Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 8, 2023

Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

RE: CCN: 245205
Cycle Start Date: May 18, 2023

Dear Administrator:

On July 27, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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August 8, 2023

Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

Re: Reinspection Results
Event ID: 813Z12

Dear Administrator:

On July 27, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 18, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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June 14, 2023

Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

RE: CCN: 245205
Cycle Start Date: May 18, 2023

Dear Administrator:

On May 18, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, 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: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 18, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 18, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

INFORMAL DISPUTE RESOLUTION (IDR) / 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 electronic 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING ______ B. WING ______	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	**3000 4TH AVENUE ANOKA, MN 55303**

(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
E 000	Initial Comments On 5/15/23 through 5/18/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		7/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/23/2023

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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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect their emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.3.7, 8.3.8, 8.4.1, 8.4.2, and 8.4.2.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/18/2023 between 08:30 a.m. and 1:00 p.m., it was revealed by a review of available documentation, the facility could not provide documentation showing monthly inspection of the emergency generator was completed for the months of October 2022 and April 2023. 2. On 05/18/2023 between 08:30 a.m. and 1:00 p.m., it was revealed by a review of available documentation, the facility could not provide documentation showing 30 of 52 weekly inspections of their emergency generator have been completed. An interview with the Environmental Services Director verified this deficient findings at the time of discovery.	E 041	This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies. Anoka Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation " " How corrective action will be accomplished for those residents found to have been affected by the deficient practice. " New Environmental Services Director (ESD) started weekly inspections and testing the week of 4/21/23 with no weeks missed to date. Monthly inspection and testing started on 5/1/2023 by the new ESD and also completed on 6/5/2023. " How the facility will identify other residents having the potential to be affected by the same deficient practice. " All residents have the potential to be affected by the deficient practice. " What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. " ESD will educate maintenance staff on emergency policies regarding generator testing and inspecting. " How the facility will monitor its	

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E 041	Continued From page 4	E 041	corrective actions to ensure that the deficient practice is being corrected and will not recur. " ESD or designee will complete Random weekly audits x4 and random monthly audits x3 using an audit tool. Results will be brought to QAPI and reviewed for compliance.	
F 000	INITIAL COMMENTS On 5/15/23 through 5/18/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued. H52052305C (MN00093549) H52052141C (MN00092616) H52052140C (MN00091780) H52052222C (MN00091500) H52058875C (MN00091307) H52052223C (MN00090652) H52052224C (MN00089177) H52052225C (MN00087621) H52052139C (MN00086340) H52052226C (MN00086128) H5205152C (MN00081379) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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F 000	Continued From page 5 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to follow physician's orders for 2 of 2 Residents (R41 and R73) reviewed for nutrition. The facility failed to obtain and document weights for both residents according to the physician's orders. Findings include: R41's Admission Record indicated admission on 01/04/20, and readmission date of 02/16/23. Diagnoses ncluded dementia, epilepsy, congestive heart failure, and adult failure to thrive. R41's quarterly Minimum Data Set (MDS) dated 04/04/23, revealed Brief Interview Mental Status (BIMS) score of 06 out of 15, cognitive impairment.	F 658	This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies. Anoka Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation " How corrective action will be accomplished for those residents found to have been affected by the deficient practice.	7/12/23

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F 658

Continued From page 6

R41's orders included obtain "WEEKLY WEIGHT ...every day shift every Saturday ...Active 2/16/2023 06:00."

R41's Care Plan dated 02/22/23 revealed, "NUTRITION: Potential for altered nutrition status due to hospitalized for weakness, other dx (diagnosis): dementia, adult failure to thrive, CHF (congestive heart failure), GERD (gastroesophageal reflux disease). Food allergies. Decreased ability to communicate needs. Nutrition screening score-7 indicating malnourished status ... Observe changes in weight, notify physician."

R41's Treatment Administration Record (TAR) revealed " . . ."WEEKLY WEIGHT ...every day shift every Saturday" ...with order date of 02/16/23. However, the TAR lacked recorded weights on:
a. 02/25/23
b. 03/25/23
c. 04/01/23
d. 05/13/23

R73's Admission Record indicated admission on 12/09/22. Diagnoses of polyneuropathy, adult failure to thrive, macular degeneration, and age-related physical debility.

R73's quarterly MDS dated 04/11/23, indicated a BIMS score of 15 out of 15, cognitively intact.

R73's Care Plan dated 04/17/23 indicated, "NUTRITION ... Weigh resident per MD [physician] order ...Date Initiated: 12/15/2022."

R73's orders included "DAILY WEIGHT ... one

F 658

" Resident R41 was weighed on 6/10/2023 and weight is stable. Resident R73 was weighed on 6/16/2023. Physician has reviewed and deemed stable so new order set to weigh 1 time every 14 days instead of daily.
" How the facility will identify other residents having the potential to be affected by the same deficient practice.
" Residents requiring weights have the potential to be affected.
" What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
" Starting 6/16/2023 weekly weights have been changed from Saturday to every Friday for increased oversight
" 100% audit of charts completed to ensure all residents with orders for weights are being followed and in compliance.
" Policy for Weight Monitoring was reviewed with no changes required.
" Education provided to nursing staff concerning following physicians orders and the policy for Weight Monitoring
" How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
" DON or designee using an audit tool will do random checks weekly X4 and then monthly x 3 with results brought to the QAPI committee to ensure compliance has been met.

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F 658	Continued From page 7	F 658		

time a day ...Active 12/10/2022."

R19's TAR indicated " . . .DAILY WEIGHT ... one time a day ...Active 12/10/2022." However, the TAR lacked recorded weights on:
a. 12/17/22
b. 12/19/22
c. 12/24/22
d. 01/02/23
e. 01/09/23
f. 01/23/23
g. 01/30/23
h. 02/04/23
i. 02/10/23
j. 02/26/23
k. 03/09/23
l. 03/11/23
m. 03/16/23
n. 03/17/23
o. 03/18/23
p. 03/20/23
q. 03/21/23
r. 04/07/23
s. 04/12/23
t. 04/15/23
u. 05/01/23
v. 05/02/23
w. 05/08/23
x. 05/15/23

R73's EMR revealed no documentation that she had refused to be weighed.

During an interview on 05/16/23 at 9:47 a.m., licensed practical nurse (LPN)-B stated R41 "was to be weighed weekly according to doctor's orders." She stated the Nurse Aides (NA) were to complete and document the weights in the electronic medical reocord (EMR). LPN-B stated

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F 658	Continued From page 8 R41 received a supplement for weight and wound healing. During an interview on 05/16/23 at 10:09 a.m., nurse aide (NA)-A stated NA's completed weights and documented the EMR. NA-A was not aware when R73 was to be weighed because she normally did not work on that side of the facility. During an interview on 05/16/23 at 10:42 a.m., LPN-B stated R73's weights were to be taken daily per doctor's orders. LPN-B stated NA's were to complete and document in the EMR. LPN-B stated "I guess they are not being 100% completed." During an interview on 05/18/23 at 1:36 p.m., the Director of Nursing (DON) reviewed R41 and R73's physician's orders and staff documentation of weights. The DON confirmed order for weekly weights for R41 and daily weights for R 73. The DON stated, "Nope, they're not in there [weights]. If the order says they should be taking weights, under no circumstances should it not be completed unless the resident refuses, and if they refuse that should be documented and I don't see that either."	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure two of two	F 677	This plan of correction is prepared and executed because it is required by the	7/12/23

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residents (Resident (R)53 and R73) who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene out of a total sample of 50 residents.

Based on observation, interview and record review, the facility failed to provide necessary care for 2 of 2 residents (R53 and R73) reviewed for dependant for assistance with activities of daily living (ADL).

Findings include:

R53's Admission Record indicated admission on 11/15/22 with diagnoses of congestive heart failure, type two diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease, and hospice services.

R53's admission minimum Data Set (MDS) dated 05/02/23, indicated cognition intact. R53 required extensive assistance of two staff members for bed mobility and transfers, but extensive assistance of one staff for personal hygiene.

R53's care plan updated 04/16/23 revealed, "I am totally dependent for Bathing/Shower ... I need extensive to total staff assist with personal hygiene and grooming ..."

During an observation and interview on 05/15/23 at 12:00 p.m., R53's hair was long and oily. R53 stated she would "love" to get her hair washed more often; "they don't always do it when [R53] get a bath on Wednesday's." R53 stated she needed ask staff to wash her hair and stated, "It's been a few weeks".

F 677

provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies. Anoka Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation

" How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
" Resident R53 interviewed on her preferences for hair care and nail care and care plan updated. Resident R73 nails trimmed and signed on with the podiatry.
" How the facility will identify other residents having the potential to be affected by the same deficient practice.
" All residents receiving ADL cares have the potential to be affected
" What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
" 100% chart audit done to ensure no other residents are missing hair care and/or nail care.
" Policy for ADL care reviewed and no revisions required.
" Education provided to nursing staff on nail trimming and how to shampoo a bed ridden resident□s hair including the use of shampoo caps

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F 677	Continued From page 10 During an interview on 05/16/23 at 10:17 a.m., nurse aide (NA)-A stated nurse aides were responsible for bathing, hair washing, and nail care. She stated these tasks were completed for R53 on Tuesday mornings. NA-A stated once they complete the task, it was documented in the resident's record by the nurse or nurse aide. NA-A stated there were no hard charts for bathing tasks. During an interview on 05/16/23 at 10:45 a.m., licensed practical nurse (LPN)-A stated both hospice and facility staff were responsible for R53's bathing tasks. LPN-A stated R53 received bed baths twice a week. LPN-A stated hospice was responsible for completing one bed bath a week, and facility staff did the other. LPN-A stated nail care and hair washing was completed on shower days. She stated nail care and hair washing was to be completed every time as long as the resident allowed it. During an interview on 05/16/23 at 11:22 a.m., nurse manager (NM)-A reported R53 received bed baths exclusively due to her condition twice a week. The NM stated it was his expectation that during the bed baths, "hair was washed, total body was washed, and staff assisted with grooming." During an interview on 05/18/23 at 09:15 a.m., neither NA-A nor NA-B could remember the last time they washed R53's hair. NA-A stated, "Random aides from agency do it." NA-A and NA-B stated the expectation was to wash hair during showers. Both NAs stated there was no specific place to document when hair was washed. NA-B stated they were responsible for documenting refusals. R53's electronic medical	F 677	" Shampoo caps will be provided to all nursing units. " How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. " DON or designee, using an audit tool, to ensure resident□s hair and nail care are completed weekly X4 and then monthly x 3 with results brought to the QAPI committee to ensure compliance has been met.	

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F 677	Continued From page 11	F 677		

record lacked evidence of refusing hair washing.

During an interview on 05/18/23 at 1:36 p.m., with the Director of Nursing (DON) and the NM, the DON stated NAs were responsible for washing hair and completing nail care during weekly baths/showers. The NM stated facility staff completed one a week for R53 and hospice staff completed the other. The NM stated, "I supposed we need more specific documentation to track it [hair washing etc], but it was expected to be part of a standard bath unless R53 refuses." The DON reviewed R53's Medication Administration Record (MAR) and Treatment Administration Record (TAR) and stated, "it doesn't say anything about shampooing her hair."

R53's hospice notebook revealed documentation of having her hair washed on
01/25/23, 02/01/23, and 02/06/23 only. There was no other documentation found in R53's hospice notebook or EMR of having her hair washed since that time.

R73's admission record indicated admission on 12/09/22 with a diagnoses of polyneuropathy, adult failure to thrive, macular degeneration, and age-related physical debility.

R73's quarterly MDS dated 04/11/23, indicated cognition intact. R73 required extensive assistance of one for bed mobility and transfers, but extensive assistance of one staff for personal hygiene.

R73's care plan dated 04/17/23 indicated "I need extensive to total staff assist with personal hygiene and grooming."

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R73's record revealed documentation of nails trimmed on 12/09/22.

During an interview on 05/15/23 at 12:30 p.m., R73 stated she had neuropathy, and her hands tended to be very shaky. R73's toenails were observed to be very long and thick. The nails on the great toes of each foot were significantly above the toes. The nails on the remaining toes had started to curl around the top of each toe. R73 stated she has not had them trimmed for approximately three to four months. She stated the last time she got them trimmed was "around January or February and my friend did it for me." R73 stated she would like to have her toenails trimmed more often. She stated she "would love to get on the list to see the podiatrist who comes around and does things like that."

During an interview on 05/16/23 at 10:09 a.m., NA-A, stated R73's nails were to be trimmed on shower days. NA-A stated NAs could complete the task when the resident was not diabetic. NA-A stated this task was documented in each resident's EMR and there were no hard charts for this task.

During an interview on 05/16/23 at 10:42 a.m., licensed practical nurse (LPN)-A stated she was responsible for ensuring R73's nails were cleaned and trimmed, but NAs could complete the task because R73 was not diabetic. She stated R73's nails should be trimmed weekly during her shower. LPN-A stated the information was documented in R73's EMR under the "Tasks" tab under "Nail Care" and no hard charts were kept for that. LPN-A stated she had not been made aware that R73 wanted to be put on the list to see the podiatrist.

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During an interview on 05/16/23 at 11:22 a.m., NM stated he expected residents had their toenails trimmed weekly on their shower day.

During an interview on 05/17/23 at 2:39 p.m., R73 stated no one had come in to trim her toenails. R73 stated, "They're gonna be tearing through my sheets before long." R73 confirmed again that her friend was the last one to cut them for her in January or February. She stated that no NA had ever offered. She stated a "manicurist" came in today and trimmed her fingernails "but I don't think she does toenails."

During an interview on 05/18/23 at 9:12 a.m., NA-B stated Activities staff were responsible for trimming resident's toenails; "There's a volunteer that comes around and I think they do it. Someone was here yesterday doing that. If Activities doesn't do it, then the Nurses usually do it." NA-B confirmed NAs were responsible for the completion of showers; "If you [NAs] do showers, you should do her toenails." NA-B stated "Yes, I do [R73's] showers sometimes and if I thought her toenails needed to be trimmed, I would." When NA-B was asked to observe R73's toenails, she stated they were too thick to trim and needed to be filed.

During an interview on 05/18/23 at 1:36 p.m., with the Director of Nursing (DON) and NM, the DON stated, "We don't have anything that specifically documents that [nail trimming], but the expectation was to be done with weekly showers." The NM stated he recently put R73 on the list to see the podiatrist. The NM stated R73's nails "may be too thick to cut." He then stated, "If [R73's toenails] were too thick to be cut, they

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F 677	Continued From page 14 should be filed."	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure respiratory equipment was maintained and stored appropriately for 1 of 1 residents (R53) reviewed for respiratory care. The facility's deficient practice increased the resident's risk of respiratory complications. Findings include: R53's face sheet indicated admission on 11/15/22 with diagnoses of congestive heart failure, chronic respiratory failure with hypoxia, atherosclerotic heart disease, pulmonary hypertension, chronic obstructive pulmonary disease, chronic kidney disease, and received hospice services. R53's admission Minimum Data Set (MDS) dated 05/02/23 indicated cognitively intact. R53's orders revealed "Patient has pulse and/or is breathing. Comfort-Focused Treatments (Allow	F 695	This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies. Anoka Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation " How corrective action will be accomplished for those residents found to have been affected by the deficient practice. " R53 Was provided a new oxygen concentrator " How the facility will identify other residents having the potential to be	7/12/23

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Natural Death) ...Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort..."

R53's comprehensive care plan revealed "I have a cardiac diagnosis requiring monitoring and medications/treatments: CHF (congestive heart failure), AFIB (atrial fibrillation), CAD (coronary artery disease), Tricuspid insufficiency ... Give oxygen as ordered by the physician."

During an observation on 05/15/23 at 12:00 p.m., R53's oxygen concentrator was covered in dust. The filter was full of gray debris and lint.

During an interview on 05/16/23 at 10:17 a.m., nurse aide (NA)-A stated licensed practical nurses (LPN), and Registered Nurses (RN) changed tubing or cleaned filters on oxygen equipment.

During an interview on 05/16/23 at 10:45 a.m., LPN-A stated LPNs and RNs were responsible for changing tubing, filling water bottles, and other routine maintenance for R53's oxygen concentrator. She stated these cares were provided weekly on Saturday's. LPN-A stated R53's oxygen equipment was maintained by [Oxygen Equipment Company]. LPN-A was not able to locate any documentation where this company had provided maintenance or care to R53's oxygen concentrator.

During an interview on 05/16/23 at 11:22 p.m., nurse manager (NM) stated he was unsure where the oxygen equipment company documented any service provided to hospice resident's oxygen equipment. The NM stated facility staff were responsible for changing tubing and humidifiers

F 695

affected by the same deficient practice.
" Other residents requiring oxygen concentrators have the potential to be affected.
" What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
" New facility practice will include weekly assessment of oxygen concentrator filters by nursing staff. Filers that are not cleaned will be cleaned or replaced. DME suppliers will be contacted for filter replacements when needed.
" Policy for Lippincott Oxygen Administration Long Term Care was reviewed and required no updates.
" Education was provided to licensed nursing staff regarding the weekly assessment of oxygen concentrator filters and filter cleaning.
" How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
" DON or designee, using an audit tool, will complete checks weekly X4 and then monthly x3 with results brought to the QAPI committee to ensure compliance has been met.

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weekly, however, he was not aware who was responsible to ensure concentrator filters were cleaned.

During an observation and interview on 05/17/23 at 2:33 p.m., R53's oxygen concentrator had been switched. R53 stated "Oh they changed a bunch of things on it [oxygen concentrator] last night." The concentrator was an all-new machine with a clean filter.

During an interview on 05/17/23 at 2:49 p.m., the NM stated the filter was dirty; "We swapped out the machine yesterday for a temporary one that had a clean filter." He stated he spoke to hospice and no one was aware who was responsible for cleaning the concentrator filter. NM contacted the oxygen equipment provider and was informed the company did not have R53's concentrator on their log for services. The NM stated "I may have been a little too trusting there. I need to develop a system to monitor concentrators in general since they're prone to that problem."

During an interview on 05/18/23 at 1:36 p.m., with the DON and NM, the DON stated "I don't believe we have a policy that says who does it [cleans oxygen concentrator filters]. [The oxygen equipment company] let [R53's] machine slip through the cracks, but a nurse here should be monitoring that it's getting done."

F 726 SS=D Competent Nursing Staff F 726 7/12/23
CFR(s): 483.35(a)(3)(4)(c)

§483.35 Nursing Services
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure

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F 726	Continued From page 17 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure staff had competency in skills and techniques necessary to care for residents. There were no continuing on-going education credits since 02/02/22 or competency evaluations available for review for 1 of 5 employees (registered nurse (RN-B)) reviewed for training competencies. Findings include:	F 726	This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies. Anoka Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to	

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F 726	Continued From page 18 Review of RN-B's employee file and training record revealed that the last on-going continuing education credits were in 02/02/22 and four from 04/20/22. RN-B was given a formal email from the Human Resources department on 04/26/23 that stated "You are receiving this email because you currently have overdue Relias Courses. We use Relias online learning to provide on-going education credits to our staff that require continuing education units and to prove regulatory compliance for education that is required by State or Federal governing agencies. Please log in and complete all overdue Relias courses no later than Wednesday, May 3rd." As of 05/18/23, Human Resources had not received any trainings from RN-B. Interview on 05/18/23 at 2:29 p.m., the Director of Nursing (DON) stated he was unaware RN-B was not current with on-going education credits. "The training should have been completed by the date on the form."	F 726	render adequate care as prescribed by regulation " How corrective action will be accomplished for those residents found to have been affected by the deficient practice. " Employee RN-B had Relias training completed on 05/22/2023. " How the facility will identify other residents having the potential to be affected by the same deficient practice. " All residents have the potential to be impacted. " What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. " Policy for Relias training was reviewed with no changes recommended. " Employees with incomplete Relias training will be reviewed completion required by 7/12/2023. Staff to be removed from the schedule if not meeting the deadline requirements. " Staff to be educated on the important of timely completion of Relias training.. " How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. " HR or designee, using an audit tool, will ensure compliance weekly x 4 and then monthly x3. Results brought to QAPI to ensure compliance has been met	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		7/12/23

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F 755	Continued From page 19 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to establish a system of records of receipt and disposition of all controlled medications, for 1 of 4 nursing units. This failure prohibits the prompt identification of loss or potential diversion of controlled medications.	F 755	This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies.	

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	245205	A. BUILDING ______ B. WING ______	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

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F 755

Continued From page 20

Findings include:

According to a Facility Related Incident (FRI) on 02/26/22 at 8:00 a.m., Licensed Practical Nurse (LPN-A) gave resident (R296) 0.5 milliliters (ml) of Dilaudid (Opioid that is used for treating pain). After giving the medication, LPN-A went to return the drug to the medication storage room but was called into another resident's room to assist with cares. At 6:30 p.m., the end of shift, LPN-A completed the medication count with the incoming nurse and then left for the day. The medication was missed on the count of drugs. In the early morning hours of 02/27/23, LPN-A went to remove her belongings out of her pockets and found the bottle of Dilaudid belonging to R296. LPN-A immediately called the facility and told the incoming nurse that she had taken the bottle home with her and that she would leave to return it to the facility. The medication was returned, and the nurse and unit manager found 0.5ml of medication left in the bottle. LPN-A was called into the facility and completed a drug test that was negative and was suspended until the investigation was completed. LPN-A was permitted back to work four days later after the investigation noted that no medication was missing from the bottle and that R296 had not missed a dose of her medication.

Interview on 05/17/23 at 11:23 a.m., LPN-A stated she had left the facility with medication in her pocket. When she realized it was in her pocket, she called the facility and returned the medication. She was drug tested and suspended until the investigation was completed. LPN-A stated, "I have never done anything like this before, and I have no idea how it was missed

F 755

Anoka Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation

" How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
" Resident has since deceased
" How the facility will identify other residents having the potential to be affected by the same deficient practice.
" Residents receiving narcotic medication have the potential to be affected.
" What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
" The policy Inventory Control of Controlled substances was reviewed and no changes were recommended.
" At shift change nurse will need to view all pages of the narcotics log book to ensure inventory count is accurate to physical count.
" Education will be provided to the licensed nurses on this procedure change.
" How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
" DON or designee will conduct random weekly audits x4 then monthly x3 using an

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F 755	Continued From page 21	F 755		

when the narcotics were counted". No other disciplinary action was taken, and she was allowed to return to work within four days.

Interview on 05/18/23 at 12:16 p.m., Registered Nurse (RN-A) stated a thorough investigation was made, and the pharmacist was consulted. RN-A stated, "The Dilaudid bottle contained 30 ml of liquid and the narcotic book stated that 3 ml was left in the bottle. The pharmacist was consulted and stated that liquid could be plus or minus 10%. Since this was a 30 ml bottle, 10% would be 3 ml. There was 0.5 ml left in the bottle at count. This falls within the plus or minus of the10%. The street value of this amount of drug would be five dollars. As far as the medication leaving the facility, LPN-A did not follow procedure with the narcotic count and the other nurse (agency) did not follow procedure either. You have to be held accountable for the things you do. A narcotic audit was started immediately, and nursing staff was routinely monitored." RN-A stated staff and LPN-A were provided education after the incident. However, she was not able to provide any written documentation of the training.

The facility policy titled, "Inventory Control of Controlled Substances," dated 01/01/22, " ...Facility should ensure that the incoming and outgoing nurses count all controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on a "Controlled Substance Count Verification/Shift Count Sheet ...The facility should reconcile the total number of controlled medications on hand, add newly received medication to the inventory, and remove medications that are completed or discontinued from the inventory, pursuant to the

audit tool to ensure the narcotic counts are correct with results brought to QAPI to ensure compliance has been met.

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F 755	Continued From page 22 Controlled Substance Verification/Shift Count Sheet ...Reconcile the number of doses remaining in the package to the number of remaining doses recorded on the Shift Count Sheet ...The facility should routinely reconcile the number of doses remaining in the package to the number of doses recorded on the Shift Count Sheet to the medication administration record." The facility policy titled, "Routine Reconciliation of Controlled Substances," dated 01/01/22, "The facility should routinely reconcile controlled substances stored in medication carts, emergency supplies and controlled substances waiting to be destroyed ...A reconciliation of controlled substances should be conducted immediately upon any suspected diversion of controlled substances."	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a medication error rate of less than five percent. A total of 14 errors were made during medication administration for 2 of 5 residents (R40 and R77) observed for medication administration. The facility's medication error rate was 56%. Findings include:	F 759	This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies. Anoka Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of	7/12/23

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F 759 Continued From page 23 F 759

Observation on 05/16/23 at 7:50 a.m., Registered Nurse (RN-B) administered R40's medication. Per resident orders "all medications may be crushed". The following medications were crushed together: Seroquel (antipsychotic to treat schizophrenia/bipolar disorder; sertraline (treat depression, anxiety, and panic disorder); empagliflozin (treat diabetes); and isosorbide mononitrate (treat angina, a type of chest pain). RN-B dropped the sertraline on the floor, picked it up and then disposed of the drug in the sharp's container. He got out another sertraline and crushed all the medications together in the same packet. RN-B emptied the packet into a medicine cup and spilled some crushed medications on the countertop. He added two teaspoons of applesauce and gave it to R40. Observation of crushed medication left in the medicine cup.

Observation on 05/17/23 at 7:00 a.m., RN-B administered R77's medication. Per resident orders "all medications may be crushed". The following medications were crushed together: acetaminophen; senna (laxative); and citalopram (used for depression). RN-B emptied the crushed packet into a medicine cup and spilled some crushed medications on the countertop. He added two teaspoons of applesauce to the container and gave it to R77.

Observation on 05/17/23 at 7:22 a.m., RN-B administered R40's medication. Per resident orders"all medications may be crushed". The following medications were crushed together: aspirin; Tylenol; empagliflozin (used for diabetes); sertraline (used for depression, anxiety, and panic disorder; and Seroquel (antipsychotic used to treat schizophrenia/bipolar disorder). RN-B spilled crushed medication on countertop and left

such character as to limit our capacity to render adequate care as prescribed by regulation

" How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
" Risk management for the cited medication errors was completed in PCC for residents R40 and R77 assessed with no adverse outcomes.
" How the facility will identify other residents having the potential to be affected by the same deficient practice.
" Residents receiving medications that are crushed have the potential to be affected by the deficient practice.
" What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
" Facility policy for Crushing Medications was reviewed with no changes recommended.
" Residents that need to have their medications crushed, need an order from the practitioner to have crushed medications administered together.
" Education provided to all licensed nurses on crushed medication administration procedure and policy.
" How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
" DON or designee will conduct random audits weekly x4, then monthly for 3 months using an audit tool with results

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F 759	Continued From page 24 almost a half teaspoon of crushed medications in the plastic packet. Interview on 05/16/23 at 9:20 a.m., licensed practical nurse (LPN-B) stated when a controlled substance was dropped on the floor, it was placed in the small envelope labeled with dated, resident name, and medication. The envelope was placed in the medication storage room to be destroyed later by two nurses in the medication destroyer and then sign paperwork to document the medication. The incident needed to be documented in the progress notes. If the pill was not a controlled substance, it was discarded in the pill container. Interview on 05/17/23 at 7:40 a.m., RN-B stated it was "not easy to get the crushed medications into that little cup. I do my best. I think the resident got 98% of the meds." He confirmed he had not documented the dropped medication for R40. RN-B stated, "You can dispose of medication in the sharps container, putting it down the sink, or flushing it in the toilet." Interview on 05/17/23 at 8:36 a.m., RN-C stated when a pill was dropped, it was placed in the small envelope located in the medicine cabinet with the drug name, date, and resident name. It needed to be put in the medication room to be destroyed at a later date by two nursing staff. RN-C confirmed there was "a lot of medication" left in R40's plastic packet. Interview on 05/17/23 at 8:45 a.m., RN-D stated whether order stated "Ok to crush," the medications were to be crushed individually. If spilled, it could be identified what medication it was, and crush a new one. "If you crush all	F 759	brought to QAPI to ensure compliance.	

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F 759	Continued From page 25 medications together, you will never know what the resident received". Phone interview on 05/17/23 at 9:50 a.m., the pharmacy consultant stated "medications should be crushed individually and given individually." During interview on 05/18/23 at 2:39 p.m., Director of Nursing (DON) stated he was "speechless" when told the 56% error rate for the facility. A facility policy for medication error rate was requested. However, none was provided	F 759		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		7/12/23

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F 812

Continued From page 26

Based on observation, interview, and document review, the facility failed to ensure foods stored in the refrigerator were labeled and dated when opened. These failures had the potential to affect all 109 residents in the facility who consumed food from the kitchen.

Findings include:

Observation of the walk-in refrigerator on 05/15/23 at 11:00 a.m., with the Assistant Dietary Manger in the main first floor kitchen revealed the following:
-an open bag of onions that had been tied closed but sliced open, lacked a label with contents and opened on date.
-an open bag of cheese, lacked a label with opened on date or use by date.
-bag of sliced cucumbers, lacked a label with opened on date or use by date.
-an open bag of cube ham, lacked a label with contents, opened on date or use by date.

Observation continued to the walk-in freezer and revealed the following:
-a bag of hashbrowns, lacked a label of contents and opened on or use by date.
-French fries, lacked a label of contents and opened on or use by date.
-wax beans, lacked a label of contents and opened on or use by date.
-hot dogs, lacked a label of contents and opened on or use by date.
-sauerkraut, lacked a label of contents and opened on or use by date.

Interview with the Assistant Dietary Manager at time of the observation confirmed the these findings.

F 812

This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies. Anoka Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation

" How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
" All items in refrigerators and freezers that have been cut or opened had been labeled prior to survey exit.
" How the facility will identify other residents having the potential to be affected by the same deficient practice.
" All residents have the potential to be affected by the deficient practice.
" What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
" Facility policy for labeling and dating food was reviewed with no changes recommended.
" Education provided to dining staff to ensure foods stored in the refrigerator or freezer were labeled and dated when open.
" How the facility will monitor its corrective actions to ensure that the

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F 812	Continued From page 27 During an interview with the Dietary Manager on 05/16/23 at 3:30 p.m., stated there were signs to remind staff, and she expected them to label and date all opened food. Review of the undated facility's policy titled, "Food Storage," stated "Refrigerated food storage...f.- All foods should be covered labeled, and dated, and routinely monitored to ensure that foods ...will be consumed by their safe use by dates or frozen (where applicable) or discarded. Frozen food ...C. All foods should be covered, labeled, and dated ..."	F 812	deficient practice is being corrected and will not recur. " Dining director or designee will conduct random audits using an audit tool weekly x4, then monthly x3 and results will be brought to the QAPI committee to ensure compliance has been met.	

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/18/2023. At the time of this survey, Anoka Rehabilitation and Living Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/23/2023

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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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Anoka Rehabilitation & Living Center is a 2-story building with a basement that was built in 2012 and determined to be of Type II(111) construction. The building shares a common wall with an assisted living facility and is separated by a 2-hour fire-rated construction. Each floor containing resident sleeping rooms are divided into smoke compartments. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to

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K 000	Continued From page 2 the corridor, and resident rooms that are monitored for automatic fire department notification. The facility has a capacity of 120 beds and had a census of 110 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition),	K 353	This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations	7/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING **02 - ANOKA CARE & REHAB CENTER** B. WING ______	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	**3000 4TH AVENUE** **ANOKA, MN 55303**

(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
K 353	Continued From page 3 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.2.1.1.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/18/2023 at 09:45 AM, it was revealed by a review of available documentation that the facility was unable to provide documentation showing that a quarterly inspection was performed on the fire sprinkler system during the first quarters of 2023. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 353	listed in the statement of deficiencies. Anoka Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation " A detailed description of the corrective action taken or planned to correct the deficiency. " Immediately upon notification of deficiency we conducted the flow testing for the sprinkler on 4/25/2023 and also 6/15/2023. " Address the measures that will be put in place to ensure the deficiency does not reoccur. " ENVIRONMENTAL SERVICES DIRECTOR will educate maintenance staff on emergency policies regarding sprinkler system testing. " Indicate how the facility plans to monitor future performance to ensure solutions are sustained. " ENVIRONMENTAL SERVICES DIRECTOR or designee will complete quarterly audits x2 using an audit tool. Results will be brought to QAPI and reviewed for compliance. " Identify who is responsible for the corrective actions and monitoring of compliance. " ENVIRONMENTAL SERVICES DIRECTOR or designee	
K 712 SS=F	Fire Drills	K 712		7/12/23

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K 712	Continued From page 4 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/18/2023 at 09:00 AM, it was revealed by a review of available documentation that the facility did not perform a fire drill in the care facility during the third shift of the 4th quarter of 2022 and all shifts on the fist quarter of 2023. An interview with the Environmental Services Director verified this deficient findings at the time of discovery.	K 712	This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies. Anoka Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation " " A detailed description of the corrective action taken or planned to correct the deficiency. " New ENVIRONMENTAL SERVICES DIRECTOR completed fire drills on 4/20/2023 @ 1354 1st shift and 5/25/2023 @ 1700 2nd shift and will follow TELs schedule moving forward. " Address the measures that will be put	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING 02 - ANOKA CARE & REHAB CENTER B. WING	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

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K 712	Continued From page 5	K 712	in place to ensure the deficiency does not reoccur. " ENVIRONMENTAL SERVICES DIRECTOR to educate maintenance staff on how to and when to conduct fire drills. " Indicate how the facility plans to monitor future performance to ensure solutions are sustained. " ENVIRONMENTAL SERVICES DIRECTOR will do audits of conducted fire drills monthly x3 using an audit tool with results brought to QAPI to ensure compliance. " Identify who is responsible for the corrective actions and monitoring of compliance. " ENVIRONMENTAL SERVICES DIRECTOR or designee	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918		7/12/23

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K 918 Continued From page 6

transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.
6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)
This REQUIREMENT is not met as evidenced by:
Based on a review of available documentation and staff interview, the facility failed to test and inspect their emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.3.7, 8.3.8, 8.4.1, 8.4.2, and 8.4.2.3. These deficient findings could have a widespread impact on the residents within the facility.

Findings include:

1. On 05/18/2023 between 08:30 AM and 1:00 PM, it was revealed by a review of available documentation, the facility could not provide documentation showing monthly inspection of the emergency generator was completed for the months of October 2022 and April 2023.

K 918

This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies. Anoka Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation

" A detailed description of the corrective action taken or planned to correct the deficiency.
" New ENVIRONMENTAL SERVICES DIRECTOR started weekly inspections

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 7 2. On 05/18/2023 between 08:30 AM and 1:00 PM, it was revealed by a review of available documentation, the facility could not provide documentation showing 30 of 52 weekly inspections of their emergency generator have been completed. An interview with the Environmental Services Director verified this deficient findings at the time of discovery.	K 918	the week of 4/21/23 with no weeks missed. Monthly inspections were completed on May 1 and June 5, 2023. " Address the measures that will be put in place to ensure the deficiency does not reoccur. " ENVIRONMENTAL SERVICES DIRECTOR will educate maintenance staff on emergency policies regarding generator testing. " Indicate how the facility plans to monitor future performance to ensure solutions are sustained. " ENVIRONMENTAL SERVICES DIRECTOR or designee will complete weekly audits x4 and monthly audits x3 using an audit tool. Results will be brought to QAPI and reviewed for compliance. " Identify who is responsible for the corrective actions and monitoring of compliance. " ENVIRONMENTAL SERVICES DIRECTOR or Designee	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 14, 2023

Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

Re: State Nursing Home Licensing Orders
Event ID: 813Z11

Dear Administrator:

The above facility was surveyed on May 15, 2023, through May 18, 2023, 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:

Judy Loecken, 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: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: ______ B. WING ______	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	**3000 4TH AVENUE ANOKA, MN 55303**

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2 000	Initial Comments	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 5/15/23 through 5/18/23, a State Licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you

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2 000	Continued From page 1	2 000		

have reviewed these orders and identify the date when they will be completed.

The following complaints were reviewed with no deficiency issued.

H52052305C (MN00093549)
H52052141C (MN00092616)
H52052140C (MN00091780)
H52052222C (MN00091500)
H52058875C (MN00091307)
H52052223C (MN00090652)
H52052224C (MN00089177)
H52052225C (MN00087621)
H52052139C (MN00086340)
H52052226C (MN00086128)
H5205152C (MN00081379)

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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction.
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/ib14_1.html The State licensing

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2 000	Continued From page 2 orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure staff had competency in skills and techniques necessary to care for residents. There were no continuing on-going education credits since 02/02/22 or competency evaluations available for review for 1 of 5 employees (registered nurse (RN-B)) reviewed for training competencies. Findings include: Review of RN-B's employee file and training record revealed that the last on-going continuing	2 300	N/A	7/12/23

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2 300	Continued From page 3	2 300		

education credits were in 02/02/22 and four from 04/20/22. RN-B was given a formal email from the Human Resources department on 04/26/23 that stated "You are receiving this email because you currently have overdue Relias Courses. We use Relias online learning to provide on-going education credits to our staff that require continuing education units and to prove regulatory compliance for education that is required by State or Federal governing agencies. Please log in and complete all overdue Relias courses no later than Wednesday, May 3rd." As of 05/18/23, Human Resources had not received any trainings from RN-B.

Interview on 05/18/23 at 2:29 p.m., the Director of Nursing (DON) stated he was unaware RN-B was not current with on-going education credits. "The training should have been completed by the date on the form."

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designated person to determine how the deficiency occurred, could review policies and procedures of Staff Competencies with Medication Administration and current standards, revise as necessary, review and educate staff on revisions, and monitor to ensure compliance.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days.

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2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs	2 920		7/12/23

Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:
B. a resident who is unable to carry out

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2 920	Continued From page 4 activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: F677 Based on observation, record review, and interviews, the facility failed to ensure two of two residents (Resident (R)53 and R73) who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene out of a total sample of 50 residents. Based on observation, interview and record review, the facility failed to provide necessary care for 2 of 2 residents (R53 and R73) reviewed for dependant for assistance with activities of daily living (ADL). Findings include: R53's Admission Record indicated admission on 11/15/22 with diagnoses of congestive heart failure, type two diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease, and hospice services. R53's admission minimum Data Set (MDS) dated 05/02/23, indicated cognition intact. R53 required extensive assistance of two staff members for bed mobility and transfers, but extensive assistance of one staff for personal hygiene. R53's care plan updated 04/16/23 revealed, "I am totally dependent for Bathing/Shower ... I need extensive to total staff assist with personal hygiene and grooming ..."	2 920	N/A	

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ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

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2 920	Continued From page 5 During an observation and interview on 05/15/23 at 12:00 p.m., R53's hair was long and oily. R53 stated she would "love" to get her hair washed more often; "they don't always do it when [R53] get a bath on Wednesday's." R53 stated she needed ask staff to wash her hair and stated, "It's been a few weeks". During an interview on 05/16/23 at 10:17 a.m., nurse aide (NA)-A stated nurse aides were responsible for bathing, hair washing, and nail care. She stated these tasks were completed for R53 on Tuesday mornings. NA-A stated once they complete the task, it was documented in the resident's record by the nurse or nurse aide. NA-A stated there were no hard charts for bathing tasks. During an interview on 05/16/23 at 10:45 a.m., licensed practical nurse (LPN)-A stated both hospice and facility staff were responsible for R53's bathing tasks. LPN-A stated R53 received bed baths twice a week. LPN-A stated hospice was responsible for completing one bed bath a week, and facility staff did the other. LPN-A stated nail care and hair washing was completed on shower days. She stated nail care and hair washing was to be completed every time as long as the resident allowed it. During an interview on 05/16/23 at 11:22 a.m., nurse manager (NM)-A reported R53 received bed baths exclusively due to her condition twice a week. The NM stated it was his expectation that during the bed baths, "hair was washed, total body was washed, and staff assisted with grooming." During an interview on 05/18/23 at 09:15 a.m.,	2 920		

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neither NA-A nor NA-B could remember the last time they washed R53's hair. NA-A stated, "Random aides from agency do it." NA-A and NA-B stated the expectation was to wash hair during showers. Both NAs stated there was no specific place to document when hair was washed. NA-B stated they were responsible for documenting refusals. R53's electronic medical record lacked evidence of refusing hair washing.

During an interview on 05/18/23 at 1:36 p.m., with the Director of Nursing (DON) and the NM, the DON stated NAs were responsible for washing hair and completing nail care during weekly baths/showers. The NM stated facility staff completed one a week for R53 and hospice staff completed the other. The NM stated, "I supposed we need more specific documentation to track it [hair washing etc], but it was expected to be part of a standard bath unless R53 refuses." The DON reviewed R53's Medication Administration Record (MAR) and Treatment Administration Record (TAR) and stated, "it doesn't say anything about shampooing her hair."

R53's hospice notebook revealed documentation of having her hair washed on 01/25/23, 02/01/23, and 02/06/23 only. There was no other documentation found in R53's hospice notebook or EMR of having her hair washed since that time.

R73's admission record indicated admission on 12/09/22 with a diagnoses of polyneuropathy, adult failure to thrive, macular degeneration, and age-related physical debility.

R73's quarterly MDS dated 04/11/23, indicated cognition intact. R73 required extensive assistance of one for bed mobility and transfers,

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but extensive assistance of one staff for personal hygiene.

R73's care plan dated 04/17/23 indicated "I need extensive to total staff assist with personal hygiene and grooming."

R73's record revealed documentation of nails trimmed on 12/09/22.

During an interview on 05/15/23 at 12:30 p.m., R73 stated she had neuropathy, and her hands tended to be very shaky. R73's toenails were observed to be very long and thick. The nails on the great toes of each foot were significantly above the toes. The nails on the remaining toes had started to curl around the top of each toe. R73 stated she has not had them trimmed for approximately three to four months. She stated the last time she got them trimmed was "around January or February and my friend did it for me." R73 stated she would like to have her toenails trimmed more often. She stated she "would love to get on the list to see the podiatrist who comes around and does things like that."

During an interview on 05/16/23 at 10:09 a.m., NA-A, stated R73's nails were to be trimmed on shower days. NA-A stated NAs could complete the task when the resident was not diabetic. NA-A stated this task was documented in each resident's EMR and there were no hard charts for this task.

During an interview on 05/16/23 at 10:42 a.m., licensed practical nurse (LPN)-A stated she was responsible for ensuring R73's nails were cleaned and trimmed, but NAs could complete the task because R73 was not diabetic. She stated R73's nails should be trimmed weekly during her

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shower. LPN-A stated the information was documented in R73's EMR under the "Tasks" tab under "Nail Care" and no hard charts were kept for that. LPN-A stated she had not been made aware that R73 wanted to be put on the list to see the podiatrist.

During an interview on 05/16/23 at 11:22 a.m., NM stated he expected residents had their toenails trimmed weekly on their shower day.

During an interview on 05/17/23 at 2:39 p.m., R73 stated no one had come in to trim her toenails. R73 stated, "They're gonna be tearing through my sheets before long." R73 confirmed again that her friend was the last one to cut them for her in January or February. She stated that no NA had ever offered. She stated a "manicurist" came in today and trimmed her fingernails "but I don't think she does toenails."

During an interview on 05/18/23 at 9:12 a.m., NA-B stated Activities staff were responsible for trimming resident's toenails; "There's a volunteer that comes around and I think they do it. Someone was here yesterday doing that. If Activities doesn't do it, then the Nurses usually do it." NA-B confirmed NAs were responsible for the completion of showers; "If you [NAs] do showers, you should do her toenails." NA-B stated "Yes, I do [R73's] showers sometimes and if I thought her toenails needed to be trimmed, I would." When NA-B was asked to observe R73's toenails, she stated they were too thick to trim and needed to be filed.

During an interview on 05/18/23 at 1:36 p.m., with the Director of Nursing (DON) and NM, the DON stated, "We don't have anything that specifically documents that [nail trimming], but the

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2 920	Continued From page 9 expectation was to be done with weekly showers." The NM stated he recently put R73 on the list to see the podiatrist. The NM stated R73's nails "may be too thick to cut." He then stated, "If [R73's toenails] were too thick to be cut, they should be filed." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, could review policies and procedures of Activities of daily living for dependant residents and current standards, revise as necessary, review and educate staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 920		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or	21545		7/12/23

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safety; or
(2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.
C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.

This MN Requirement is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to ensure a medication error rate of less than five percent. A total of 14 errors were made during medication administration for 2 of 5 residents (R40 and R77) observed for medication administration. The facility's medication error rate was 56%.

N/A

Findings include:

Observation on 05/16/23 at 7:50 a.m., Registered

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21545	Continued From page 11 Nurse (RN-B) administered R40's medication. Per resident orders "all medications may be crushed". The following medications were crushed together: Seroquel (antipsychotic to treat schizophrenia/bipolar disorder; sertraline (treat depression, anxiety, and panic disorder); empagliflozin (treat diabetes); and isosorbide mononitrate (treat angina, a type of chest pain). RN-B dropped the sertraline on the floor, picked it up and then disposed of the drug in the sharp's container. He got out another sertraline and crushed all the medications together in the same packet. RN-B emptied the packet into a medicine cup and spilled some crushed medications on the countertop. He added two teaspoons of applesauce and gave it to R40. Observation of crushed medication left in the medicine cup. Observation on 05/17/23 at 7:00 a.m., RN-B administered R77's medication. Per resident orders "all medications may be crushed". The following medications were crushed together: acetaminophen; senna (laxative); and citalopram (used for depression). RN-B emptied the crushed packet into a medicine cup and spilled some crushed medications on the countertop. He added two teaspoons of applesauce to the container and gave it to R77. Observation on 05/17/23 at 7:22 a.m., RN-B administered R40's medication. Per resident orders"all medications may be crushed". The following medications were crushed together: aspirin; Tylenol; empagliflozin (used for diabetes); sertraline (used for depression, anxiety, and panic disorder; and Seroquel (antipsychotic used to treat schizophrenia/bipolar disorder). RN-B spilled crushed medication on countertop and left almost a half teaspoon of crushed medications in the plastic packet.	21545		

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Interview on 05/16/23 at 9:20 a.m., licensed practical nurse (LPN-B) stated when a controlled substance was dropped on the floor, it was placed in the small envelope labeled with dated, resident name, and medication. The envelope was placed in the medication storage room to be destroyed later by two nurses in the medication destroyer and then sign paperwork to document the medication. The incident needed to be documented in the progress notes. If the pill was not a controlled substance, it was discarded in the pill container.

Interview on 05/17/23 at 7:40 a.m., RN-B stated it was "not easy to get the crushed medications into that little cup. I do my best. I think the resident got 98% of the meds." He confirmed he had not documented the dropped medication for R40. RN-B stated, "You can dispose of medication in the sharps container, putting it down the sink, or flushing it in the toilet."

Interview on 05/17/23 at 8:36 a.m., RN-C stated when a pill was dropped, it was placed in the small envelope located in the medicine cabinet with the drug name, date, and resident name. It needed to be put in the medication room to be destroyed at a later date by two nursing staff. RN-C confirmed there was "a lot of medication" left in R40's plastic packet.

Interview on 05/17/23 at 8:45 a.m., RN-D stated whether order stated "Ok to crush," the medications were to be crushed individually. If spilled, it could be identified what medication it was, and crush a new one. "If you crush all medications together, you will never know what the resident received".

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Phone interview on 05/17/23 at 9:50 a.m., the pharmacy consultant stated "medications should be crushed individually and given individually."

During interview on 05/18/23 at 2:39 p.m., Director of Nursing (DON) stated he was "speechless" when told the 56% error rate for the facility.

A facility policy for medication error rate was requested. However, none was provided.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designated person to determine how the deficiency occurred, could review policies and procedures of Medication Administration and current standards, revise as necessary, review and educate staff on revisions, and monitor to ensure compliance.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days.

21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction	21630		7/12/23

Subp. 2. Destruction of medications.
A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years.
B. Unused portions of other prescription drugs remaining in the nursing home after the

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death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to establish a system of records of receipt and disposition of all controlled medications, for 1 of 4 nursing units. This failure prohibits the prompt identification of loss or potential diversion of controlled medications.

N/A

Findings include:

According to a Facility Related Incident (FRI) on 02/26/22 at 8:00 a.m., Licensed Practical Nurse (LPN-A) gave resident (R296) 0.5 milliliters (ml) of Dilaudid (Opioid that is used for treating pain). After giving the medication, LPN-A went to return the drug to the medication storage room but was called into another resident's room to assist with cares. At 6:30 p.m., the end of shift, LPN-A completed the medication count with the incoming nurse and then left for the day. The medication was missed on the count of drugs. In the early morning hours of 02/27/23, LPN-A went to remove her belongings out of her pockets and found the bottle of Dilaudid belonging to R296. LPN-A immediately called the facility and told the incoming nurse that she had taken the bottle

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21630	Continued From page 15 home with her and that she would leave to return it to the facility. The medication was returned, and the nurse and unit manager found 0.5ml of medication left in the bottle. LPN-A was called into the facility and completed a drug test that was negative and was suspended until the investigation was completed. LPN-A was permitted back to work four days later after the investigation noted that no medication was missing from the bottle and that R296 had not missed a dose of her medication. Interview on 05/17/23 at 11:23 a.m., LPN-A stated she had left the facility with medication in her pocket. When she realized it was in her pocket, she called the facility and returned the medication. She was drug tested and suspended until the investigation was completed. LPN-A stated, "I have never done anything like this before, and I have no idea how it was missed when the narcotics were counted". No other disciplinary action was taken, and she was allowed to return to work within four days. Interview on 05/18/23 at 12:16 p.m., Registered Nurse (RN-A) stated a thorough investigation was made, and the pharmacist was consulted. RN-A stated, "The Dilaudid bottle contained 30 ml of liquid and the narcotic book stated that 3 ml was left in the bottle. The pharmacist was consulted and stated that liquid could be plus or minus 10%. Since this was a 30 ml bottle, 10% would be 3 ml. There was 0.5 ml left in the bottle at count. This falls within the plus or minus of the10%. The street value of this amount of drug would be five dollars. As far as the medication leaving the facility, LPN-A did not follow procedure with the narcotic count and the other nurse (agency) did not follow procedure either. You have to be held accountable for the things you do. A narcotic audit	21630		

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was started immediately, and nursing staff was routinely monitored." RN-A stated staff and LPN-A were provided education after the incident. However, she was not able to provide any written documentation of the training.

The facility policy titled, "Inventory Control of Controlled Substances," dated 01/01/22, " ...Facility should ensure that the incoming and outgoing nurses count all controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on a "Controlled Substance Count Verification/Shift Count Sheet ...The facility should reconcile the total number of controlled medications on hand, add newly received medication to the inventory, and remove medications that are completed or discontinued from the inventory, pursuant to the Controlled Substance Verification/Shift Count Sheet ...Reconcile the number of doses remaining in the package to the number of remaining doses recorded on the Shift Count Sheet ...The facility should routinely reconcile the number of doses remaining in the package to the number of doses recorded on the Shift Count Sheet to the medication administration record."

The facility policy titled, "Routine Reconciliation of Controlled Substances," dated 01/01/22, "The facility should routinely reconcile controlled substances stored in medication carts, emergency supplies and controlled substances waiting to be destroyed ...A reconciliation of controlled substances should be conducted immediately upon any suspected diversion of controlled substances."

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designated person to

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21630	Continued From page 17 determine how the deficiency occurred, could review policies and procedures, and review standard related to proper storage and dispoal of medication, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21630		