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	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Annandale Care Center Inc	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 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. Based on observation and interview the facility failed to label and properly dispose of expired medications reviewed in 1 of 2 medications carts. This had the potential to 17 out of 34 residents in the facility whose medications were stored in the cart.Findings include:On 8/12/25 at 11:59 during review of the medication cart following a medication pass licensed practical nurse (LPN)-A discovered six bottles of medication with no open dates noted, and two of those six bottles were expired.Photocopies taken on 8/12/2025 at 12:00 p.m. showed the following medications:1. Tylenol 500 milligram (mg) tablets, expired in July of 2025 and lacked an open date.2. Tylenol 500 milligram (mg) tablets, expired in July of 2025 and lacked an open date.3. Tylenol 325mg tablets, lacked an open date.4. Tylenol 500mg tablets, lacked an open date.5. Docusate Sodium 100mg tablets, lacked an open date.6. Senna Time 8.6mg-50mg tablets, lacked an open date.On 8/12/25 at 12:00p.m, LPN-A confirmed all six bottles were not labeled appropriately, and the two Tylenol bottles listed above were expired. LPN-A stated the medication should not be used as the staff had no way to know when the bottle was opened, and some were expired. During the interview, the director of nursing (DON) came into the room and confirmed the two bottles of Tylenol were expired and all six bottles, listed above, were undated and would be destroyed. The DON's expectation was when a resident was admitted to the facility the nurse on duty should check the orders to make sure it was the appropriate medication, check all expiration dates, and put an open date on the bottle. The DON stated the importance of labeling each bottle with open dates for the staff to know how long the medication was ok to be used for, and the importance of not using expired medications as they lose their efficacy once that expiration date has passed.The facility policy Medication storage last revised 7/2025, indicated drug containers with missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing, and the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals.

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