STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	03/05/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure assessed interventions to reduce the risk of pressure ulcer formation were implemented for 1 of 1 residents (R37) reviewed for pressure ulcer care. Findings include: R37's quarterly Minimum Data Set (MDS), dated [DATE], identified R37 was cognitively intact and required extensive assistance to completed their activities of daily living (ADLs). Further, R37 was at risk for pressure ulcers and had one (1) unhealed stage 2 pressure ulcer, and had been formally and clinically assessed. R37's care plan, dated [DATE], identified R37 had a stage III pressure ulcer on (right) lateral malleolus (a bony projection on either side of the ankle) and listed a goal which read, Pressure ulcer will be healed by 5/18/2020. A series of interventions were listed to help R37 meet this goal which included, Pillow placed under right foot to float while in bed. In addition, an undated, provided nursing assistant care sheet listed R37 with an intervention which read, Float Heels. On 3/4/20, at 9:34 a.m. R37 was observed laying in bed. R37's heels were not floated with any visible devices or pillows and R37 had shoes on. At 10:48 a.m. (over an hour later), R37 remained in bed without their heels float and their shoes remained on. During interview on 3/04/20, at 10:50 a.m. nursing assistant (NA)-A stated R37 had been in bed since returning from breakfast around 9:00 a.m. NA-A acknowledged the lack of a pillow under R37's heels and stated it appeared to have been forgotten. Further, R37 will often refuse to have his shoes removed when in bed. On 3/05/20, at 9:06 a.m. registered nurse (RN)-A was interviewed and stated R37 should not have his shoes on while in bed and his heels should have been floated. R37 was dependant on staff for repositioning, and floating his heels was done to help prevent the development of pressure ulcers on his heels. The facility policy for pressure ulcer assessment and prevention was requested, however not provided.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively reassess and implement a process to ensure consumed fluids were adequately tracked and monitored to help prevent fluid overload for 1 of 1 residents (R3) reviewed who had an ordered fluid restriction. Findings include: R3's quarterly Minimum Data Set (MDS), dated [DATE], identified R8 had moderate cognitive impairment and was independent with eating after set up. Further, R3 had several medical [DIAGNOSES REDACTED]. R3's Nutritional Assessment, dated 12/9/19, identified R3 consumed a reduced calorie, regular texture diet with small portions. R3's fluid intake was identified as 1500-2000 cc's (cubic centimenters) a day and R3 was labeled as being at high risk for nutrition. Further, R3's Hydration Assessment was completed on 12/3/19, and identified R3 was independent with fluid consumption. On 3/220, at 7:48 p.m. R3 was observed sitting in her wheelchair with her feet flat on the floor. R3's feet and legs had visible swelling and R3 expressed she should probably have them elevated. R3 explained she had kidney problems and should likely be on [MEDICAL TREATMENT] (a process which removes excess fluid and toxins from the blood for people with kidney failure). R3 expressed she consumed swelling pills to reduce her fluid build-up, however, then voiced frustration as they (staff) won't let me have what I want to drink and proceeded to pick up a water mug from her bedside table which was empty to accentuate the point. R3's Emergency Department (ED) report, dated 2/25/20, identified R3 had been seen in the ED with severe underlying [MEDICAL CONDITION] (low heart rate of less than normal adult heart rate of 60 beats per minute) with a heart rate in the 40's. R3 was listed as receiving a daily dose of [MEDICATION NAME] (a diuretic medication) and R3 was kept in the ED under observation with several [DIAGNOSES REDACTED]. R3 returned to the nursing home on [DATE], with orders for a fluid restriction not to exceed 2000 ml (milliliters) in a day. R3's care plan, last revised 3/2/20, indicated R3 received a reduced calorie diet, and made poor choices with excessive use of salt on foods. R3 was to receive 1440 cc's from dietary per day, and was allowed 560 cc's from nursing staff per day (to total 2000 cc's per day). R3 was listed as being at risk of dehydration and directed staff to encourage fluids at meals and in between and continued, Independent with meals and fluids between meals. R3's medical record was reviewed and lacked evidence R3 had been comprehensively reassessed for their nutritional and hydration needs, including R3's input, despite having to present at the ED and being ordered with a fluid restriction. Further, there was no evidence in the medical record R3's total fluid intake (consumed with meals and in-between meals) was consistently tracked and monitored to ensure the ordered fluid restriction was not breached increasing R3's risk for fluid overload. On 3/5/20, at 1:35 p.m. licensed practical nurse (LPN)-A stated she was unaware how the fluid intake was tracked for R3. LPN-A stated R3 was able to request water or fluids, if she wished, however, again reiterated she was unsure as to how all consumed fluids were tracked for R3. On 3/5/20, at 1:39 p.m registered nurse (RN)-C stated a plan was identified to let staff know the amount of fluids R3 could have between meals, however, staff did not track R3's actual intake of fluid outside of meals. RN-C stated R3's intake at meals was monitored by the dietary staff, however, this would not accurately reflect her total daily intake. On 3/5/20, at 1:47 p.m. NA-B stated R3 can have whatever fluids were allowed on the care plan. A review of the current NAR (Nursing Assistant-Registered) Daily Assignment Sheet B Wing dated 3/4/20, lacked any indication of a fluid restriction, and only identified No Orange juice d/t (due to)diarrhea. NA-B stated they thought R3's fluids from nursing staff were tracked in the Medication Administration Record [REDACTED]. A facility Intake and Output policy dated 12/19, identified intake and output may be recorded for residents who may be on fluid restrictions. The policy identified all fluids are to be recorded at the end of the shift. The policy indicated the provider, dietary staff, and care plan was to be updated as indicated.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure [MED] was labeled with current administration orders to reduce the risk of error for 1 of 2 residents (R40) observed to receive [MED] during the survey. Further, the facility failed to ensure a multi-dose vial of [MEDICATION NAME] solution was dated when opened to reduce the risk of administration after expiration. This had potential to affect 47 of 47 existing residents and future new admissions who could be provided the remaining, potentially expired solution. Findings include: INSULIN: On [DATE], at 7:50 a.m. licensed practical nurse (LPN)-A was observed preparing [MEDICATION NAME] administration for R40 using a [MEDICATION NAME] Flex Pen which was dated as opened on [DATE]. The [MED] labeled directed to provide R40 with 77 units of the medication, however, LPN-A stated the medication administration record (MAR) directed to provide 80 units of the medication. LPN-A explained the staff had been directed to go by the MAR directions versus the label if a discrepancy was found. Further, LPN-A stated the [MED] label should have had a sticker affixed to it which directed staff to a change in orders, however, LPN-A stated she was unaware who was responsible to ensure the sticker was attached. R40's Physician order [REDACTED]. When

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) interviewed on [DATE], at 2:44 p.m. registered nurse (RN)-D stated the pharmacy had dispensed several [MED] pens for R40 and the orders had since changed. RN-D stated the labels should have been amended to reflect the change in physician orders [REDACTED]. [MEDICATION NAME]: A PAR Pharmaceutical [MEDICATION NAME] manufacturer insert, dated ,[DATE], identified the solution was used for intradermal injection(s) to help determine the presence of [MEDICAL CONDITION] (an infectious agent). The insert provided storage instructions for the medications including bold lettering describing, Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. On [DATE], at 1:46 p.m. a medication room tour was completed with licensed practical nurse (LPN)-A present. The refrigerator was opened and a single, opened vial of [MEDICATION NAME] was found. The vial had no plastic cover present along with visible solution inside with approximately 8 doses left. The vial label identified the product had been dispensed from the pharmacy on [DATE], however, neither the label of the vial nor the package had any visible dates written on them which identified when the vial was opened or due to expire. LPN-A verified these findings and stated they were unsure how long the vial was good for after it was opened. When interviewed on [DATE], at 1:56 p.m. registered nurse (RN)-B stated all medication vials and bottles were to be dated when opened to ensure expired medication was not given. RN-B stated [MEDICATION NAME] was good for 30 days after being opened. A provided Administration of Medications and Treatments policy, revised ,[DATE], identified staff were to compare the prescription label with the MAR and verify the correct resident was being given the medications. Further, the policy directed a, Direction Change Refer to Med Sheet, should be placed on labels if the orders change and the pharmacy should be notified. Additionally, the policy also identified under Other Considerations, staff were to either check with pharmacy for any other meds which needed to be dated when opened, or date all meds when opened.