

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER Annandale Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to comprehensively assess environmental hazards and/or ensure the environment was free from accident hazards for 1 of 3 residents (R1) reviewed for falls. The facility's failures caused actual harm when R1 tripped and fell on a mechanical lift which resulted R1 suffering multiple rib fractures with hemothorax, unstable T11 fracture, and a large laceration to her elbow.</p> <p>Findings include:</p> <p>R1's admission Record dated 4/17/24, identified R1's diagnoses included dementia with other behavioral disturbance, Hospice care, muscle weakness, unsteady gait, impaired safety awareness, and history of falls.</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], R1 required limited assistance for activities of daily living (ADLs), and mobility and had severe cognitive impairment.</p> <p>R1's care plan initiated 4/1/25, indicated R1 had a history of falls, impaired safety awareness, and unsteady gait. Staff interventions included providing assistance with mobility/ADLs.</p> <p>R1's fall risk assessment completed 4/1/25, indicated R1 is a high risk for falls related to muscle weakness, cognitive impairment, unsteady gait, and impaired safety awareness.</p> <p>R1's progress note dated 5/20/25 at 10:50 p.m. indicated R1 appeared to trip on a mechanical lift parked against a wall outside of her room as she turned the corner out of her room with her walker, attempting to ambulate independently. The note indicated R1 fell on her left side sustaining a large skin tear to her elbow, upper arm, and part of forearm with left side. R1 complained about ribs pain.</p> <p>R1's emergency department (ED) note dated 5/20/25 at 11:47 p.m. indicated R1 presented to ED for ground level fall with trauma, multiple or serious injuries. The note stated exam revealed laceration of left elbow, which was not amenable to repair, chest wall tenderness and left sided rib fractures.</p> <p>R1's progress note dated 5/21/25 at 2:21 a.m., indicated R1 was admitted at the hospital with multiple ribs fracture to her left side, hemothorax (a condition where blood accumulates in the space between the lung and the chest wall) to her right side and an unstable spinal fracture to T11.</p> <p>(continued on next page)</p>

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.

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

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/17/25 at 10:51 a.m., a family member (FM)-A stated she turned and saw R1 when she was falling down just outside her room. FM-A stated R1 had a walker, and her back hit part of the mechanical lift parked a foot or two from her doorway against the wall.</p> <p>During an interview on 6/17/25 at 11:09 a.m., FM-B stated R1 walked right outside of her room and her walker got caught by the mechanical lift parked right outside her room against the wall a foot from her doorway when she fell on the lift.</p> <p>During an interview on 6/17/25 at 12:52 p.m., nursing assistant (NA)-D stated she witnessed R1's fall and stated R1 landed with her left side on the mechanical lift which was one or two feet from her doorway. NA-D stated nursing staff did not have a designated spot to park the lifts and she did not recall receiving any education about environmental safety hazards.</p> <p>During an interview on 6/17/25 at 2:54 p.m., licensed practical nurse (LPN)-A stated on 5/20/25 R1 fell on the legs of the mechanical lift with her left side and started bleeding heavily. LPN-A stated R1 was one person assist with mobility and supervision. LPN-A did not recall receiving any education about environmental safety hazards after the incident.</p> <p>During an observation on 6/16/2025 11:37 a.m., a mechanical lift was observed parked against the wall less than a foot just outside of R5's doorway. During continuous observation, another mechanical lift was parked against the wall of R4's room with two wheels visible in R4's doorway. At 11:45 a.m., an unknown nursing staff member was noted to be in the hallway moving back and forth from the nursing station walking by the lifts.</p> <p>During an interview on 6/16/25 at 1:32 p.m., NA-A stated nursing staff have been trained on how to use the mechanical lift during their orientation. NA-A stated she was educated to put the mechanical lift on the right side of the hallway, against the wall between residents' rooms during her orientation. NA-A stated she did not receive any education about a designated spot to park the mechanical lifts. NA-A stated nursing staff had to use their own judgment to put the lift in the middle against the wall to prevent any accident. NA-A did not identify the lift parked against the walls in the hallway as a safety and/or tripping hazard.</p> <p>During an interview on 6/16/25 at 2:17 p.m., NA-B indicated sometime between new employee orientation but before R1's accident, she was trained only to park the mechanical lift on the right side of the hallway against the wall facing one way. That training did not address any specific spot the lifts should park other than the right side of the hallway. NA-B explained after R1's fall nursing staff did not receive any education pertaining to the storage of lifts and/or where in the hallway they should be parked and did not identify the lifts in the hallway a safety hazard for residents.</p> <p>During an interview on 6/17/25 at 10:23 a.m., NA-C stated she was directed to put the mechanical lift locked against the wall on the right side, using common sense not to put it on the resident's doorway. NA-C stated she did not receive any environmental safety hazard education recently.</p> <p>During an interview on 6/16/25 at 4:10 p.m., LPN-A stated nursing staff were supposed to park the mechanical lift on the right side of the hallway against the wall without blocking or inside the egress of the resident's doorway. LPN-A stated night shift should put them in the tub room if they were not using them, but nurses have to use their own judgment about putting the lift on the hallway.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/17/25 at 10:43 a.m., LPN-B stated they did not have a specific spot to put the mechanical lift as long as it was not blocking the doorway. LPN-B stated she did not recall receiving any environmental safety hazard education recently.</p> <p>During an interview on 6/17/25 at 9:46 a.m., a registered nurse (RN)-A stated after using the lifts, nursing staff have to put it at a safe location not blocking the hallway. RN-A stated he did not receive any direction about parking the lift at a designated location.</p> <p>During an interview on 6/17/25 at 1:25 p.m., RN-B stated she was responsible for training nursing assistants upon hire and she was part of the safety committee. RN-B stated she did provide training at the facility skills fair last week including how to use the mechanical lift, however she did not provide environmental safety hazard education to the nursing staff recently. Nursing staff were directed to park the mechanical lift on the right side of the hallway against the wall. No specific education pertaining to R1's incident had been provided, and no audits regarding how lifts have been parked properly in the hallway was conducted.</p> <p>During an interview on 6/17/25 at 3:19 p.m., the director of nursing (DON) stated R1 was a high risk for falls and was having increased confusion due to her dementia condition. The interdisciplinary team (IDT) did root cause analysis after the incident but did not consider the placement of the mechanical lift as a contributing factor in the incident. DON stated she did not do anything to address the mechanical lift parked in the hallway as a potential fall hazards or try to figure out a different safe location to store them after its used. DON explained she had not provided any environmental safety hazards education to the staff or audits regarding the residents' ability to safely maneuver around the mechanical lift in the environment for ambulatory residents who independently used assistive devices.</p> <p>During an interview on 6/17/25 at 3:52 p.m., the administrator stated during the IDT meeting they discussed R1's fall incident and determined it was related to R1 increased weakness and confusion but did not consider the lift as contributing factor to her injuries. The administrator stated R1 sustained injuries when she fell on the lift. The administrator stated the facility procedure was to park the mechanical lift on the right side of hallway against the wall because of a lack of storage. The administrator stated they met every morning with IDT and discussed many items including falls and their Quality Assurance and Performance Improvement (QAPI) meeting was scheduled for 6/20/25.</p> <p>The facility Environmental Hazards Policy dated January 2012 and revised in November 2020, indicated the facility shall maintain a safe, clean and orderly interior and directed staff to survey their assigned work area routinely to ensure a properly maintained, safe clean and orderly environment.</p>		