Electronically delivered
February 24, 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 informed you of imposed enforcement remedies.

On February 1, 2021, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effectiveMarch 14, 2021, will remain in effect.

This Department continues to recommend that CMS impose a 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.

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.

As we notified you in our letter of January 28, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 14, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" 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 April 6, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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/ 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 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 02/01/2021

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

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F 000	INITIAL COMMENTS On 1/28/21 - 2/1/21, 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. The following complaint was found to be SUBSTANTIATED: H5364040C (MN00069362) with deficiency issued at F808 H5364041C (MN00069438) H5364042C (MN00060563) H5364044C (MN00058798) The following complaints were found to be UNSUBSTANTIATED: H5364039C (MN00067011) H5364043C (MN00060412) H5364045C (MN00068341) 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 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be	F 808		3/5/21

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

Electronically Signed | 03/02/2021

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F 808	Continued From page 1 prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a physician prescribed mechanically altered diet was provided to 1 of 7 residents (R2) reviewed for theraputics diets. Findings include: R2's significant change Minimum Data Set (MDS), dated 11/14/20, identified R2 had intact cognition; however had a diagnosis of dementia and a traumatic brain injury. The MDS indicated R2 had further diagnosis of dysphagia (difficulty swallowing), gastroesophageal reflux disease (GERD), and chronic obstructive pulmonary disease (COPD). In addition, R5 had been edentulous (no natural teeth), had not shown any possible swallowing issues with current interventions, and ate independently. An RN [registered nurse] Nursing Assessment-Version 3, dated 11/14/20, identified R2 had difficulty swallowing liquids and had impaired swallowing. The assessment indicated R2's "Current diet is nectar thick liquids and pureed textures and crushed medications." A section labeled "ORAL" identified R2 utilized upper and lower dentures. No referrals had been indicated. R2's care plan section labeled Nutritional Status,	F 808	F808 – Therapeutic Diet Prescribed by Physician 1) How corrective action will be accomplished for those residents found to be affected: It is the policy of Annandale Care Center that it will ensure all residents receive their meals according to physician orders in relation to texture and consistency-modified diets. All dietary staff will be retrained Preparing Resident Trays and Accuracy and Quality of Tray Line Service. All dietary and nursing staff will be retrained on the policies for Texture and Consistency-Modified Diets, Mechanical Soft Diets, Puree Diets, Therapeutic Diets and the Tray Passing Policy and Procedure. Retraining of staff will be completed as of 03/05/2021. 2) How to identify other residents having the potential to be affected by the same practice: On 01/22/2021, dietary staff were retrained on the Dietary Tray Passing policy, with emphasis on the fact that they are responsible for delivering the trays to	

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F 808	Continued From page 2 edited on 11/10/20, identified R2 received a pureed texture diet with nectar thick liquids related to dysphagia with an approach that he received this altered diet. R2's abuse prevention care plan, edited on 11/23/20, identified he was vulnerable related to dysphagia with an approach to refer to individual care plan problems, goals, and approaches to minimize the risk of abuse. In addition, the care plan section labeled "ADL [activity of daily living] eating" indicated R2 had been independent with eating, had a history of aspiration, and had been at risk for choking related to dysphagia. A Physician Order Report, dated 1/1/21 - 2/1/21, indicated R2 had a physician prescribed diet that directed staff to provide him with nectar thick liquids, pureed textures, and to offer him snacks between meals. A progress note on 1/22/21, at 1:45 p.m. indicated R2 had been given lunch food that had not been pureed. The progress note identified R2 had been "fine" when the incorrect diet had been discovered; however, R2 had spit out phlegm and experienced pain near his diaphragm 30 minutes after the event. A progress note, recorded on 1/22/21, at 3:10 p.m. indicated R2 had "expelled a chunk of chicken." A progress note on 1/23/21, at 12:20 a.m. indicated R2 had reported discomfort in his chest due to him having consumed the wrong textured food. A completed State agency (SA) submitted follow up investigation, dated 1/27/21, identified the	F 808	the resident and ensuring the tray contents match the diet card. On 02/26/2021, the Dietary Tray Passing policy was split into three separate policies. These policies are now the Tray Passing Policy and Procedure, Accuracy and Quality of Tray Line Service and Preparing Resident Trays in order to also ensure accuracy prior to the trays leaving the kitchen as well as during the delivery process. 3) Measures put into place or systemic changes made to ensure practice will not recur: In addition to the retraining of all dietary and nursing staff on the policies and procedures related to preparing and delivering of resident trays as well as the types of modified texture diets, the Accuracy and Quality of Tray Line Service was implemented on 03/03/2021. 4) How to monitor performance to assure solutions are sustained, that correction is achieved and sustained; implemented, evaluated and integrated into QA system: Effective 03/03/21, ongoing compliance audits will be conducted by the Director of Dietary Services, the Assistant Dietary Manager or their designee to ensure resident trays with texture and consistency-modified diet orders are being prepared and delivered according to policy. Weeks one and two will be one meal per day for 5 days/week. Week three will be one meal per day for 3 days/week. Week four will be one meal per day for 2 days/week until 100%	

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F 808	Continued From page 3 facility's completed investigation into the incident. The report outlined nursing assistant (NA)-C had obtained R2's and another resident's ready to deliver lunch trays from the kitchen and brought them to R2 and the other resident. The process had been for the kitchen staff to label a plate and match it to a tray; however, the diet cards for the plates were not matched to the diet cards on the trays. The facility had discovered a kitchen staff had placed the wrong plate on R2's and the other resident's trays. R2 had received a regular meal which resulted in him having experienced "some pain/discomfort in his diaphragm" and "coughing up phlegm." The report indicated the facility had developed a new tray passing policy after the incident had occurred in which the dietary manager (DM) had reviewed with the employees. In addition, the report indicated no alleged perpetrator (AP) had been identified. The report lacked actions or evidence of a systemic response by the facility to educate all facility staff in regards to food delivery processes that ensured residents were given the correct physician ordered food items at all times of the day. During interview on 1/29/21, at 11:07 a.m. NA-A stated dietary staff brought the meal "trays down on the carts." NA-A explained she checked the meal cards "at times" to ensure the residents received the correct food; however, she voiced she had become "so used to the routine that [she] will not always check" them. NA-A denied she had received any recent education on ensuring residents received the correct food items as ordered by their physicians. When interviewed on 1/29/21, at 11:32 a.m. NA-B stated she "tries to look at" the tray cards before	F 808	compliance is consistently being achieved. Any discrepancies identified by the audits will be addressed with additional policy and procedures changes made if warranted. 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 3/05/2021.	

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F 808	Continued From page 4	F 808		

she passes out meal trays; however, she explained dietary staff "passes the trays now." NA-B denied she had received any recent education on ensuring residents received the correct food items as ordered by their physicians.

During interview on 1/29/21, at approximately 12:15 p.m. cook (C)-A stated the kitchen's process for prepped meal trays relied on a dietary aide listing off a residents name and their associated diet to the staff member. That staff member would then place the correct food items on the plates. C-A explained she had remembered the incident; however, could not remember any real details other than "it was a plate swap" in which the "trays were completely normal just a different plate." C-A stated nursing staff had delivered R2's and the other resident's meal trays that day after the kitchen had prepared them and further explained that in response to the incident dietary staff were now the only staff members who delivered the meal trays as "is is something we should have caught."

When interviewed on 1/29/21, at 12:49 p.m. assistant dietary director (ADD) stated when dietary staff prepped meal trays the dietary assistants would tell the cooks the resident's name, diet, and any other information required. Once the cook finished preparing the plate, they would hand it back to the dietary assistant and the resident's name would again be stated. The dietary assistant finished the process by wrapping the plate and placing it on the tray with the associated diet card. The ADD explained R2 and the other resident's trays had been the last two trays prepped for lunch in which a dietary assistant had wrapped them right away; however, had not placed them on the trays. The ADD had

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F 808	Continued From page 5	F 808		

not known who had placed the plates on the trays prior to NA-C taking the trays and delivering them. The ADD stated after the incident a new policy and procedure had been developed that required only dietary staff to pass resident meal trays. In addition, the ADD stated she had only provided education to dietary staff regarding the new policy and procedure processes. The ADD denied having completed audits to ensure the new policy and procedure had been followed or that residents' meal trays had been prepared per physician orders.

During interview on 1/29/21, at 1:09 p.m. dietary aide (DA)-A stated she had taken the last two lunch meal trays which had belonged to R2 and another resident after the cooks had wrapped the plates so that they "could keep up." DA-A explained about half way down the hall NA-C had approached her and she had agreed to NA-C's offered assistance for NA-C to deliver the trays the rest of the way. DA-A explained dietary staff now passed out the meal trays and set the residents up with the trays so that they could perform a visual check of the trays before they left the resident's room. DA-A voiced, "It [the incident] could have been a lot worse, " and, "Accidents happen but this [residents getting the wrong diet order] cannot happen."

When interviewed on 1/29/21, at 1:34 p.m. NA-C stated she had visualized R2's tray card long enough to ensure the tray had been his and that the dessert had been pureed. NA-C explained she "did not think anything of it [the chicken having been the wrong texture]" and when she had went back after the meal to check on R2 he had stated, "I almost choked to death." NA-C offered R2 alternative meal options after he had

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F 808	Continued From page 6	F 808		

voiced he did not wish to eat any more on his meal. When NA-C had visualized R2's plate, she stated R2 had cut up chicken and a vegetable blend. NA-C explained after she had brought R2 his tray she brought the other tray to that associated resident and assisted her to eat; however, NA-C stated diet orders can change and thus at that time "it [the other resident was being fed pureed food] did not click with me.". NA-C explained the two resident tray cards and other items on the meal trays had been correct; however, the meal plates had been switched. NA-C confirmed she is supposed to make sure that the tray card, the resident, and the meal is correct before the resident received food items. NA-C reported, "We no longer pass the trays now." Further, NA-C denied having received disciplinary action related to the incident or education to ensure residents received the correct diet and food items as ordered by their physician.

During interview on 1/29/21, at 4:07 p.m. the director of nursing (DON) stated education had only been provided to dietary staff after the incident as the meal tray had "came out of the kitchen." The DON confirmed NA-C and other nursing staff had not received education about providing residents with appropriate diet textured foods despite nursing staff providing residents with food items at times other than meals. The DON explained her expectation was for staff to look at the resident diet orders and to make sure the residents received food items based on their physician diet orders.

When interviewed on 2/1/21, at 10:46 a.m. R2 stated the incident had been "terrible." R2 explained his plate had "bigger pieces" and when

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he had tried to chew them, "I could not swallow them." Further, R2 explained, "I was choking like crazy." R2 stated he "normally gets mashed up foods" which he had no concerns with and thus R2 explained he had not paid any attention to what had been on his plate that meal and just started eating. After the incident, R2 stated, "It had hurt like hell for awhile," and it "stuck in the middle of my chest," in which he had experienced pain for about half the day after choking. R2 explained, "I now look before I eat."

During a subsequent interview on 2/1/21, at 11:05 a.m. the DON stated the facility had gone back and forth regarding which department would be best to deliver meal trays in which due to R2's choking the facility had went back to only dietary delivering meal trays. The DON explained nursing staff, which included NA-C, should have been educated/retrained right away after the incident. The DON stated, "We overlooked a big piece." The DON stated her expectation was that if staff questioned food items being delivered to residents they should not deliver the tray and should discuss their concerns with the nurse or dietary staff. The DON denied the facility had performed audits to ensure food being delivered from the kitchen had been prepared per physician orders.

When interviewed on 2/1/21, at 12:00 p.m. the administrator stated the facility had determined the two trays being taken from the kitchen had their plates switched. The administrator explained they encourage the facility departments to work together; however, when NA-C asked if she could help DA-A deliver the last two remaining meal trays "we lost our second check." The administrator stated she expected staff to "know

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 8	F 808		

what they were giving a resident before they gave it to them." Further, the administrator stated she also expected staff to follow physician orders regarding food texture, and she explained if staff did not follow physician diet orders the outcomes for the resident could be choking and/or death.

A policy Diet Policy/Enhanced Foods, dated 8/2/16, identified the following diet types in the following order: regular, reduced sodium, reduced calorie, small/large portions, and mechanically soft or enhanced pureed. The section labeled mechanically soft or enhanced pureed indicated "Any of the above diets may be altered in texture to meet a resident's needs and that a registered nurse (RN) or a certified dietary manager (CDM) can downgrade mechanically soft or enhanced pureed diets and a speech language pathologist (SLP) can upgrade this type of diet. The policy failed to indicate preparation directions or descriptions that identified what a mechanically soft or enhanced pureed diet consisted of.

Electronically delivered
February 24, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: ZPN611

Dear Administrator:

The above facility was surveyed on January 28, 2021 through February 1, 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 02/01/2021

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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 1/28/21 - 2/1/2, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT compliance with the MN State Licensure. The following complaint was found to be SUBSTANTIATED:	2 000		

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2 000	Continued From page 1 H5364040C (MN00069362) with licensing orders issued. H5364041C (MN00069438) H5364042C (MN00060563) H5364044C (MN00058798) The following complaints were found to be UNSUBSTANTIATED: H5364039C (MN00067011) H5364043C (MN00060412) H5364045C (MN00068341) You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01	2 000		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician.	2 945		3/5/21

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2 945	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure a physician prescribed mechanically altered diet was provided to 1 of 7 residents (R2) reviewed for theraputics diets. Findings include: R2's significant change Minimum Data Set (MDS), dated 11/14/20, identified R2 had intact cognition; however had a diagnosis of dementia and a traumatic brain injury. The MDS indicated R2 had further diagnosis of dysphagia (difficulty swallowing), gastroesophageal reflux disease (GERD), and chronic obstructive pulmonary disease (COPD). In addition, R5 had been edentulous (no natural teeth), had not shown any possible swallowing issues with current interventions, and ate independently. An RN [registered nurse] Nursing Assessment-Version 3, dated 11/14/20, identified R2 had difficulty swallowing liquids and had impaired swallowing. The assessment indicated R2's "Current diet is nectar thick liquids and pureed textures and crushed medications." A section labeled "ORAL" identified R2 utilized upper and lower dentures. No referrals had been indicated. R2's care plan section labeled Nutritional Status, edited on 11/10/20, identified R2 received a pureed texture diet with nectar thick liquids related to dysphagia with an approach that he received this altered diet. R2's abuse prevention care plan, edited on 11/23/20, identified he was	2 945	CORRECTED	

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2 945	Continued From page 3	2 945		

vulnerable related to dysphagia with an approach to refer to individual care plan problems, goals, and approaches to minimize the risk of abuse. In addition, the care plan section labeled "ADL [activity of daily living] eating" indicated R2 had been independent with eating, had a history of aspiration, and had been at risk for choking related to dysphagia.

A Physician Order Report, dated 1/1/21 - 2/1/21, indicated R2 had a physician prescribed diet that directed staff to provide him with nectar thick liquids, pureed textures, and to offer him snacks between meals.

A progress note on 1/22/21, at 1:45 p.m. indicated R2 had been given lunch food that had not been pureed. The progress note identified R2 had been "fine" when the incorrect diet had been discovered; however, R2 had spit out phlegm and experienced pain near his diaphragm 30 minutes after the event.

A progress note, recorded on 1/22/21, at 3:10 p.m. indicated R2 had "expelled a chunk of chicken."

A progress note on 1/23/21, at 12:20 a.m. indicated R2 had reported discomfort in his chest due to him having consumed the wrong textured food.

A completed State agency (SA) submitted follow up investigation, dated 1/27/21, identified the facility's completed investigation into the incident. The report outlined nursing assistant (NA)-C had obtained R2's and another resident's ready to deliver lunch trays from the kitchen and brought them to R2 and the other resident. The process had been for the kitchen staff to label a plate and

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2 945	Continued From page 4	2 945		

match it to a tray; however, the diet cards for the plates were not matched to the diet cards on the trays. The facility had discovered a kitchen staff had placed the wrong plate on R2's and the other resident's trays. R2 had received a regular meal which resulted in him having experienced "some pain/discomfort in his diaphragm" and "coughing up phlegm." The report indicated the facility had developed a new tray passing policy after the incident had occurred in which the dietary manager (DM) had reviewed with the employees. In addition, the report indicated no alleged perpetrator (AP) had been identified. The report lacked actions or evidence of a systemic response by the facility to educate all facility staff in regards to food delivery processes that ensured residents were given the correct physician ordered food items at all times of the day.

During interview on 1/29/21, at 11:07 a.m. NA-A stated dietary staff brought the meal "trays down on the carts." NA-A explained she checked the meal cards "at times" to ensure the residents received the correct food; however, she voiced she had become "so used to the routine that [she] will not always check" them. NA-A denied she had received any recent education on ensuring residents received the correct food items as ordered by their physicians.

When interviewed on 1/29/21, at 11:32 a.m. NA-B stated she "tries to look at" the tray cards before she passes out meal trays; however, she explained dietary staff "passes the trays now." NA-B denied she had received any recent education on ensuring residents received the correct food items as ordered by their physicians.

During interview on 1/29/21, at approximately

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2 945	Continued From page 5 12:15 p.m. cook (C)-A stated the kitchen's process for prepped meal trays relied on a dietary aide listing off a residents name and their associated diet to the staff member. That staff member would then place the correct food items on the plates. C-A explained she had remembered the incident; however, could not remember any real details other than "it was a plate swap" in which the "trays were completely normal just a different plate." C-A stated nursing staff had delivered R2's and the other resident's meal trays that day after the kitchen had prepared them and further explained that in response to the incident dietary staff were now the only staff members who delivered the meal trays as "is is something we should have caught." When interviewed on 1/29/21, at 12:49 p.m. assistant dietary director (ADD) stated when dietary staff prepped meal trays the dietary assistants would tell the cooks the resident's name, diet, and any other information required. Once the cook finished preparing the plate, they would hand it back to the dietary assistant and the resident's name would again be stated. The dietary assistant finished the process by wrapping the plate and placing it on the tray with the associated diet card. The ADD explained R2 and the other resident's trays had been the last two trays prepped for lunch in which a dietary assistant had wrapped them right away; however, had not placed them on the trays. The ADD had not known who had placed the plates on the trays prior to NA-C taking the trays and delivering them. The ADD stated after the incident a new policy and procedure had been developed that required only dietary staff to pass resident meal trays. In addition, the ADD stated she had only provided education to dietary staff regarding the new policy and procedure processes. The ADD	2 945		

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2 945	Continued From page 6	2 945		

denied having completed audits to ensure the new policy and procedure had been followed or that residents' meal trays had been prepared per physician orders.

During interview on 1/29/21, at 1:09 p.m. dietary aide (DA)-A stated she had taken the last two lunch meal trays which had belonged to R2 and another resident after the cooks had wrapped the plates so that they "could keep up." DA-A explained about half way down the hall NA-C had approached her and she had agreed to NA-C's offered assistance for NA-C to deliver the trays the rest of the way. DA-A explained dietary staff now passed out the meal trays and set the residents up with the trays so that they could perform a visual check of the trays before they left the resident's room. DA-A voiced, "It [the incident] could have been a lot worse, " and, "Accidents happen but this [residents getting the wrong diet order] cannot happen."

When interviewed on 1/29/21, at 1:34 p.m. NA-C stated she had visualized R2's tray card long enough to ensure the tray had been his and that the dessert had been pureed. NA-C explained she "did not think anything of it [the chicken having been the wrong texture]" and when she had went back after the meal to check on R2 he had stated, "I almost choked to death." NA-C offered R2 alternative meal options after he had voiced he did not wish to eat any more on his meal. When NA-C had visualized R2's plate, she stated R2 had cut up chicken and a vegetable blend. NA-C explained after she had brought R2 his tray she brought the other tray to that associated resident and assisted her to eat; however, NA-C stated diet orders can change and thus at that time "it [the other resident was being fed pureed food] did not click with me.".

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2 945	Continued From page 7	2 945		

NA-C explained the two resident tray cards and other items on the meal trays had been correct; however, the meal plates had been switched. NA-C confirmed she is supposed to make sure that the tray card, the resident, and the meal is correct before the resident received food items. NA-C reported, "We no longer pass the trays now." Further, NA-C denied having received disciplinary action related to the incident or education to ensure residents received the correct diet and food items as ordered by their physician.

During interview on 1/29/21, at 4:07 p.m. the director of nursing (DON) stated education had only been provided to dietary staff after the incident as the meal tray had "came out of the kitchen." The DON confirmed NA-C and other nursing staff had not received education about providing residents with appropriate diet textured foods despite nursing staff providing residents with food items at times other than meals. The DON explained her expectation was for staff to look at the resident diet orders and to make sure the residents received food items based on their physician diet orders.

When interviewed on 2/1/21, at 10:46 a.m. R2 stated the incident had been "terrible." R2 explained his plate had "bigger pieces" and when he had tried to chew them, "I could not swallow them." Further, R2 explained, "I was choking like crazy." R2 stated he "normally gets mashed up foods" which he had no concerns with and thus R2 explained he had not paid any attention to what had been on his plate that meal and just started eating. After the incident, R2 stated, "It had hurt like hell for awhile," and it "stuck in the middle of my chest," in which he had experienced pain for about half the day after choking. R2

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2 945	Continued From page 8 explained, "I now look before I eat." During a subsequent interview on 2/1/21, at 11:05 a.m. the DON stated the facility had gone back and forth regarding which department would be best to deliver meal trays in which due to R2's choking the facility had went back to only dietary delivering meal trays. The DON explained nursing staff, which included NA-C, should have been educated/retrained right away after the incident. The DON stated, "We overlooked a big piece." The DON stated her expectation was that if staff questioned food items being delivered to residents they should not deliver the tray and should discuss their concerns with the nurse or dietary staff. The DON denied the facility had performed audits to ensure food being delivered from the kitchen had been prepared per physician orders. When interviewed on 2/1/21, at 12:00 p.m. the administrator stated the facility had determined the two trays being taken from the kitchen had their plates switched. The administrator explained they encourage the facility departments to work together; however, when NA-C asked if she could help DA-A deliver the last two remaining meal trays "we lost our second check." The administrator stated she expected staff to "know what they were giving a resident before they gave it to them." Further, the administrator stated she also expected staff to follow physician orders regarding food texture, and she explained if staff did not follow physician diet orders the outcomes for the resident could be choking and/or death. A policy Diet Policy/Enhanced Foods, dated 8/2/16, identified the following diet types in the following order: regular, reduced sodium, reduced calorie, small/large portions, and mechanically	2 945		

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2 945	Continued From page 9 soft or enhanced pureed. The section labeled mechanically soft or enhanced pureed indicated "Any of the above diets may be altered in texture to meet a resident's needs and that a registered nurse (RN) or a certified dietary manager (CDM) can downgrade mechanically soft or enhanced pureed diets and a speech language pathologist (SLP) can upgrade this type of diet. The policy failed to indicate preparation directions or descriptions that identified what a mechanically soft or enhanced pureed diet consisted of. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods given, offered, or consumed by residents reflect the nutritional needs according to physician ordered therapeutic diets and to prevent food intake hazards for residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to therapeutic diets. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are appropriate. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 945		