DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 27, 2025

Administrator
ANNANDALE CARE CENTER INC
500 PARK STREET EAST
ANNANDALE, MN 55302

RE: CCN: 245364
Cycle Start Date: June 17, 2025

Dear Administrator:

On July 2, 2025, we notified you a remedy was imposed. On July 23, 2025 the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 23, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 17, 2025 be discontinued as of July 23, 2025. (42 CFR 488.417 (b))

In our letter of July 2, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 17, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 27, 2025

Administrator
ANNANDALE CARE CENTER INC

500 PARK STREET EAST
ANNANDALE, MN 55302

Re: Reinspection Results
Event ID: CBMX12

Dear Administrator:

On July 23, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 17, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 2, 2025

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

RE: CCN: 245364
Cycle Start Date: June 17, 2025

Dear Administrator:

On June 17, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 17, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 17, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 17, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 17, 2025NO DATA, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Annandale Care Center Inc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 17, 2025NO DATA. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 17, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245364	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	500 PARK STREET EAST , ANNANDALE, Minnesota, 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
F0000	INITIAL COMMENTS On 6/16/25 to 6/17/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H#53645567C (MN00113273), with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		
F0689 SS = G	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 record review, the facility failed to comprehensively assess environmental hazards and/or ensure the environment was free from accident hazards for 1 of 3 residents (R1) reviewed for	F0689	How corrective action will be accomplished for the residents found to be affected: Immediate education provided to nursing staff on storage of lifts. This has been completed through verbal education as well as sending notification through Niuz communicating change in practice along with new policy information. How the facility will identify other residents having the potential to be affected by same practice: All current residents will be reviewed for fall risk using John Hopkins Fall assessment. Those considered to be high risk will have room/environment checked for safety concerns. What measures will be put into place, or systemic	07/15/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245364	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	500 PARK STREET EAST , ANNANDALE, Minnesota, 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
F0689 SS = G	Continued from page 1 falls. The facility's failures caused actual harm when R1 tripped and fell on a mechanical lift which resulted R1 suffering multiple rib fractures with hemothorax, unstable T11 fracture, and a large laceration to her elbow. Findings include: R1's Admission Record dated 4/17/24, identified R1's diagnoses included dementia with other behavioral disturbance, Hospice care, muscle weakness, unsteady gait, impaired safety awareness, and history of falls. R1's admission Minimum Data Set (MDS) dated 3/12/25, R1 required limited assistance for activities of daily living (ADLs), and mobility and had severe cognitive impairment. R1's care plan initiated 4/1/25, indicated R1 had a history of falls, impaired safety awareness, and unsteady gait. Staff interventions included providing assistance with mobility/ADLs. R1's fall risk assessment completed 4/1/25, indicated R1 is a high risk for falls related to muscle weakness, cognitive impairment, unsteady gait, and impaired safety awareness. R1's progress note dated 5/20/25 at 10:50 p.m. indicated R1 appeared to trip on a mechanical lift parked against a wall outside of her room as she turned the corner out of her room with her walker, attempting to ambulate independently. The note indicated R1 fell on her left side sustaining a large skin tear to her elbow, upper arm, and part of forearm with left side. R1 complained about ribs pain. R1's emergency department (ED) note dated 5/20/25 at 11:47 p.m. indicated R1 presented to ED for ground level fall with trauma, multiple or serious injuries. The note stated exam revealed laceration of left elbow, which was not amenable to repair, chest wall tenderness and left sided rib fractures. R1's progress note dated 5/21/25 at 2:21 a.m., indicated R1 was admitted at the hospital with multiple	F0689	Continued from page 1 changes made to ensure deficient practice will not recur. All new nursing staff will be educated on lifts not being stored in hallways and to be placed in tub room when not in use. Orientation paperwork has been updated for new hires as well as pool staff orientation forms. Annual training to be completed with nursing staff on-going. A new policy for Mechanical Lift Storage has been completed and sent out through Niuz communication system for all nursing staff to review and read. An environmental worksheet has been created as an audit tool to be used on a regular basis to observe for any environmental safety concerns. How facility will monitor its corrective actions to ensure the deficient practice is being corrected and not recur. Audit being completed by DON or designee to ensure lifts are not being stored in hallway weekly x4, then monthly x3 months. Environmental Safety Audit to be completed monthly x3 months then quarterly. Added to QAPI Action Plan to monitor progress and process. Results will be shared at monthly QAPI meeting and Safety Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245364	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	500 PARK STREET EAST , ANNANDALE, Minnesota, 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
F0689 SS = G	Continued from page 2 ribs fracture to her left side, hemothorax (a condition where blood accumulates in the space between the lung and the chest wall) to her right side and an unstable spinal fracture to T11. During an interview on 6/17/25 at 10:51 a.m., a family member (FM)-A stated she turned and saw R1 when she was falling down just outside her room. FM-A stated R1 had a walker, and her back hit part of the mechanical lift parked a foot or two from her doorway against the wall. During an interview on 6/17/25 at 11:09 a.m., FM-B stated R1 walked right outside of her room and her walker got caught by the mechanical lift parked right outside her room against the wall a foot from her doorway when she fell on the lift. During an interview on 6/17/25 at 12:52 p.m., nursing assistant (NA)-D stated she witnessed R1's fall and stated R1 landed with her left side on the mechanical lift which was one or two feet from her doorway. NA-D stated nursing staff did not have a designated spot to park the lifts and she did not recall receiving any education about environmental safety hazards. During an interview on 6/17/25 at 2:54 p.m., licensed practical nurse (LPN)-A stated on 5/20/25 R1 fell on the legs of the mechanical lift with her left side and started bleeding heavily. LPN-A stated R1 was one person assist with mobility and supervision. LPN-A did not recall receiving any education about environmental safety hazards after the incident. During an observation on 6/16/2025 11:37 a.m., a mechanical lift was observed parked against the wall less than a foot just outside of R5's doorway. During continuous observation, another mechanical lift was parked against the wall of R4's room with two wheels visible in R4's doorway. At 11:45 a.m., an unknown nursing staff member was noted to be in the hallway moving back and forth from the nursing station walking by the lifts. During an interview on 6/16/25 at 1:32 p.m., NA-A stated nursing staff have been trained on how to use the mechanical lift during their orientation. NA-A stated she was educated to put the mechanical lift on the right side of the hallway, against the wall between	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245364	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	500 PARK STREET EAST , ANNANDALE, Minnesota, 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
F0689 SS = G	Continued from page 3 residents' rooms during her orientation. NA-A stated she did not receive any education about a designated spot to park the mechanical lifts. NA-A stated nursing staff had to use their own judgment to put the lift in the middle against the wall to prevent any accident. NA-A did not identify the lift parked against the walls in the hallway as a safety and/or tripping hazard. During an interview on 6/16/25 at 2:17 p.m., NA-B indicated sometime between new employee orientation but before R1's accident, she was trained only to park the mechanical lift on the right side of the hallway against the wall facing one way. That training did not address any specific spot the lifts should parked other than the right side of the hallway. NA-B explained after R1's fall nursing staff did not receive any education pertaining to the storage of lifts and/or where in the hallway they should be parked and did not identify the lifts in the hallway a safety hazard for residents. During an interview on 6/17/25 at 10:23 a.m., NA-C stated she was directed to put the mechanical lift locked against the wall on the right side, using common sense not to put it on the resident's doorway. NA-C stated she did not receive any environmental safety hazard education recently. During an interview on 6/16/25 at 4:10 p.m., LPN-A stated nursing staff were supposed to park the mechanical lift on the right side of the hallway against the wall without blocking or inside the egress of the resident's doorway. LPN-A stated night shift should put them in the tub room if they were not using them, but nurses have to use their own judgment about putting the lift on the hallway. During an interview on 6/17/25 at 10:43 a.m., LPN-B stated they did not have a specific spot to put the mechanical lift as long as it was not blocking the doorway. LPN-B stated she did not recall receiving any environmental safety hazard education recently. During an interview on 6/17/25 at 9:46 a.m., a registered nurse (RN)-A stated after using the lifts, nursing staff have to put it at a safe location not blocking the hallway. RN-A stated he did not receive any direction about parking the lift at a designated location.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245364	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	500 PARK STREET EAST , ANNANDALE, Minnesota, 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
F0689 SS = G	Continued from page 4 During an interview on 6/17/25 at 1:25 p.m., RN-B stated she was responsible for training nursing assistants upon hire and she was part of the safety committee. RN-B stated she did provide training at the facility skills fair last week including how to use the mechanical lift, however she did not provide environmental safety hazard education to the nursing staff recently. Nursing staff were directed to park the mechanical lift on the right side of the hallway against the wall. No specific education pertaining to R1's incident had been provided, and no audits regarding how lifts have been parked properly in the hallway was conducted. During an interview on 6/17/25 at 3:19 p.m., the director of nursing (DON) stated R1 was a high risk for falls and was having increased confusion due to her dementia condition. The interdisciplinary team (IDT) did root cause analysis after the incident but did not consider the placement of the mechanical lift as a contributing factor in the incident. DON stated she did not do anything to address the mechanical lift parked in the hallway as a potential fall hazards or try to figure out a different safe location to store them after its used. DON explained she had not provided any environmental safety hazards education to the staff or audits regarding the residents' ability to safely maneuver around the mechanical lift in the environment for ambulatory residents who independently used assistive devices. During an interview on 6/17/25 at 3:52 p.m., the administrator stated during the IDT meeting they discussed R1's fall incident and determined it was related to R1 increased weakness and confusion but did not consider the lift as contributing factor to her injuries. The administrator stated R1 sustained injuries when she fell on the lift. The administrator stated the facility procedure was to park the mechanical lift on the right side of hallway against the wall because of a lack of storage. The administrator stated they met every morning with IDT and discussed many items including falls and their Quality Assurance and Performance Improvement (QAPI) meeting was scheduled for 6/20/25. The facility Environmental Hazards Policy dated January 2012 and revised in November 2020, indicated the facility shall maintain a safe, clean and orderly	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245364	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	500 PARK STREET EAST , ANNANDALE, Minnesota, 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
F0689 SS = G	Continued from page 5 interior and directed staff to survey their assigned work area routinely to ensure a properly maintained, safe clean and orderly environment.	F0689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 2, 2025

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

Re: Event ID: CBMX11

Dear Administrator:

The above facility survey was completed on June 17, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	**500 PARK STREET EAST , ANNANDALE, Minnesota, 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
20000	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: On 6/16/25 to 6/17/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed the order and identify the date when it will be completed.	20000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	**500 PARK STREET EAST , ANNANDALE, Minnesota, 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
20000	Continued from page 1 The following complaint was reviewed: H53645567C (MN00113273) with a licensing order issued at (1665). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	20830	Corrected	07/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	**500 PARK STREET EAST , ANNANDALE, Minnesota, 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
20830	Continued from page 2 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively assess environmental hazards and/or ensure the environment was free from accident hazards for 1 of 3 residents (R1) reviewed for falls. The facility's failures caused actual harm when R1 tripped and fell on a mechanical lift which resulted R1 suffering multiple rib fractures with hemothorax, unstable T11 fracture, and a large laceration to her elbow. Findings include: R1's Admission Record dated 4/17/24, identified R1's diagnoses included dementia with other behavioral disturbance, Hospice care, muscle weakness, unsteady gait, impaired safety awareness, and history of falls. R1's admission Minimum Data Set (MDS) dated 3/12/25, R1 required limited assistance for activities of daily living (ADLs), and mobility and had severe cognitive impairment. R1's care plan initiated 4/1/25, indicated R1 had a history of falls, impaired safety awareness, and unsteady gait. Staff interventions included providing assistance with mobility/ADLs. R1's fall risk assessment completed 4/1/25, indicated R1 is a high risk for falls related to muscle weakness, cognitive impairment, unsteady gait, and impaired safety awareness. R1's progress note dated 5/20/25 at 10:50 p.m. indicated R1 appeared to trip on a mechanical lift parked against a wall outside of her room as she turned the corner out of her room with her walker, attempting to ambulate independently. The note indicated R1 fell on her left side sustaining a large skin tear to her elbow, upper arm, and part of forearm with left side. R1 complained about ribs pain.	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	**500 PARK STREET EAST , ANNANDALE, Minnesota, 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
20830	Continued from page 3 R1's emergency department (ED) note dated 5/20/25 at 11:47 p.m. indicated R1 presented to ED for ground level fall with trauma, multiple or serious injuries. The note stated exam revealed laceration of left elbow, which was not amenable to repair, chest wall tenderness and left sided rib fractures. R1's progress note dated 5/21/25 at 2:21 a.m., indicated R1 was admitted at the hospital with multiple ribs fracture to her left side, hemothorax (a condition where blood accumulates in the space between the lung and the chest wall) to her right side and an unstable spinal fracture to T11. During an interview on 6/17/25 at 10:51 a.m., a family member (FM)-A stated she turned and saw R1 when she was falling down just outside her room. FM-A stated R1 had a walker, and her back hit part of the mechanical lift parked a foot or two from her doorway against the wall. During an interview on 6/17/25 at 11:09 a.m., FM-B stated R1 walked right outside of her room and her walker got caught by the mechanical lift parked right outside her room against the wall a foot from her doorway when she fell on the lift. During an interview on 6/17/25 at 12:52 p.m., nursing assistant (NA)-D stated she witnessed R1's fall and stated R1 landed with her left side on the mechanical lift which was one or two feet from her doorway. NA-D stated nursing staff did not have a designated spot to park the lifts and she did not recall receiving any education about environmental safety hazards. During an interview on 6/17/25 at 2:54 p.m., licensed practical nurse (LPN)-A stated on 5/20/25 R1 fell on the legs of the mechanical lift with her left side and started bleeding heavily. LPN-A stated R1 was one person assist with mobility and supervision. LPN-A did not recall receiving any education about environmental safety hazards after the incident. During an observation on 6/16/2025 11:37 a.m., a mechanical lift was observed parked against the wall less than a foot just outside of R5's doorway. During continuous observation, another mechanical lift was parked against the wall of R4's room with two wheels visible in R4's doorway. At 11:45 a.m., an unknown	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	**500 PARK STREET EAST , ANNANDALE, Minnesota, 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
20830	Continued from page 4 nursing staff member was noted to be in the hallway moving back and forth from the nursing station walking by the lifts. During an interview on 6/16/25 at 1:32 p.m., NA-A stated nursing staff have been trained on how to use the mechanical lift during their orientation. NA-A stated she was educated to put the mechanical lift on the right side of the hallway, against the wall between residents' rooms during her orientation. NA-A stated she did not receive any education about a designated spot to park the mechanical lifts. NA-A stated nursing staff had to use their own judgment to put the lift in the middle against the wall to prevent any accident. NA-A did not identify the lift parked against the walls in the hallway as a safety and/or tripping hazard. During an interview on 6/16/25 at 2:17 p.m., NA-B indicated sometime between new employee orientation but before R1's accident, she was trained only to park the mechanical lift on the right side of the hallway against the wall facing one way. That training did not address any specific spot the lifts should parked other than the right side of the hallway. NA-B explained after R1's fall nursing staff did not receive any education pertaining to the storage of lifts and/or where in the hallway they should be parked and did not identify the lifts in the hallway a safety hazard for residents. During an interview on 6/17/25 at 10:23 a.m., NA-C stated she was directed to put the mechanical lift locked against the wall on the right side, using common sense not to put it on the resident's doorway. NA-C stated she did not receive any environmental safety hazard education recently. During an interview on 6/16/25 at 4:10 p.m., LPN-A stated nursing staff were supposed to park the mechanical lift on the right side of the hallway against the wall without blocking or inside the egress of the resident's doorway. LPN-A stated night shift should put them in the tub room if they were not using them, but nurses have to use their own judgment about putting the lift on the hallway. During an interview on 6/17/25 at 10:43 a.m., LPN-B stated they did not have a specific spot to put the mechanical lift as long as it was not blocking the	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	**500 PARK STREET EAST , ANNANDALE, Minnesota, 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
20830	Continued from page 5 doorway. LPN-B stated she did not recall receiving any environmental safety hazard education recently. During an interview on 6/17/25 at 9:46 a.m., a registered nurse (RN)-A stated after using the lifts, nursing staff have to put it at a safe location not blocking the hallway. RN-A stated he did not receive any direction about parking the lift at a designated location. During an interview on 6/17/25 at 1:25 p.m., RN-B stated she was responsible for training nursing assistants upon hire and she was part of the safety committee. RN-B stated she did provide training at the facility skills fair last week including how to use the mechanical lift, however she did not provide environmental safety hazard education to the nursing staff recently. Nursing staff were directed to park the mechanical lift on the right side of the hallway against the wall. No specific education pertaining to R1's incident had been provided, and no audits regarding how lifts have been parked properly in the hallway was conducted. During an interview on 6/17/25 at 3:19 p.m., the director of nursing (DON) stated R1 was a high risk for falls and was having increased confusion due to her dementia condition. The interdisciplinary team (IDT) did root cause analysis after the incident but did not consider the placement of the mechanical lift as a contributing factor in the incident. DON stated she did not do anything to address the mechanical lift parked in the hallway as a potential fall hazards or try to figure out a different safe location to store them after its used. DON explained she had not provided any environmental safety hazards education to the staff or audits regarding the residents' ability to safely maneuver around the mechanical lift in the environment for ambulatory residents who independently used assistive devices. During an interview on 6/17/25 at 3:52 p.m., the administrator stated during the IDT meeting they discussed R1's fall incident and determined it was related to R1 increased weakness and confusion but did not consider the lift as contributing factor to her injuries. The administrator stated R1 sustained injuries when she fell on the lift. The administrator stated the facility procedure was to park the mechanical lift on the right side of hallway against	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER INC	**500 PARK STREET EAST , ANNANDALE, Minnesota, 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
20830	Continued from page 6 the wall because of a lack of storage. The administrator stated they met every morning with IDT and discussed many items including falls and their Quality Assurance and Performance Improvement (QAPI) meeting was scheduled for 6/20/25. The facility Environmental Hazards Policy dated January 2012 and revised in November 2020, indicated the facility shall maintain a safe, clean and orderly interior and directed staff to survey their assigned work area routinely to ensure a properly maintained, safe clean and orderly environment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review policies and procedures and re-educate staff on a designated spot or storage for the mechanical lifts according to the safety commettee instructions. The DON or designees could conduct periodic audits, request PT/OT assessments on mechanical lifts/electric chairs/recliners to ensure ongoing compliance and safety on proper maneuver around the mechanical lift by independent ambulatory residents in the environment. The DON could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensuer ongoing compliance. TIME PERIOD OF CORRECTION: twenty-one (21) days	20830		