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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZF4W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00951

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245364**

2.STATE VENDOR OR MEDICAID NO.
(L2) **244742800**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/27/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Brenda Fischer, Unit Supervisor 02/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/29/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/09/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245364

February 27, 2018

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 February 12, 2018, the above facility is 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.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 27, 2018

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

RE: Project Number S5364030

Dear Ms. Reitmeier:

On January 23, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 5, 2018. 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 February 27, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 5, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 12, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 5, 2018, effective February 12, 2018 and therefore remedies outlined in our letter to you dated January 23, 2018, 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 related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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(L3) **ANNANDALE CARE CENTER**
(L4) **500 PARK STREET EAST**
(L5) **ANNANDALE, MN** (L6) **55302**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/05/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NE II 02/13/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Debby Baker, Enforcement Specialist 02/27/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 23, 2018

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

RE: Project Number S5364030

Dear Ms. Reitmeier:

On January 5, 2018, 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 electronically attached CMS-2567 whereby corrections are required.

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (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 February 14, 2018, 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 February 14, 2018 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 April 5, 2018 (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 July 5, 2018 (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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. 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,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	01/05/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 1/2/18 through 1/5/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 1/2/18 to 1/5/18, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Annandale Care Center was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		2/12/18

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

Electronically Signed | 02/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	01/05/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 1 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential verbal abuse were immediately reported to the administrator and state agency for 1 of 1 residents (R47) who alleged verbal abuse from staff. Findings include: R47's 5-day PPS (Prospective Payment System) minimum data assessment (MDS) completed on 12/24/17 indicated resident had intact cognition and required limited assistance of one to two staff for completion of dressing, grooming, transferring	F 609	1) How corrective action will be accomplished for those residents found to be affected: It is the policy of Annandale Care Center that potential incidents of abuse or neglect be filed in accordance with federal regulation and in accordance with the Facility Abuse Prevention Plan Policy and Procedure. Re-training will be provided to all RN□s and LPN□s on the Facility Abuse Prevention Plan Policy and Procedure. Specific items that will be highlighted are what situations would be considered suspected maltreatment,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	01/05/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 and mobility. The resident face sheet, dated 1/5/18 identified R47's primary diagnoses on admission included: pathological fracture of the right ankle, dorsopathy (spinal disease), other congenial valgus deformity of feet, age related osteoporosis without current pathological fracture. During interview on 1/3/18, at 2:55 p.m. R47 stated she felt intimidated in therapy on 12/31/17 when forced to walk with her brace when she was experiencing extreme pain. R47 reported she had expressed her concerns regarding pain and hesitancy about walking with therapy staff. She was told by physical therapy assistant (PTA)-A she had to walk to the dining room. R47 stated she felt PTA-A did not listen to her concerns and was told she needed to walk to the dining room. R47 stated she experienced increased pain following the walk. R47 stated a family member (FM)-B was present during this incident. During interview on 1/4/18, at 12:45 p.m. R47 reported she was seen at the pain clinic for a previously scheduled appointment and, while there, received medication for pain and a MRI of her right foot and ankle. R47 stated a fracture was noted in her right foot which would require additional follow up with the orthopedic surgeon who performed her original surgery. R47 described her pain level as an eight on a scale of one to ten and further described it to be shooting pain at times. R47 was sitting in her wheelchair with her right leg elevated and a blanket on her lap. During interview on 1/4/18, at 2:14 p.m. FM-B stated she was present over the weekend and observed physical therapy staff, PTA-A to be "extremely rude and condescending." This	F 609	when to report to the Administrator, review of reporting timeline requirements and the process to be used for the subsequent investigation including documentation of all interactions with residents, families, care providers, etc. 2) How to identify other residents having the potential to be affected by the same practice: A facility wide audit of incident reports was done on January 9, 2018 and found in compliance with reporting requirements. 3) Measures put into place or systemic changes made to ensure practice will not recur: Staff are aware that all allegations of abuse made by residents and/or their family members are to be reported immediately to the Administrator for determination of outside reporting requirements. On 02/02/2018, the RN and LPN staff were given a copy of the Facility Abuse Prevention Plan Policy and Procedure and were required to sign off indicating they have reviewed and understand the policy. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system: Designated facility staff will continue to immediately report to outside agencies and investigate all incidents of suspected	

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	245364	A. BUILDING _____ B. WING _____	01/05/2018

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F 609	Continued From page 3 caused R47 "horrible pain and distress." FM-B stated she contacted the facility on 1/1/18 to follow up regarding the situation she observed. Although FM-B had spoken with registered nurse (RN)-C regarding her concerns, she did not feel anything was done in follow up. FM-B stated FM-A followed up with SSA on 1/2/18 and relayed the observation on 12/31/17 made by FM-B of rude staff interaction and lack of consideration for pain and emotional state of R47. During interview on 1/4/18, at approximately 3:30 p.m. RN-C stated she had received a phone call from FM-B on 1/1/18 regarding the care (R47) experienced on the previous day. RN-C summarized the concern as related to interaction with PTA-A and concerns with use of the adaptive boot. RN-C stated she had sent emails related to this concerns to the therapy department and administrative staff because it was a holiday. RN-C stated she had followed up with R47 and stated R47 did not express concerns to her. RN-C did not feel any further follow through was indicated at that time. A review of R47's electronic progress notes did not identify this interaction, however, copies were received of email communication sent to therapy director on 1/1/18 at 12:51 p.m., which described the use of the "boot" as very painful, and staff interaction as being "very rude and short". Additionally, an email was sent to the social services assistant (SSA) and the director of nursing on 1/1/18 at 12:56 p.m. to advise them of the same information. On 1/5/18, at 11:44 a.m. the SSA stated he had received an email upon return to the office on 1/2/18 from registered nurse (RN)-C regarding an	F 609	maltreatment according to facility policies and procedures. The DON or designee will audit the incident reports weekly for one month. These results will be reviewed by the Quality Assurance committee who will determine when compliance is indicated. 5) The date deficiency will be corrected: Compliance date: February 12, 2018	

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F 609	Continued From page 4	F 609		

incident which had occurred on the weekend regarding someone being "rude". The RN-C informed the SSA in the email a follow up interview had been completed with R47 and no concerns were identified. The SSA then stated FM-A approached him on 1/3/18 with concerns regarding the care provided on the weekend, as reported by FM-B. SSA stated upon notification of the information, he proceeded with a report to the state agency. They should have notified the state agency right away when they were contacted about the event on 1/1/18.

During interview on 1/5/18, at 12:23 p.m. the director of nursing (DON) stated concerns and interactions should be documented in the progress notes. The DON stated any type of potential abuse was to be reported immediately to state agency, but no later than the two hours, stating the report would be filed and then the incident investigated. In review of this situation, the DON stated RN-C completed a follow up interview with R47 to validate the concern reported, stating RN-C was informed by R47 there were no concerns.

On 1/5/18, at 2:15 p.m. R47 denied RN-C spoke to her in follow up on the 1/1/18, stating no one had spoken to her regarding the negative staff interaction, her pain and distress.

A policy, titled Annandale Health and Community Services' Facility Abuse Prevention Plan Policy and Procedure, most recently revised on 8/17, identified under the policy that "Staff is required to report suspected maltreatment IMMEDIATELY, but no later than 2 [two] hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or

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F 609	Continued From page 5 no later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator, and Director of Nursing, as well as the appropriate state agencies.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to accurately code restorative nursing programs on the Minimum Data Set for 3 of 3 residents (R24, R38,) reviewed for mobility. Findings include: R24's quarterly Minimum Data Set (MDS) dated 11/20/17, indicated R24 had upper extremity limited range of motion on one side and lower extremity limited range of motion on both sides. R24 was coded not receiving any days of restorative nursing of at least 15 minutes in a restorative nursing program for the Assessment Reference Date (ARD) period of 11/14/17-11/20/17. R24's Occupational Therapy Discharge Information dated 10/27/17, identified R24 had contractures and directed rehab aids to perform passive range of motion (PROM) to bilateral ankles and hamstring stretch with 30 second holds two to three times each five times per week.	F 641	F641 Accuracy of Assessments 1) How corrective action will be accomplished for those residents found to be affected: Additional training was provided to MDS Coordinator/RN on 1/8/2018 regarding the requirement to include rehab nursing minutes on the MDS per the RAI manual. 2) How to identify other residents having the potential to be affected by the same practice: Each resident□s Rehab Nursing documentation was reviewed to ensure that the rehab nursing minutes would both be documented and available to be included on each resident□s next scheduled MDS for all due dates after February 1, 2018. 3) Measures put into place or systemic changes made to ensure practice will not	2/12/18

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F 641	Continued From page 6 R24's Nursing Rehab/ Fit 4 Life Participation Log dated November 2017, identified R24 received five days of PROM to her bilateral ankles and hamstring greater than 15 minutes a day during the ARD period of 11/14/17- 11/20/17. During interview on 1/5/18, at 9:37 a.m. nursing assistant (NA)-C stated she was a rehab aid and R24 received restorative nursing to her ankles and a hamstring stretch five times a week. When interviewed on 1/5/17, at 12:22 p.m. clinical director (CD) stated R24 received five days of more than 15 minutes of restorative nursing during the ARD period. the MDS was not coded accurately to reflect the restorative nursing R24 received. R38's quarterly MDS dated 12/15/17, indicated R38 had upper extremity limited range of motion on both sides and lower extremity limited range of motion on both sides. R24 was coded as not receiving any days of restorative nursing of at least 15 minutes in a restorative nursing program for the ARD period of 12/9/17- 12/15/17. R38's Physical Therapy Updated Information dated 7/20/17, directed rehab aid to complete upper and lower extremity range of motion (ROM) per handout provided with one repetition of each motion three to five times per week. R38's Nursing Rehab/ Fit 4 Life Participation Log dated December 2017, identified R38 received three days of ROM to her upper and lower extremities of at least 15 minutes for the ARD period of 12/9/17- 12/15/17.	F 641	recur: Rehab Nursing forms updated 2/5/2018 to require the documentation of all minutes of rehab or restorative nursing completed by each resident during their assessment period in accordance with the RAI Manual. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system: The DON or designee will audit completed MDS' on a weekly basis for one month to ensure the consistent reporting of rehab nursing minutes until compliance has been achieved. Audit results will be submitted for review by the Quality Assurance committee who will determine when compliance is indicated. 5) The date deficiency will be corrected: Compliance date: February 12, 2018	

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F 641	Continued From page 7	F 641		

During interview on 1/5/18, at 9:37 a.m. NA-C stated R38 received range of motion to her upper and lower extremities three to five times a week.

When interviewed on 1/5/17, at 12:22 p.m. CD stated during R38's ARD period R38 had three days of at least 15 minutes worth of time recorded for restorative nursing. The MDS was not coded correctly to reflect the restorative therapy R38 received.

R25's quarterly MDS dated 11/21/17 indicated resident had severe cognitive impairment and was dependent on staff for complete assistance of two staff members for all aspects of ADL's. R25 was noted to have limited upper extremely and lower extremely range of motion (ROM) which affected both sides. R25 was coded as not receiving any days of restorative nursing of at least 15 minutes in a restorative nursing program for the Assessment Review Date (ARD) of 11/16/17 -11/21/17.

R25's Nursing Rehab/Fit 4 Life Participation log, dated November 2017, identified R25 received passive range of motion (PROM) to her upper and lower extremities bilaterally on three separate days during the ARD period of 11/16/17-11/21/17 for a period of 20 minutes each day.

During interview on 1/4/18, at 6:58 a.m. nursing assistant (NA)-D was observed providing PROM to R25. NA-D stated R25 is provided with rehab nursing is provided is provided three to five times a week, adding R25's level of mobility has improved with provision of exercises.

When interviewed on 1/5/17, at 12:22 p.m. the CD stated R25 received three days of more than

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F 641	Continued From page 8 15 minutes of restorative nursing during the ARD period and the MDS was not coded accurately to reflect the restorative nursing R25 received. The MDS 3.0 RAI Manual v 1.15 dated 10/17, directed staff to " Review the restorative nursing program notes and/or flow sheets in the medical record. For the 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period."	F 641		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety with smoking for 1 of 1 residents (R37) who smoked while residing in the facility. Findings include: R37 was admitted to the facility on 10/10/17. R37's undated Resident Face Sheet, identified an admission diagnosis of "Nicotine Dependence." During initial entrance conference on 1/2/18, at 11:30 a.m. , the clinical manager registered nurse (RN)-A stated the facility did not have any	F 689	F689 Free of Accident Hazards/Supervision/Devices 1) How corrective action will be accomplished for those residents found to be affected: A Smoking Assessment was completed on 1/5/2018 for R37. The Smoking Policy and Procedure was updated to require a smoking assessment be completed for all residents who are known to be smoking while a current resident of Annandale Care Center. Staff education on the	2/1/18

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F 689	Continued From page 9 residents that smoked on campus as they are "smoke free." RN-A further clarified that one resident did smoke, however off campus with family. During an observation on 1/2/18, at 12:53 p.m., R37 and a younger woman were on the edge of the facility parking lot next to the 3 pine trees. Both were smoking. R37 was sitting in her wheel chair (w/c) wearing a coat, and her lap was covered with a blanket. R37 was observed ashing appropriately off to her right. According to R37's undated face sheet, R37 had the diagnoses of personal history of transient ischemic attack (TIA), cerebral infarction (CVA) and hemiplegia, unspecified affecting left nondominate side, and nicotine dependence. The Admission minimum data set (MDS), dated 10/25/17, indicated R37 was moderately cognitively impaired, and was dependant on 1-2 staff for most of R37's activities of daily living. During interview on 1/3/18, at 12:50 p.m., R37 stated that she smoked two cigarettes a day when her daughter visited. R37 stated that she and her daughter go outside to the edge of the parking lot next to the pine trees. R37 stated her daughter held onto her cigarettes and lighter. R37 stated she knew the campus was smoke free, but stated that that no one has said she could not smoke on the edge of the parking lot. R37 stated she has never burned herself since her stroke. R37 stated no one from the facility has ever observed her smoking. Shortly after the interview with R37, at 1:01 p.m., the resident's daughter assisted R37 to get her coat on, and propelled R37 out the front door of	F 689	Smoking Policy and Procedure will be conducted with staff on 2/1/2018, 2/13/2018 and 2/14/2018. 2) How to identify other residents having the potential to be affected by the same practice: A chart audit was conducted on January 8th and 9th to determine if there were any other residents who were known smokers and hadn□t had a smoking assessment completed. No other residents were determined to need a smoking assessment. 3) Measures put into place or systemic changes made to ensure practice will not recur: RN Admission Checklist was updated to include a Smoking Assessment to be completed for known (current) smokers. Smoking Assessments will be reviewed on a quarterly basis for as long as the resident continues to smoke. The Care Planning Team, LPN□s and NAR□s were all given a copy of the Smoking Policy and Procedure to review. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system: The DON or designee will audit completion of the smoking assessment	

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F 689	Continued From page 10 the facility to edge of the parking lot next to the 3 pine trees. R37's daughter had pulled her car around to use as a shelter from the wind, while they smoked. Review of R37's electronic medical record (eMR), identified there was no evidence R37 had been assessed for safe smoking. Further review of the eMR and paper care plans, there was no evidence that the facility had addressed R37's smoking. During an interview on 1/4/18, at 1:36 p.m., nursing assistant (NA)-A stated that she had never seen R37 smoke, but after she and her daughter returned from outside, R37 smelled like cigarette smoke. In an interview on 1/5/18, at 10:03 a.m., the unit case manager RN-B stated on several occasions, she had asked R37 if she was smoking. R37 denied doing so. Another unit manager RN-C interjected, stating "we do not assess residents who smoke off property with their family." However, after observations were shared with RN-B and RN-C, both verified R37 appeared to be smoking on facility property. During an interview on 1/5/18, at 10:34 a.m., NA-B stated she had never seen her smoke, but when she came back in from outside with family, R37 smelled of cigarette smoke. During interview on 1/5/18, at 11:22 a.m., the director of nursing (DON) stated that she knew R37 smoked, but was informed by staff that R37 smoked off property with family. DON stated that she has seen R37's daughter take R37 out the front door past her office, but had never watched	F 689	for 10% of the resident population weekly for one month. These results will be discussed and reviewed at the Quality Assurance Committee who will determine when compliance is indicated. 5) The date deficiency will be corrected: Correction date: February 1, 2018	

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F 689	Continued From page 11 where they actually went. DON verified the parking lot location where R37 and family were observed to smoke was on the facility property. The facility policy, entitled: Annandale Care Center Smoking (undated), the policy indicated the facility was smoke free to residents and all admissions / family representatives would be informed of this prior to admission. The policy further indicated: "when a resident is a known (current) smoker and has the potential to be an at risk smoker, the RN will complete the smoking Risk Assessment located under observations in the Matrix computer charting."	F 689		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to address the psychosocial needs of 1 of 1 residents (R25) reviewed for behavioral concerns. Findings include:	F 740	F740 Behavioral Health Services 1) How corrective action will be accomplished for those residents found to be affected: Activity 1 to 1 visits were increased for resident R25. The Director of Activities	2/12/18

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F 740	Continued From page 12 R25's quarterly MDS dated 11/21/17 indicated resident had severe cognitive impairment and was dependent on staff for complete assistance of two staff members for all aspects of ADL's. R25 was noted to display behavioral symptoms note directed towards others on a daily basis. R25's resident face sheet, dated 1/5/18 , included the following diagnoses: dysthymic disorder, unspecified mood disorder, generalized anxiety disorder, Alzheimer's disease, restlessness and agitation, and chronic pain syndrome. The care plan, dated 11/20/17, identified R25 behavior of calling out. Staff were directed to use lavender spray, weighted blanket, assist resident to musical entertainment, soft music, nature sounds with use of videos or CD's, offer to take for a wheelchair ride around the facility, and apply soothing lotion to hands. A review of nursing assistant care sheet, that is used to direct resident care, dated 1/3/18, identified that R25 calms down with music and singing. During observation on 1/3/18, at 7:06 p.m. R25 was noted to be seated in a reclining chair with foam boots in place bilaterally with feet resting on elevated foot ledge, hands are crossed across chest, with hands clenched in a closed position. A weighted blanket was noted on a folded chair, pillows, clothing, and other items. The television set had the Amazing Race reality television show playing. An activity pillow was sitting on the dresser in front of the television. R25 noted to be calling out 13 times a noise which sounded like "Here" or "There" from start of observation at 7:06 p.m. until trained medical assistant (TMA)-A provided R25 with crushed acetominophen	F 740	scheduled a time with R25□s family to re-do the initial activity assessment with a goal of developing a plan more tailored around R25□s previous interests and preferences. R25 was admitted to hospice on 1/23/2018. Hospice agency will provide R25 with additional 1 to 1 services to include visits by an RN two times/week, the HHA one time/week, the Chaplain every other week, OT/massage once or twice per week and Music Therapy once per week. Behavior Monitoring Tracking for R25 was updated to include vocalizations. 2) How to identify other residents having the potential to be affected by the same practice: An audit of the Activity Plan of Care and Behavior Monitoring Tracking Sheets for all residents was conducted on January 15th and 16th to ensure the plan of care was meeting the needs of each resident and included activities preferred by the resident. 3) Measures put into place or systemic changes made to ensure practice will not recur: The Activity Plan of Care will be updated upon each resident□s change in status/condition or in accordance with a significant change MDS. Activity assessments will be reviewed with the resident□s quarterly MDS and adjusted as deemed necessary to best meet the needs of the resident. All interventions	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 13 mixture per scheduled dosing at 7:13 p.m. TMA-A provided R25 with prompts to take med and offered water after med was given. TMA-A did not offer additional interventions to alter resident vocalizations. R25 continued to call out on 14 more occasions until 7:35 p.m., at which time nursing assistants (NA)'s E and F arrived to perform bedtime cares including oral cares, personal cares, and assisting into bed. While assisting resident for bed, NA-E, and NA-F provided explanations with step by step descriptions while providing cares. During this time, R25 did not call out or resist. NA-E stated R25 will call out at times but is unsure why. On 1/04/18, at 9:16 a.m. resident was noted to be seated in her reclining wheel chair in her room with body positioned in good alignment. R25 was sitting with arms extended on lap, eyes are closed, facial expression is calm, without grimacing, furrowed brows, or made no verbalizations. The television is on a daytime talk show. A review of narrative note of 1/4/18 identified positive one to one visit with activity staff and R25 with use of sensory activities including a the use of soft, relaxation music CD for resident, staff combed her hair, re-filled and activated her essential oil diffuser, massaged hands with lavender essential oil/lotion, used Tai Chi to stimulate circulation in legs, applied neck vibrator and gave resident a soft toy to hold. Resident did not open eyes. Did call out once or twice but not loudly. During interview on 1/4/18, at 1:38 p.m. the activity director (AD) stated R25 will respond positively to interaction. The AD did state other	F 740	attempted will be documented and noted regarding their effectiveness. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system: Activity Director or designee will audit resident Activity Plans of Care for 10% of the resident population weekly for 1 month. A summary report will be submitted to the Quality Assurance Committee who will determine when compliance is indicated. 5) The date deficiency will be corrected: Compliance date: February 12, 2018	

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	245364	A. BUILDING _____ B. WING _____	01/05/2018

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F 740	Continued From page 14	F 740		

residents have expressed dismay at resident calling out, and the interventions are hoped to provide a calm environment for resident.

A review of the case consultation from the Associated Clinic of Psychology, dated 8/4/17, identified resident continued to present with loud vocalizations since her admission to the facility. The following recommendations were made to attempt to mitigate vocalizations and improve comfort: heavy weighted blanket, soft fuzzy comfortable blankets, pillows, stuffed animals, hand massage, comfortable temperatures, aromas, pet and music therapy, therapeutic touch and other sensory stimulus that is know to support comfort and increase calmness, moving resident around to mitigate distress for other residents who are noticing her vocalizations, noting resident may required either increased or decreased stimulation. The recommendation also included involvement of family to become aware of likes, dislikes, and preferences.

A review of R25 behavior sheets had categories of feelings of helplessness, loss of interest, appetite changes, sleep changes, instability or restlessness, loss of energy, self loathing, concentration, increase in physical complaints, and tearful/sad expression. There was an area where additional behaviors could be identified, but this was blank.

Review of R25's monthly Behavior Occurrence sheet for October, November, and December 2017 identified the no behaviors for October and December. In the month of November, there are multiple entries for instability or restlessness on day shift. The frequency was marked as "5+" with the interventions of comfort, discuss, one to one,

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F 740	Continued From page 15 or encourage social setting. The results of these interventions were "not sustain redirection." Although R25 had frequent "vocalizations," these were not identified on the monitoring sheets. During interview on 1/5/18, at 9:56 a.m. NA-G stated R25 loves to listen to old country classical music and has enjoyed musicals and movies. NA-G also commented there was a busy pillow R25 enjoyed with bright colors. NA-G stated if R25 began to call out they would often bring her down with the nurses or the staff. NA-G stated when R25 called out it was often because of an unmet need, such as pain related, need for change after elimination, or the desire to lay down or get up. NA-G stated that she was aware of this because she had spoken with family. NA-G stated on some days she calls out and the reason is undetermined, but interventions are through trial and error. During interview on 1/5/18, at 12:37 p.m. the director of nursing stated she would review the process for updating nursing assistant care sheets and sharing effective interventions for R25 and utilize the interventions as outlined on the care plan. A policy was requested care plan development but was not received.	F 740		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		2/12/18

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F 880	Continued From page 16 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 17 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to analyze monthly surveillance data for trends and patterns to reduce the spread of illness and infections. This had the potential to effect all 51 residents residing in the facility. Findings include: The October 2017, infection control surveillance log identified two facility acquired respiratory infections, one respiratory infection acquired prior to admission, two facility acquired urinary tract infections, one urinary tract infection acquired prior to admission and one case of congestive obstructive pulmonary disease flare up. The facility Infection Summary Report dated 10/1/17-10/31/17, tracked the numbers of infections/	F 880	F880 Infection Prevention and Control 1) How corrective action will be accomplished for those residents found to be affected: The Infection Control Nurse will evaluate and analyze monthly infection reports for trends as well as compare to the year prior. 2) How to identify other residents having the potential to be affected by the same practice: The Infection Control Nurse will	

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F 880	Continued From page 18 illness' and if they were acquired in house or were admitted to the facility with the infection/illness. The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented. The November 2017, infection control surveillance log identified one facility acquired gastrointestinal infections, six facility acquired respiratory infections, one respiratory infection acquired prior to admission, five facility acquired urinary tract infections, one urinary tract infection acquired prior to admission, two facility acquired skin infections, one skin infection acquired prior to admission. The Infection Summary Report dated 11/1/17- 11/30/17, tracked the numbers of infections/ illness' and if they were acquired in house or were admitted to the facility with the infection/illness. The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented. The December 2017, infection control surveillance log identified six facility acquired respiratory infections, one respiratory infection acquired prior to admission, one facility acquired ear pain, one facility acquired urinary tract infection and one urinary tract infection acquired prior to admission. The Infection Summary Report dated 12/1/17- 12/31/17, tracked the numbers of infections/ illness' and if they were acquired in house or were admitted to the facility with the infection/illness. The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented.	F 880	communicate with the clinical staff on a regular basis regarding ongoing infections/illnesses being treated within the facility. The Infection Control Nurse will monitor resident progress notes and orders regularly to ensure all staff are following standard infection control measures. 3) Measures put into place or systemic changes made to ensure practice will not recur: The structure of the Infection Control Program was reviewed and revised by the team and nursing staff was re-trained on the revised policy. A facility infections tracking sheet was added to be used for both residents and staff. A facility-wide Staff Call-In Form was created and put into effect on 2/1/2018. The Director of Nursing took over responsibility for management of the Infection Control Program and will serve as the Infection Control Nurse. The Infection Control Nurse will continuously analyze/monitor any noted trends or patterns in infections/illnesses including any interventions implemented. Regular communication regarding ongoing infections/illnesses between the Infection Control Nurse and the clinical staff will ensure that the process is being followed. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system:	

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F 880	Continued From page 19 During interview on 1/5/17, at 12:10 p.m. the director of nursing stated an analysis of the surveillance data had not been completed since September 2017. The facility practice was to analyze the data collected from the surveillance tools and summarize the information quarterly. The information was then brought to the quality assurance meeting and discussed on a quarterly basis. Further, a monthly analysis of the illness' and infections was important to rule out any trending or patterns. If patterns or trends were identified, interventions could be initiated to help prevent illness or infections including staff education and system process review. The facility Infection Control Policy dated 11/17, indicated "The objective of this requirement is for the facility to develop a comprehensive Infection Control Policy that establishes a facility-wide system for the prevention, identification, investigation and control of infection of residents." The policy identified surveillance as a system "designed to identify possible communicable diseases or infections before they can spread to other persons in the facility." The policy did not address analysis of the surveillance data collected.	F 880	The Infection Control Nurse will audit the implementation of the data entry process and tracking sheet, reports generated, monthly summary completion and yearly comparison analysis on a monthly basis. The results will be reviewed monthly by the Quality Assurance committee and quarterly with the facility Medical Director to ensure ongoing compliance. 5) The date deficiency will be corrected: Compliance date: February 12, 2018	

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	245364	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/02/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Annandale Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Annandale Care Center is a 1-story building with no basement. The building was constructed at 5 different times. The original building was constructed in 1982 and was determined to be of Type II(000) construction. In 1986 , an addition was constructed to the north and was determined to be of Type II(000) construction. In 1990 an addition was constructed at the front entrance and was determined to be of Type II(000) construction. In 2004 and addition was constructed to the ends of A and B wings and was determined to be of Type II(000) construction. In 2008 an addition was added to the northwest corner of the facility and was determined to be of type II(000) construction. The facility was surveyed as one building. The building is automatic sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 51 at time of the survey.	K 000		

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

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.

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

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		