DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 15, 2021

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

RE: CCN: 245364
Cycle Start Date: January 6, 2021

Dear Administrator:

On January 28, 2021, we notified you a remedy was imposed. On March 12, 2021 the Minnesota Department(s) 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 March 5, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 14, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 28, 2021, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 14, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 5, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
January 28, 2021

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

RE: CCN: 245364
Cycle Start Date: January 6, 2021

Dear Administrator:

On January 6, 2021, a survey was completed at your facility by the Minnesota Department(s) 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically 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 Region V Office for imposition. The CMS Region V Office 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 March 14, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 14, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 14, 2021.

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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 $11,160; 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 March 14, 2021, 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 will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 14, 2021. 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)

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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 SIXTH MONTH AFTER THE LAST DAY OF THE

SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 6, 2021 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) 565-9462

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, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: 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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/06/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 1/4/21 - 1/6/21 at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations § 483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/4/21 - 1/6/21, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found to be NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Additionally, as a result of the investigation a COVID-19 Focused Infection Control survey was also conducted 1/4/21 - 1/6/21 at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was NOT in full compliance. The following complaint was found to be SUBSTANTIATED: H5364035C (MN00067045, MN00067022, MN00067046, MN000047, MN00067035) with deficiency issued at F755 H5364038C (MN00068638) with deficiencies issued at F880 and F755 The following complaints were found to be UNSUBSTANTIATED:	F 000		

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

Electronically Signed | 02/09/2021

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 01/06/2021

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	Continued From page 1 H5364037C (MN00067065) As a result of the investigation deficiencies were identified at F606 and F609. 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. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(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. §483.12(a)(4) Report to the State nurse aide	F 606		2/5/21

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 01/06/2021

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 606	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a background check was obtained and verified prior to allowing unsupervised access to residents for 2 of 13 employees reviewed as part of a background check sample following an investigation of a narcotic medication theft involving a staff member (See F755). Findings include: On 1/4/21, licensed practical nurse (LPN)-C's employee file lacked evidence a background study had been obtained and verified upon hire or during her employment at the facility. In addition, LPN-C's file lacked evidence of an Annandale Care Center - Hiring Packet Checklist. LPN-C's employee file indicated she had been hired on 6/19/20, with a start date of 6/22/20, and had been terminated on 11/6/20. The facility was asked to provide documentation of LPN-C background study, but no additional documents were provided. A requested Employee Information report dated 1/5/21, at 3:33 p.m. identified DA-B had been hired on 9/1/20 and was an active dietary employee. Dietary aide (DA)-B's background check indicated it had been performed on 1/5/21, with no evidence a background check had been submitted previously. When interviewed via telephone on 1/5/21, at	F 606	F606 – Not Employ/Engage Staff w/Adverse Actions This plan of correction constitutes Annandale Care Center's written compliance for the deficiencies cited. However, the submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1) How corrective action will be accomplished for those residents found to be affected: It is the policy of AHCS that each newly hired employee will satisfactorily complete a background study through the MN Department of Human Services prior to first day of work. Training was conducted with Human Resources staff on the Background Study policy and procedures and they are aware of the importance of not allowing an employee to work without a completed background study. 2) How to identify other residents having the potential to be affected by the same practice: An audit of all employee personnel files was conducted to verify all employees had background studies completed and on file as of 01/08/2021. Another audit of all	

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 01/06/2021

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 606	Continued From page 3 1:56 p.m. the director of nursing (DON) stated facility staff were unable to find LPN-C's background study. The DON voiced the facility had contacted the Minnesota (MN) Department of Human Services (DHS); however, she explained MN DHS had been unable to provide them with proof that a background check had been initiated. The DON stated human resources (HR) had been responsible for completing LPN-C's background study upon LPN-C's hire. The DON explained this HR staff member was no longer employed at the facility; however, an HR staff member was in the process of being trained. The DON denied the facility had reviewed employee files to ensure each employee had a background study obtained and verified after the HR member left her employment. The DON stated LPN-C's lack of a background study had appeared to be an isolated incident. During a telephone interview on 1/5/21, at 3: 57 p.m. the administrator stated the facility performed a digital check list to ensure items were completed for new employees, which included a background check. When questioned on LPN-C's digital check list, the administrator stated, "We found the form but did not actually do the check." When interviewed via telephone on 1/6/21, at 12:38 p.m. HR-A stated her typical practice had been to perform the background check with the employee present. HR-A stated she could not say with 100 percent accuracy that she had completed LPN-C's background check; however, she verbalized that she felt it had been done. HR-A explained for background check auditing the facility had used an electronic form; however, she stated she had relied a lot on the emails that	F 606	newly hired employees between 01/08/21 and 02/03/21 was conducted on 02/03/21 – all were found to have completed background studies on file. 3) Measures put into place or systemic changes made to ensure practice will not recur: Human Resources staff have developed an electronic new hire checklist to be used with every new hire to ensure compliance. Monthly audits of new hire background studies have been added as a permanent part of the process once compliance audits have been completed and the QA Committee has determined consistent compliance is being achieved. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system: Human Resources staff will complete audits of all newly hired employees every two weeks for a period of 3 months. Audits will be used to verify completion of background studies prior to employee's first day of work. Audit results will be submitted to the QA Committee for review, to determine that compliance continues to be achieved and approve going to monthly audits. 5) The date deficiency will be corrected: 01/08/2021	

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 01/06/2021

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 606	Continued From page 4 came from DHS "as once it was in the system it would generate what was going on." During a follow-up telephone interview on 1/6/21, at 1:46 p.m. the administrator stated DA-B's background study had been missed potentially due to, "Dietary thought HR was doing it and HR thought dietary was doing it." The administrator explained she felt, "It [DA-B's background study] slipped through the cracks and no one knew who was supposed to do it." The administrator stated employee background studies are very important and have to be done to keep residents safe. A policy Annandale Health & Community Services' Facility Abuse Prevention Plan, dated 8/1/05, indicated, "All employees will have a background check initiated at hire. Potential employees will be screened for a history of abuse, neglect or mistreating residents. This includes checking with the appropriate licensing boards and registries. If a background study is pending, staff will follow the recommendations of the background study for needed supervision." A policy Background Study, reviewed 1/2020, indicated that newly hired employees completed a background study through MN DHS prior to their first day of work. The policy identified the employee met with the HR manager or delegate to complete the background study together and that the HR manager or delegate followed up with the employee prior to the first day of work to ensure the entire process had been completed.	F 606		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		2/5/21

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 01/06/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 5 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(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. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of medication theft to the State Agency (SA) within 24 hours for 5 of 5 residents (R1, R2, R3, R4, R5) reviewed for misappropriation of property. Findings include: R1's annual Minimum Data Set (MDS) dated 11/25/20, identified R1 had severe cognitive	F 609	F609- Reporting of Alleged Violations within 24 hours This plan of correction constitutes Annandale Care Center's written compliance for the deficiencies cited. However, the submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements	

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 01/06/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 6 impairment, had the ability to usually understand others and others usually understood her, and she required extensive physical assist for cares. Diagnosis included dementia and chronic pain. The MDS indicated R1 had received scheduled and as needed pain medication with opioid pain medication administered daily. R1's self reported occasional, moderate pain; however, had been unable to express if the pain had impacted her sleep or day to day activities. R2's admission MDS dated 9/28/20, identified R2 had severe cognitive impairment, had the ability to usually understand others and others usually understood her, and she required limited to extensive physical assist with cares. Diagnosis included left humerus (upper arm bone) fracture, arthritis, osteoporosis, and unspecified pain. The MDS indicated R2 had received scheduled and as needed pain medication with opioid pain medication administered daily. R1 self reported occasional pain with a score of 9 based on a zero to ten pain scale. R3's quarterly MDS dated 12/11/20, identified R3 had intact cognition and communication skills and had been overall dependent on others for her cares. Diagnosis included chronic pain, abnormal posture, and osteoporosis. The MDS indicated R3 had received scheduled pain medication with opioid pain medication administered daily. The MDS identified R3's ability to participate in a pain interview; however, one had not been conducted at that time. R4's quarterly MDS dated 10/10/20, identified R4 had moderate cognitive impairment, had the ability to usually understand others and others usually understood her, and she required	F 609	established by state and federal law. 1) How corrective action will be accomplished for those residents found to be affected: It is the policy of Annandale Care Center that potential incidents of abuse or neglect be filed in accordance with federal regulation and in accordance with the facility Vulnerable Adult Prevention Plan Policy and Procedure. Staff was re-trained on the Vulnerable Adult Prevention Plan Policy and Procedures and are aware of the need to report to agencies in a timely manner. 2) How to identify other residents having the potential to be affected by the same practice An audit of timeliness reporting for VA reports for the past 3 months was completed on February 5, 2021. All incidents that required reporting have been filed. 3) Measures put into place or systemic changes made to ensure practice will not recur: Staff have been retrained regarding the reporting of abuse/neglect immediately to the DON/Administrator for determination of outside reporting requirements. Education has been provided and staff are being retrained on the VA Abuse Prevention Plan Policy and Procedures and specifically the reporting of suspicion of drug diversion. Retraining of staff will be completed by Friday, February 12, 2021.	

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 01/06/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 7 extensive physical assist for cares. Diagnosis included Alzheimer's dementia, history of transient ischemic attack (TIA) (lack of blood flow to the brain), anxiety and depression, arthritis, and chronic pain syndrome. The MDS indicated R4 had received scheduled and as needed pain medication with antianxiety and opioid pain medication administered daily. The MDS indicated R4 had been unable to verbalize pain status; however, staff indicated R4 verbalized pain and displayed nonverbal indicators of pain daily. R5's admission MDS dated 8/18/20, identified R5 had intact cognition and communication skills and had required extensive physical assist for cares. Diagnosis included vertebrae (spinal bone) fracture and low back pain. The MDS indicated R5 had received scheduled and as needed pain medication with opioid pain medication administered daily. The MDS identified R5's ability to participate in a pain interview: however, one had not been conducted at that time. An initial report was submitted to the SA on 11/5/20, at 8:15 p.m. by the director of nursing (DON). The incident report identified an allegation that a nursing staff member had possibly documented forged signatures of other nursing staff members when she had destroyed narcotic medications belonging to R1 and R4 after the narcotic "had been dropped or popped out of card." The date and time of the incident was identified as 11/5/20, at 7:00 p.m. Subsequent incident reports were submitted to the SA on 11/6/20, at 2:14 p.m., 2:22 p.m., 2:29 p.m., and 2:37 p.m. respectively by the DON. The incident reports identified the SA had directed the	F 609	4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system. Designated facility staff will continue to immediately report to outside agencies and investigate all incidents of suspected maltreatment according to facility policies and procedures. Audits will be conducted once a week for two weeks and then monthly until 100% compliance has been achieved. Audit results will be brought to the Quality Assurance committee meeting to monitor effectiveness and determine when compliance has been achieved. 5) The date each deficiency will be corrected 02/12/2021	

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 01/06/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 8	F 609		

facility to submit a separate report for each involved resident. In addition, the four incident reports identified an allegation of "probable drug diversion" of R1, R2, R3, and R5's narcotic medication by a nursing staff member. The date and time of the incidents was identified as 11/5/20, at 6:00 p.m.

Follow up incident investigation reports submitted to the SA on 11/12/20, for R1, R2, R3, and R4 all indicated, "On 11/3/20 it was brought to the DON's attention that some nurses felt [licensed practical nurse (LPN)-C] may be diverting narcotics by wasting the medication and saying it was dropped or taken from the wrong card." In addition, the summary identified, "On the morning of 11/4/20, 3 nurses came to see the DON saying they had been looking at the narcotic log book, and felt signatures may have been forged as a cosigner for wasted medication. A few nurses adamantly said some of the signatures were not theirs and a couple of wastes had no cosigner at all."

When interviewed on 1/4/21, at 4:20 p.m. the DON stated that on 11/3/20, "later in the day," nursing staff brought allegations of narcotic medication concerns to her. The DON explained after she had started the investigation, "I thought there was enough evidence that we were going to have to do something; however, the DON further explained it had taken her "time to put everything together." The DON stated after nursing staff had confirmed their signatures [documented as cosigners for narcotic destruction] had not been theirs she "knew that it [the allegation] was reportable." The DON stated she had reported the allegation to the SA after she had talked to the administrator; however, she explained, "We

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 01/06/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 9	F 609		

had to wait for legal." In addition, the DON expressed there had been "no physical danger" to the residents and, "We just felt no further financial abuse was going to happen while waiting for legal," as LPN-C had not been working during the time of the investigation. The DON confirmed if there is an allegation of abuse the allegation is to be reported [to the SA] within two hours and she confirmed the allegation should have been reported on 11/3/20.

When interviewed via telephone on 1/5/21, at 3:57 p.m. the administrator stated she expected staff to report abuse "right away;" however, she explained, "I think our thought process was skewed" based on how the investigation had been initiated. In addition, the administrator stated she had initially thought it had been a "peer issue until we actually looked into it and felt we needed to report." The administrator explained, "In hindsight we should have just filled it [SA abuse report] out."

A policy Annandale Health & Community Services' Facility Abuse Prevention Plan, dated 8/1/05, indicated, "The Administrator is notified immediately of any suspected abuse. Immediately is defined as 'as soon as possible but no later than 24 hours after an incident'. Social Services or other designated staff will immediately report to appropriate agencies." In addition, the policy identified, "All employees of AHCS [Annandale Health Care System] are mandated reporters of any suspected abuse or neglect of a Vulnerable Adult. The Social Services department or designee will file the report during normal business hours; after hours, on weekends or holidays, the RN [registered nurse]/LPN on duty or on-call are trained to make

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 01/06/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 10 the submission, " and, "Any person with the knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal if the report is made in good faith."	F 609		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755		2/5/21

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 01/06/2021

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 755	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure nursing staff followed acceptable standards of practice for the disposition of narcotic medication and/or controlled substances (medications regulated and classified by the Drug Enforcement Agency (DEA)) in a manner to prevent potential drug diversion for 5 of 5 residents (R1, R2, R3, R4, R5) reviewed for controlled medication administration and destruction. In addition, the facility failed to have a systematized oversight process to identify discrepancies and unusually patterns related to narcotic and controlled medication administration, destruction, and documentation practices. Findings include: R1's annual Minimum Data Set (MDS) dated 11/25/20, identified R1 had severe cognitive impairment with diagnosis of dementia and chronic pain. The MDS indicated R1 had received scheduled and as needed pain medication with opioid pain medication administered daily. R2's admission MDS dated 9/28/20, identified R2 had severe cognitive impairment with diagnosis of left humerus (upper arm bone) fracture, arthritis, and unspecified pain. The MDS indicated R2 had received scheduled and as needed pain medication with opioid pain medication administered daily. R3's quarterly MDS dated 12/11/20, identified R3 had intact cognition with a diagnosis of chronic pain. The MDS indicated R3 had received scheduled pain medication with opioid pain	F 755	F755 – Pharmacy Srvcs/Procedures/Pharmacist/Records This plan of correction constitutes Annandale Care Center's written compliance for the deficiencies cited. However, the submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1) How corrective action will be accomplished for those residents found to be affected: It is the policy of Annandale Care Center that all controlled substances are used in compliance with all governing bodies. The policies in place were revised to ensure the facility's compliance with these regulations. Formal audits and controls were implemented as of 2/3/2021. 2) How to identify other residents having the potential to be affected by the same practice: On 2/3/2021, an audit was conducted for the month of January, 2021 including comparison of signatures in the narcotic log book with the annual signature verification form, verification that all wasting or destruction of controlled substances had a cosigner, identification of any unusual patterns by any single staff person, analysis to determine if any specific nurse was administering more PRN controlled medications than when	

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 01/06/2021

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 755	Continued From page 12 medication administered daily. R4's quarterly MDS dated 10/10/20, identified R4 had moderate cognitive impairment with diagnosis of Alzheimer's dementia, arthritis, and chronic pain syndrome. The MDS indicated R4 had received scheduled and as needed pain medication with antianxiety and opioid pain medication administered daily. R5's admission MDS dated 8/18/20, identified R5 had intact cognition with diagnosis of vertebrae (spinal bone) fracture and low back pain. The MDS indicated R5 had received scheduled and as needed pain medication with opioid pain medication administered daily. An initial report was submitted to the SA on 11/5/20, at 8:15 p.m. by the director of nursing (DON). The incident report identified an allegation that licensed practical nurse (LPN)-C had possibly documented forged signatures of other nursing staff members when she had destroyed narcotic medications belonging to R1 and R4 after the narcotic "had been dropped or popped out of card." Subsequent incident reports were submitted to the SA on 11/6/20, at 2:14 p.m., 2:22 p.m., 2:29 p.m., and 2:37 p.m. respectively by the DON. The incident reports identified the SA had directed the facility to submit a separate report for each involved resident. In addition, the four incident reports identified an allegation of "probable drug diversion" of R1, R2, R3, and R5's narcotic medication by LPN-C. Follow up incident investigation reports submitted to the SA on 11/12/20, for R1, R2, R3, and R4 all	F 755	compared to other nurses and verification that narcotics signed out of the narcotic log book were also documented in the electronic health record. Audit results were all consistent with expected standards of practice and in accordance with facility policies and procedures. 3) Measures put into place or systemic changes made to ensure practice will not recur: The Controlled-Narcotic Medication, Destruction of Medication, Emergency Medication Kit, and the Medication Administration policies were revised to ensure compliance. As of February 12, 2021, education will have been completed for all licensed nursing staff and trained medication aides on the revised Drug Diversion, Administration and Documentation of Controlled Medication, Destruction of Controlled Medication and Drug Diversion policies. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system: Nursing leadership will conduct weekly audits for 4 weeks and monthly thereafter until 100% compliance is achieved to ensure medication policies are followed and the facility is maintaining compliance with all regulations. The audit log results will be submitted to the QA Committee for review to determine that compliance continues to be achieved and approve discontinuation of monthly audits.	

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 01/06/2021

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 755	Continued From page 13	F 755	5) The date deficiency will be corrected: 2/12/2021	

indicated, "On 11/3/20 it was brought to the DON's attention that some nurses felt [LPN-C] may be diverting narcotics by wasting the medication and saying it was dropped or taken from the wrong card." Further, the report identified, "On the morning of 11/4/20, 3 nurses came to see the DON saying they had been looking at the narcotic log book, and felt signatures may have been forged as a cosigner for wasted medication. A few nurses adamantly said some of the signatures were not theirs and a couple of wastes had no cosigner at all." In addition, the report identified after the completed investigation process there had been a policy and procedure change which indicated the facility would perform routine audits of the narcotic log and electronic medical records for any irregularities or discrepancies, along with verifying nursing staff and trained medication aide signatures upon hire with annually witnessed leadership reverification thereafter.

LPN-C's employee file indicated a hire date of 6/29/20 and an employment termination date of 11/6/20. LPN-C had been a full time employee with main hours scheduled 2:00 p.m. to 10:30 p.m.

An undated facility provided summary of events indicated a history of alleged narcotic mishandling by LPN-C stated as, "On August 27, 2020 a warning was issued to [LPN-C] as it was found that she was signing narcotics out of the narcotic ledger and not recording them as given to residents. A conference statement was done with [LPN-C] and we followed up with audits."

The undated document additionally included a summary section, dated 11/5/20, identified a

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 01/06/2021

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 755	Continued From page 14	F 755		

more recent audit had been completed which had found [LPN-C] had on multiple occasions signed that narcotics had been wasted due to the medication falling on the floor, having been removed from the wrong card, or in which the medication had "popped" out of the card. These instances had been identified to occur at "higher levels than any other staff nurses."

The facility provided summary audit indicated the narcotic books for wing A and wing B had been audited in which the following had been identified:

- Wing A book indicated seven narcotic destruction entries that ranged from 8/20/20 through 10/24/20 having occurred between the hours of 1:20 p.m. and 10:05 p.m. The audit indicated the destruction of five oxycodone doses belonged to R2 and R3 and two hydromorphone doses having had belonged to R5. The reasons for the medication destruction indicated one dose had fallen on the floor, one dose had popped out of the card, four doses were from the wrong card, and one dose indicated it had been wasted; however, lacked a documented reason. Cosigner information indicated one "illegible" nurse signature and four identified nurse signatures. Two nurses had been identified to indicate their documented cosign on two of the entries had not been theirs and one nurse had been unable to verify an additional entry co-signature as hers.

- Wing B book indicated eight oxycodone destruction entries that ranged from 9/29/20 through 10/31/20 having occurred between the hours of 3:00 p.m. and 12:45 a.m. The oxycodone dosages belonged to R1 and R4. The reasons for the medication destruction indicated three of the doses had been found in the narcotic

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 01/06/2021

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 755	Continued From page 15	F 755		

drawer out of the card, four doses were from the wrong card, and one dose had fallen on the floor. Cosigner information indicated three entries that lacked a cosigner signature and four identified nurse signatures. Two nurses had been identified to indicate their documented cosign on two of the entries had not been theirs and [registered nurse (RN)-A] had been identified to indicate the signature documented on 10/6/20, at 6:00 p.m. had not been her's as she had not worked on that date.

Facility nursing schedule, dated 10/6/20, indicated RN-A had not worked on 10/6/20 at 6:00 p.m.

Individual Narcotic Record sheets for R1, dated 9/26/20 through 11/2/20, indicated R1 had been administered 100 doses of combined scheduled and PRN oxycodone. Further, the sheets identified five entries that indicated LPN-C as the only nurse who had destroyed R1's oxycodone during the time frame.

Medication administration history reports, dated 10/1/20 through 11/30/20, indicated R1 had a physician order (PO) for oxycodone 5mg every four hours (hrs) as needed (PRN) and oxycodone 5mg twice a day before cares for diagnosis of unspecified pain. The October report identified R1 had received 21 doses of the PRN oxycodone in which all 21 doses had been administered by LPN-C. The November report identified R1 had received zero doses of the PRN oxycodone.

An Individual Narcotic Record sheet for R2, dated 9/29/20 through 10/29/20, indicated R2 had been administered 30 doses of PRN oxycodone. Further, the sheets identified one entry that

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 01/06/2021

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 755	Continued From page 16	F 755		

indicated LPN-C as the only nurse who had destroyed R2's oxycodone during the time frame.

Medication administration history reports, dated 10/1/20 through 11/30/20, indicated R2 had a (PO) for oxycodone 5mg every four hrs PRN for diagnosis of unspecified pain. The October report identified R2 had received 29 doses of the PRN oxycodone in which 20 doses were administered by LPN-C and nine doses were administered by other staff. The November report identified R2 had received five doses of the PRN oxycodone from staff other then LPN-C.

Individual Narcotic Record sheets for R3, dated 8/19/20 through 8/25/20 and 10/14/20 through 10/27/20, indicated R3 had been administered 90 doses of combined scheduled and PRN oxycodone. Further, the sheets identified four entries that indicated LPN-C as the only nurse who had destroyed R3's oxycodone during that time frame.

Medication administration history reports, dated 10/1/20 through 11/30/20, indicated R3 had a (PO) for oxycodone 5mg every six hrs PRN and oxycodone 5mg four times a day for diagnosis of pathological lumbar compression fracture. The October report identified R3 had received four doses of the PRN oxycodone in which all four doses had been administered by LPN-C. The November report identified R3 had received one dose of the PRN oxycodone from staff other then LPN-C.

An Individual Narcotic Record sheet for R4, dated 8/27/20 through 11/4/20, indicated R4 had been administered 16 doses of PRN oxycodone. Further, the sheets identified three entries that

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 01/06/2021

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 755	Continued From page 17	F 755		

indicated LPN-C as the only nurse who had destroyed R4's oxycodone during the time frame.

Medication administration history reports, dated 10/1/20 through 11/30/20, indicated R4 had a (PO) for oxycodone 5mg every four hrs PRN for diagnosis of unspecified pain. The October report identified R4 had received nine doses of the PRN oxycodone in which seven doses were administered by LPN-C and two doses were administered by other staff. The report identified R4 had received four doses of the PRN oxycodone in which one dose had been administered by LPN-C on 11/4/20.

Individual Narcotic Record sheets for R5, dated 8/18/20 through 9/5/20, indicated R5 had been administered 59 doses of PRN hydromorphone. Further, the sheets identified the dosing of the hydromorphone to be 4mg every 4 hrs as needed.. In addition, the sheets identified two entries that indicated LPN-C as the only nurse who had destroyed R5's hydromorphone during the time frame.

Medication administration history reports for October and November 2020 were not available for R5 due to R5's discharge from the facility on 9/23/20.

During interview on 1/4/21, at 1:38 p.m. RN-A stated it was required that after she administered a controlled or narcotic medication she had to document the administration in both the resident's electronic medication administration record (eMAR) and in the medication cart narcotic book. RN-A explained it was required when she destroyed a controlled or narcotic medication she had to document the destruction in the

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 01/06/2021

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 755	Continued From page 18	F 755		

medication cart narcotic book and on two additional designated forms located in the RN office's locked closet that housed the MedSafe medication destruction container. Further, RN-A explained it was required practice that two staff had to document and witness the controlled or narcotic medication destruction. RN-A stated she had verified to facility administration and the local police department that some of the documented cosign signatures identified as potentially her's in the narcotic book had not been signed by her.

When interviewed on 1/4/21, at 1:50 p.m. LPN-A stated not too long after LPN-C had started working for the facility she had noticed during her own medication administration passes that it appeared as if LPN-C "gave more narcotics to residents then they typically took when other nurses worked." Further, LPN-A explained she would often find LPN-C had signed narcotics out in the narcotic book but did not sign the same narcotic out in the eMAR. LPN-A explained at the time administration had been updated about her concerns. LPN-A stated it was required to have two staff involved in the destruction of any controlled medication.

During interview on 1/4/21, at 4:20 p.m. the DON stated her expectation would be that any controlled medication was to be documented in both the eMAR and the medication cart narcotic book. Further, the DON explained her expectations regarding controlled medication destruction would be that the process should be documented in the narcotic book as to why the destruction was required and that the actual destruction process step was witnessed by two staff. The DON voiced that LPN-C had not performed these expectations consistently and

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 01/06/2021

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 755	Continued From page 19	F 755		

back in August of 2020 when she had questioned LPN-C, she "would give excuses." The DON stated audits at that time had been completed regarding LPN-C's narcotic administration and documentation practices in which the audits had shown improvements and "no major concerns." No further audits had been completed that pertained to LPN-C's medication administration performance. The DON voiced she had not had knowledge of any further concerns regarding LPN-C's controlled medication documentation and destruction practices until LPN-D had updated her in November of 2020 on concerns she had regarding LPN-C. The DON explained during staff interviews staff had voiced confirmation that some of the cosigned signatures had not been theirs. In addition, the DON explained she had not felt any resident had missed any scheduled medication dose/s in relation to LPN-C's actions of potential controlled medication theft; however, the DON did voice the financial impact to the residents had been a concern. The DON stated facility practice had been for the night nurse to do audits that watched for discrepancies and further explained this had been the reason LPN-D "brought the issues to light."

During a telephone interview on 1/5/21, at 12:47 p.m. LPN-C confirmed she had access to resident controlled medications during her employment and she further confirmed she had knowledge of the facility's policy for narcotic medication documentation and destruction procedures. LPN-C explained after she had administered a controlled medication she documented the administration in the resident's eMAR and in the narcotic book and then when she destroyed a narcotic medication this process

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 01/06/2021

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 755	Continued From page 20	F 755		

had required two staff. LPN-C voiced there had been occasions where documentation had been missed due to "the computer system was bad" or she had gotten busy and would forget to sign out the administered medications in the eMAR. LPN-C denied resident medication theft practices and stated that she has not used drugs recreationally.

During a telephone interview on 1/5/21, at 1:42 p.m. LPN-D stated she had felt "something was off" when she and LPN-C had performed a shift change controlled medication count. LPN-D voiced she had been unable to remember the exact date of this count with LPN-C. LPN-D explained she noticed in the narcotic book that a pill had been destroyed the day before by LPN-C with an indicated reason that it had fell out of the card. LPN-D stated LPN-C had explained she had destroyed the medication with another staff member; however, LPN-D could not recall the nurse that LPN-C had indicated. In addition, LPN-D voiced she had again questioned another narcotic destruction entry completed by LPN-C during the following day's evening shift count in which LPN-C had again stated she had destroyed the medication due to something had been wrong with the card. LPN-D stated she had reported her suspicions to the DON the following morning after that second shift count with LPN-C.

Formal night shift narcotic and controlled medication audits performed prior to the allegation were not provided.

A policy Medication Destruction, revised 11/19, indicated medications were to be destroyed in a safe, efficient manner consistent with established facility procedures and DEA requirements in

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 01/06/2021

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 755	Continued From page 21	F 755		

which two nurses were to perform and witness the destruction of controlled medications/narcotics and schedule II-V medications. The policy failed to identify steps and/or processes the facility took to decrease the risk of drug diversion above and beyond general shift to shift narcotic counting and the policy further failed to direct staff on potential signs of drug diversion and how to identify drug diversion indicators.

A policy Controlled/Narcotic Medications, reviewed 3/20, indicated the procedure in the event a controlled drug dose had become broken, partially used, discarded or lost required the nurse to record the dose on the narcotic book page, the nurse and another nurse would co-sign the proof of use sheet (narcotic book page), and the medication would be placed in the MedSafe for destruction. The policy failed to identify steps and/or processes the facility took to decrease the risk of drug diversion above and beyond general shift to shift narcotic counting and the policy further failed to direct staff on potential signs of drug diversion and how to identify drug diversion indicators.

A policy Administration of Medications, revised 3/5/19, indicated six rights of medication administration staff were to follow when medications were administered. The sixth right identified pertained to the right documentation in which staff were to, "Promptly and accurately document the medication administration." The policy further indicated, "After each medication is administered, document each medication in the correct box in the MAR (medication administration record), " and to, "Ensure accurate documentation of all medications." The policy

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 01/06/2021

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 755	Continued From page 22 failed to identify steps and/or processes the facility took to decrease the risk of drug diversion above and beyond general shift to shift narcotic counting and the policy further failed to direct staff on potential signs of drug diversion and how to identify drug diversion indicators.	F 755		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		2/12/21

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 01/06/2021

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 880	Continued From page 23 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure all staff entering the facility were completing COVID screening prior to	F 880	F880- Infection Prevention & Control 1) How corrective action will be	

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 01/06/2021

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 880	Continued From page 24 entering resident care area for the prevention and potential transmission of COVID-19. This had the potential to affect all 29 residents currently residing in the facility at the time of the COVID-19 focused survey. Findings include: On 1/04/21, at 11:00 a.m. the survey team entered the facility via the building's locked main entrance. Surveyors completed a COVID-19 symptom and screening questionnaire, reviewed by a facility' employee after. A facility employee took temperatures, assured eye protection and masks were in place, and hand hygiene was performed before allowing surveyors entrance to the facility. During the entrance conference on 1/04/21, at 11:20 a.m. the director of nursing (DON) stated the facility had 7 confirmed cases (1 currently in the hospital) of COVID-19. During interview on 1/04/21, at 11:52 a.m. licensed practical nurse (LPN)-A stated all employees enter through the back door employee entrance. LPN-A stated staff are to perform hand hygiene, put on their mask and face shield and fill out the questionnaire before entering the facility. LPN-A then stated that another staff person is to verify the information is correction and the form is completed. On 1/04/21, at 12:00 p.m. the employee entrance was observed. There were designated area for staff to complete hand hygiene along with an area to store individualized face shields and masks and complete questionnaires on a clipboard A review of the facilities Annandale Health and Community Services Employee COVID-19	F 880	accomplished for those residents found to be affected: It is the policy of Annandale Care Center that all potential risks of communicable disease transmission be monitored and controlled to prevent the spread of these types of diseases. The Daily Staff Screening during COVID procedure ensures this standard is met each day at the facility. A meeting of the QA Committee was convened on 02/09/2021 to conduct a RCA and develop a plan of correction. All staff will be retrained in the process of self-screening and made even more aware of the importance of fully completing all steps of the self-screening procedure as of 02/12/2021. 2) How to identify other residents having the potential to be affected by the same practice: Daily audits of the Staff Self-Screening Sheets have been conducted since 2/1/2021 to ensure compliance with the staff screening requirements. Daily audits confirm the screenings are being completed per policy and the facility is remaining in compliance. 3) Measures put into place or systemic changes made to ensure practice will not recur: In addition to the retraining of all staff on the self-screening process and the importance of completing all steps per policy, a new policy and procedure for 3x/day monitoring of the self-screening sheets by designated nursing staff during	

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 01/06/2021

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 880	Continued From page 25 Screening sheets, indicated NA-B worked on 11/26/20. The screening documented NA-A had a temperature (temp) of 96.0 Fahrenheit (F). Even though there was a documented staff screener signature to verify NA-B completed the form, the section of whether NA-B has signs/symptoms (S/S), this column was blank. A review of the facilities Annandale Health and Community Services Employee COVID-19 Screening sheets, from 11/26/20 - 11/29/20, for NA-B the following was documented: > 11/26/20 - temp 96.0 F, s/s area was blank > 11/27/20 - temp 96.9 F, s/s area was blank > 11/29/20 - temp 97.1 F, s/s area was blank > 11/29/20 - there was no evidence of NA-B being screened. In a further review of the facilities Annandale Health and Community Services Employee COVID-19 Screening sheets, from 11/26/20 - 11/30/20, indicated that there was a total of eight (8) employees who had their screening process verified, lacking documention of whether they had s/s of COVID-19. During an interview on 1/04/21, at 3:48 p.m. the director of nursing (DON) after review of the facility's COVID staff screening sheets, the DON stated "it appears we have an issue with staff completing them." DON stated that the facility had a "informal" process, having the nurses checking the screening sheets as a third check for staff documentation. Don stated that the nurses had been educated to review the screening sheets for completion each shift. However, this appears this is not being done.	F 880	shift change was implemented as of 2/5/2021. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system: Effective 02/08/21, ongoing compliance audits will be conducted by the Director of Nurses, Infection Preventionist or Administrator of all shifts starting with 4x/week for one week, twice weekly for one week and continue twice weekly until 100% compliance is consistently being achieved. Any discrepancies identified by monitoring of the self-screening sheets at shift change will be addressed with the staff member immediately. Staff member who didn't complete the self-screening per policy will be pulled from the schedule immediately and screened for signs/symptoms of COVID19. If none are determined, staff member will be issued a verbal warning and retrained on the staff self-screening process as well as informed that any additional violations of this policy could result in further disciplinary action including and up to immediate termination. Audit results will be submitted to the QA Committee for final review to determine that compliance continues to be achieved. 5) The date deficiency will be corrected: This deficiency has been corrected as of 2/12/2021.	

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 01/06/2021

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 880	Continued From page 26 An interview 1/04/21, at 4:46 p.m. LPN-B also stated that staff need to screen themselves with a witness of another staff member. However, LPN-B was unaware that nurses were to check the screening sheets for completion by staff. LPN-B stated "maybe the registered nurses do that." A review of the CDC's guidance, entitled: Criteria for Return to Work for Healthcare Personnel with Suspected for Confirmed COVID-19 (Interim Guidance) indicated the following: "Time-Based Strategy. Exclude from work until: 10 days have passed since the date of their first positive (COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test." A review of the facility's policy, entitled: Annandale Care Center COVID-19: Infection Prevention & Control (last reviewed 12/2020) indicated that "All residents and staff will be tested if symptomatic" and went on to list the signs and symptoms the facility will screen their employees for.	F 880		

Electronically delivered
January 28, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: RL3511

Dear Administrator:

The above facility was surveyed on January 4, 2021 through January 6, 2021 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.

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:

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/06/2021

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: On 1/4/21 - 1/6/21, an abbreviated survey was completed at your facility to conduct a complaint investigations. Your facility was found to be NOT in compliance with MN State Licensure. The following complaint was found to be SUBSTANTIATED:	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 01/06/2021

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 H5364035C H5364038C The following complaints were found to be UNSUBSTANTIATED: H5364037C However, as a result of the investigation state licensing orders were issued.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure all staff entering the facility were completing COVID screening prior to entering resident care area for the prevention and potential transmission of COVID-19. This had the potential to affect all 29 residents currently residing in the facility at the time of the COVID-19 focused survey. Findings include: On 1/04/21, at 11:00 a.m. the survey team entered the facility via the building's locked main entrance. Surveyors completed a COVID-19 symptom and screening questionnaire, reviewed by a facility' employee after. A facility employee took temperatures, assured eye protection and masks were in place, and hand hygiene was	21375	CORRECTED	2/12/21

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 01/06/2021

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
21375	Continued From page 2	21375		

performed before allowing surveyors entrance to the facility. During the entrance conference on 1/04/21, at 11:20 a.m. the director of nursing (DON) stated the facility had 7 confirmed cases (1 currently in the hospital) of COVID-19.

During interview on 1/04/21, at 11:52 a.m. licensed practical nurse (LPN)-A stated all employees enter through the back door employee entrance. LPN-A stated staff are to perform hand hygiene, put on their mask and face shield and fill out the questionnaire before entering the facility. LPN-A then stated that another staff person is to verify the information is correction and the form is completed.

On 1/04/21, at 12:00 p.m. the employee entrance was observed. There were designated area for staff to complete hand hygiene along with an area to store individualized face shields and masks and complete questionnaires on a clipboard

A review of the facilities Annandale Health and Community Services Employee COVID-19 Screening sheets, indicated NA-B worked on 11/26/20. The screening documented NA-A had a temperature (temp) of 96.0 Fahrenheit (F). Even though there was a documented staff screener signature to verify NA-B completed the form, the section of whether NA-B has signs/symptoms (S/S), this column was blank.

A review of the facilities Annandale Health and Community Services Employee COVID-19 Screening sheets, from 11/26/20 - 11/29/20, for NA-B the following was documented:

> 11/26/20 - temp 96.0 F, s/s area was blank
> 11/27/20 - temp 96.9 F, s/s area was blank
> 11/29/20 - temp 97.1 F, s/s area was blank

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 01/06/2021

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
21375	Continued From page 3 > 11/29/20 - there was no evidence of NA-B being screened. In a further review of the facilities Annandale Health and Community Services Employee COVID-19 Screening sheets, from 11/26/20 - 11/30/20, indicated that there was a total of eight (8) employees who had their screening process verified, lacking documention of whether they had s/s of COVID-19. During an interview on 1/04/21, at 3:48 p.m. the director of nursing (DON) after review of the facility's COVID staff screening sheets, the DON stated "it appears we have an issue with staff completing them." DON stated that the facility had a "informal" process, having the nurses checking the screening sheets as a third check for staff documentation. Don stated that the nurses had been educated to review the screening sheets for completion each shift. However, this appears this is not being done. An interview 1/04/21, at 4:46 p.m. LPN-B also stated that staff need to screen themselves with a witness of another staff member. However, LPN-B was unaware that nurses were to check the screening sheets for completion by staff. LPN-B stated "maybe the registered nurses do that." A review of the CDC's guidance, entitled: Criteria for Return to Work for Healthcare Personnel with Suspected for Confirmed COVID-19 (Interim Guidance) indicated the following: "Time-Based Strategy. Exclude from work until: 10 days have passed since the date of their first positive (COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test."	21375		

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 01/06/2021

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
21375	Continued From page 4 A review of the facility's policy, entitled: Annandale Care Center COVID-19: Infection Prevention & Control (last reviewed 12/2020) indicated that "All residents and staff will be tested if symptomatic" and went on to list the signs and symptoms the facility will screen their employees for. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program, including daily cumulative tracking and trending of all illnesses in the facility, immediate implementation of droplet precautions to mitigate COVID-19 transmission, ensure the appropriate use of PPE and that staff are prevented from working with symptoms of COVID-19, and that cares are being performed appropriately and timely. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
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	21980		2/5/21

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 01/06/2021

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 5	21980		

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 another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(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

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 01/06/2021

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 6 (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 document review, the facility failed to ensure a background check was obtained and verified prior to allowing unsupervised access to residents for 2 of 13 employees reviewed as part of a background check sample following an investigation of a narcotic medication theft involving a staff member (See F755). Findings include: On 1/4/21, licensed practical nurse (LPN)-C's employee file lacked evidence a background study had been obtained and verified upon hire or during her employment at the facility. In addition, LPN-C's file lacked evidence of an Annandale Care Center - Hiring Packet Checklist. LPN-C's employee file indicated she had been hired on 6/19/20, with a start date of 6/22/20, and had been terminated on 11/6/20. The facility was asked to provide documentation of LPN-C background study, but no additional documents were provided. A requested Employee Information report dated 1/5/21, at 3:33 p.m. identified DA-B had been hired on 9/1/20 and was an active dietary employee. Dietary aide (DA)-B's background check indicated it had been performed on 1/5/21, with no evidence a background check had been submitted previously. When interviewed via telephone on 1/5/21, at	21980	CORRECTED	

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 01/06/2021

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 7 1:56 p.m. the director of nursing (DON) stated facility staff were unable to find LPN-C's background study. The DON voiced the facility had contacted the Minnesota (MN) Department of Human Services (DHS); however, she explained MN DHS had been unable to provide them with proof that a background check had been initiated. The DON stated human resources (HR) had been responsible for completing LPN-C's background study upon LPN-C's hire. The DON explained this HR staff member was no longer employed at the facility; however, an HR staff member was in the process of being trained. The DON denied the facility had reviewed employee files to ensure each employee had a background study obtained and verified after the HR member left her employment. The DON stated LPN-C's lack of a background study had appeared to be an isolated incident. During a telephone interview on 1/5/21, at 3: 57 p.m. the administrator stated the facility performed a digital check list to ensure items were completed for new employees, which included a background check. When questioned on LPN-C's digital check list, the administrator stated, "We found the form but did not actually do the check." When interviewed via telephone on 1/6/21, at 12:38 p.m. HR-A stated her typical practice had been to perform the background check with the employee present. HR-A stated she could not say with 100 percent accuracy that she had completed LPN-C's background check; however, she verbalized that she felt it had been done. HR-A explained for background check auditing the facility had used an electronic form; however, she stated she had relied a lot on the emails that came from DHS "as once it was in the system it	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 01/06/2021

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 8 would generate what was going on." During a follow-up telephone interview on 1/6/21, at 1:46 p.m. the administrator stated DA-B's background study had been missed potentially due to, "Dietary thought HR was doing it and HR thought dietary was doing it." The administrator explained she felt, "It [DA-B's background study] slipped through the cracks and no one knew who was supposed to do it." The administrator stated employee background studies are very important and have to be done to keep residents safe. A policy Annandale Health & Community Services' Facility Abuse Prevention Plan, dated 8/1/05, indicated, "All employees will have a background check initiated at hire. Potential employees will be screened for a history of abuse, neglect or mistreating residents. This includes checking with the appropriate licensing boards and registries. If a background study is pending, staff will follow the recommendations of the background study for needed supervision." A policy Background Study, reviewed 1/2020, indicated that newly hired employees completed a background study through MN DHS prior to their first day of work. The policy identified the employee met with the HR manager or delegate to complete the background study together and that the HR manager or delegate followed up with the employee prior to the first day of work to ensure the entire process had been completed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of drug diversion by nursing staff. The facility should re-educate staff identified in the citation to policies and procedures, and	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 01/06/2021

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 9 audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		