

Protecting, Maintaining and Improving the Health of All Minnesotans

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

Jovens Lapson

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 03/03/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION			E SURVEY IPLETED
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		245364	B. WING				02/	01/2021
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	completed at your investigations. You in compliance with	11, an abbreviated survey was facility to conduct complaint or facility was found to be NOT 42 CFR Part 483, Long Term Care Facilities.						
	SUBSTANTIATED	0069362) with deficiency 0069438) 0060563)						
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	as your allegation of Department's access acceptable electron facility will be conducted substantial compliance been attained in acceptation.	of correction (POC) will serve of compliance upon the eptance. Upon receipt of an nic POC, a revisit of your ucted to validate that ance with the regulations has ecordance with your						
F 808 SS=D		rescribed by Physician (1)(2)	F 8	808				3/5/21
	§483.60(e) Therap §483.60(e)(1) Ther	eutic Diets rapeutic diets must be						
LABORATOR'	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	SNATURE		TITLE			(X6) DATE
Electron	ically Signed							03/02/2021

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 808	§483.60(e)(2) The delegate to a registask of prescribing therapeutic diet, to law. This REQUIREME by: Based on interview failed to ensure a prechanically altereresidents (R2) revisions include: R2's significant characteristic (MDS), dated 11/1. cognition; however and a traumatic brack (ADS), and chrord disease (COPD). It edentulous (no nat possible swallowin interventions, and an RN [registered Assessment-Versic R2 had difficulty swimpaired swallowin R2's "Current diet in pureed textures an section labeled "Ol upper and lower definicated.	attending physician. attending physician may tered or licensed dietitian the a resident's diet, including a the extent allowed by State NT is not met as evidenced v and record review, the facility physician prescribed ed diet was provided to 1 of 7 ewed for theraputics diets. ange Minimum Data Set 4/20, identified R2 had intact had a diagnosis of dementia ain injury. The MDS indicated gnosis of dysphagia (difficulty besophageal reflux disease nic obstructive pulmonary naddition, R5 had been ural teeth), had not shown any g issues with current ate independently.	F8	F808 – Therapeutic Diet Pre Physician 1) How corrective action will accomplished for those reside that it will ensure all residents meals according to physician relation to texture and consistency-modified diets. All dietary staff will be retrain Resident Trays and Accuracy of Tray Line Service. All diet nursing staff will be retrained policies for Texture and Consistency-Modified Diets, Soft Diets, Puree Diets, Therand the Tray Passing Policy Procedure. Retraining of state completed as of 03/05/2021. 2) How to identify other resident the potential to be affected be practice: On 01/22/2021, dietary staff retrained on the Dietary Tray policy, with emphasis on the are responsible for delivering the state of the potential to the potential to the potential to the affected be practice: On 01/22/2021, dietary staff retrained on the Dietary Tray policy, with emphasis on the are responsible for delivering	be dents found to Care Center s receive their n orders in ded Preparing y and Quality tary and d on the Mechanical rapeutic Diets and aff will be dents having y the same were Passing fact that they	

NAME OF PROVIDER OR SUPPLIER ANNANDALE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	SURVEY PLETED
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FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 phelgm and experienced pain near his diaphragm 30 minutes after the event. Effective 03/03/2721, ongoing compliance audits will be conducted by the Director of Dietary Services, the Assistant Dietary Manager or their designee to ensure	ANNAND	ALE CARE CENTER						
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. He 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 was split into three separate policies. These policies are now the Tray Passing Policy was split into three separate policies. These policies are now the Tray Passing Policy was split into three separate policies. These policies are now the Tray Passing Policy was split into three separate policies. These policies are now the Tray Passing Policy was split into three separate policies. These policies are now the Tray Passing Policy was split into three separate policies. These policies are now the Tray Passing Policy was split and Preparing Resident Trays in order to also ensure as well as during the kitchen as w	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
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 A progress note on 1/23/21, at 12:20 a.m. 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%	F 808	edited on 11/10/20, pureed texture diet related to dysphagi received this alterecare plan, edited or vulnerable related to refer to individua and approaches to addition, the care p [activity of daily livin been independent to aspiration, and had related to dysphagi. A Physician Order I indicated R2 had a directed staff to proliquids, pureed text between meals. A progress note on indicated R2 had be not been pureed. Thad been "fine" who discovered; however experienced pain nafter the event. A progress note, rep.m. indicated R2 had reducted R3 had reducted R4 had reducted R5 had red	with nectar thick liquids a with an approach that he diet. R2's abuse prevention in 11/23/20, identified he was o dysphagia with an approach I care plan problems, goals, minimize the risk of abuse. In lan section labeled "ADLing] eating" indicated R2 had with eating, had a history of been at risk for choking a. Report, dated 1/1/21 - 2/1/21, physician prescribed diet that ovide him with nectar thick tures, and to offer him snacks 1/22/21, at 1:45 p.m. een given lunch food that had he progress note identified R2 en the incorrect diet had been er, R2 had spit out phlegm and ear his diaphragm 30 minutes 1/23/21, at 12:20 a.m. exported discomfort in his chest consumed the wrong textured agency (SA) submitted follow	F 8	308	the resident and ensuring the tray contents match the diet card. On 02/26/2021, the Dietary Tray Passin policy was split into three separate policies. These policies are now the Passing Policy and Procedure, Accand Quality of Tray Line Service an Preparing Resident Trays in order the sitchen as well as during the deprocess. 3) Measures put into place or syste changes made to ensure practice werecur: In addition to the retraining of all dia and nursing staff on the policies an procedures related to preparing and delivering of resident trays as well at types of modified texture diets, the Accuracy and Quality of Tray Line Swas implemented on 03/03/2021. 4) How to monitor performance to a solutions are sustained, that correct achieved and sustained; implemented and integrated into QA sy Effective 03/03/21, ongoing complia audits will be conducted by the Direct Dietary Services, the Assistant Diet Manager or their designee to ensur resident trays with texture and consistency-modified diet orders are being prepared and delivered accorpolicy. Weeks one and two will be meal per day for 5 days/week. Wethree will be one meal per day for 3 days/week. Week four will be one	e Tray uracy d o also eaving livery mic vill not etary d d as the Service assure tion is ted, ystem: ance ector of eary e e rding to one ek meal	

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F 808	The report outlined obtained R2's and a deliver lunch trays of them to R2 and the had been for the kit match it to a tray; he plates were not ma trays. The facility had placed the wro resident's trays. R2 which resulted in hi pain/discomfort in hup phlegm." The redeveloped a new traincident had occurr manager (DM) had In addition, the repoperpetrator (AP) had lacked actions or expense by the facin regards to food densured residents of the carts." NA-A meal cards "at time received the correct she had become "swill not always check had received any reresidents received to ordered by their physician ordered for the carts."	investigation into the incident. nursing assistant (NA)-C had another resident's ready to from the kitchen and brought other resident. The process schen staff to label a plate and owever, the diet cards for the tched to the diet cards on the ad discovered a kitchen staffing plate on R2's and the other had received a regular meal m having experienced "some his diaphragm" and "coughing port indicated the facility had ay passing policy after the ed in which the dietary reviewed with the employees. For tindicated no alleged dispension between the correct collity to educate all facility staff delivery processes that were given the correct cood items at all times of the s" to ensure the residents to food; however, she voiced of used to the routine that [she] ck" them. NA-A denied she ecent education on ensuring the correct food items as	F8	compliance is consistently be achieved. Any discrepancie the audits will be addressed additional policy and proced made if warranted. Audit resubmitted to the QA Commi review to determine that concontinues to be achieved. 5) The date deficiency will be This deficiency has been co 3/05/2021.	es identified by with lures changes sults will be ittee for final mpliance	

stated she "tries to look at" the tray cards before

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F 808	she passes out me explained dietary sind-B denied she heducation on ensur correct food items and correct food items. During interview on 12:15 p.m. cook (Corrocess for prepperaide listing off a result associated diet to the member would the conthe plates. C-A cremembered the incremember any real plate swap" in which normal just a different staff had delivered meal trays that day them and further explained in the plate and plate swap who delives the something we should be something we should be assistant dietary did dietary staff prepperassistants would tename, diet, and any once the cook finish would hand it back the resident's name dietary assistant fir the plate and placing associated diet car the other resident's trays prepped for literals.	al trays; however, she taff "passes the trays now." ad received any recent ing residents received the as ordered by their physicians. 1/29/21, at approximately)-A stated the kitchen's d meal trays relied on a dietary sidents name and their he staff member. That staff in place the correct food items explained she had cident; however, could not details other than "it was a h the "trays were completely ent plate." C-A stated nursing R2's and the other resident's after the kitchen had prepared could consider that in response to the ff were now the only staff vered the meal trays as "is is	F 80			

			CON	3) DATE SURVEY COMPLETED C		
		245364	B. WING _			/01/2021
	PROVIDER OR SUPPLIER DALE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PARK STREET EAST ANNANDALE, MN 55302	,	
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F 808	not known who had prior to NA-C taking them. The ADD state policy and procedurequired only dietar trays. In addition, the provided education new policy and prodenied having comnew policy and prodenied having interview on aide (DA)-A stated lunch meal trays where another resident afplates so that they explained about has approached her an offered assistance the rest of the way. now passed out the residents up with the perform a visual cheft the resident's residents up with the perform a visual cheft the resident's resident pould have "Accidents happen wrong diet order] could have stated she had visue enough to ensure the dessert had be she "did not think a having been the wrhad went back after the provided have the dessert had be she "did not think a having been the wrhad went back after the provided have the provided have the dessert had be she "did not think a having been the wrhad went back after the provided have the	d placed the plates on the trays g the trays and delivering ated after the incident a new re had been developed that ry staff to pass resident meal he ADD stated she had only to dietary staff regarding the cedure processes. The ADD pleted audits to ensure the cedure had been followed or all trays had been prepared per a 1/29/21, at 1:09 p.m. dietary she had taken the last two hich had belonged to R2 and ter the cooks had wrapped the "could keep up." DA-A all way down the hall NA-C had de she had agreed to NA-C's for NA-C to deliver the trays and set the ne trays so that they could neck of the trays before they boom. DA-A voiced, "It [the e been a lot worse, " and, but this [residents getting the	F 80	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP CO 500 PARK STREET EAST ANNANDALE, MN 55302		70 17202 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 808	voiced he did not y meal. When NA-C stated R2 had cut blend. NA-C expla his tray she broug associated resider however, NA-C stand thus at that tir being fed pureed to NA-C explained the other items on the however, the mean NA-C confirmed stat the tray card, correct before the NA-C reported, "V now." Further, NA disciplinary action education to ensure the state of the NA-C reported in the tray card, correct before the NA-C reported, "V now." Further, NA disciplinary action education to ensure the state of the tray card, correct before the NA-C reported, "V now." Further, NA disciplinary action education to ensure the tray card, t	age 6 wish to eat any more on his had visualized R2's plate, she up chicken and a vegetable lined after she had brought R2 ht the other tray to that ht and assisted her to eat; lated diet orders can change me "it [the other resident was food] did not click with me.". In two resident tray cards and meal trays had been correct; Il plates had been switched, he is supposed to make sure the resident, and the meal is resident received food items. We no longer pass the trays -C denied having received related to the incident or the residents received the od items as ordered by their	F 8	08			
	director of nursing only been provided incident as the metaltichen." The DON nursing staff had reproviding resident foods despite nurs with food items at DON explained he look at the resident he residents recephysician diet order the incident stated the incident	n 1/29/21, at 4:07 p.m. the (DON) stated education had d to dietary staff after the eal tray had "came out of the N confirmed NA-C and other not received education about s with appropriate diet textured sing staff providing residents times other than meals. The er expectation was for staff to at diet orders and to make sure ived food items based on their ers. on 2/1/21, at 10:46 a.m. R2 thad been "terrible." R2 thad been "terrible." R2					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ON NUMBER: A. BUILDING COM		TE SURVEY MPLETED C		
		245364	B. WING		02	// 01/2021	
	PROVIDER OR SUPPLIER DALE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COL 500 PARK STREET EAST ANNANDALE, MN 55302	•	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 808	he had tried to cher them." Further, R2 crazy." R2 stated h foods" which he ha R2 explained he had what had been on h started eating. Afte had hurt like hell formiddle of my chest pain for about half the explained, "I now look but had been on heart to about half the explained, "I now look but had been on heart to about half the explained, "I now look but had been on heart to about half the explained, "I now look but had been on heart to about half the explained, "I now look but he facility delivering meal tray staff, which include educated/retrained. The DON stated he questioned food ite residents they should discuss their dietary staff. The Diperformed audits to from the kitchen had orders. When interviewed administrator stated the two trays being their plates switched they encourage the together; however, help DA-A deliver the trays "we lost our significant to check the swellost our significant to check the swellost our significant heart the two trays being their plates switched they encourage the together; however, help DA-A deliver the trays "we lost our significant the state of the same had been and the state of the same had been and the same	w them, "I could not swallow explained, "I was choking like he "normally gets mashed up d no concerns with and thus ad not paid any attention to his plate that meal and just rethe incident, R2 stated, "It rewhile," and it "stuck in the "in which he had experienced the day after choking. R2 bok before I eat." Interview on 2/1/21, at 11:05 and the facility had gone back which department would be I trays in which due to R2's had went back to only dietary ys. The DON explained nursing d NA-C, should have been right away after the incident. We overlooked a big piece." For expectation was that if staff ims being delivered to all not deliver the tray and in concerns with the nurse or ON denied the facility had been prepared per physician and the facility had determined taken from the kitchen had a taken from the kitchen had a facility departments to work when NA-C asked if she could he last two remaining meal	F 8	08			

	N OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPI		TE SURVEY MPLETED			
		245364	B. WING		1	C / 01/2021
	PROVIDER OR SUPPLIER DALE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 500 PARK STREET EAST ANNANDALE, MN 55302	•	01/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 808	what they were giving it to them." Further, also expected staff regarding food texts did not follow physic for the resident courage of the resident courage. A policy Diet Policy, 8/2/16, identified the following order: regularie, small/large soft or enhanced purpose of the above of the tolerance of the small propose of the purpose of the small propose of the small	ge 8 ng a resident before they gave the administrator stated she to follow physician orders ure, and she explained if staff cian diet orders the outcomes Id be choking and/or death. /Enhanced Foods, dated e following diet types in the ular, reduced sodium, reduced portions, and mechanically ureed. The section labeled r enhanced pureed indicated liets may be altered in texture s needs and that a registered tified dietary manager (CDM) chanically soft or enhanced speech language pathologist this type of diet. The policy eparation directions or entified what a mechanically ureed diet consisted of.	F 80	08		



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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

Jovens Stapson

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

PRINTED: 03/03/2021 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00054	B. WING		0000	
		00951	D. WINO		02/0	1/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ANNANI	DALE CARE CENTER		(STREET EA ALE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall l	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of I lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	conducted to deterr Licensure. Your fac	TS: an abbreviated survey was mine compliance with State ility was found to be NOT and MN State Licensure.				
	The following comp SUBSTANTIATED:	laint was found to be				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/02/21 **Electronically Signed**

TITLE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY
74101044	or contraction	BERTIN ISTATION TO MBETA	A. BUILDING:			
		00951	B. WING		1	C 01/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANNAND	ALE CARE CENTER		STREET EA ALE, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	issued. H5364041C (MN00H5364042C (MN00H5364044C (MN00H5364044C (MN00H5364039C (MN00H5364045C (MN	20069362) with licensing orders 20069438) 2060563) 2058798) Claints were found to be ED: 2067011) 2060412) 2068341) Departicipate in the electronic ensure orders consistent with eartment of Health tin 14-01 O Subp. 1 Assistance with ersonnel g personnel. Nursing	2 945			3/5/21
	served diets as pre help in eating must receipt of the meals unhurried and in a enhances each res Adaptive self-help contribute to the reeating. Food and fibe observed and dereported to the nurs resident's care duri observation of a de	termine that residents are scribed. Residents needing be promptly assisted upon and the assistance must be manner that maintains or ident's dignity and respect. Devices must be provided to sident's independence in luid intake of residents must eviations from normal are responsible for the ng the work period the eviation was made. Persistent as must be reported to the n.				

Minnesota Department of Health

STATE FORM 5699 ZPN611 If continuation sheet 2 of 10

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					0	
		00951	B. WING		02/0	1/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ANNAN	DALE CARE CENTER		(STREET E. Ale, Mn 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 945	Continued From pa	ge 2	2 945			
	by: Based on interview failed to ensure a p mechanically altere	ent is not met as evidenced and record review, the facility hysician prescribed d diet was provided to 1 of 7 ewed for theraputics diets.		CORRECTED		
Ì	Findings include:					
	(MDS), dated 11/14 cognition; however and a traumatic bra R2 had further diag swallowing), gastro (GERD), and chron disease (COPD). In edentulous (no natu	nge Minimum Data Set 1/20, identified R2 had intact had a diagnosis of dementia in injury. The MDS indicated nosis of dysphagia (difficulty esophageal reflux disease ic obstructive pulmonary addition, R5 had been ural teeth), had not shown any issues with current tee independently.				
	R2 had difficulty sw impaired swallowing R2's "Current diet is pureed textures and section labeled "OF	nurse] Nursing on 3, dated 11/14/20, identified allowing liquids and had g. The assessment indicated is nectar thick liquids and d crushed medications." A RAL" identified R2 utilized intures. No referrals had been				
	edited on 11/10/20, pureed texture diet related to dysphagia received this altered	ion labeled Nutritional Status, identified R2 received a with nectar thick liquids a with an approach that he diet. R2's abuse prevention 11/23/20, identified he was				

Minnesota Department of Health

STATE FORM 5699 ZPN611 If continuation sheet 3 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
		00951	B. WING			C 01/2021
	NAME OF PROVIDER OR SUPPLIER ANNANDALE CARE CENTER 500 PARK ANNANDA					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 945	vulnerable related to refer to individual and approaches to addition, the care pleated for the care pleated to definition, and had related to dysphagia. A Physician Order Findicated R2 had a directed staff to proliquids, pureed text between meals. A progress note on indicated R2 had be not been pureed. The had been "fine" who discovered; however experienced pain not after the event. A progress note, report, indicated R2 had reduced to him having of food. A completed State aup investigation, data facility's completed The report outlined obtained R2's and adeliver lunch trays fithem to R2 and the	o dysphagia with an approach l care plan problems, goals, minimize the risk of abuse. In lan section labeled "ADL g] eating" indicated R2 had with eating, had a history of been at risk for choking	2 945			

Minnesota Department of Health

STATE FORM 5699 ZPN611 If continuation sheet 4 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
			71. 501251110.			c
		00951	B. WING		02/0	01/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ANNANI	DALE CARE CENTER		(STREET EA ALE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 945	match it to a tray; he plates were not matrays. The facility had placed the wro resident's trays. R2 which resulted in his pain/discomfort in hup phlegm." The redeveloped a new traincident had occurr manager (DM) had In addition, the repoperpetrator (AP) had lacked actions or everyonse by the faction regards to food densured residents with physician ordered from the carts." NA-A meal cards "at time received the correct she had become "swill not always check had received any residents received to residents received to she passes out me explained dietary stays. When interviewed of stated she "tries to she passes out me explained dietary stays." NA-B denied she had education on ensur correct food items at a correct fo	owever, the diet cards for the tched to the diet cards on the ad discovered a kitchen staffing plate on R2's and the other had received a regular meal minate having experienced "some his diaphragm" and "coughing port indicated the facility had any passing policy after the ed in which the dietary reviewed with the employees. For tindicated no alleged dispensed been identified. The report widence of a systemic could be ensured all facility staff delivery processes that were given the correct bood items at all times of the solution of the site of the explained she checked the site of the residents to ensure the residents to used to the routine that [she] ck" them. NA-A denied she ecent education on ensuring the correct food items as	2 945			

Minnesota Department of Health

STATE FORM 5899 ZPN611 If continuation sheet 5 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NOW		IDENTIFICATION NUMBER:	A. BUILDING:		СОМІ	COMPLETED	
						С	
		00951	B. WING		02/	01/2021	
NAME OF PROVIDER OR S	UPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ANNANDALE CADE C	ENTER	500 PAR	STREET EA	AST			
ANNANDALE CARE C	ENIER	ANNANDA	ALE, MN 55	302			
(X4) ID SUMN	MARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PRÉFIX (EACH DE		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETE DATE	
17.0		,	17.0	DEFICIENCY)			
2 945 Continued F	rom pa	ge 5	2 945				
		-					
)-A stated the kitchen's					
		d meal trays relied on a dietary					
J		idents name and their					
		ne staff member. That staff ne					
		explained she had					
		cident; 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						
		plained that in response to the					
		f were now the only staff					
		ered the meal trays as "is is					
something v	something we should have caught."						
When inten	iewed o	on 1/29/21, at 12:49 p.m.					
		ector (ADD) stated when					
		d meal trays the dietary					
		I the cooks the resident's					
		other information required.					
		hed preparing the plate, they					
		to the dietary assistant and					
		would again be stated. The					
dietary assis	stant fini	ished the process by wrapping					
the plate an	d placin	g it on the tray with the					
		d. The ADD explained R2 and					
		trays had been the last two					
		nch in which a dietary					
		ped them right away; however,					
		n on the trays. The ADD had					
		placed the plates on the trays					
		the trays and delivering					
		ted after the incident a new					
		re had been developed that					
		y staff to pass resident meal					
		e ADD stated she had only					
		to dietary staff regarding the sedure processes. The ADD					

Minnesota Department of Health

STATE FORM 5699 ZPN611 If continuation sheet 6 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED	
		A. BUILDING:				
		00951	B. WING			C 01/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANNANI	DALE CARE CENTER		STREET EA			
			ALE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 945	Continued From pa	ge 6	2 945			
	denied having comp	pleted audits to ensure the cedure had been followed or I trays had been prepared per				
	aide (DA)-A stated lunch meal trays wh another resident aft plates so that they explained about had approached her and offered assistance the rest of the way. now passed out the residents up with the perform a visual cheft the resident's reincident] could have	1/29/21, at 1:09 p.m. dietary she had taken the last two nich had belonged to R2 and ter the cooks had wrapped the could keep up." DA-A if way down the hall NA-C had dishe had agreed to NA-C's for NA-C to deliver the trays DA-A explained dietary staff a meal trays and set the e trays so that they could eck of the trays before they form. DA-A voiced, "It [the elbeen a lot worse, " and, but this [residents getting the annot happen."				
	stated she had visus enough to ensure the the dessert had been she "did not think a having been the work had went back after had stated, "I almost offered R2 alternation voiced he did not work meal. When NA-C stated R2 had cut us blend. NA-C explain his tray she brough associated resident however, NA-C state and thus at that times she was a state of the	on 1/29/21, at 1:34 p.m. NA-C alized R2's tray card long he tray had been his and that en pureed. NA-C explained hything of it [the chicken ong texture]" and when she is the meal to check on R2 he is the choked to death." NA-C we meal options after he had ish to eat any more on his had visualized R2's plate, she up chicken and a vegetable hed after she had brought R2 the other tray to that and assisted her to eat; ited diet orders can change e "it [the other resident was hod] did not click with me."				

Minnesota Department of Health

STATE FORM 5699 ZPN611 If continuation sheet 7 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
			A. BUILDING:			_
		00951	B. WING		02/0) 1/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANNANI	DALE CARE CENTER		(STREET EA Ale, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 945	NA-C explained the other items on the interviewed incident as the residents foods despite nursi with food items at ti DON explained her look at the resident the resident recipies and items." Further, and items at ti DON explained her look at the resident the resident recipies with foods and items at ti DON explained her look at the resident the resident recipies with foods. When interviewed incident as the mean with food items at ti DON explained her look at the resident the resident recipies with foods. When interviewed incident is plate he had tried to cheve them. Further, R2 crazy." R2 stated her looks which he had R2 explained he had what had been on her started eating. After had hurt like hell for middle of my chest.	e two resident tray cards and meal trays had been correct; plates had been switched. e is supposed to make sure he resident, and the meal is esident received food items. e no longer pass the trays of denied having received elated to the incident or e residents received the ditems as ordered by their as ordered by their as a constant of the confirmed NA-C and other of received education about with appropriate diet textured and staff providing residents mes other than meals. The expectation was for staff to diet orders and to make sure red food items based on their	2 945			

Minnesota Department of Health

STATE FORM 5899 ZPN611 If continuation sheet 8 of 10

Minnesota Department of Health						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00951	B. WING		02/01/2021	
		00951			02/0	1/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		500 PARK	STREET EA	AST		
ANNANL	DALE CARE CENTER	ANNANDA	ALE, MN 55	302		
0/4) ID	CLIMMA DV CTA					()(5)
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
2 945	Continued From pa	ge 8	2 945			
2 340	Continued i Tom pa	ge o	2 343			
	explained, "I now lo	ok before I eat."				
	During a subseque	nt interview on 2/1/21, at 11:05				
	a.m. the DON state	d the facility had gone back				
	and forth regarding	which department would be				
	best to deliver mea	I trays in which due to R2's				
	choking the facility	had went back to only dietary				
	delivering meal tray	s. The DON explained nursing				
		d NA-C, should have been				
		right away after the incident.				
		Ve overlooked a big piece."				
		er expectation was that if staff				
		ms being delivered to				
		ıld not deliver the tray and				
		r concerns with the nurse or				
		ON denied the facility had				
	performed audits to	ensure food being delivered				
	from the kitchen ha	d been prepared per physician				
	orders.					
		on 2/1/21, at 12:00 p.m. the				
		d the facility had determined				
		taken from the kitchen had				
		d. The administrator explained				
		facility departments to work				
		when NA-C asked if she could				
		ne last two remaining meal				
	trays "we lost our se					
		d she expected staff to "know				
		ng a resident before they gave				
	it to them." Further, the administrator stated she					
		to follow physician orders				
		ure, and she explained if staff				
		cian diet orders the outcomes				
	tor the resident cou	ld be choking and/or death.				
	A	(Falancia Falancia 1.4				
		/Enhanced Foods, dated				
		e following diet types in the				
		ular, reduced sodium, reduced				
	calorie, small/large portions, and mechanically					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00951	B. WING		02/0) 1/2021
ANNANDALE CARE CENTER 500 PARK			DRESS, CITY, S STREET EA ALE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 945	soft or enhanced purechanically soft or "Any of the above do to meet a resident's nurse (RN) or a cercan downgrade merpureed diets and a (SLP) can upgrade failed to indicate prodescriptions that idesoft or enhanced purechanced purechanced by residents and to prevent residents of the factor create policies are staff on specific requested to therapeut registered dietician, audits for a designal determined by the CP erformance Improdensure food items or residents are approaches findings to Quarecommendations and further monitoring of the service of the servi	ureed. The section labeled renhanced pureed indicated iets may be altered in texture aneeds and that a registered tified dietary manager (CDM) chanically soft or enhanced speech language pathologist this type of diet. The policy eparation directions or entified what a mechanically ureed diet consisted of. CHOD OF CORRECTION: registered dietician, or ure foods given, offered, or ents reflect the nutritional physician ordered therapeutic tood intake hazards for elity. The facility could update and procedures, and educate uirements or interventions ic diets. The administrator, or designee could perform ated amount of time as Quality Assurance vement (QAPI) committee to given, offered, or consumed by priate. The facility could report API for further and determine the need for	2 945			

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