



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 19, 2024

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

RE: CCN: 245364
Cycle Start Date: November 19, 2024

Dear Administrator:

On November 19, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 19, 2024

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

Re: Reinspection Results
Event ID: 9V3012

Dear Administrator:

On November 19, 2024 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 October 23, 2024. 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
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 31, 2024

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

RE: CCN: 245364
Cycle Start Date: October 23, 2024

Dear Administrator:

On October 23, 2024, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, 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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

Annandale Care Center Inc

October 31, 2024

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the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Terri Ament, Regional Operations Supervisor, Rapid Response

Health Regulation Division

Minnesota Department of Health

Duluth Technology Village

11 East Superior Street, Suite 290

Duluth, Minnesota 55802-2007

Email: teresa.ament@state.mn.us

Office: (218) 302-6151 Mobile: (218) 766-2720

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 23, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 23, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Annandale Care Center Inc

October 31, 2024

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a loop at the end of the last name.

Kamala Fiske-Downing

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 11/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/23/2024
NAME OF PROVIDER OR SUPPLIER ANNANDALE CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 10/22/24 through 10/23/24, 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: H53649589C (MN00107599) 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.	F 000			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from falls for 2 of 3 residents (R1, R2) reviewed for	F 689	How corrective action will be accomplished for the residents found to be affected:	11/15/24	

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

TITLE

(X6) DATE

Electronically Signed

11/05/2024

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: 245364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/23/2024	
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F 689	<p>Continued From page 1 falls.</p> <p>Findings include:</p> <p>R1's care plan dated 6/12/22, directed R1 required extensive assist of two staff for bed mobility.</p> <p>R1's readmission Minimum Data Set (MDS) dated 9/20/24 indicated R1 had diagnoses of pneumonia and anxiety. The MDS indicated R1 required a mechanical lift for transfers, and two staff for bed mobility. In addition, the MDS indicated R1 had no history of falls.</p> <p>The undated Nursing Assistant Assignment sheet (nursing assistant care guide) directed R1's bed mobility to be provided with assistance of two staff, and transfers to be completed with one staff and the mechanical stand assist lift.</p> <p>On 10/18/24 a progress note indicated R1 had a witnessed fall at 6:30 a.m. R1 stiffened his body and slipped out of bed landing on his left side. R1 had no injuries.</p> <p>On 10/22/24 at 1:32 p.m., R1 stated nursing assistant (NA)-A provided cares by herself on 10/18/24. When she attempted to sit him up at the edge of the bed, he fell to the floor. There were supposed to be two staff get him out of bed in the morning.</p> <p>On 10/22/24 at 2:30 p.m., NA-A stated she provided cares independently to R1 on the morning of 10/18/24. He slid to the floor when she attempted to sit him up on the edge of the bed. The Nursing Assistant Assignment sheet directed</p>	F 689	<p>Immediate education provided to staff involved with resident's falls was completed including following resident care plans and use of nursing assistant assignment sheets. R1 was changed to assist of 2 with full body mechanical lift and orders obtained for therapy to eval and treat for bed mobility and transfers. R2 was in therapy at time of fall, therapy was notified to ensure plan of care was appropriate for resident.</p> <p>How the facility will identify other residents having the potential to be affected by same practice: DON reviewed all Nursing Assistant Assignment sheets in collaboration with RN Case managers to identify all resident requiring assist with transfers and updated to be more clear on the level of assist required. All staff educated on need to follow each resident's individualized care plan needs. Adjustments made as necessary to the NAR sheets.</p> <p>What measures will be put into place, or systemic changes made to ensure deficient practice will not recur. DON reviewed and updated the policy titled Standards of Care for Activities of Daily Living. All staff provided education on policy relating to Standards of Care for Activities of Daily Living.</p> <p>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 nursing assistants are</p>	

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F 689	<p>Continued From page 2</p> <p>R1 was supposed to have two staff assist for bed mobility, and one staff for transfers.</p> <p>On 10/22/24 at 3:02 p.m., licensed practical nurse (LPN)-A stated she was working on 10/18/24 when R1 fell. NA-A was trying to get him out of bed by herself, and R1 required assistance of two staff to get out of bed.</p> <p>On 10/23/24 at 9:04 a.m., registered nurse (RN)-A stated Nursing Assistant Assignment sheets were updated daily. The NAs were expected to carry them, and reference the sheets as they reflected each residents' current care plan. Two staff should have been present for R1's morning cares on 10/18/24.</p> <p>On 10/23/24 at 10:03 a.m., the director of nursing (DON) stated the Nursing Assistant Assignment sheets were updated when the care plans were updated. NA-A did not follow the care plan when she attempted to get him up by herself.</p> <p>On 10/23/24 at 12:06 p.m., physical therapist (PT)-A stated R1 had been assessed and discharged from physical therapy on 10/9/24. At that time, the recommendation was made to provide assistance of two staff for bed mobility, due to his stiff tone. The assistance of two staff included getting him up and out of bed. Once he was out of bed, R1 could transfer with the mechanical stand assist lift and one staff.</p> <p>R2's care plan dated 4/3/24 indicated she required assist of one staff and the mechanical standing lift for transfers.</p> <p>R2's quarterly MDS dated 8/29/24 indicated R1 had diagnoses of debility, heart failure and</p>	F 689	<p>carrying and referring to the Nursing Assignment Sheets when providing cares to residents weekly x4 weeks and monthly x 3 months.</p> <p>Audits being conducted by DON or designee to ensure that nursing assistants are completing cares per care plan/Nursing Assistant Assignment weekly x4 weeks and monthly x 3 months.</p> <p>Added to QAPI Action Plan to monitor progress and process. Results will be shared at monthly QAPI meeting.</p>	

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

PRINTED: 11/19/2024
FORM APPROVED
OMB NO. 0938-0391

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F 689	<p>Continued From page 3</p> <p>dementia. The MDS indicated R2 was dependent for transfers, and required substantial assistant with bed mobility. R2's MDS indicated she had no history of falls.</p> <p>The undated Nursing Assistant Assignment sheet directed R2's transfers to be completed with one staff using the mechanical stand assist lift.</p> <p>On 10/5/24 a progress note indicated R2 had a witnessed fall in the morning after becoming weak, and was lowered to the floor. R2 had no injuries.</p> <p>On 10/23/24 at 8:48 a.m., LPN-B stated she was working on 10/5/24 when R2 fell. It appeared NA-B had transferred R2 without the mechanical lift. NA-B did not have the Nursing Assistant Assignment sheet with her at the time of the incident.</p> <p>On 10/23/24 at 9:30 a.m., NA-B stated she was caring for R2 on 10/5/24. She was transferring R2 with a gait belt when R2 was lowered to the floor. She did not read the Nursing Assistant Assignment sheet to determine how she should transfer R2.</p> <p>On 10/23/24 at 12:16 p.m., PT-A stated R2 was not strong enough to transfer without a lift.</p> <p>The facility policy Routine Resident Care dated 3/23, directed following each resident's care plan for activities of daily living (ADL)s, including bathing, dressing, eating, toileting, and encouraging participation in recreational activities.</p>	F 689		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 31, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 9V3011

Dear Administrator:

The above facility was surveyed on October 22, 2024 through October 23, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Annandale Care Center Inc

October 31, 2024

Page 2

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

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

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

Terri Ament, Regional Operations Supervisor, Rapid Response

Health Regulation Division

Minnesota Department of Health

Duluth Technology Village

11 East Superior Street, Suite 290

Duluth, Minnesota 55802-2007

Email: teresa.ament@state.mn.us

Office: (218) 302-6151 Mobile: (218) 766-2720

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00951	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2024
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NAME OF PROVIDER OR SUPPLIER ANNANDALE CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 10/22/24 through 10/23/24, 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 orders were issued. Please indicate in your electronic plan of correction you</p>	2 000		
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

11/05/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00951	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2024
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2 000	<p>Continued From page 1</p> <p>have reviewed these orders and identify the date when they will be completed.</p> <p>The following complaint was reviewed: H53649589C (MN00107599) with a licensing order issued at 4658.0520 Subp. 1. 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.</p> <p>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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> 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</p>	2 000		

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from falls for 2 of 3 residents (R1, R2) reviewed for falls. Findings include: R1's care plan dated 6/12/22, directed R1 required extensive assist of two staff for bed mobility.	2 830	Corrected	11/15/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00951	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2024
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NAME OF PROVIDER OR SUPPLIER ANNANDALE CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302
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2 830	<p>Continued From page 3</p> <p>R1's readmission Minimum Data Set (MDS) dated 9/20/24 indicated R1 had diagnoses of pneumonia and anxiety. The MDS indicated R1 required a mechanical lift for transfers, and two staff for bed mobility. In addition, the MDS indicated R1 had no history of falls.</p> <p>The undated Nursing Assistant Assignment sheet (nursing assistant care guide) directed R1's bed mobility to be provided with assistance of two staff, and transfers to be completed with one staff and the mechanical stand assist lift.</p> <p>On 10/18/24 a progress note indicated R1 had a witnessed fall at 6:30 a.m. R1 stiffened his body and slipped out of bed landing on his left side. R1 had no injuries.</p> <p>On 10/22/24 at 1:32 p.m., R1 stated nursing assistant (NA)-A provided cares by herself on 10/18/24. When she attempted to sit him up at the edge of the bed, he fell to the floor. There were supposed to be two staff get him out of bed in the morning.</p> <p>On 10/22/24 at 2:30 p.m., NA-A stated she provided cares independently to R1 on the morning of 10/18/24. He slid to the floor when she attempted to sit him up on the edge of the bed. The Nursing Assistant Assignment sheet directed R1 was supposed to have two staff assist for bed mobility, and one staff for transfers.</p> <p>On 10/22/24 at 3:02 p.m., licensed practical nurse (LPN)-A stated she was working on 10/18/24 when R1 fell. NA-A was trying to get him out of bed by herself, and R1 required assistance of two staff to get out of bed.</p>	2 830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00951	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2024
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NAME OF PROVIDER OR SUPPLIER ANNANDALE CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302
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2 830	<p>Continued From page 4</p> <p>On 10/23/24 at 9:04 a.m., registered nurse (RN)-A stated Nursing Assistant Assignment sheets were updated daily. The NAs were expected to carry them, and reference the sheets as they reflected each residents' current care plan. Two staff should have been present for R1's morning cares on 10/18/24.</p> <p>On 10/23/24 at 10:03 a.m., the director of nursing (DON) stated the Nursing Assistant Assignment sheets were updated when the care plans were updated. NA-A did not follow the care plan when she attempted to get him up by herself.</p> <p>On 10/23/24 at 12:06 p.m., physical therapist (PT)-A stated R1 had been assessed and discharged from physical therapy on 10/9/24. At that time, the recommendation was made to provide assistance of two staff for bed mobility, due to his stiff tone. The assistance of two staff included getting him up and out of bed. Once he was out of bed, R1 could transfer with the mechanical stand assist lift and one staff.</p> <p>R2's care plan dated 4/3/24 indicated she required assist of one staff and the mechanical standing lift for transfers.</p> <p>R2's quarterly MDS dated 8/29/24 indicated R1 had diagnoses of debility, heart failure and dementia. The MDS indicated R2 was dependent for transfers, and required substantial assistant with bed mobility. R2's MDS indicated she had no history of falls.</p> <p>The undated Nursing Assistant Assignment sheet directed R2's transfers to be completed with one staff using the mechanical stand assist lift.</p> <p>On 10/5/24 a progress note indicated R2 had a</p>	2 830		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER ANNANDALE CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302
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2 830	<p>Continued From page 5</p> <p>witnessed fall in the morning after becoming weak, and was lowered to the floor. R2 had no injuries.</p> <p>On 10/23/24 at 8:48 a.m., LPN-B stated she was working on 10/5/24 when R2 fell. It appeared NA-B had transferred R2 without the mechanical lift. NA-B did not have the Nursing Assistant Assignment sheet with her at the time of the incident.</p> <p>On 10/23/24 at 9:30 a.m., NA-B stated she was caring for R2 on 10/5/24. She was transferring R2 with a gait belt when R2 was lowered to the floor. She did not read the Nursing Assistant Assignment sheet to determine how she should transfer R2.</p> <p>On 10/23/24 at 12:16 p.m., PT-A stated R2 was not strong enough to transfer without a lift.</p> <p>The facility policy Routine Resident Care dated 3/23, directed following each resident's care plan for activities of daily living (ADL)s, including bathing, dressing, eating, toileting, and encouraging participation in recreational activities.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procesures regarding follwing care plans and nursing assitant care guides. The (DON) or designee educate all nuring assistants on these policies and procedures. The DON or designee could audit the nursing assistnats, and report the results to the Quality Performance Improvement Committee (QAPI).</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 830		