MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Annandale Care Center

Facility Address:
500 Park Street East

Facility City:
Annandale

State: Minnesota | **ZIP:** 55302 | **County:** Wright

Report Number:
H5364021

Date of Visit:
December 19 and 20, 2016

Time of Visit:
9:45 a.m. to 3:15 p.m.
10:00 a.m. to 3:00 p.m.

Date Concluded:
April 3, 2017

Investigator's Name and Title:
Peggy Boeck, RN, Special Investigator

☒ **Nursing Home**

Allegation(s):
It is alleged that neglect occurred when a resident did not receive Coumadin as ordered for several days. The resident required hospitalization.

☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, neglect occurred when the facility failed to follow the resident's physician order. The resident did not receive blood thinner (Coumadin) for 15 days and died as a result of complications.

The resident was admitted to the facility after a stroke. The resident had a history of atrial fibrillation. The resident was on Coumadin and the dose was determined by blood tests.

During a review of the resident's medication record, a nurse discovered the resident's Coumadin was stopped without a physician's order, because the blood test required to dose the Coumadin was not performed as prescribed by the resident's physician. The physician's order was not entered into the facilities electronic medication record and the test was not performed to determine the resident's next Coumadin dose. The missing information in the electronic medication record automatically discontinued all previous medication orders for the Coumadin medication. The facility had no other means of tracking resident's prescribed Coumadin. The resident's Coumadin was stopped and not administered for 15 days.

The nurse immediately contacted the resident's physician who ordered a blood test and the results were 1.1, which was below the resident's goal of 2 to 3. The physician ordered the oral Coumadin medication restarted along with an injectable blood thinner called Lovenox. Over the next eight days, the physician continued to monitor the resident's blood test results and prescribe Coumadin and Lovenox injections. Eight

days after the medications were resumed, the resident's blood test results remained low at 1.7.

On the tenth day of the new Coumadin and Lovenox orders, the resident complained of severe abdominal pain and was sent to the hospital. It was discovered the resident had an abdominal wall hematoma. A large area of blood pooled along the muscles where the injections were given, despite blood levels remaining below the range of 2 to 3. The injectable blood thinner Lovenox was discontinued and the oral Coumadin dose continued. The resident returned to the facility, but continued to have abdominal pain for two more days and presented with new symptoms that included weakness, confusion, hallucinations, and vomiting. The facility contacted the resident's physician and the resident was sent to the hospital.

Hospital records indicated the resident continued to bleed internally and the resident was transferred to another hospital that was better able to manage the resident's need for a higher level of care. The resident's internal bleeding could be not stopped and the resident passed away.

The primary physician indicated the trauma at the site of the Lovenox injections could lead to bleeding, a side effect of Lovenox injections.

The death certificate indicated the resident died of acute blood loss because of an abdominal muscle bleed.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility had no system, policies or procedures in place to monitor and ensure residents who were dependent on lab results to obtain medication orders, were obtaining those services as prescribed.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

The facility corrective action included revision of policies related to anticoagulant medication, staff education, and all anticoagulant orders were audited.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food,

clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports

Other pertinent medical records:

- [x] Hospital Records
- [x] Death Certificate

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Four

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ○ Yes ○ No ◉ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Deceased

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Four

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 13

Physician Interviewed: ◉ Yes ○ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

- [x] Personal Care
- [x] Nursing Services
- [x] Infection Control
- [x] Medication Pass
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Annandale Police Department

Annandale City Attorney

Wright County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/11/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5364021. As a result, the following deficiencies are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect,	F 225		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/11/2017

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 225	Continued From page 1 exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or 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. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (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 record review the facility failed to report immediately to the state agency an allegation of neglect for one of five residents (R1) reviewed when R1 did not receive Coumadin	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/11/2017

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 225	Continued From page 2 medication for 15 days and was subsequently hospitalized. Findings include: R1's medical record was reviewed. R1 was admitted on October 13, 2016. R1's diagnoses included chronic atrial fibrillation and stroke with right side weakness. R1's physician's order dated 10/26/2016, indicated Coumadin 5 milligrams every day to prevent further strokes due to atrial fibrillation. The facility's medication error report form completed by RN-F dated 11/15/2016, indicated R1 had not received Coumadin from 10/31/2016 to 11/15/2016. An interview was conducted with RN-F at 11:41 a.m. on 12/20/2016. RN-F stated that s/he discovered the omission of R1's Coumadin while conducting a medication review. RN-F stated that s/he notified the director of nursing (DON) and the physician. RN-F stated s/he did not file a report with the state agency. An interview was conducted on 12/20/2016, at 2:21 p.m. with DON-K, who stated s/he did not file a report to the state agency on 11/15/2016, because R1 had good vital signs and no signs of a stroke. A vulnerable adult report was filed with the state agency on 11/28/2016 by DON-K after R1 had been hospitalized on 11/25/2016 and 11/27/2016. The facility's abuse prevention policy and procedure dated 11/2016, indicated all staff were required to report suspected neglect (failure to	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/11/2017

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 225	Continued From page 3 provide goods and services to a resident that are necessary to avoid harm) immediately to the administrator, director of nursing, as well as the state agency. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain mental anguish, or emotional distress.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse,	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/11/2017

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 226	Continued From page 4 neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to implement their policy and procedure to report an allegation of neglect to the state agency for one of five residents (R1) reviewed when R1 did not received Coumadin for 15 days and was subsequently hospitalized. Findings include: R1's medical record was reviewed. R1 was admitted on October 13, 2016. R1's diagnoses included chronic atrial fibrillation and stroke with right side weakness. R1 received Coumadin to prevent further strokes due to atrial fibrillation. An internal medication error report form completed by RN-F dated 11/15/2016, indicated R1 had not received Coumadin from 10/31/16 to 11/15/2016. An interview was conducted with RN-F at 11:41 a.m. on 12/20/2016. RN-F stated that s/he discovered the omission of R1's Coumadin while conducting a medication review. RN-F stated that s/he notified the director of nursing (DON) and the physician. RN-F stated s/he did not file a report with the state agency. An interview was conducted with DON-K at 2:21 p.m. on 12/20/2016. DON-K stated s/he did not file a report to the state agency on 11/15/2016, because R1 had good vital signs and no signs of	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/11/2017

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 226	Continued From page 5 a stroke. A vulnerable adult report was filed with the state agency on 11/28/2016 by DON-K after R1 had been hospitalized on 11/25/2016 and 11/27/2016. The facility's abuse prevention policy and procedure dated 11/2016, indicated all staff were required to report suspected neglect (failure to provide goods and services to a resident that are necessary to avoid harm) immediately to the administrator, director of nursing, as well as the state agency. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain mental anguish, or emotional distress.	F 226		
F 333 SS=G	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were free of significant medication errors for one of five residents (R1) reviewed when R1 was not administered Coumadin (an oral blood thinner) for 15 days and was subsequently hospitalized, and died. Findings include: R1's medical record was reviewed. R1 was admitted with a diagnoses that included chronic atrial fibrillation and stroke with right side weakness. R1 received Coumadin (an oral blood thinning medication) to prevent further strokes.	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/11/2017

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 333	Continued From page 6 R1's care plan dated 11/17/2016, indicated R1 required limited assistance of one staff for toileting. R1's physician's order dated 10/14/2016 indicated R1's international normalized ratio (INR) a lab test that measured how long it took blood to clot, value was 1.4, give Coumadin 5 milligrams (mg) 10/14/2016 through 10/16/14, and recheck INR on 10/17/2016. The therapeutic goal set by the physician for the INR value was between 2-3. R1's physician's order dated 10/17/2016 indicated R1's INR value was 2.0, give Coumadin 5 mg 10/17/2016 through 10/18/2016, and recheck INR on 10/19/2016. R1's physician's order dated 10/19/2016 indicated R1's INR value was 2.4, give Coumadin 5 mg 10/19/2016 through 10/23/2016 and recheck INR on 10/24/2016. R1's physician's order dated 10/24/2016 indicated R1's INR value was 2.3, give Coumadin 5 mg 10/24/2016 through 10/25/2016 and recheck INR on 10/26/2016. R1's physician's order dated 10/26/2016 indicated R1's INR value was 2.3 give Coumadin 5 mg 10/26/2016 through 10/30/2016 and recheck INR on 10/31/2016. Medical records indicated there was no INR check completed on 10/31/2016 as ordered by R1's physician. R1's medication administration record (MAR) reviewed from 10/14/2016 to 11/27/2016 indicated R1 did not receive Coumadin from	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/11/2017

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 333	Continued From page 7 10/31/16 through 11/15/2016. A medication error report completed by RN-F dated 11/15/2016, indicated R1 had not received Coumadin from 10/31/16 to 11/14/2016, due to a transcription error in which the order to recheck the INR was not entered, so a new order for Coumadin was not received. R1's medical record indicated the physician consulted regarding the omission of Coumadin on 11/15/2016. R1's physician order dated 11/15/2016 indicated R1's INR value was 1.1 give Coumadin 5 mg 11/15/2016 through 11/17/2016, recheck INR on 11/18/2016, and start Lovenox injection 100 mg every 12 hours until INR is therapeutic (range of 2-3.) R1's physician order dated 11/18/16 indicated R1's INR value was 1.0, give Coumadin 7.5 mg on 11/18/2016 and 11/19/2016 and 5 mg on 11/20/16, recheck INR 11/21/16. R1's physician orders date 11/21/16 indicated R1's INR was 1.6, give Coumadin 7.5 mg on 11/21/10616, 5 mg on 11/22/2016, recheck INR on 11/23/2016 and continue Lovenox injections. R1's physician orders dated 11/23/16 indicated R1's INR was 1.7, give Coumadin 7.5 mg on 11/23/2016 through 11/25/2016, give 5 mg on 11/26/2016 and 11/27/2016, recheck INR on 11/28/2016 and continue Lovenox injections. R1's nursing progress note dated 11/25/2016, at 12:46 p.m. indicated R1 reported severe pain and an order was received by the physician to send	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/11/2017

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 333	Continued From page 8 R1 to the emergency room. R1's emergency room provider progress note dated 11/25/2016, at 3:45 p.m. indicated R1's INR value was 1.8 and diagnosed R1 with an abdominal wall hematoma (a collection of blood outside of a vessel). R1 was discharged back to the facility after approximately five hours. R1's physician's order dated 11/25/2016 indicated R1's INR was 1.8, give Coumadin 5 mg 11/25/2016 through 11/27/2016, stop Lovenox injections due to the abdominal wall hematoma. R1's nursing progress note dated 11/25/2016, at 9:55 p.m. indicated R1 had been weak and required two staff to help R1 stand. R1's nursing progress note dated 11/26/2016, at 3:45 a.m. indicated R1 complained of severe abdominal pain. R1 was given 650 mg of Tylenol for the pain. The medical record did not indicate if the Tylenol was effective. R1's nursing progress note dated 11/26/2016 at 9:23 a.m. indicated R1 was slow to answer questions and had vomited a small amount of undigested food. R1's nursing progress note dated 11/26/2016 at 9:49 a.m. indicated R1 had been confused and hallucinating all morning. R1's nursing progress note dated 11/26/2016 at 11:02 a.m. indicated R1's blood sugar was 351 but R1 was not symptomatic. The provider's nurse was updated on the emergency room visit on 11/25/2016 and that R1 was confused, hallucinating, and had vomited this morning.	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/11/2017

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 333	Continued From page 9 R1's nursing progress note dated 11/26/2016 at 9:51 p.m. indicated when staff got R1 up for dinner at 4:45 p.m. they needed to use a transfer device to move R1 out of bed. However, during the transfer R1 looked as if R1 was going to pass out. The staff stopped the transfer and assisted R1 back to bed. R1 felt cool and clammy when touched. The nurse took R1's vital signs. R1's temperature was 97.1, pulse 68, respirations 28, and the blood pressure was 86/40. The nurse rechecked the blood pressure 30 minutes later and R1's blood pressure was 121/72. Fluid was encouraged and at 9:00 p.m. the nurse rechecked the blood pressure it was 148/80. R1's nursing progress dated 11/27/2016 at 1:49 a.m. indicated R1 had stomach pain that was terrible and R1 was given an icepack. R1's nursing progress note dated 11/27/2016 at 7:52 a.m. indicated R1 was too weak to stand and could not transfer using a gait belt and one staff. R1 required three staff to bring R1 to the toilet. R1 indicated he had abdominal pain when straining on the toilet. R1 was assisted off the toilet to the wheelchair with three staff. The nurse took R1's vital signs. R1's temperature 96.1, pulse 84, respirations 32, and the blood pressure was 122/46. R1 indicated s/he was very sleepy. R1's nursing progress noted dated 11/27/2016 at 8:29 a.m. indicated the nurse contacted a nurse practitioner at R1's clinic and received orders to send R1 to the emergency room. R1's emergency room provider progress note dated 11/27/2016, at 10:02 a.m. indicated R1's INR was 4.2 with internal bleeding due to	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/11/2017

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 333	Continued From page 10	F 333		

Lovenox injections. The same day, R1 was transferred to another hospital better able to manage the care R1 required.

R1's hospital discharge summary dated 12/9/2016 at 5:09 p.m. indicated the hospital was unable to reverse the effects of R1's bleeding. R1 passed way 11/28/2016 at 9:00 p.m. due to acute blood loss.

R1's death certificate dated 11/28/2016 indicated cause of death as acute blood loss from abdominal bleed.

An interview was conducted on 12/22/2016, at 9:09 a.m. with medical record coordinator (MRC)-M, who stated his/her job duties included transcribing orders. S/he stated s/he entered R1's Coumadin to be given from 10/26/2016 through 10/30/2016 and forgot to enter the order to recheck the INR. MRC-M stated without the INR recheck, the Coumadin order expired and dropped off the electronic medication administration record on 10/30/2016.

An interview was conducted on 12/20/2016, at 11:41 a.m. with RN-F, who stated that s/he discovered the omission of R1's Coumadin when conducting a medication review on 11/15/2016. RN-F stated s/he notified the director of nursing (DON) and the physician.

An interview was conducted on 12/21/2016, at 2:18 p.m. with the doctor of pharmacy (Pharm.D.)-L, who stated s/he completed a monthly review of R1's medications on 11/14/2016 and noted the Coumadin had expired on 10/30/2016. S/he further stated there had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/11/2017

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 333	Continued From page 11 been no red flag in the nurse's notes or the physician's notes to check deeper as to why R1 was no longer receiving Coumadin. Pharm.D.-L stated there was no other place in the medical record that tracked a resident on Coumadin. A review of the facility's policy on order transcription dated 11/2016, indicated medical records personnel or a nurse entered new Coumadin orders into the computer without a stop date, and a second verification of the order was completed by a nurse.	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5364021. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21545	Continued From page 2 toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were free of significant medication errors for one of five residents (R1) reviewed when R1 was not administered Coumadin (an oral blood thinner) for 15 days and was subsequently hospitalized, and died. Findings include: R1's medical record was reviewed. R1 was admitted with a diagnoses that included chronic atrial fibrillation and stroke with right side weakness. R1 received Coumadin (an oral blood thinning medication) to prevent further strokes. R1's care plan dated 11/17/2016, indicated R1 required limited assistance of one staff for	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21545	Continued From page 3 toileting. R1's physician's order dated 10/14/2016 indicated R1's international normalized ratio (INR) a lab test that measured how long it took blood to clot, value was 1.4, give Coumadin 5 milligrams (mg) 10/14/2016 through 10/16/14, and recheck INR on 10/17/2016. The therapeutic goal set by the physician for the INR value was between 2-3. R1's physician's order dated 10/17/2016 indicated R1's INR value was 2.0, give Coumadin 5 mg 10/17/2016 through 10/18/2016, and recheck INR on 10/19/2016. R1's physician's order dated 10/19/2016 indicated R1's INR value was 2.4, give Coumadin 5 mg 10/19/2016 through 10/23/2016 and recheck INR on 10/24/2016. R1's physician's order dated 10/24/2016 indicated R1's INR value was 2.3, give Coumadin 5 mg 10/24/2016 through 10/25/2016 and recheck INR on 10/26/2016. R1's physician's order dated 10/26/2016 indicated R1's INR value was 2.3 give Coumadin 5 mg 10/26/2016 through 10/30/2016 and recheck INR on 10/31/2016. Medical records indicated there was no INR check completed on 10/31/2016 as ordered by R1's physician. R1's medication administration record (MAR) reviewed from 10/14/2016 to 11/27/2016 indicated R1 did not receive Coumadin from 10/31/16 through 11/15/2016. A medication error report completed by RN-F	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21545	Continued From page 4 dated 11/15/2016, indicated R1 had not received Coumadin from 10/31/16 to 11/14/2016, due to a transcription error in which the order to recheck the INR was not entered, so a new order for Coumadin was not received. R1's medical record indicated the physician was notified of the omission of Coumadin on 11/15/2016. R1's physician order dated 11/15/2016 indicated R1's INR value was 1.1 give Coumadin 5 mg 11/15/2016 through 11/17/2016, recheck INR on 11/18/2016, and start Lovenox injection 100 mg every 12 hours until INR is therapeutic (range of 2-3.) R1's physician order dated 11/18/16 indicated R1's INR value was 1.0, give Coumadin 7.5 mg on 11/18/2016 and 11/19/2016 and 5 mg on 11/20/16, recheck INR 11/21/16. R1's physician orders date 11/21/16 indicated R1's INR was 1.6, give Coumadin 7.5 mg on 11/21/10616, 5 mg on 11/22/2016, recheck INR on 11/23/2016 and continue Lovenox injections. R1's physician orders dated 11/23/16 indicated R1's INR was 1.7, give Coumadin 7.5 mg on 11/23/2016 through 11/25/2016, give 5 mg on 11/26/2016 and 11/27/2016, recheck INR on 11/28/2016 and continue Lovenox injections. R1's nursing progress note dated 11/25/2016, at 12:46 p.m. indicated R1 reported severe pain and an order was received by the physician to send R1 to the emergency room. R1's emergency room provider progress note dated 11/25/2016, at 3:45 p.m. indicated R1's INR	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21545	Continued From page 5 value was 1.8 and diagnosed R1 with an abdominal wall hematoma (a collection of blood outside of a vessel). R1 was discharged back to the facility after approximately five hours. R1's physician's order dated 11/25/2016 indicated R1's INR was 1.8, give Coumadin 5 mg 11/25/2016 through 11/27/2016, stop Lovenox injections due to the abdominal wall hematoma. R1's nursing progress note dated 11/25/2016, at 9:55 p.m. indicated R1 had been weak and required two staff to help R1 stand. R1's nursing progress note dated 11/26/2016, at 3:45 a.m. indicated R1 complained of severe abdominal pain. R1 was given 650 mg of Tylenol for the pain. The medical record did not indicate if the Tylenol was effective. R1's nursing progress note dated 11/26/2016 at 9:23 a.m. indicated R1 was slow to answer questions and had vomited a small amount of undigested food. R1's nursing progress note dated 11/26/2016 at 9:49 a.m. indicated R1 had been confused and hallucinating all morning. R1's nursing progress note dated 11/26/2016 at 11:02 a.m. indicated R1's blood sugar was 351 but R1 was not symptomatic. The provider's nurse was updated on the emergency room visit on 11/25/2016 and that R1 was confused, hallucinating, and had vomited this morning. R1's nursing progress note dated 11/26/2016 at 9:51 p.m. indicated when staff got R1 up for dinner at 4:45 p.m. they needed to use a transfer device to move R1 out of bed. However, during	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21545	Continued From page 6 the transfer R1 looked as if R1 was going to pass out. The staff stopped the transfer and assisted R1 back to bed. R1 felt cool and clammy when touched. The nurse took R1's vital signs. R1's temperature was 97.1, pulse 68, respirations 28, and the blood pressure was 86/40. The nurse rechecked the blood pressure 30 minutes later and R1's blood pressure was 121/72. Fluid was encouraged and at 9:00 p.m. the nurse rechecked the blood pressure it was 148/80. R1's nursing progress dated 11/27/2016 at 1:49 a.m. indicated R1 had stomach pain that was terrible and R1 was given an icepack. R1's nursing progress note dated 11/27/2016 at 7:52 a.m. indicated R1 was too weak to stand and could not transfer using a gait belt and one staff. R1 required three staff to bring R1 to the toilet. R1 indicated he had abdominal pain when straining on the toilet. R1 was assisted off the toilet to the wheelchair with three staff. The nurse took R1's vital signs. R1's temperature 96.1, pulse 84, respirations 32, and the blood pressure was 122/46. R1 indicated s/he was very sleepy. R1's nursing progress noted dated 11/27/2016 at 8:29 a.m. indicated the nurse contacted a nurse practitioner at R1's clinic and received orders to send R1 to the emergency room. R1's emergency room provider progress note dated 11/27/2016, at 10:02 a.m. indicated R1's INR was 4.2 with internal bleeding due to Lovenox injections. The same day, R1 was transferred to another hospital better able to manage the care R1 required. R1's hospital discharge summary dated 12/9/2016 at 5:09 p.m. indicated the hospital was	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21545	Continued From page 7	21545		

unable to reverse the effects of R1's bleeding. R1 passed way 11/28/2016 at 9:00 p.m. due to acute blood loss.

R1's death certificate dated 11/28/2016 indicated cause of death as acute blood loss from abdominal bleed.

An interview was conducted on 12/22/2016, at 9:09 a.m. with medical record coordinator (MRC)-M, who stated his/her job duties included transcribing orders. S/he stated s/he entered R1's Coumadin to be given from 10/26/2016 through 10/30/2016 and forgot to enter the order to recheck the INR. MRC-M stated without the INR recheck, the Coumadin order expired and dropped off the electronic medication administration record on 10/30/2016.

An interview was conducted on 12/20/2016, at 11:41 a.m. with RN-F, who stated that s/he discovered the omission of R1's Coumadin when conducting a medication review on 11/15/2016. RN-F stated s/he notified the director of nursing (DON) and the physician.

An interview was conducted on 12/21/2016, at 2:18 p.m. with the doctor of pharmacy (Pharm.D.)-L, who stated s/he completed a monthly review of R1's medications on 11/14/2016 and noted the Coumadin had expired on 10/30/2016. S/he further stated there had been no red flag in the nurse's notes or the physician's notes to check deeper as to why R1 was no longer receiving Coumadin. Pharm.D.-L stated there was no other place in the medical record that tracked a resident on Coumadin.

A review of the facility's policy on order transcription dated 11/2016, indicated medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21545	Continued From page 8 records personnel or a nurse entered new Coumadin orders into the computer without a stop date, and a second verification of the order was completed by a nurse. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21545		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were free of neglect for one of five residents (R1) reviewed when R1 was	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21850	Continued From page 9 not administered Coumadin (an oral blood thinner) for 15 days and was subsequently hospitalized, and died. Findings include: The facility's abuse prevention policy and procedure dated 11/2016 indicated neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain mental anguish, or emotional distress. R1's medical record was reviewed. R1 was admitted with a diagnoses that included chronic atrial fibrillation and stroke with right side weakness. R1 received Coumadin (an oral blood thinning medication) to prevent further strokes. R1's care plan dated 11/17/2016, indicated R1 required limited assistance of one staff for toileting. R1's physician's order dated 10/14/2016 indicated R1's international normalized ratio (INR) a lab test that measured how long it took blood to clot, value was 1.4, give Coumadin 5 milligrams (mg) 10/14/2016 through 10/16/14, and recheck INR on 10/17/2016. The therapeutic goal set by the physician for the INR value was between 2-3. R1's physician's order dated 10/17/2016 indicated R1's INR value was 2.0, give Coumadin 5 mg 10/17/2016 through 10/18/2016, and recheck INR on 10/19/2016. R1's physician's order dated 10/19/2016 indicated R1's INR value was 2.4, give Coumadin 5 mg 10/19/2016 through 10/23/2016 and recheck INR on 10/24/2016.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21850	Continued From page 10 R1's physician's order dated 10/24/2016 indicated R1's INR value was 2.3, give Coumadin 5 mg 10/24/2016 through 10/25/2016 and recheck INR on 10/26/2016. R1's physician's order dated 10/26/2016 indicated R1's INR value was 2.3 give Coumadin 5 mg 10/26/2016 through 10/30/2016 and recheck INR on 10/31/2016. Medical records indicated there was no INR check completed on 10/31/2016 as ordered by R1's physician. R1's medication administration record (MAR) reviewed from 10/14/2016 to 11/27/2016 indicated R1 did not receive Coumadin from 10/31/16 through 11/15/2016. A medication error report completed by RN-F dated 11/15/2016, indicated R1 had not received Coumadin from 10/31/16 to 11/14/2016, due to a transcription error in which the order to recheck the INR was not entered, so a new order for Coumadin was not received. R1's medical record indicated the physician consulted regarding the omission of Coumadin on 11/15/2016. R1's physician order dated 11/15/2016 indicated R1's INR value was 1.1 give Coumadin 5 mg 11/15/2016 through 11/17/2016, recheck INR on 11/18/2016, and start Lovenox injection 100 mg every 12 hours until INR is therapeutic (range of 2-3.) R1's physician order dated 11/18/16 indicated R1's INR value was 1.0, give Coumadin 7.5 mg	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21850	Continued From page 11 on 11/18/2016 and 11/19/2016 and 5 mg on 11/20/16, recheck INR 11/21/16. R1's physician orders date 11/21/16 indicated R1's INR was 1.6, give Coumadin 7.5 mg on 11/21/10616, 5 mg on 11/22/2016, recheck INR on 11/23/2016 and continue Lovenox injections. R1's physician orders dated 11/23/16 indicated R1's INR was 1.7, give Coumadin 7.5 mg on 11/23/2016 through 11/25/2016, give 5 mg on 11/26/2016 and 11/27/2016, recheck INR on 11/28/2016 and continue Lovenox injections. R1's nursing progress note dated 11/25/2016, at 12:46 p.m. indicated R1 reported severe pain and an order was received by the physician to send R1 to the emergency room. R1's emergency room provider progress note dated 11/25/2016, at 3:45 p.m. indicated R1's INR value was 1.8 and diagnosed R1 with an abdominal wall hematoma (a collection of blood outside of a vessel). R1 was discharged back to the facility after approximately five hours. R1's physician's order dated 11/25/2016 indicated R1's INR was 1.8, give Coumadin 5 mg 11/25/2016 through 11/27/2016, stop Lovenox injections due to the abdominal wall hematoma. R1's nursing progress note dated 11/25/2016, at 9:55 p.m. indicated R1 had been weak and required two staff to help R1 stand. R1's nursing progress note dated 11/26/2016, at 3:45 a.m. indicated R1 complained of severe abdominal pain. R1 was given 650 mg of Tylenol for the pain. The medical record did not indicate if the Tylenol was effective.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21850	Continued From page 12 R1's nursing progress note dated 11/26/2016 at 9:23 a.m. indicated R1 was slow to answer questions and had vomited a small amount of undigested food. R1's nursing progress note dated 11/26/2016 at 9:49 a.m. indicated R1 had been confused and hallucinating all morning. R1's nursing progress note dated 11/26/2016 at 11:02 a.m. indicated R1's blood sugar was 351 but R1 was not symptomatic. The provider's nurse was updated on the emergency room visit on 11/25/2016 and that R1 was confused, hallucinating, and had vomited this morning. R1's nursing progress note dated 11/26/2016 at 9:51 p.m. indicated when staff got R1 up for dinner at 4:45 p.m. they needed to use a transfer device to move R1 out of bed. However, during the transfer R1 looked as if R1 was going to pass out. The staff stopped the transfer and assisted R1 back to bed. R1 felt cool and clammy when touched. The nurse took R1's vital signs. R1's temperature was 97.1, pulse 68, respirations 28, and the blood pressure was 86/40. The nurse rechecked the blood pressure 30 minutes later and R1's blood pressure was 121/72. Fluid was encouraged and at 9:00 p.m. the nurse rechecked the blood pressure it was 148/80. R1's nursing progress dated 11/27/2016 at 1:49 a.m. indicated R1 had stomach pain that was terrible and R1 was given an icepack. R1's nursing progress note dated 11/27/2016 at 7:52 a.m. indicated R1 was too weak to stand and could not transfer using a gait belt and one staff. R1 required three staff to bring R1 to the	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21850	Continued From page 13 toilet. R1 indicated he had abdominal pain when straining on the toilet. R1 was assisted off the toilet to the wheelchair with three staff. The nurse took R1's vital signs. R1's temperature 96.1, pulse 84, respirations 32, and the blood pressure was 122/46. R1 indicated s/he was very sleepy. R1's nursing progress noted dated 11/27/2016 at 8:29 a.m. indicated the nurse contacted a nurse practitioner at R1's clinic and received orders to send R1 to the emergency room. R1's emergency room provider progress note dated 11/27/2016, at 10:02 a.m. indicated R1's INR was 4.2 with internal bleeding due to Lovenox injections. The same day, R1 was transferred to another hospital better able to manage the care R1 required. R1's hospital discharge summary dated 12/9/2016 at 5:09 p.m. indicated the hospital was unable to reverse the effects of R1's bleeding. R1 passed way 11/28/2016 at 9:00 p.m. due to acute blood loss. R1's death certificate dated 11/28/2016 indicated cause of death as acute blood loss from abdominal bleed. An interview was conducted on 12/22/2016, at 9:09 a.m. with medical record coordinator (MRC)-M, who stated his/her job duties included transcribing orders. S/he stated s/he entered R1's Coumadin to be given from 10/26/2016 through 10/30/2016 and forgot to enter the order to recheck the INR. MRC-M stated without the INR recheck, the Coumadin order expired and dropped off the electronic medication administration record on 10/30/2016.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21850	Continued From page 14 An interview was conducted on 12/20/2016, at 11:41 a.m. with RN-F, who stated that s/he discovered the omission of R1's Coumadin when conducting a medication review on 11/15/2016. RN-F stated s/he notified the director of nursing (DON) and the physician. An interview was conducted on 12/21/2016, at 2:18 p.m. with the doctor of pharmacy (Pharm.D.)-L, who stated s/he completed a monthly review of R1's medications on 11/14/2016 and noted the Coumadin had expired on 10/30/2016. S/he further stated there had been no red flag in the nurse's notes or the physician's notes to check deeper as to why R1 was no longer receiving Coumadin. Pharm.D.-L stated there was no other place in the medical record that tracked a resident on Coumadin. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	21850		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21980	Continued From page 15 (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to report immediately to the state agency an allegation of neglect for one of five residents (R1) reviewed when R1 did not receive Coumadin medication for 15 days and was subsequently hospitalized.	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21980	Continued From page 16 Findings include: R1's medical record was reviewed. R1 was admitted on October 13, 2016. R1's diagnoses included chronic atrial fibrillation and stroke with right side weakness. R1's physician's order dated 10/26/2016, indicated Coumadin 5 milligrams every day to prevent further strokes due to atrial fibrillation. The facility's medication error report form completed by RN-F dated 11/15/2016, indicated R1 had not received Coumadin from 10/31/2016 to 11/15/2016. An interview was conducted with RN-F at 11:41 a.m. on 12/20/2016. RN-F stated that s/he discovered the omission of R1's Coumadin while conducting a medication review. RN-F stated that s/he notified the director of nursing (DON) and the physician. RN-F stated s/he did not file a report with the state agency. An interview was conducted on 12/20/2016, at 2:21 p.m. with DON-K, who stated s/he did not file a report to the state agency on 11/15/2016, because R1 had good vital signs and no signs of a stroke. A vulnerable adult report was filed with the state agency on 11/28/2016 by DON-K after R1 had been hospitalized on 11/25/2016 and 11/27/2016. The facility's abuse prevention policy and procedure dated 11/2016, indicated all staff were required to report suspected neglect (failure to provide goods and services to a resident that are necessary to avoid harm) immediately to the administrator, director of nursing, as well as the	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/11/2017

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) COMPLETE DATE
21980	Continued From page 17 provide goods and services to a resident that are necessary to avoid harm) immediately to the administrator, director of nursing, as well as the state agency. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain mental anguish, or emotional distress. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	21980		