive to d strike out. When this and explain what was to a different extremity, which				
	Therapy Discharge indicated: "Please of	Rehab Visions Occupational Information, dated 2/24/17, complete washing and drying M (range of motion) on [both]				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00951	B. WING		05/0	)4/ <b>2017</b>
	NAME OF PROVIDER OR SUPPLIER  ANNANDALE CARE CENTER  STREET AD  500 PARI  ANNAND					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 895	arms and hands 3-5 R38's Rehab Vision Information, , dated "please completed (range of motion pro 3-5x/wk."  R38's care plan (last that "R38 participate to prevent contracted the care plan that Red [nursing] rehab programmer of motion] 3/Complete bilateral teleft hand."  Review of R38's motions from March to Attachment C ident May 1-3, 2017 - red April 1-30, 2017 - red the 5th documented March 1-31, 2017 - with one treatment another "O" (MD appropriate of the motion of the stated the rehabilitation staff which is cover direct care poto lead the facility's stated if resident's a visitors, or refuses, reschedule their refload. Rehab-A stated	5x/week (time per week)." In as Physical Therapy Discharge 6/8/16, the orders indicated: [both] [lower extremities] ROM ogram in a supine (on back)  St reviewed 4/21/17), indicated es in a nursing rehab program ures." The facility indicated in 38 was to receive, "Nsg gram: up to 3-5 x/wk has with tremities] PROM [passive 5x/wk [3 to 5 times a week]. upper extremity ROM. Wash onthly ROM data collection May 2017 entitled: ified the following:	2 895			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00951	B. WING			C <b>05/04/2017</b>	
	PROVIDER OR SUPPLIER  DALE CARE CENTER	500 PARK	ORESS, CITY, S STREET EA ALE, MN 553				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 895	department and see ROM. Rehab-A revitool from March to I frequency of ROM v R38.  During an interview Wing care manage stated the Rehab R progression with the week (on Fridays), any of the residents unaware that R38 da week for the month In an interview on 5 occupational theraplast quarterly screen noticeable change in the resident fluctual behavior and cognit rehab to complete F week as they have a R18 facesheet had with Lewy Bodies, to	en 3-5 times each week for ewed the ROM data collection May 2017 and identified the was not being completed for on 5/3/17 at 1:59 p.m., the B r, registered nurse (RN)-B N reviews resident e rehabilitation staff once a for changes and concerns with a RN-B stated she was the of March and April 2017.  1/4/17 at 9:01 a.m., the poist (OTR)-A, stated during the non 2/24/17, there was non R38's ROM. OTR-A stated the day to day because of the control of the co	2 895				
	and sleep disorder. 3/15/17, identified s totally dependent w functional limitation nursing section of the nursing had not occurred.	R18's quarterly MDS, dated evere cognitive impaired, ith all ADLs and had no s in ROM. The restorative ne MDS identified restorative curred.					
	Therapy Discharge indicated: "Please of ROM (range of mot	Rehab Visions Occupational Information, dated 11/19/16, complete [upper extremity] ion) program", on 4/13/17: upper extremity] ROM					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00951	B. WING		C <b>05/04/2017</b>	
	NAME OF PROVIDER OR SUPPLIER  ANNANDALE CARE CENTER  500 PAR ANNAND				1 00/0	1/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	program. Refer to F maintenance program. During an interview occupational therapexpectations was for times each week for In R18's Rehab Vis Discharge Informatindicated: "Please of extremities] ROM (In supine (on back) 3-R18's care plan, up "[R18] participates in maintain current ab ability to do ADLs." "bilateral LE ROM programment back) X [times] 20 redirection 3-5 times of extremity] ROM programment from the standard section of the most tools, entitled: Attack received ROM for the Sth documented appointment, vinderch 1-31, 2017 - with one treatment and two others documented appointment, visitor During interview on assistant director of a standard sections.	ROM FMP (functional am) for further information." on 5/4/17 at 9:01 a.m., the bist (OTR)-A stated her for treatments completed 3-5 r R18.  It ions Physical Therapy ion, dated 6/08/16, the orders completed [both] [lower range of motion program in a 5x/wk."  I dated 4/24/17, indicated, in a nursing rehab program to ility and to prevent decline in Rehab nursing to perform program in supine (on R18's reps [repetitions] each wk [weekly], and "UE [upper orgam" 3-5 times a week.  Inthly ROM data collection chement C, indicated R18 he following frequency:  I developed 1 treatment received only 4 treatments with das "O" (MD sitor, etc)  I received only 6 treatments documented as "I" (illness) umented as "O" (MD received only 6 treatments documented as "O" (MD received on	2 895			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00951	B. WING			C <b>04/2017</b>
	NAME OF PROVIDER OR SUPPLIER  ANNANDALE CARE CENTER  STREET A  500 PAR  ANNANI					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 895	An interview on 5/4, stated the last quaridentified no noticea R18 fluctuated from behavior and cognit rehab to complete f week as they have.  R67's Resident Factoresident had arthritiquarterly MDS of 3 cognitively intact and to two staff to compidentified R67 had for motion of bilateral shoulder, elbow, wrindication R67 receous R67's care plan, up resident was to part program which considerate with Nursing Rehability of the CT Evaluation 9/21/16, identified with upper body dretwo to complete low program was developed which was developed wheek.  During interview on	/17 at 9:01 a.m., OTR-A, terly OT screen on 4/13/17, able decline in R18's ROM. In day to day because of tion. They expect nursing ROM exercises 3-5 times a directed for R18.  The Sheet, undated, identified is in multiple sites. R67's /14/17 identified resident was addirected assistance of one olete ADL's. The MDS functional limitations in range all upper extremities of ist and hand. There was no ived any restorative nursing.  Idated 3/15/17, identified ticipate in the Fit 4 Life sisted of stretches, ercises and strength training jursday programs. The care R67 had shoulder orgram 3 to 5 times per week	2 895			
	right shoulder, hip,	and thigh but dislikes taking this. R67 stated exercises				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING:			(3) DATE SURVEY COMPLETED	
	00951		B. WING		C <b>05/04/2017</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANNANI	DALE CARE CENTER		STREET EA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 895	are completed with trained by therapy", completed with any completed on an avenue She stated her, "She since coming to the had some limitation right hand and held body.  Review of the facility collection tools, enting R67 received ROM program as follows:  May 1-3, 2017 - received ROM program as follows:  May 1-3, 2017 - received ROM program as follows:  May 1-3, 2017 - received ROM program as follows:  May 1-3, 2017 - received ROM program as follows:  May 1-3, 2017 - received ROM program as follows:  "O" representing Other than the frequency of "30" another activity), and March 1-31, 2017 with the frequency of 9 entries identified as "A", and LOA (leave of abserdance) January 1-28, 201" "O" with no addition identified as "A", and LOA (leave of abserdance) January 1-31, 2017 received 15 minutes was identified as "A (illness), and 3 entries to be compared to the first program as follows:	by an "Aide who has been however these are not frequency. The exercises are verage of one time per week. oulders are definitively worse" facility. Per observation R67 s with opening and closing her her right shoulder close to her with the shoulder close to her by monthly ROM data itled: Attachment C, indicated bilateral shoulder exercise eleved only 1 treatments at 0", five entries were denoted ther (MD appt, visitor, etc) with action, 1 entry indicated "A" (in another entry indicated "R." received only 3 treatments of 20-30-20, with an additional entry identified as "A" for ther activity. T-2 entries are identified as all information, 1 entry was done noted resident was on noce).  1 entry identified resident so of 1:1 interaction, 1 entry ", 2 entries indicated "I"	2 895			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00951	B. WING		05/0	) 4/ <b>2017</b>
	PROVIDER OR SUPPLIER  DALE CARE CENTER	500 PARK	DRESS, CITY, S STREET EA ALE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	During interview on Rehab-A stated R67 4 Life, on Tuesday stated R67 had corparticipation in clase exercise/stretch proweek, Rehab-A stated her exercises when unable to return at exercises. Rehab-A more pain when corpain interview on stated R67 had voor right shoulder and redication. NA-A seperform in bed as to exercise are to be a puring interview on doctorate physical to does have limitation mobility is uncomformation has placed her on a worked with R67 relimitations and compouring interview on OTR-A stated R67 ROM, both active a complete independent assistance-passive for rehab nursing to ROM with table top present during this	5/3/17, at 12:06 p.m. 7 comes to exercise class, Fit and Thursdays. Rehab-A histently declined is and was to receive shoulder orgram three to five times a red if R67 was not ready for they arrived, they were a later time to complete is stated R67 does complain of impleting exercises and she a difference in R67's shoulder.  5/3/17, at 1:19 p.m. NA-A calized increased pain in the more requests for pain tated R67 had exercises to aught by therapy and completed with rehab nursing.  5/3/17, at 1:35 p.m. with herapist (DPT)-A stated R67 has related to arthritis and related to arthritis and related. Occupational therapy a ROM program and has garding her shoulder fort.  5/4/17, at 9:01 a.m. with was admitted with decrease and passive (exercises ently-active, and with a complete active assisted exercises. DPT-A who was interview, stated R67 has inctional changes in her recent	2 895			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED		
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NAME OF PROVIDER OR SUF	PLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
ANNANDALE CARE CE	NTER		STREET EA			
PREFIX (EACH DEFI	CIENCY MUST BE	OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
R36 had arthrimpacted. R3identified residentified residentified residentified residentified residentified resident purctional R36's Rehabidischarge instrehab nursing upper extrem the end of mocompleted 3 to Life class.  R36's care plather resident purction of the residen	d Resident Faitis with difficulties with difficulties quarterly dent had mode and received at ete ADL's. The limitation in It is a support of the support of	eational therapy ed 11/25/16, identified t resident with right prolonged stretch at routine was to be ek and attend the Fit 4  ed 2/6/17, identified nursing rehab at ability and prevent an directed Rehab s [repetitions] with movement for tion, elbow suspiration/pronation, I full fist (all 5 x week." R36 was class.  by information sheet, ab nursing was to ing stretching eek 5 times with a 30  DM data collection nursing as follows:	2 895			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00951	B. WING		05/0	)4/ <b>2017</b>
	NAME OF PROVIDER OR SUPPLIER  ANNANDALE CARE CENTER  500 PAF ANNANI					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	entries were denoted appt, visitor, etc) will entry indicated "A" entry indicated "R." March 1-31, 2017 with the frequency of additional 2 entries therapy. February 1-28, 201 treatment with the frequency of additional 2 entries therapy. February 1-31, 2017 treatment with a frequency of and two dates "I" (in January 1-31, 2017 treatment with a frequency of and one noted incided December 1-31, 2017 treatment with a frequency of the frequency of t	ed "O" representing Other (MD th no additional information, 1 (in another activity), and 1  received only 5 treatments of 15 1:1 minutes, with an where resident had refused  7-received 2 episodes of requency of "15" 1:1 minutes, llness) was indicatedreceived 5 episodes of quency of "15" 1:1 minutes, lent where resident refused. 16-received 12 episodes of quency of "15" 1:1 minutes  5/3/17, at 12:06 p.m. 6 has been an active the program. R36 was to get the program. R36 was to get the program. R36 was an exercise group so the PROM completed at times due to shab Nursing tasks to be  5/4/17 at 9:01 a.m. OTR-A en evaluated and exercise group so the program of the program and abduction, sion, forearm on, wrist flexion/extension, and exion/extension 3-5 x week."	2 895			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		С	
		00951	B. WING			4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ANNANDALE CARE CENTER			STREET EA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 23	2 895			
2 093	R15's undated Res diagnosis of arthritis 3/18/17 indicated a the need for extens staff to complete Alfunctional impairmerestorative nursing.  The physical therapdated 9/8/16, identiof 2 and use of the note directed rehablower extremity RO R15's care plan, reparticipation in the maintain current abnursing rehab proglower extremity RO In review of the modecember 2016 thr R15 received ROM program as follows  December 1-31, 2017 of 15 1:1 (one to one) January 1-31, 2017 of 15 1:1 minutes February 1-28, 201 with the frequency notation of "O".	ident Face Sheet identified a s. R15's quarterly MDS of severe cognitive deficit and live assistance of one to two DL's. The MDS identified no ent of range of motion or any by evaluation information, fied R15 received assistance Medi-Lift with transfers. The laides to complete bilateral M 3 to 5 times a week.  Viewed on 3/20/17, identified rehab nursing program to ility. The care plan outlined the ram to assist with bilateral M 3 to 5 times per week.  Inthly rehabilitation logs from the representation of the plan outlined the ram to assist with bilateral bilateral shoulder exercise in 16 - received 8 treatments of	2 093			
	Rehab-A stated the exercises as direct	y were unable to complete ted because of limited time.  5/4/17, at 9:01 a.m. DPT-A				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00951	B. WING		05/0	; 4/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
ANNANDALE CARE CENTER			STREET EA				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 895	extremity ROM with week to maintain further changes in his function buring interview on who is responsible stated they had reversely April of 2017 and not had declined and we evaluating this programmes.  During interview on director of nursing interview on director of nursing in programmes in the and the intent was in the and the intent was in the needs of the resurd the Policy, titled Rehampers and independence, style, prevention of complications of discussive staff regard audit to ensure it is	t up to complete bilateral lower h 20 repetitions 3-5 times per unction, and had had no tional ability.  5/4/17, at 9:31 a.m. ADON, for the nursing rehab program, iewed the tracking log from oted completion of exercises ere currently in the process of gram but had made no  5/4/17, at 12:20 p.m. the dentified the ROM Rehab process of being re-evaluated to look at alternative to meet sidents.  abilitation and Restorative reviewed 5/12. identified under at, first bullet: "Nursing care is conservation of abilities of on of optimal levels of function, adaptation to an altered life deterioration, and sability whenever possible."  THOD OF CORRECTION: sing or designee could reding range of motion and completed as directed.	2 895				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 910	MN Rule 4658.0525 Incontinence	5 Subp. 5 A.B Rehab -	2 910			6/5/17	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		00951	B. WING		05/04/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANNANI	DALE CARE CENTER		STREET EA ALE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 910	Continued From page 25		2 910			
	have a continuous management to recunnecessary use of comprehensive results home must ensure A. a resident without an indwelling unless the resident that catheterization B. a resident with receives appropriate prevent urinary traces.	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ag catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder the treatment and services to infections and to restore as the infection as possible.				
	by: Based on observation review, the facility for reassess a change residents (R39) review. Findings include: R39's admission M12/28/16, indicated cognitively impaired she needed total as had occasional incompisodes of incontinuous assessment (CAA) had urinary urgency occasional dribbling mobility impairment Assessment dated	ent is not met as evidenced ion, interview and document ailed to comprehensively in continence status for 1 of 1 iewed for urinary incontinence.  inimum Data Set (MDS) dated she was moderately d. The MDS further indicated sist of two with toileting and ontinence (seven or less nence). R39's care area dated 12/28/16, identified she y and had problems with g, and had cognitive and t. R39's Bowel And Bladder 12/28/16, indicated she was and bladder and she would call		Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
	00951	B. WING			C <b>04/2017</b>	
NAME OF PROVIDER OR SUPPLIER			TATE, ZIP CODE			
ANNANDALE CARE CENTER		( STREET EA ALE, MN 553				
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE	
at night every four hor History (lists episode continence of urine) or identified she was incompared as was frequently incompared episodes). R39 Assessment dated 3/2 incontinent of urine at The assessment furth toileting and toilet every Point Of Care History indicated she was incompared with various times over R39's care plan dated on a will call toileting dribbling of urine, and products.  During interview 5/2/2 nurse (RN)-B stated had an increase in in urinary tract infection antibiotic on 3/26/17. Sure if R39 still had puring interview 5/2/2 assistant (NA)-B state nights and R39 will ushe has to use the base works night incontinent and was a a.m.  During interview 5/2/2 assistant was a a.m.	e day and toilet with bedpan ours. R39's Point Of Care is of incontinent and dated 12/22/16 to 1/17/17, continent of urine once.  I dated 3/30/17, indicated she sist of two with toileting and tinent of urine (seven or 9's Bowel and Bladder /29/17, indicated she was and wore absorbent pads. her indicated she will call for ery four hours at night. A y dated 3/23/17 to 3/30/17, continent of urine 11 times wer the day.  d 1/12/17, indicated she was plan related to occasional d wore an incontinence  17, at 3:06 p.m. registered she thought the reason R39 continence was related to a nand was started on a RN-B stated she was not problems with incontinence.  17, at 3:24 p.m. nursing ted he works evenings and sually let him know when athroom on the evening shift.	2 910				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00951	B. WING		C <b>05/04/2017</b>	
NAME OF				274TE 7/D 00DE	1 03/0	7/2011
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S STREET EA	STATE, ZIP CODE		
ANNANE	OALE CARE CENTER		ALE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 27	2 910			
	shift and R39 was uwhen she gets up ir	isually incontinent of urine in the morning.				
	she works the day s week R39 was inco	2/17, at 3:30 p.m. NA-C stated shift and about 2-3 times a ntinent of urine. She got R39 I she was incontinence of a urine.				
	she works the day s at night and this ma incontinent at night. usually wet when sh	3/17, at 7:08 a.m. NA-E stated shift and R39 was very sleepy by be a reason why she was NA-E stated (R39) was ne wakes up, but during the when she needs to use the				
		5/3/17, at 7:20 a.m. R39 was ding in the toilet with NA-D				
	stated she did not rewith urinary inconting reassess R39's blad	8/17, at 10:56 a.m. RN-B ealize (R39) had an increase nence, and they needed to dder function, and develop a more specific to her needs.				
	Procedure revised 2 that the facility will e is incontinent of bla and assessed, give continence or resto and/or bowel functionappropriate treatment policy to also identified resident who are conformed to the purpose of in the policy further in	er and Bowel Policy and 2/15, indicated "It is the policy ensure that each resident that dder and/or bowel is identified in the opportunity to achieve re as much normal bladder on as possible through use of ent and services. It is the fry risk factors and assess entinent of bladder and bowel maintaining current function." indicated the RN determines eting or bladder/bowel				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00951	B. WING			C <b>04/2017</b>
	PROVIDER OR SUPPLIER  DALE CARE CENTER	STREET ADI	DRESS, CITY, S STREET EA ALE, MN 55		, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 910	retraining program a planned and staff a SUGGESTED MET The director of nurs all residents who not to assure they are retreatment/services toileting. The director could conduct randocare; to ensure appimplemented.	as assessed. This is care are informed of the plan.  THOD OF CORRECTION: Sing or designee, could review eeded assistance with toileting, receiving the necessary to prevent potential decline in or of nursing or designee, om audits of the delivery of propriate care and services are R CORRECTION: Twenty-one	2 910			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		00951	B. WING		05/04/2017
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE	
ANNANDA	ALE CARE CENTER		K STREET EAST DALE, MN 55302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correction pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart.  Determination of where corrected requires corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessment of the runumber and MN Rule.	ther a violation has been mpliance with all			
	that may result from norders provided that at the Department within notice of assessment  INITIAL COMMENTS You have agreed to preceipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURY	
AND I DAY OF GOTALESTICA	BENTH TO WHOM NO MIDEN.	A. BUILDING: _		OOM! EETE	-5
	00951	B. WING		05/04/2	2017
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANNANDALE CARE CENTER	500 PARK \$	STREET EAST			
ANNANDALE GARE GENTER	ANNANDAI	E, MN 55302			
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SIZE (SECTION)  TO SECTION (SECTION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000 Continued From page	1	2 000			
Department of Health of you electronically. Althesis necessary for State Senter the word "correct text. You must then ind State licensure process completion date, the data corrected prior to electric Minnesota Department.  On May 1st to May 4th Department's staff, visithe following correction Please indicate in your correction that you have and identify the date with Minnesota Department the State Licensing Confederal software. Tagin assigned to Minnesota Nursing Homes.  The assigned taginum column entitled "ID Prestatute/rule out of comp "Summary Statement of and replaces the "To Correction order. This of findings which are in vitafter the statement, "The evidence by." Following are the Suggested Met Time period for Correct PLEASE DISREGARD FOURTH COLUMN Will "PROVIDER'S PLAN CO	orders being submitted to hough no plan of correction Statutes/Rules, please red" in the box available for licate in the electronic red; under the heading red your orders will be ronically submitting to the role reviewed these orders, then they will be completed.  To fleath is documenting rection Orders using rection Order	2 000			

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Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING: COMPLE			
		00951	B. WING		05	6/04/2017
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE <b>K STREET EAST</b>	E, ZIP CODE		
ANNAND	ALE CARE CENTER	ANNANI	DALE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From page	e 2	2 000			
		JIREMENT TO SUBMIT A TION FOR VIOLATIONS OF STATUTES/RULES.				
2 565	MN Rule 4658.0405 Plan of Care; Use	Subp. 3 Comprehensive	2 565			
		nprehensive plan of care personnel involved in the				
	by: Based on observation review, the facility fail interventions as direct (R38, R18, R67, R15 range of motion (RON This had the potentia	n, interview and document led to implement care plan sted for 5 of 5 residents, and R36) who received M) from restorative nursing. I to effect 28 residents g a restorative nursing				
	Findings include:					
	Alzheimer's dementia depression and Contr sites. R38's Significal Minimum Data Set (N indicated the resident impaired, was totally of daily living (ADLs). had functional limitati upper extremities whi	MDS), dated 4/14/2017, t was severely cognitively dependant with all activities The MDS identified R38 ons in ROM on one side of ich included shoulder, elbow, restorative nursing section				

Minnesota Department of Health

STATE FORM 6899 L7J811 If continuation sheet 3 of 29

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00951	B. WING			5/04/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ANNANDA	ALE CARE CENTER		RK STREET EAST			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	DALE, MN 55302	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
2 565	Continued From page	e 3	2 565			
	implemented.					
	nursing rehab progra The facility indicated was to receive, "Nsg to 3-5 x/wk has with I PROM [passive rang times a week]. Comp ROM. Wash left hand During observations nursing assistant reh R38's to provide ROI on his back and wrap cloth around his left I ROM of R38's should continued to provide and foot, repeating th	nat "R38 participates in a sum to prevent contractures." in the care plan that R38 [nursing] rehab program: up ROM, LE [lower extremities] e of motion] 3/-5x/wk [3 to 5 lote bilateral upper extremity				
	tools from March to N	nthly ROM data collection May 2017 entitled: ed the following frequency:				
	the 5th documented March 1-31, 2017 - ru with one treatment do	ceived only 4 treatments with				
	not scheduled as dire However, at times the					

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00951 B. WING 05/04/20	2017
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  500 PARK STREET EAST  ANNANDALE, MN 55302	
	(X5) COMPLETE DATE
2 565  Continued From page 4  to lead the facility's exercise group daily. Rehab-A identified because of the heavy work load ROM does not get always get completed. Rehab-A reviewed the ROM data collection tool from March to May 2017 and the ROM frequency was not met for R38 as identified by the care plan.  During an interview on 5/3/17 at 1:59 p.m., Wing B care manager registered nurse (RN)-B stated the Rehab RN reviews with the rehab staff once a week (on Fridays), to sel if there are changes or concerns with the residents. RN-B stated she was unaware that R38 had not received ROM 3-5 times a week for the months of March and April 2017, as identified by the care plan.  R18's facesheet (undated) had the diagnoses of dementia with Lewy Bodies, transient ischemic attack (TIA) and sleep disorder. R18's quarterly MDS, dated 3'15/17, indicated they were severely cognitively impaired and totally dependant with all ADLs and had not functional limitations in ROM. The restorative nursing section identified restorative nursing had not occurred.  R18's care plan, updated 4/24/17, indicated, "[R18] participates in a nursing rehab program to maintain current ability and to prevent decline in ability to ADLs." Rehab nursing to perform "bilateral LE ROM program in supine (on R18's back) X (times) 20 reps (repetitions) each direction 3-5 times w/k (weekly), and "UE (upper extremity) ROM program" 3-5 times a week.  Review of the monthly ROM data collection tools, entitled: Attachment C (last revised 3/08), indicated that R18 received ROM for the following	

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Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU COMPLE	
		00951	B. WING		05/04	4/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANNANDA	ALE CARE CENTER		STREET EAST			
	CLIMMA DV CT		LE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 565	Continued From page	2 5	2 565			
	the 5th documented a visitor, etc) March 1-31, 2017 - re with one treatment do and two others docum appointment, visitor, etc.  During interview on 5 assistant director of n ROM data collection to missing ROM treatmer ROM was not being in R67's Resident Face resident had arthritis in quarterly MDS of 3/1 was cognitively intact one to two to complet including. The MDS is limitations in range of extremities of shoulded There was no indications.	erived only 4 treatments with as "O" (MD appointment, eceived only 6 treatments ocumented as "I" (illness) mented as "O" (MD etc)  44/2017 at 11:20 a.m., the ursing (ADON) reviewed the rool, and stated R18 was ents. R18's care plan for mplemented.  Sheet, undated, identified in multiple sites. R67's 4/17 identified the resident in required staff assistance of the activities of daily living dentified R67 had functional motion bilateral upper er, elbow, wrist and hand. on R67 received any				
	reported increased paright shoulder, hip, and pain medications for the are completed with by trained by therapy", h	5/3/17, at 11:07 a.m. R67 ain and discomfort in her ad thigh but dislikes taking his. R67 stated exercises an "Aide who has been owever these are not equency. The exercises are				
	completed on an aver She stated her, "Show since coming to the fa had some limitations"	rage of one time per week.  Ilders are definitively worse  acility. Per observation R67  with opening and closing her er right shoulder close to her				

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Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLE	
		00951	B. WING		05/0	4/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ΔΝΝΔΝΠΔ	ALE CARE CENTER	500 PARK	STREET EAST			
AIIIAIIDA	TEL OAKE GERTEK	ANNANDA	LE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 565	Continued From page	e 6	2 565			
	resident was to partic program which consist balance-transfer exer for Tuesday and Thur plan also identified Reexercise/stretch prograwith Nursing Rehab program of the monthly titled: Attachment C (IR67 received ROM bit program at the following May 1-3, 2017 - received ROM bit program at the following Review of the monthly titled: Attachment C (IR67 received ROM bit program at the following Roman at the follow	sted of stretches, cises and strength training sday programs. The care 67 had shoulder from 3 to 5 times per week rogram.  y ROM data collection tools, ast revised 3/08), indicated lateral shoulder exercise fing frequency:				
	April 1-30, 2017 - received 15 minutes of dentified as "A", (illness), and 3 entries December 1-31, 2017 received 15 minutes of dentified as "A", (illness), and 3 entries dentified as "A", (illness), and 3 entries dentified as "A", with the frequency of 9 entries identified as information, and 1 entries and 2 entries and 3	erived only 1 treatments at five entries were denoted er (MD appointment, visitor, I information, 1 entry ner activity), and another fused.  Eceived only 3 treatments 20-30-20, with an additional "O", with no additional try identified as "A" for er activity.  2 entries are identified as information, 1 entry was one noted resident was on ee).  entry identified resident of 1:1 interaction, 1 entry 2 entries indicated "I"				

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE S COMPLI	
		00951	B. WING		05/0	4/2017
	ROVIDER OR SUPPLIER	500 PARK \$	RESS, CITY, STA STREET EAST LE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 565	4 Life, on Tuesday an stated R67 had consparticipation in class a exercise/stretch prograweek, Rehab-A stated her exercises when the unable to return at a lexercises as directed.  R36's undated Resider R36's qualified resident had impairment and receivate for complete ADL any functional limitation.  R36's care plan, editer was to be evaluated to occupational therapy toning. The care plan recommendations out Nursing was instructer "right upper extremity stretch at the end of reflexion and abduction forearm suspiration/pflexion/extension, and fingers)flexion/extension, and fingers)flexion/extension also to attend the Fit and Review of the facility monthly logs for R36's nursing of PROM to	comes to exercise class, Fit dong Thursdays. Rehab-A istently declined and was to receive shoulder and three to five times a dong of the particle of the parti	2 565			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
				<del></del>		
			D WING		1	
		00951	B. WING		05/0	4/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			STREET EAST			
ANNANDA	ALE CARE CENTER		ALE, MN 55302			
			ALE, MIN 55502			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
IAO		,	IAG	DEFICIENCY)		
2 565	Continued From page	8	2 565			
	May 1-3, 2017 - recei	ved 1 treatment				
		eived only 7 treatments at				
		1:1 (one to one) minutes, 5				
		"O" representing Other (MD				
		etc) with no additional				
		ndicated "A" (in another				
	activity), and 1 entry i	`				
	'	eceived only 5 treatments				
		15 1:1 minutes, with an				
		here resident had refused				
	therapy.					
		received 2 episodes of				
		quency of "15" 1:1 minutes,				
	and two dates "I" (illne	•				
	_	eceived 5 episodes of				
	· ·	uency of "15" 1:1 minutes,				
	and one noted incider	nt where resident refused.				
	Di	10147 140.00				
	During interview on 5					
	Rehab-A stated R36					
		Life program and has been				
		e program. R36 was to				
		tretch with standing frame,				
		range of motion) to right				
		ab-A stated R36 was an				
		xercise group so the PROM				
		ompleted at times due to				
	prioritizing other Reha	ab Nursing tasks to be				
	completed.					
		ent Face Sheet identified a				
		R15's quarterly MDS of				
		evere cognitive deficit and				
	the need for extensive	e assistance of one to two				
	staff to complete ADL	's. The MDS identified no				
	functional impairment	of range of motion.				
	R15's care plan, revie	ewed 3/20/17, identified R15				
	_ ·	al ROM to lower extremities				

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MILLIFESOI	a Department of Fleatt					
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	EIEU
		00951	B. WING		05/0	4/2017
NAME ===	DO//IDED 02 0//25: :==		DDEOC OFF: 5=:	TE 7/D 00DE	, , , , ,	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ANNAND	ALE CARE CENTER		STREET EAST			
		ANNAND	ALE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROFEMENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From page	9	2 565			
	with nursing rehab proto maintain current ab	ogram 3 to 5 times per week bility.				
	December 2016 thru	nly rehabilitation logs from February 2017 identified ilateral shoulder exercise				
	15 1:1 (one to one) m January 1-31, 2017 - of 15 1:1 minutes February 1-28, 2017	6 - received 8 treatments of inutes received only 7 treatments - received only 5 treatments 15 1:1 minutes, and one				
		/3/17, at 12:06 p.m. were unable to complete d in the care plan because				
	director of nursing (Do	0/4/17, at 12:20 p.m. the ON) stated she was aware not being completed on the nended and the facility was g the process.				
	12/02, identified that the deliverance of car	lanning Process , dated the care plan was to direct re provided and eflective of following the plan				
	The director of nursin	OD OF CORRECTION: g (DON) or designee could wing the individualized plan ensure compliance.				
	TIME PERIOD FOR (	CORRECTION: Twenty-one				

Minnesota Department of Health STATE FORM

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		00951	B. WING		05	5/04/2017
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
ANNANDA	ALE CARE CENTER		DALE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From page	e 10	2 565			
	(21) days.					
2 830	Proper Nursing Care Subpart 1. Care in g receive nursing care custodial care, and si individual needs and the comprehensive re plan of care as desc 4658.0405. A nursing of bed as much as powritten order from the	eneral. A resident must and treatment, personal and upervision based on preferences as identified in esident assessment and ribed in parts 4658.0400 and g home resident must be out possible unless there is a extending physician that the in bed or the resident	2 830			
	by: Based on observation review, the facility fai an outside psychiatry recommendations for reviewed who receive services.  Findings include: R51's quarterly Minin 2/25/17, identified R5 required extensive as of daily living (ADLs). R51 displayed symptimes as the services of displayed symptimes as the services of daily living (ADLs).	nt is not met as evidenced n, interview and document led to coordinate care with v service and act on their 1 of 1 residents (R51) ed outside psychiatry  num Data Set (MDS) dated in had intact cognition and esistance with her activities Further, the MDS identified oms of depression including, ing little energy," nearly				

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Minnesota Department of Health

STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			756.2516			
		00951	B. WING		05/	04/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ΓE, ZIP CODE		
ANNANDA	ALE CARE CENTER		STREET EAST			
			ALE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From page 11		2 830			
	was seated in an electhallway. R51 had vis lower extremities with her arms and neck. Fhurt, "Awful bad," at till R51's care plan dated depression and was timedication. The care "Worries and ruminate body/medical problem attempt gradual dose when indicated and mupdate the physician lacked any intervention.	ible contractures on her nearly constant tremors of R51 stated her contractures imes.  d 2/28/17, identified R51 had taking antidepressant e plan identified R51, es over changes in ns," and directed staff to reductions of medications nonitor R51's status and as needed. The care plan				
	Note dated 3/31/17, in adjustment and person been working with the from some family relawas identified to, "ro about the same with and sweating," and, "Further, the note iden Recommendations, a report sadness and dependent from Cymbaltapain and depression] her reports of sadness deferred to her PCP [R51's following physical All All All All All All All All All A	enality disorder(s) and had expsychologist to help cope ationship stressors. R51 exports her own mood is continued episodes of crying [R51] does report pain." atified a section labeled, and listed R51, "Continues to expressive symptoms may a [medication used to treat if not contraindicated, given a s and pain. This will be exprimary care provider]." cian progress note dated had chronic pain and exty. The note listed an, an," section and identified				

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Minnesota Department of Health

ANANDALE CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  SOD PARK STREET EAST ANNANDALE, MN 55302  (X4) ID PREFIX TAG  COMPLETED  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  COMPLETE  STREET ADDRESS, CITY, STATE, ZIP CODE  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2 830  Continued From page 12  "Moderate episode of recurrent major depressive disorder," and, "Chronic pain of both extremities." The physician increased R51's ordered Fentanyl patch (narcotic duragesic patch) and identified R51 was, "Stable," on her current medication regimen for depression. There was no identified reference or dictation addressing the psychologist' recommendation to consider adding Cymbalta to R51's medication regimen as identified in the 3/31/17 note.  R51's medical record was reviewed and lacked any evidence R51's physician had addressed or	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  500 PARK STREET EAST  ANNANDALE, MN 55302   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 830  Continued From page 12  "Moderate episode of recurrent major depressive disorder," and, "Chronic pain of both extremities."  The physician increased R51's ordered Fentanyl patch (narcotic duragesic patch) and identified R51 was, "Stable," on her current medication regimen for depression. There was no identified reference or dictation addressing the psychologist' recommendation to consider adding Cymbalta to R51's medication regimen as identified in the 3/31/17 note.  R51's medical record was reviewed and lacked	AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPL	160
ANNANDALE CARE CENTER    SUMMARY STATEMENT OF DEFICIENCIES   ANNANDALE, MN 55302			00951	B. WING		05/0	4/2017
ANNANDALE CARE CENTER  ANNANDALE, MN 55302    X(3)   ID   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ITE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETE DATE	ANNANDA	ALE CARE CENTER					
"Moderate episode of recurrent major depressive disorder," and, "Chronic pain of both extremities." The physician increased R51's ordered Fentanyl patch (narcotic duragesic patch) and identified R51 was, "Stable," on her current medication regimen for depression. There was no identified reference or dictation addressing the psychologist' recommendation to consider adding Cymbalta to R51's medication regimen as identified in the 3/31/17 note.  R51's medical record was reviewed and lacked	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP	) BE	COMPLETE
considered the psychologist's recommendation. Further, R51's signed physician orders dated 4/4/17, lacked any orders or trial dosing of Cymbalta.  When interviewed on 5/4/17, at 8:36 a.m. nursing assistant (NA)-A stated R51's mood, "hasn't really changed," in the past months. NA-A stated R51 still does have episodes of crying, "Every once in awhile," about being unable to care for herself or return to her home.  During interview on 5/4/17, at 12:04 p.m. registered nurse (RN)-A stated R51 had a history of pain and recently had her narcotic medication dosing increased as a result. RN-A stated R51 also had, a lot of personal "stuff," going on in her life; however, felt R51's mood was good. At 12:41 p.m. RN-A stated she had reviewed R51's medical record and spoke to R51's nurse practitioner. The psychologist's recommendation to consider adding Cymbalta had not been addressed because someone missed it. Further, RN-A stated the recommendations should have been looked at and addressed.  A facility Psychology Services policy dated	2 830	"Moderate episode of disorder," and, "Chror The physician increas patch (narcotic duragr R51 was, "Stable," on regimen for depression reference or dictation psychologist' recomm Cymbalta to R51's medical record any evidence R51's possidered the psych Further, R51's signed 4/4/17, lacked any ord Cymbalta.  When interviewed on assistant (NA)-A state changed," in the past still does have episod awhile," about being a return to her home.  During interview on 5 registered nurse (RN) of pain and recently hosing increased as a also had, a lot of persife; however, felt R51 p.m. RN-A stated she medical record and spractitioner. The psychological record and spractitioner and spractitioner and spractitioner and spractical record and spractical recor	recurrent major depressive nic pain of both extremities." sed R51's ordered Fentanyl esic patch) and identified in her current medication on. There was no identified addressing the rendation to consider adding edication regimen as 17 note.  was reviewed and lacked hysician had addressed or ologist's recommendation. physician orders dated ders or trial dosing of  5/4/17, at 8:36 a.m. nursing ed R51's mood, "hasn't really months. NA-A stated R51 les of crying, "Every once in unable to care for herself or 1/4/17, at 12:04 p.m.  1-A stated R51 had a history and her narcotic medication a result. RN-A stated R51 lonal "stuff," going on in her 's mood was good. At 12:41 had reviewed R51's poke to R51's nurse chologist's recommendation of mbalta had not been omeone missed it. Further, mmendations should have ddressed.	2 830	DEFICIENCY)		

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00074	B. WING		0.5/0	4/004=
NAME OF D	ROVIDER OR SUPPLIER	00951	RESS, CITY, STA	TE ZIR CORE	05/0	4/2017
			STREET EAST			
ANNANDA	ALE CARE CENTER	ANNANDA	LE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830		e 13 rocedure which included,	2 830			
	"Dictated notes are se charts. Notes with re	ent to the facility for resident commendations are ary physician at the next				
	The director of nursin inservice nursing staf	OD OF CORRECTION: g (DON) or designee could f regarding making sure dations are acted upon nsure compliance.				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
2 895	MN Rule 4658.0525 S Motion	Subp. 2.B Rehab - Range of	2 895			
	that is directed toward through positioning an implemented and ma					
	receives appropriate	a limited range of motion treatment and services to tion and to prevent further motion.				
	by: Based on observation review, the facility fail	t is not met as evidenced  i, interview and document ed to provide restorative range of motion (ROM) as				

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Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE COMPI	
			/ 50.25 to			
		00951	B. WING		05/	04/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ANNANDA	ALE CARE CENTER		STREET EAST ALE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From page 14		2 895			
	directed for 5 of 5 residents (R38, R18, R67, R36 and R15) reviewed for ROM services.					
	Findings include:					
	Alzheimer's dementiadepression and contribution of the resident impaired, was totally of daily living (ADLs). had functional limitation upper extremities whi wrist and hand. The identified no restoration of the resident impaired, was totally of daily living (ADLs). had functional limitation upper extremities whi wrist and hand. The identified no restoration of the resident in the	ated) had the diagnoses of with behaviors, major actures of muscle on Significant Change in Status IDS), dated 4/14/2017, was severely cognitively dependant with all activities. The MDS identified R38 ons in ROM on one side of ch included shoulder, elbow, restorative nursing section of programs occurred.  on 05/03/2017 at 9:10 a.m., abilitation (Rehab)-A entered of M. Rehab-A positioned R38 ped a warm moist wash and. Rehab-A completed er, elbow, and hand. She ROM to R38's left leg, knee e same on the right side, 's right shoulder, arm and				
	a.m., Rehab-A, stated ROM, pull away and s occurred, you stop ar					
	Therapy Discharge In indicated: "Please con	hab Visions Occupational formation, dated 2/24/17, mplete washing and drying range of motion) on [both]				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	=1ED
		00951	B. WING		05/0	4/2017
NAME OF D				TE 7/10 00005	1 03/0	7/2017
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ANNANDA	ALE CARE CENTER		STREET EAST ALE, MN 55302			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	<del></del>	PROVIDER'S PLAN OF CORRECT	TION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 895	95 Continued From page 15		2 895			
	arms and hands 3-5x R38's Rehab Visions Information, , dated 6 "please completed [be	/week (time per week)." In Physical Therapy Discharge /8/16, the orders indicated: oth] [lower extremities] ROM iram in a supine (on back)				
	that "R38 participates to prevent contracture the care plan that R36 [nursing] rehab progra ROM, LE [lower extre range of motion] 3/-5x	reviewed 4/21/17), indicated in a nursing rehab program es." The facility indicated in 8 was to receive, "Nsg am: up to 3-5 x/wk has with emities] PROM [passive k/wk [3 to 5 times a week]. per extremity ROM. Wash				
	Review of R38's mon tools from March to M Attachment C identifie					
	the 5th documented a March 1-31, 2017 - re	eived only 4 treatments with as "AG" (agitated) aceived only 7 treatments accumented as "AG" and				
	not scheduled as dire However, at times the cover direct care posi to lead the facility's ex stated if resident's are visitors, or refuses, it reschedule their reha load. Rehab-A stated					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00951	B. WING		05/0	4/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
ANNANDA	ALE CARE CENTER		STREET EAST LE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
2 895	ROM. Rehab-A review tool from March to Ma frequency of ROM was R38.  During an interview o Wing care manager, I stated the Rehab RN progression with the rweek (on Fridays), for any of the residents. I unaware that R38 did a week for the months. In an interview on 5/4 occupational therapis last quarterly screen on ticeable change in the resident fluctuated behavior and cognition.	3-5 times each week for wed the ROM data collection ay 2017 and identified the as not being completed for in 5/3/17 at 1:59 p.m., the B registered nurse (RN)-B reviews resident rehabilitation staff once a rechanges and concerns with RN-B stated she was not receive ROM 3-5 times is of March and April 2017.  1/17 at 9:01 a.m., the to (OTR)-A, stated during the on 2/24/17, there was no R38's ROM. OTR-A stated diday to day because of in. They expect the nursing DM exercises 3-5 times a	2 895			
	with Lewy Bodies, tra and sleep disorder. R 3/15/17, identified sex totally dependent with functional limitations in nursing section of the nursing had not occur In review of R18's Re Therapy Discharge In indicated: "Please con	n ROM. The restorative MDS identified restorative red.  hab Visions Occupational formation, dated 11/19/16, mplete [upper extremity] n) program", on 4/13/17:				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			3) DATE SURVEY COMPLETED	
		00951	B. WING		05/0	4/2047	
NAME OF D					05/0-	4/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA <sup>T</sup> <b>K STREET EAST</b>				
ANNANDA	ALE CARE CENTER		ALE, MN 55302				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE	
2 895	- Communication page 11		2 895				
	During an interview of occupational therapis expectations was for times each week for In R18's Rehab Vision Discharge Information indicated: "Please contextremities] ROM (raisupine (on back) 3-5x R18's care plan, update "[R18] participates in maintain current ability ability to do ADLs." For "bilateral LE ROM proback) X [times] 20 regularection 3-5 times where extremity] ROM programment and two offices appointment, vision March 1-31, 2017 - rewith one treatment do and two others documappointment, visitor, expectations are suppointment, visitor, expectations are suppointment.	n) for further information." n 5/4/17 at 9:01 a.m., the t (OTR)-A stated her treatments completed 3-5 R18.  Ins Physical Therapy n, dated 6/08/16, the orders impleted [both] [lower inge of motion program in a k/wk."  Instead 4/24/17, indicated, a nursing rehab program to the and to prevent decline in the hab nursing to perform forgram in supine (on R18's to see [repetitions] each to [weekly], and "UE [upper tram" 3-5 times a week.  In the ROM data collection ment C, indicated R18 to following frequency:  In the answer of the atments the intervence only 4 treatments with the second only 6 treatments to cumented as "I" (illness) mented as "O" (MD)					
	assistant director of n	ursing (ADON) reviewed the tool, and stated R18 was					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING	<del></del>		
		00951	B. WING		05/0	04/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ANNANDA	ALE CARE CENTER		STREET EAST			
	QUILLEN OT		ALE, MN 55302			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	5 Continued From page 18		2 895			
	An interview on 5/4/1 stated the last quarter identified no noticeab R18 fluctuated from dehavior and cognition	7 at 9:01 a.m., OTR-A, rly OT screen on 4/13/17, le decline in R18's ROM. lay to day because of n. They expect nursing DM exercises 3-5 times a				
	resident had arthritis quarterly MDS of 3/1 cognitively intact and to two staff to comple identified R67 had fur of motion of bilateral shoulder, elbow, wrist	nctional limitations in range				
	resident was to partic program which consis balance-transfer exer for Tuesday and Thur plan also identified Re	sted of stretches, cises and strength training sday programs. The care 67 had shoulder ram 3 to 5 times per week				
	9/21/16, identified res with upper body dress two to complete lower program was develop	formation form, dated sident required limited assist sing and extensive assist of r body. A Rehab Nursing sed to assist resident with etch program 3 to 5 times				
	reported increased paright shoulder, hip, ar	5/3/17, at 11:07 a.m. R67 ain and discomfort in her ad thigh but dislikes taking his. R67 stated exercises				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00951	B. WING		05/0	4/2017
	ROVIDER OR SUPPLIER	500 PARK \$	RESS, CITY, STA STREET EAST LE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 895	trained by therapy", h completed with any fr completed on an aver She stated her, "Show since coming to the fahad some limitations right hand and held hebody.  Review of the facility collection tools, entitle R67 received ROM biprogram as follows:  May 1-3, 2017 - receit April 1-30, 2017 - receithe frequency of "30", "O" representing Other on additional informat another activity), and March 1-31, 2017 - rewith the frequency of 9 entries identified as information, and 1 emparticipation in another February 1-28, 2017-"O" with no additional identified as "A", and LOA (leave of absence January 1-31, 2017-1 received 15 minutes of was identified as "A", (illness), and 3 entries December 1-31, 2017 received 15 minutes of identified "O", with no	van "Aide who has been owever these are not equency. The exercises are rage of one time per week. Alders are definitively worse acility. Per observation R67 with opening and closing her er right shoulder close to her emonthly ROM data ed: Attachment C, indicated lateral shoulder exercise eved 0 treatments at five entries were denoted er (MD appt, visitor, etc) with cion, 1 entry indicated "A" (in another entry indicated "R." eceived only 3 treatments 20-30-20, with an additional "O", with no additional try identified as "A" for er activity. 2 entries are identified as information, 1 entry was one noted resident was on ee). entry identified resident of 1:1 interaction, 1 entry 2 entries indicated "I"	2 895			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00951	B. WING	<del></del>	05/04/2017	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANNANDALE CARE CENTER		STREET EAST LE, MN 55302			
CLIMMADY C		1			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
2 895 Continued From page	e 20	2 895			
During interview on 5 Rehab-A stated R67 4 Life, on Tuesday ar stated R67 had cons participation in class exercise/stretch prog week, Rehab-A state her exercises when to unable to return at an exercises. Rehab-A state her exercises. Rehab-A state her exercises. Rehab-A state her exercises. Rehab-A state her exercises are to be contained.  During interview on 5 stated R67 had vocate right shoulder and medication. NA-A state perform in bed as tau exercises are to be contained.  During interview on 5 doctorate physical the does have limitations mobility is uncomfort has placed her on an worked with R67 regulimitations and comfort  During interview on 5 OTR-A stated R67 we ROM, both active and complete independed assistance-passive). for rehab nursing to 6 ROM with table top of present during this in	comes to exercise class, Fit and Thursdays. Rehab-A istently declined and was to receive shoulder ram three to five times a dif R67 was not ready for ney arrived, they were later time to complete stated R67 does complain of pleting exercises and she difference in R67's shoulder.  23/17, at 1:19 p.m. NA-A lized increased pain in the ore requests for pain ted R67 had exercises to 19th by therapy and 19th by therapy and 19th period with rehab nursing.  23/17, at 1:35 p.m. with 19th erapist (DPT)-A stated R67 related to arthritis and 19th able. Occupational therapy ROM program and has 19th arding her shoulder 19th at 19th and 19th are admitted with decrease 19th and 19th are admitted with decrease 19th active, and with 19th are active, and with 19th are developed a program 19th active, stated R67 has 19th are recent 19th a				

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:		
		00951	B. WING		0.	5/04/2017
	ROVIDER OR SUPPLIER	500 PAR	DDRESS, CITY, STATE  K STREET EAST  DALE, MN 55302	, ZIP CODE	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	R36's undated Resid R36 had arthritis with impacted. R36's qualidentified resident had impairment and receistaff to complete ADL any functional limitati.  R36's Rehab Vision discharge instructions rehab nursing was to upper extremity ROM the end of movement completed 3 to 5 times.  R36's care plan, last the resident participal program to maintain of further decline. The converse of the prolonged stretch at a shoulder flexion and a flexion/extension, for wrist flexion/extension fingers) flexion/extension fingers) flexion/extension to attend the Fit.  An Updated physical dated 4/2/17, identificated 4/2/17, iden	ent Face Sheet identified a difficulty with multiple joints arterly MDS of 1/31/17 d moderate cognitive ved assistance of one to two ved assistance ved and therapy as to be very well as the ved as ved and attend the Fit 4 ved attending ved as ved	2 895			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
	00951	B. WING		05/	04/2017	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	ΓΕ, ZIP CODE			
	500 PARK	STREET EAST				
ANNANDALE CARE CENTER	ANNAND	ALE, MN 55302				
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
appt, visitor, etc) with entry indicated "A" (entry indicated "R." March 1-31, 2017 - with the frequency of additional 2 entries witherapy. February 1-28, 2017 treatment with the frequency of additional 2 entries witherapy. February 1-28, 2017 treatment with the frequency of additional 2 entries with a frequency of the second of the sec	d "O" representing Other (MD h no additional information, 1 in another activity), and 1  received only 5 treatments of 15 1:1 minutes, with an where resident had refused  7-received 2 episodes of equency of "15" 1:1 minutes, lness) was indicated.  received 5 episodes of quency of "15" 1:1 minutes, ent where resident refused.  16-received 12 episodes of quency of "15" 1:1 minutes, ent where resident refused.  16-received 12 episodes of quency of "15" 1:1 minutes  5/3/17, at 12:06 p.m. 6 has been an active 4 Life program and has been the program. R36 was to stretch with standing frame, erange of motion) to right hab-A stated R36 was an exercise group so the PROM completed at times due to hab Nursing tasks to be  5/4/17 at 9:01 a.m. OTR-A in evaluated and ceive "right upper extremity onged stretch at the end of der flexion and abduction, sion, forearm in, wrist flexion/extension, and exion/extension 3-5 x week."	2 895				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00951	B. WING		0	5/04/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE			
ANNANDA	ALE CARE CENTER		K STREET EAST ALE, MN 55302				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 895	Continued From page	23	2 895				
	diagnosis of arthritis. 3/18/17 indicated a set the need for extensive staff to complete ADL	ent Face Sheet identified a R15's quarterly MDS of evere cognitive deficit and e assistance of one to two 's. The MDS identified no of range of motion or any					
	dated 9/8/16, identified of 2 and use of the M	evaluation information, ad R15 received assistance edi-Lift with transfers. The ides to complete bilateral 3 to 5 times a week.					
	participation in the rel maintain current abilit nursing rehab prograi	ewed on 3/20/17, identified hab nursing program to by. The care plan outlined the m to assist with bilateral 3 to 5 times per week.					
	December 2016 thru	nly rehabilitation logs from February 2017 identified ilateral shoulder exercise					
	15 1:1 (one to one) m January 1-31, 2017 - of 15 1:1 minutes February 1-28, 2017	6 - received 8 treatments of inutes received only 7 treatments - received only 5 treatments 15 1:1 minutes, and one					
		/3/17, at 12:06 p.m. were unable to complete d because of limited time.					
	During interview on 5	/4/17, at 9:01 a.m. DPT-A					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00951			05/04/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ANNANDA	ALE CARE CENTER		STREET EAST LE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
2 895	extremity ROM with a week to maintain function changes in his function. During interview on 50 who is responsible for stated they had review April of 2017 and note had declined and were evaluating this program changes.  During interview on 50 director of nursing ide program was in the program was in the program was in the program Nursing, review Policy, titled Rehab Program Nursing, review Policy statement, directed toward the corresidents, restoration and independence, as style, prevention of decomplications of disable SUGGESTED METHOThe director of nursing the policy statement.	p to complete bilateral lower 20 repetitions 3-5 times per stion, and had had no snal ability.  4/17, at 9:31 a.m. ADON, the nursing rehab program, wed the tracking log from ad completion of exercises e currently in the process of m but had made no  4/17, at 12:20 p.m. the shifted the ROM Rehab rocess of being re-evaluated look at alternative to meet lents.  silitation and Restorative viewed 5/12. identified under first bullet: "Nursing care is conservation of abilities of of optimal levels of function, daptation to an altered life eterioration, and collity whenever possible."  OD OF CORRECTION: g or designee could ng range of motion and	2 895			
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
2 910	MN Rule 4658.0525 S Incontinence	Subp. 5 A.B Rehab -	2 910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST IDENTIFICATION NUMBER:			COMPLETED	
7.112 1 27.11	IND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING: _		001/11 22	
		00951	B. WING		05/04/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANNAND	ALE CARE CENTER		STREET EAST			
	I		LE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From page	25	2 910			
	have a continuous promanagement to reduce unnecessary use of comprehensive resident who without an indwelling unless the resident's that catheterization who receives appropriate	o enters a nursing home catheter is not catheterized clinical condition indicates as necessary; and is incontinent of bladder treatment and services to infections and to restore as				
	by: Based on observation review, the facility fail reassess a change in residents (R39) review Findings include: R39's admission Mini 12/28/16, indicated sl cognitively impaired. she needed total assi had occasional incontepisodes of incontine assessment (CAA) da had urinary urgency a occasional dribbling, mobility impairment. Assessment dated 12	t is not met as evidenced  n, interview and document ed to comprehensively continence status for 1 of 1 wed for urinary incontinence.  mum Data Set (MDS) dated ne was moderately The MDS further indicated st of two with toileting and tinence (seven or less nce). R39's care area ated 12/28/16, identified she and had problems with and had cognitive and R39's Bowel And Bladder at/28/16, indicated she was d bladder and she would call				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00951	B. WING		05	5/04/2017	
	PROVIDER OR SUPPLIER	500 PARK	DRESS, CITY, STAT	E, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 910	for toileting during the at night every four hor History (lists episodes continence of urine) of identified she was incompleted extensive associated as was frequently incontinence of urine as was frequently incontinence episodes). R39 Assessment dated 3/3 incontinent of urine and The assessment furth toileting and toilet every point Of Care History indicated she was incompleted with various times over R39's care plan dated on a will call toileting dribbling of urine, and products.  During interview 5/2/1 nurse (RN)-B stated is had an increase in incomplete in incomplete in the urinary tract infection antibiotic on 3/26/17. Sure if R39 still had producted to the product of	e day and toilet with bedpan urs. R39's Point Of Care of incontinent and lated 12/22/16 to 1/17/17, ontinent of urine once.  dated 3/30/17, indicated she sist of two with toileting and inent of urine (seven or 's Bowel and Bladder 29/17, indicated she was not wore absorbent pads. Her indicated she will call for ery four hours at night. A dated 3/23/17 to 3/30/17, ontinent of urine 11 times er the day.  I 1/12/17, indicated she was plan related to occasional wore an incontinence  7, at 3:06 p.m. registered she thought the reason R39 continence was related to a land was started on a RN-B stated she was not roblems with incontinence.  7, at 3:24 p.m. nursing ed he works evenings and sually let him know when throom on the evening shift.	2 910				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00951	B. WING		05/04/2017		
					1 00/04/2011		
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATI	E, ZIP CODE			
ANNAND	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE		
2 910	shift and R39 was use when she gets up in to buring interview 5/2/she works the day she week R39 was incontrol up this morning and somedium amount of urange interview 5/3/1 she works the day she at night and this may incontinent at night. It usually wet when she day she will tell us who bathroom.  During observation 5/in the bathroom voiding assisting her.  During interview 5/3/1 stated she did not rease with urinary incontiner reassess R39's bladded new plan that was more than the facilities Bladder Procedure revised 2/2 that the facility will en is incontinent of bladd and assessed, given a continence or restore and/or bowel function appropriate treatment policy to also identify resident who are continent of the purpose of ma	ually incontinent of urine he morning.  17, at 3:30 p.m. NA-C stated ift and about 2-3 times a inent of urine. She got R39 he was incontinence of a ine.  17, at 7:08 a.m. NA-E stated ift and R39 was very sleepy be a reason why she was NA-E stated (R39) was wakes up, but during the ien she needs to use the interest of	2 910				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00951	B. WING		05/0	4/2017
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
ANNANDA	ALE CARE CENTER		STREET EAST LE, MN 55302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 910	retraining program as planned and staff are SUGGESTED METH. The director of nursin all residents who need to assure they are rectreatment/services to toileting. The director could conduct random care; to ensure approimplemented.	assessed. This is care informed of the plan.  OD OF CORRECTION: g or designee, could review ded assistance with toileting,	2 910			

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