DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8ZGD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00893

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245205**

2.STATE VENDOR OR MEDICAID NO.
(L2) **261960100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANOKA REHABILITATION AND LIVING CENTER**
(L4) **3000 4TH AVENUE**
(L5) **ANOKA, MN** (L6) **55303**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2012**

6. DATE OF SURVEY **12/08/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor 12/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 12/19/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/07/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS
Posted 12/22/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/23/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245205
December 19, 2016

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation & Living Center
3000 Fourth Avenue
Anoka, MN 55303

Dear Mr. Dolinsky:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 30, 2016 the above facility is certified for or recommended for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 120 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File
Office of Health Facility Complaints

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 19, 2016

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation & Living Center
3000 Fourth Avenue
Anoka, MN 55303

RE: Project Number S5205027 & H5205041

Dear Mr. Dolinsky:

On November 4, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 21, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 8, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 8, 2016 the Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 30, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 21, 2016, effective November 30, 2016 and therefore remedies outlined in our letter to you dated November 4, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245205 Y1	A. Building B. Wing Y2	12/8/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0279	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	11/30/2016	LSC	11/30/2016	LSC	11/30/2016
ID Prefix F0309	Correction	ID Prefix F0315	Correction	ID Prefix F0329	Correction
Reg. # 483.25	Completed	Reg. # 483.25(d)	Completed	Reg. # 483.25(l)	Completed
LSC	11/30/2016	LSC	11/30/2016	LSC	11/30/2016
ID Prefix F0334	Correction	ID Prefix F0353	Correction	ID Prefix F0425	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.30(a)	Completed	Reg. # 483.60(a),(b)	Completed
LSC	11/30/2016	LSC	11/30/2016	LSC	11/30/2016
ID Prefix F0428	Correction	ID Prefix F0431	Correction	ID Prefix F0441	Correction
Reg. # 483.60(c)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed
LSC	11/30/2016	LSC	11/30/2016	LSC	11/30/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2016	LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 12/19/2016	SIGNATURE OF SURVEYOR 10562	DATE 12/08/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/21/2016	☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245205 (Y1)	A. Building B. Wing (Y2)	12/8/2016 (Y3)

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 11/30/2016	ID Prefix F0353 Reg. # 483.30(a) LSC	Correction Completed 11/30/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 12/19/2016	SIGNATURE OF SURVEYOR 10562	DATE 12/08/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/21/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8ZGD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00893

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245205**

2.STATE VENDOR OR MEDICAID NO.
(L2) **261960100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANOKA REHABILITATION AND LIVING CENTER**
(L4) **3000 4TH AVENUE**
(L5) **ANOKA, MN** (L6) **55303**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2012**

6. DATE OF SURVEY **10/21/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Christine Bodick-Nord, HFE NE II 11/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 11/22/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/07/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 11/23/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

REVISED

Electronically delivered
November 11, 2016

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, Minnesota 55303

RE: Project Number S5205026 and Complaint Investigation Number H5205041

Dear Mr. Dolinsky:

Please note: language was added to the letter to identify the complaint that was investigated at the time of the October 21, 2016 survey.

On October 21, 2016, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the October 21, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5205041 that was found to be substantiated at F315 and F353.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343 Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 30, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 30, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 January 21, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 21, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 4, 2016

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, Minnesota 55303

RE: Project Number S5205026

Dear Mr. Dolinsky:

On October 21, 2016, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343 Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 30, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 30, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 January 21, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 21, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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 _____	10/21/2016

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
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. An investigation of complaint H5205041 was completed at the time of the recertification survey. The complaint was substantiated and deficiencies were cited at F315 and F353. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225		11/30/16

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

Electronically Signed | 11/12/2016

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F 225	Continued From page 1 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were immediately reported to the state agency (SA) and/or thoroughly investigated for 1 of 4 residents (R416) reviewed for abuse and neglect. Findings include: R416's Admission Record identified R416 admitted to the facility on 10/12/16, with diagnosis including End Stage Renal Disease (ESRD). Social Services Assessment dated 10/14/16, identified R416 was cognitively intact. Progress note dated 10/13/16, at 9:00 a.m. noted "Staff Nurse reported patient verbalized he did not want to go to Dialysis today, stating to the	F 225	The facility must not employ individuals who have been□ Found guilty of abusing, neglecting, or mistreating residents by a court of law; or Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown	

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F 225	Continued From page 2 nurse that at dialysis he is treated rough, CCU LSW [critical care unit licensed social worker] and son updated. Son verbalized he would like to be called and put on speaker for tomorrows [sp] Optimal Rounds between 10:30-11:00." Additional review of progress notes dated 10/13/16 through 10/19/16, revealed no further mention of the reported abuse. During interview on 10/20/16, at 1:48 p.m. social services (SS)-B stated a verbal report was given to her on the morning of 10/13/16, about R416 not wanting to go to dialysis, but she did not contact the dialysis facility. On 10/14/16, rounds were held with R416's son, and the incident was not brought up by the son. SS-B stated she was not certain if he attended the same dialysis center after his admission. SS-B did state if a resident reported being treated roughly at the nursing home, it would be reported to the director of social services (DSS) and the nurse manager, and an investigation would be started. SS-B also stated this would be reportable to the state, since all residents are considered a vulnerable adult and the responsibility of the nursing home, even when sent out to another facility for care. This incident was not reported to DSS or the administrator. During interview on 10/20/16, at 2:01 p.m. assistant director of nursing (ADON) was not aware of R416's report, but would expect this be dealt with immediately. Staff would be expected to ensure resident is safe, report to her, the DSS, or administrator. Further, ADON stated this incident should have been reported to the state. During interview on 10/20/16, at 2:10 p.m. clinical	F 225	source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Resident(s) #416 identified in this statement of deficiency for the incident for the allegation of abuse were reviewed and investigated. The allegation was reported to the state agency, investigation was reviewed and completed, and care plan reviewed and updated. All staff will be educated by 11/30/16 on mandated reporting, and protocols for response to allegations of abuse/neglect, including ensuring the allegation is immediately reported to the administrator and to the state agency and thorough investigation is completed according to	

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F 225	Continued From page 3 manager (CM)-A stated he was informed of the incident by licensed practical nurse (LPN)-A the morning of 10/13/16, after R416 had left for dialysis. CM-A then went to a meeting, and instructed SS-B to call the ESRD facility to report it to them, but was not aware if this was done or not. CM-A stated this is reportable to the state. During interview on 10/21/16, at 8:23 a.m. LPN-A stated R416 had reported to her that he did not want to go to dialysis, because they [staff] were rough. When the transport company arrived, it was found that he was going to a different company than he reported were rough. LPN-A stated when CM-A came in that morning, she reported the incident to him. Any abuse is reported to the CM. During interview on 10/21/16, at 8:37 a.m. DSS stated with abuse the first step would be to speak to the resident. Staff notify DSS, who initiates reporting and the investigation. The nurse on the unit is able to report the claim to the state. The floor nurses are trained to enter the data into their risk management document. DSS stated this incident was not reported to the state when it was initially reported to staff, and verified it should have been. DSS denied knowledge of the incident prior to the survey. Facility policy titled Resident/client/participant Protection Policy and Procedure revision date 8/16, indicated employees must always report alleged abuse/neglect immediately to the supervisor. It also noted if there is suspicion that abuse occurred, it will be reported to the state in accordance with state law.	F 225	policy. The Director of Social Services, Director of Nursing or Administrator and/or designee will implement corrective actions for other residents potentially affected by this practice including: Residents potentially affected by the practice as outlined in the statement of deficiency will be identified through resident interview/audits, to be completed by 11 /11/16. Identified allegations for abuse, neglect, and misappropriation of property will be reported immediately to the administrator and state agency, and thoroughly investigated according to policy. The Director of Nursing and/or designee will implement measures to ensure that this practice does not recur, including: review of the following policies and procedures: Resident Protection Policies including review that each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion, utilization of resident protection process and forms and staff interview/audits. Management staff involved with investigations will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures on Resident Protection Policies. Training of staff will be completed by 11/30 /16.	

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F 225	Continued From page 4	F 225	The Director of Social Services, Director of Nursing and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: full utilization of the resident protection policy and procedure. To ensure correction is achieved and sustained facility will continue to follow the resident protection procedure. The facility will use tools and resources including the Investigation and Witness Guidelines and Checklist from the Resident Protection manual. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee for six months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility Director of Social Services, Director of Nursing and Executive Director will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		11/30/16

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F 226	Continued From page 5 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their vulnerable adult policy to ensure all alleged violations involving reported abuse was immediately reported to the administrator and the state agency for 1 of 4 residents (R416) reviewed. Findings include: Facility policy titled Resident/client/participant Protection Policy and Procedure, revision date 8/16, indicated employees must always report alleged abuse/neglect immediately to the supervisor. It also noted if there is suspicion that abuse occurred, it will be reported to the state in accordance with state law. Progress note dated 10/13/16, at 9:00 a.m. noted "Staff Nurse reported patient verbalized he did not want to go to Dialysis today, stating to the nurse that at dialysis he is treated rough, CCU LSW [critical care unit licensed social worker] and son updated. Son verbalized he would like to be called and put on speaker for tomorrows [sp] Optimal Rounds between 10:30-11:00." The incident was not reported to the state until 10/20/16.	F 226	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Resident(s) #416 identified in this statement of deficiency for the incident for the allegation of abuse were reviewed and investigated. The allegation was reported to the state agency, investigation was reviewed and completed, and care plan reviewed and updated. All staff will be educated by 11/30 /16 on mandated reporting, and protocols for response to allegations of abuse/neglect, including ensuring the allegation is immediately reported to the administrator and to the state agency and thorough investigation is completed according to policy. The Director of Social Services, Director of Nursing or Administrator and/or designee will implement corrective actions for other residents potentially affected by this practice including:	

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F 226	Continued From page 6 During interview on 10/20/16, at 1:48 p.m. social services (SS)-B stated a verbal report was given to her on the morning of 10/13/16 about R416 not wanting to go to dialysis, but she did not contact the dialysis facility, and did not report this to the state agency. SS-B also stated this would be reportable to the state, since all residents are considered a vulnerable adult and the responsibility of the nursing home, even when sent out to another facility for care. This incident was not reported to DSS or the administrator. During interview on 10/20/16, at 2:01 p.m. assistant director of nursing (ADON) was not aware of R416's report, but would expect this be dealt with immediately. Staff would be expected to ensure resident is safe, report to her, the DSS, or administrator. Further, ADON stated this incident should have been reported to the state. During interview on 10/20/16, at 2:10 p.m. clinical manager (CM)-A stated he was informed of the incident by licensed practical nurse (LPN)-A the morning of 10/13/16, after R416 had left for dialysis. CM-A then went to a meeting, and instructed SS-B to call the ESRD facility to report it to them, but was not aware if this was done or not. CM-A stated this is reportable to the state. During interview on 10/21/16, at 8:23 a.m. LPN-A stated R416 had reported to her that he did not want to go to dialysis, because they [staff] were rough. When the transport company arrived, it was found that he was going to a different company than he reported were rough. LPN-A stated when CM-A came in that morning, she reported the incident to him. Any abuse is reported to the CM.	F 226	Residents potentially affected by the practice as outlined in the statement of deficiency will be identified through resident interview/audits, to be completed by 11 /11/16. Identified allegations for abuse, neglect, and misappropriation of property will be reported immediately to the administrator and state agency, and thoroughly investigated according to policy. The Director of Nursing and/or designee will implement measures to ensure that this practice does not recur, including: review of the following policies and procedures: Resident Protection Policies including review that each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion, utilization of resident protection process and forms and staff interview/audits. Management staff involved with investigations will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures on Resident Protection Policies. Training of staff will be completed by 11/30/16. The Director of Social Services, Director of Nursing and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: full utilization of the resident protection policy and procedure. To ensure correction is achieved and	

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F 226	Continued From page 7 During interview on 10/21/16, at 8:37 a.m. DSS stated with abuse the first step would be to speak to the resident. Staff notify DSS, who initiates reporting and the investigation. The nurse on the unit is able to report the claim to the state. The floor nurses are trained to enter the data into their risk management document. DSS stated this incident was not reported to the state when it was initially reported to staff, and verified it should have been. DSS denied knowledge of the incident prior to the survey.	F 226	sustained facility will continue to follow the resident protection procedure. The facility will use tools and resources including the Investigation and Witness Guidelines and Checklist from the Resident Protection manual. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee for six months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility Director of Social Services, Director of Nursing and Executive Director will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		11/30/16

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F 279	Continued From page 8 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan to minimize the risk of burns for 1 of 1 residents (R35) reviewed for safety related to coffee burns. Findings include: R35's Care Area Assessment (CAA) dated 1/19/16, identified a physical limitation causing weakness, limited range of motion, or poor coordination. R35's quarterly Minimum Data Set (MDS) dated 9/22/16, identified R35 as being cognitively intact, a diagnosis of hemiplegia, and had an impairment of her upper extremity. During interview on 10/18/16, at 11:26 a.m. R35 stated she had blisters on her bilateral thighs from a coffee burn sustained after spilling coffee,	F 279	It is the policy of Anoka Rehabilitation and living center to provide care and services by qualified persons in accordance with each resident□s written plan of care. IDT reassessed F35□s safety risk for handling hot beverages. A summary of the reassessment was completed 10/20/16. The care plan was reviewed and revised based on the reassessment by the interdisciplinary team on 10/20/16. Corresponding updates have been made care plan and kardex to reflect patient safety regarding hot beverages. Household staff were updated on the changes on 10/20/16. To identify residents who have a safety risk involving hot liquids, the IDT will review all residents on LTC. The individual care plans and kardex will be updated as	

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F 279	Continued From page 9 saying she liked to place the cup between her knees to carry it back to her room. R35 stated she sustained the burn approximately a week ago. A facility nursing note, dated 10/11/16, indicated R35 had spilled coffee in her lap after breakfast while bringing the cup back to her room. An interdisciplinary team review summary, dated 10/12/16, identified that the incident had been reviewed, interventions put in place, and indicated the "Care plan is up to date." R35's current care plan, last reviewed 10/13/16, did not include a safety diagnosis related to the coffee burns, nor did it have any interventions related to the burns. Review of the facility's nursing assistant group sheets, undated, identified R35 was "not to eat alone in her room." The sheets did not direct nursing assistants to assist R35 with coffee. During observation on 10/19/16, at 7:23 a.m. R35 was sitting at breakfast. A standard uncovered coffee mug, approximately 1/2 full, sat on the table on her right side. On 10/19/16, at 11:25 a.m., nursing assistant (NA)-B stated after burning herself, R35 had a device to hold onto her coffee instead of placing the coffee cup in between her knees, but was not aware of what kind of device R35 used. NA-B went on to state staff were suppose to assist R35 with getting coffee during meals. NA-B stated the nursing assistant sheets did not contain any information related to the burns, but they "probably should."	F 279	indicated by the review. On-going, the LTC residents will be reassessed quarterly and PRN change in condition. All LTC admissions will be assessed to identify individual safety needs for dining upon admission, significant change and quarterly and to reflect their individualized needs. The care plan and kardex will be updated with the findings. The Change in Condition and Care Plan policy will be reviewed and revised as necessary. Random Careplan audits will be completed once weekly x 3 weeks, monthly x 3 then quarterly for 2 quarters. Audits results will be reported to Quality Assurance Committee for review and further recommendations to ensure resident safety. The Director of Nursing or designee will be responsible for compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16.	

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F 279	Continued From page 10 During interview on 10/19/16, at 11:35 a.m. licensed practical nurse (LPN)-C was not aware of any device R35 used to hold her coffee. LPN-C stated R35 refused a covered coffee cup and would go to the coffee machine by herself in between meals. LPN-C went on to state, after the burn, staff tried to assist R35 with getting coffee when in the dining room. LPN-C further reported interventions regarding the burn "should be on her [R35's] care plan." On 11/20/16, at 2:10 p.m., assistant director of nursing (ADON) stated after the incident R35 was not suppose to get coffee by herself, and the staff were suppose to get the coffee for her. The ADON further stated the care plan should have been updated to reflect this intervention.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and monitor a wound, which developed in the facility for 1 of 3 residents (R23) observed for skin conditions not pressure related.	F 309	It is the policy of Anoka rehabilitation and living Center to provide each resident the necessary care and services to attain or maintain the highest practicable physical wellbeing.	11/30/16

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F 309	Continued From page 11 Findings include: R23's admission Minimum Data Set (MDS) dated 10/4/16, indicated R23 was cognitively intact. The MDS indicated R23 did not have any skin impairments. The MDS identified diagnoses of diabetes mellitius and end stage renal insufficiency. On 10/18/16, at 11:03 a.m. R23's left leg was observed to have a wound on her left shin, the wound was covered with a dark leathery solid tissue, no drainage or odor was present. The area surrounding the wound was slightly red and swollen. R23 stated that she was not sure what happened but had noticed it a couple of days ago, as well as a nursing assistant, who told R23 she had reported it to a nurse. During a follow up interview on 10/18/16, at 5:47 p.m. R23 stated she had reported the wound on her leg to a nurse today, but the nurse told her it was fine as long as it was not draining. R23's skin care plan dated 9/27/16, directed staff to monitor for signs and symptoms of infection and complete the facility skin risk assessment per protocol. R23's Nur [Nurse] Bath Skin Check dated 10/10/16, did not indicate R23 had a wound to the left lower leg. R23's October Treatment Administration Record directed staff to complete a weekly skin assessment every Monday evening. The 10/19/16, skin assessment was not completed. R23's nurse practitioner progress note dated	F 309	R23 had the Nurse Manager and Nurse Practitioner reassess her skin on 10/20/16 and skin assessment was completed on 10/20/16. The identified abrasion was monitored and the abrasion is now healed as of 11/10/16. Weekly Skin Checks will be completed during the resident□s weekly baths. New findings will be reported to the nurse. All Nursing Assistants will also report any skin concerns to nurse during routine cares, notify the nurse, and the nurse will document the Nursing Assistant concern and skin will be assessed by the nurse. A licensed nurse will complete the weekly skin check on all current residents to ensure all alterations in skin integrity are documented. The procedure for Weekly Skin Checks and the Skin Assessment Protocol were reviewed and revised as necessary on 11/11/16. The on-going procedure continues to be that the licensed nursing staff will follow facility skin assessment protocol which includes completing a skin check upon admission, a Braden Scale upon admission and weekly four weeks, quarterly, and change in condition an as needed. Body audits will be completed upon admission, with the weekly bath or any concern reported by staff members of any alteration in skin integrity. Concern areas will be assessed, monitor and appropriate treatment will be put in place. Individual resident care plans will be	

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F 309	Continued From page 12 10/19/16, indicated that R23 had an abrasion on the left extremity on the shin from an unknown incident and recommended to leave it open to air and to monitor. R23's medical record did not provide any monitoring of the wound for signs and symptoms of infection. During interview on 10/20/16, at 12:36 p.m. nursing assistant (NA)-G stated that all skin changes are to be reported to the nurse for follow up. NA-G stated she had not noticed any areas of concern on R23. During observation on 10/20/16, at 12:39 p.m. licensed practical nurse (LPN)-D observed the left lower extremity of R23 and stated she had not been aware that R23 had the wound. LPN-D further stated that when a new skin concern is identified a risk management form should be completed and then monitored. During interview on 10/20/16, at 12:51 p.m. registered nurse (RN)-B stated she was not aware that R23 had a wound on her left lower shin. RN-B observed and measured the wound. RN-B described the wound as a little warm, a little red and swollen. RN-B measured the wound at 1.5 centimeters (cm) by 0.75 cm. RN-B stated that the wound looked like possible trauma and that there should have been documentation on it when it was reported. RN-B stated she would notify the nurse practitioner to examine and recommend treatment. During interview on 10/20/16, at 2:15 p.m. the assistant director of nursing (ADON) stated that any new skin area should be documented and the	F 309	updated as necessary to reflect changes. Staff education was conducted on skin audits and alteration in skin integrity was conducted on November 9th, 10th, 11th, 2016. Random skin assessment audits will be completed once weekly x 3 weeks, monthly x 3 then quarterly for 2 quarters. Audits results will be reported to Quality Assurance Committee for review and further recommendations. The Director of Nursing or designee will be responsible for compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16.	

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F 309	Continued From page 13 nurse manager, and nurse practitioner should be updated and then to start any treatments recommended. The facility's Policy and Procedure for the Prevention and Treatment of Skin Breakdown dated 8/11, indicated the skin would be observed daily with cares by the nursing assistant and if any skin concerns were noted to report them immediately to the nurse. The policy also directed weekly skin audits were to be done by a licensed nurse and to notify the nurse manager upon identification of a wound. The policy further directed staff that when a wound was present there should be daily wound monitoring.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess a resident who experienced incontinence for a trial voiding program and provide consistent staff assistance to assist a resident to the toilet for 1 of 1 residents (R35) observed for urinary	F 315	It is the policy of Anoka Rehab and Living Center to ensure that residents receive appropriate treatment and services to prevent UTI and restore and/or maintain as much normal bladder function as possible.	11/30/16

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F 315	Continued From page 14 incontinence. Findings include: R35's quarterly Minimum Data Set (MDS) dated 9/22/16, indicated R35 was cognitively intact and needed extensive assistance to toilet. The MDS indicated a trial toileting program was not attempted since urinary incontinence was noted in the facility. The MDS indicated R35 was always incontinent, with no episodes of continent voiding. The MDS identified the diagnoses of multiple sclerosis, hemiplegia and depression. R35's Urinary Incontinence Care Area Assessment (CAA) dated 2/1/16, indicated R23 was incontinent with modifiable risk factors of psychological problems and restricted mobility. The CAA identified urinary urgency and depression as risk factors. The CAA identified R35 had functional incontinence (incontinence where a person usually knows when they need to urinate however, for physical or mental reasons can not get to the bathroom physically) and was prescribed diuretics and antidepressants. A care plan was developed to minimize risks and to toilet per care plan. R35's Nur [Nurse] PRN Data Collections dated 9/21/16, indicated no new interventions or environmental modifications had been added since the last review and a trial toileting program had not been attempted because it had not been assessed although the assessment indicated a toileting program was currently being used to manage R35's urinary incontinence. The assessment further indicated R35 relied on staff for toileting needs.	F 315	R35: A reassessment for 3 day bowel and bladder incontinence, was completed on November 7th 8th and 9th 2016. The care plan was reviewed and revised on 11/11/16 which includes the identification of the type of incontinence and the toileting plan. Corresponding updates have been made to the care plan. For other residents who may be affected by this practice, a bowel and bladder assessment will be completed to identify or confirm the type of incontinence and develop or revise a toileting plan. Care plans will be updated based on the assessments. Three current residents with incontinence will be reassessed per week ongoing. The Bowel and Bladder Policy was reviewed and revised as necessary on 11/10/16. Staff members were trained as it relates to their respective roles and responsibilities regarding Bowel and Bladder policy and procedures on November 9th, 10th, 11th, 2016. Random audits will be completed to ensure toileting plans are administered as per the individual resident care plan. These audits will be completed weekly x 3 week rotating shifts. Then monthly for 3 months and quarterly for 2 quarters. Results will be reported to the Quality Assurance Committee for review for further recommendation.	

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F 315	Continued From page 15 R35's care plan dated updated 2/22/16, directed staff to assist R35 with toileting upon rising, after meals, at bedtime and as needed. The care plan also indicated R35 used disposable briefs. During interview on 10/20/16, at 1:15 p.m. nursing assistant (NA)- F stated that R35 was always incontinent of urine and that the staff assist her to change her brief every two hours. NA-F stated that R35 knew when her brief was wet but not when she had to void. During interview on 10/21/16, at 8:28 a.m. R35 stated that she could tell when she had to urinate and could completely empty her bladder while on the toilet, however, most of the times she had to wait up to a half hour to use the bathroom and would become incontinent waiting for staff to assist her. R35 further stated that at this time of the morning she usually will just urinate in her brief because there is no one to assist her and then the nursing assistants would change her pad. R35 stated that she did not have a schedule for when the nursing assistants are to toilet her. R35 further stated that she had been awake since 5:30 a.m. and no one had assisted her to the toilet yet today and that she needed to void now. R35 put on her call light for assistance. On 10/21/16, at 8:41 a.m. NA-B answered R35's call light and asked R35 if she needed her pad changed. R35 replied, "No I want to go on the toilet." NA-B assisted R35 to the toilet and stated that R35's pad was dry. R35 proceeded to void completely on the toilet. During interview on 10/21/16, at 8:45 a.m. NA-B stated that usually they can assist R35 to the	F 315	The Director of Nursing or designee will be responsible for compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16.	

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F 315	Continued From page 16 toilet one to two times a day. NA-B further stated that usually the staff change her incontinent brief four to five times a shift. NA-B further stated that the staff cannot consistently meet R35's needs of toileting her, due to the lack of staff on the unit. During interview on 10/21/16, at 9:15 a.m. licensed practical nurse (LPN)-C stated R35 was capable of knowing when she had to go to the bathroom and staff should be offering to take her to the toilet. LPN-C further stated that it was very difficult to meet all the residents needs and it has been a real struggle. On 10/21/16, at 2:54 p.m. the assistant director of nursing reviewed R35's quarterly bowel and bladder assessment and stated that since R35 knows when she had the urge to void then a trial toileting program should have been assessed and an individualized care plan should have been developed with specific times to toilet R35. The ADON stated that staff should be taking her to the toilet to void and not waiting so long that she became incontinent. The ADON further stated that there were not enough hands to go around and "that's the truth." On 10/21/16, at 3:20 p.m. NA-D stated that R35's call light is not answered timely to toilet her because the staff are busy assisting other residents in the dining room and the aids can't be in two places at once.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		11/30/16

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F 329	Continued From page 17 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify a physician clinical rational/justification for continued use of an antidepressant for 1 of 5 residents (R47) reviewed for unnecessary medications. Findings include: R47's Admission Record dated 7/26/16, indicated R47's diagnoses included chronic obstructive pulmonary disease, diabetes, and major depression. A quarterly Minimum Data Set (MDS) dated	F 329	It is the policy of Anoka Rehabilitation and Living Center that each resident□s drug regimen is free from unnecessary drugs. R47: A gradual dose reduction was initiated on October 22, 2016 after the MD assessed and spoke to the patient. The Prozac was reduced from 40mg to 20mg on a trial basis and will be reviewed at the next GDR date. The pharmacy consultant and interdisciplinary team completed a drug regimen review (GDR) on November 4th	

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F 329	Continued From page 18 9/22/16, indicated R47's cognition was intact. R47's Care Area Assessment (CAA) Psychotropic Drug Use dated 4/7/16, indicated R47 received Prozac for depression and staff would monitor for effectiveness of the Prozac. R47's patient health questionnaire (PHQ-9) (depression score) completed 9/22/16, indicated less than mild depression. R47's target behaviors sheet, which the facility uses for mood monitoring, were reviewed from 9/22 through 10/21/16, and indicated R47 had 3 out of 90 episodes of crying or sadness. A review of R47's Associated Clinic of Psychology note dated 8/30/16, indicated R47 reported R47's mood as not as bad as it was. A review of R47's Associated Clinic of Psychology note dated 9/7/16, indicated R47 was doing fine. A review of R47's Associated Clinic of Psychology note dated 9/13/16, indicated R47 reported that R47's mood had improved. R47 continued to be active in the facility activities. A physician order dated 9/1/16, indicated R47 had an order for Prozac 40 milligrams (mg) by mouth in the morning, which was started on 9/7/14. A review of R47's Pharmacy Consultation Reports dated from 11/5/15 through 8/2/16, lacked recommendations for the tapering the dosage of Prozac. A review of R47's Medication Regimen Review dated from 10/5/15 through 10/15/16 lacked documentation for a Prozac tapering recommendation. During interview on 10/21/16, at 4:00 p.m. the assistant director of nursing (ADON) stated there was no tapering completed for R47's Prozac. On 10/21/16, at 4:32 p.m. a telephone call was	F 329	and 7th 2016 to identify any other resident that may benefit from a gradual dose reduction. Affected residents, had a comprehensive gradual dose reduction review on 11/8 through 11/9, 2016. Residents on psychotropic medication will be reviewed weekly at IDT and then discussed with the ACP team as needed. Staff was trained as it relates to their respective roles and responsibilities regarding the Psychotropic Medication policy and procedures on November 9th, 10th 11th, 2016. Random GDR audits will be completed once weekly x 3 weeks, monthly x 3 then quarterly for 2 quarters. Audit results will be reported to Quality Assurance Committee for review and further recommendations. The Director of Nursing or designee will be responsible for compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16.	

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F 329	Continued From page 19 made to the pharmacy consultant and voice message was left. No return call was received. A policy was requested and none provided.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's	F 334		11/30/16

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F 334	Continued From page 20 legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the Center's for Disease Control's (CDC) recommendation related to pneumococcal conjugate vaccine (PCV13) had not been offered for 5 of 5 residents (R19, R23,	F 334	It is the policy of Anoka Rehabilitation and Living to offer PPSV 23 and PCV 13 to all residents as required. Resident R # 19 was discharged to home	

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F 334	Continued From page 21 R87, R97, R259) In addition the CDC's recommendation for the pneumococcal polysaccharide vaccine 23 (PPSV23) had not been offered for 1 of 5 residents (R23) whose vaccination histories were reviewed. Findings include: Center for Disease Control and Prevention identified, adults 65 years of age or older should receive one dose of of PPSV23. In addition, those 65 years or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose. R19's Immunization Report dated 10/21/16, indicated the 82 year old resident had received the PPSV23 on 10/1/04, but was never offered the PCV13 vaccine. R19's undated Admission Record indicated R19 had a diagnosis of chronic obstructive pulmonary disease. R23's Immunization Report dated 10/21/16, indicated the 72 year old did not have documentation that she had received or declined the PPSV23 or PCV13. R23's undated Admission Record indicated R19 had a diagnosis of chronic obstructive pulmonary disease. R87's Immunization Report dated 10/21/16, indicated the 83 year old had received the PPSV23 on 12/4/03, but was never offered the PCV13. R97's Immunization Report dated 10/21/16, indicated the 85 year old had received the	F 334	on 10/23/16. Resident R #23 hospital records indicate she received the PPSV 23 on 4/21/11 and PCV 13 on 2/2/16. Resident R # 87 was offered PCV 13 and a consent was signed. The PCV 13 administration is on hold until administration is clinically indicated. Resident # R 97 was offered PCV 13 and a consent was signed. The PCV 13 administration is on hold until administration is clinically indicated. Resident # R259 was offered PCV 13 and a consent was signed, it will be administered by 11/14/16. The above patients have a current immunization status for PPSV 23. A house wide audit was completed on 11/11/16 to identify those that have not been offered a vaccination. Those residents and new admissions that need to receive the vaccination is on-going. The pneumococcal vaccine policy has been reviewed and revised in consultation with the Medical Director on 11/4/16. On November 9th, 10th, 11th, 2016, the clinical team was in-serviced on the policy and procedures of offering and administering the PPSV 23 and PCV 13 to residents that need it. Going forward, the facility policy will be followed. All new admission immunization history will be reviewed upon admission per policy, and PPSV 23 and PCV 13 record	

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F 334	Continued From page 22 PPSV23 on 1/22/09, but was never offered PCV13. R97's undated Admission Record indicated R97 had a diagnosis of chronic obstructive pulmonary disease. R259's Immunization Report dated 10/21/16, indicated the 77 year old had received the PPSV23 on 12/4/03, but was never offered the PCV13. R259's undated Admission Record indicated R259 had diagnoses of chronic obstructive pulmonary disease with acute exacerbation, shortness of breath and wheezing. During interview on 10/21/16, at 7:43 a.m. registered nurse (RN)- A stated that the facility had been instructed by the local clinic not to offer PPSV23 or PCV13 to short term rehab residents, in order to track them better. RN-A also stated that it was up to the short term rehab physician's to address their pneumococcal status with the residents. RN-A stated that regarding the long term care residents they were reviewed on a case by case basis, however, could not provide the facility's plan on offering the PCV13 vaccine. The undated facility policy Pneumococcal Vaccine Program indicated the purpose of the program was to reduce the incidence of pneumococcal disease and the morbidity and mortality attributed to the infection. The policy indicated that the CDC recommendations for pneumococcal vaccines were updated in 2016 and included the PCV13 and PPSV23 vaccinations. The policy also indicated that all new admissions would be screened and given the pneumococcal vaccines unless specifically ordered otherwise.	F 334	will be audited for all new admission weekly x 3 weeks and monthly for 3 months. The audit results will be reviewed at QA meetings for compliance and recommendation. The Director of Nursing or designee will be responsible for compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16.	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353		11/30/16

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F 353	Continued From page 23 The facility must have sufficient nursing staff to provide nursing and related services to 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. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet resident care needs timely for 5 of 5 residents (R35, R130, R96, R47, R87, R229) with concerns about toileting and/or other cares. In addition, 2 of 3 (FM-A, FM-B) family members and 7 of 9 staff members (NA-F, LPN-E, NA-C, LPN-C, ADON, NA-D, NA-E) who expressed concerns with the lack of staffing and inability to provide timely assistance with cares. Findings include:	F 353	It is the policy of ARLC to provide sufficient nursing staff to provide nursing and related services to 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. R229 was re-evaluated for self-choice routines which will be care planned and added to the Kardex/POC as indicated. The following residents #: 35, 130, 96, 47	

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F 353	Continued From page 24 RESIDENT CONCERNS WITH THE LACK OF ADEQUATE STAFFING: R35 stated during interview on 10/21/16, at 8:28 a.m. that she could tell when she had to urinate and could completely empty her bladder while on the toilet, however, most of the times she had to wait up to a half hour to use the bathroom and would become incontinent waiting for staff to assist her. R35 further stated that at this time of the morning she usually will just urinate in her brief because there is no one to assist her and then the nursing assistants would change her pad. R35 stated that she did not have a schedule for when the nursing assistants are to toilet her. R35 further stated that she had been awake since 5:30 a.m. and no one had assisted her to the toilet yet today and that she needed to void now. R35 put on her call light for assistance. R130's quarterly Minimum Data Set (MDS) dated 7/22/16, indicated R130 was cognitively intact and needed supervision to toilet. On 10/17/16, at 6:16 p.m. R130 stated that he frequently has waited an hour and a half for help after putting on his call light to be able to go to the bathroom and was supposed to wait for help as he had fallen previously going to the bathroom by himself. R130 added that it happened more during the night R96's quarterly MDS dated 9/8/16, indicated R96 was cognitively intact. On 10/17/16, at 6:07 p.m. R96 stated she had to wait 20-25 minutes for assistance with cares especially after dinner as the staff just cannot get to you [R96] in time. R96 stated she had to wait three to four times a week	F 353	were re-evaluated for continence cares and the care plan and Kardex were reviewed and updated. Residents will be evaluated by the IDT for self-choice routines which will be care planned and added to the Kardex/POC as indicated. The residents and families mentioned in statement of deficiencies will be interviewed with concerns investigated by the IDT team. Follow-up including results to be reported back to the residents and/or responsible parties. For all other residents who may be affected by this practice, call light audits and resident interviews will be completed to ensure compliance with response time. The IDT team will review the workflow for the households to ensure that staff members are available to answer the call lights timely and that break times are staggered for direct caregivers. The case mix levels on each 2nd floor households will be evaluated and compared to staffing on the schedule. Adjustments will be made as indicated by the data. Memory care household breakfast time is changing to 8am (from 7:30 AM) to accommodate resident morning routines and will be trialed beginning 11/16/16. IDT members will be assigned to support the resident experience at meal times. Education will be provided to staff regarding the changes to resident dining	

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F 353	Continued From page 25 and cannot do anything for herself. R47's quarterly MDS dated 9/22/16, indicated R47 was cognitively intact and needed extensive assistant to toilet. On 10/18/16, at 3:31 p.m. R47 stated that sometimes she had to wait 30 minutes to go to the bathroom. R47 further stated the other night she had to take herself to the bathroom but was not able to wipe herself. R47 stated that waiting for assistance happened quite frequently, although it occurred on all shifts, it happened more often overnight. During a follow up interview on 10/19/16, at 1:47 p.m. R47 stated that one evening a resident was choking in the dining room, R47 did not know who the resident was, and residents had to find a nurse as the dining room was not supervised. R47 stated she frequently assisted residents with getting beverages and meals as there was not anyone in the dining room. R229's quarterly MDS dated 9/29/16, indicated R229 had moderate cognitive impairments and required extensive assistance with ADL's. On 10/21/16, at 9:00 a.m. R229's call light was observed to be on for 30 minutes and 41 seconds. R229's call light was answered by a nursing assistant at 9:30 a.m. R229 stated that he had wanted to lay down and that it always took a long time for call lights to be answered. FAMILY CONCERNS WITH LACK OF ADEQUATE STAFFING: During interview on 10/17/16, at 4:36 p.m. family member (FM)-A stated that there was a concern with staffing mostly surrounding meal times.	F 353	and options to accommodate residents sleep preferences on 11/16/16. Dining room experience audits will be completed 5x a week for 2 weeks, rotating the meals that are observed, frequency will be changed based upon the outcome of the audits. Findings will be reported to QA for adjustments as needed. Random audits regarding resident wait times for assistance will be completed three times per week for two weeks, two times per week for two weeks and then weekly as needed to ensure compliance. The audit results will be reviewed at QA meetings for compliance and recommendation. Director of Nursing will ensure compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16	

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During interview on 10/18/16, at 11:52 a.m. FM-B stated staff were unable to provide adequate supervision to prevent falls. FM-B also stated that there was a lack of supervision in the dining room on the memory care unit and often on the weekends when visiting there are up to three residents eating breakfast without staff supervision, and was concerned about possible choking.

STAFF CONCERNS WITH BEING UNABLE TO COMPLETE CARES:

During interview on 10/19/16, at 12:44 p.m. nursing assistant (NA)-F stated that mornings can be really rough to supervise and more staff would help in the mornings.

During interview on 10/19/16, at 12:45 p.m. licensed practical nurse (LPN)-E stated that it is difficult to supervise the dining room for an hour and a half as there are medications and treatments that need to be completed. LPN-E stated that the dining room is not supervised 100% of the time, but the nurse will peak in when there is time.

During interview on 10/21/16, at 9:02 a.m. NA-C stated there was not enough staff to meet the residents needs. NA-C stated that R229 had been waiting at least a half hour to lay down and that staff do the best that they can (observation of R229).

During interview on 10/21/16, at 9:09 a.m. LPN-C stated that it had been very difficult to meet the residents needs and it has been a real struggle to

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to even get resident treatments done as ordered somedays. LPN-C stated that she tried to assist the nursing assistants as much as possible, but then she gets behind and cannot complete everything.

During interview on 10/21/16, at 3:02 p.m. the assistant director of nursing (ADON) stated that there were not enough hands to go around and "that is the truth."

During interview on 10/21/16, at 3:20 p.m. NA-D stated that there was not enough staff to meet the residents needs. NA-D stated all kinds of cares were behind because there was not enough staff on the unit. NA-D stated that there was always different staff working on the unit. NA-D stated that the staffing concerns have been reported, however, nothing has been done. NA-D further stated the busiest times are during meals when the staff are assisting residents to eat more independent staff are finished and put on their call lights to be repositioned or toileted and the lights don't get answered because you can't be in two places at once. NA-D stated that residents frequently complain about staffing and get very "furious" their needs are not being met. NA-D stated it takes up to twenty minutes to do cares with a resident, and then you walk out of the resident's room and there are many many lights going off and other residents are waiting for help.

During interview on 10/21/16, at 3:34 p.m. NA-E stated that the staff try their best but residents continuously complain that cares are not getting done. The residents get upset when you can't get to them in time because all the call lights are going off. NA-E stated there just is not enough staff and we need an extra nursing assistant.

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F 353	Continued From page 28 NA-E further stated that staff get very behind and residents have had incontinent accidents because they are not toileted when they need to be. During interview on 10/21/16, at 3:05 p.m. nursing secretary (NS)-A stated she used a staffing template to schedule the nursing staff, However, does not really follow budgeted hours based on the template but rather two nursing assistants are scheduled on each unit, one nurse on each long term care unit and two nurses on the short term care units for the a.m. and p.m. shifts. NS-A stated this was what she was instructed on how to schedule the building. NS-A further stated that as far as she new, scheduling was based on the number of residents and not how complex the residents were. During interview on 10/21/16, at 3:42 p.m. the assistant executive director stated that the staffing ratios were based on "case mix" and also stated that the census changed almost daily. The assistant executive director further stated that mornings are traditionally busy with staff trying to get residents to breakfast and trying to get them ready for the day. A policy on staffing was requested and the facility could not provide one.	F 353		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit	F 425		11/30/16

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F 425	Continued From page 29 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an order for calcium acetate was transcribed and administered per physician order for 1 of 1 resident (R416) reviewed. Findings include: R416's Admission Record identified R416 admitted to the facility on 10/12/16, with diagnosis including End Stage Renal Disease (ESRD). R416's Medication Administration Record (MAR) identified an order for calcium acetate (phos binder) tablet 667 milligrams (mg). Give two tablets by mouth two times a day related to ESRD. (Calcium acetate is used for reducing blood phosphate levels in people with end-stage kidney disease on dialysis).	F 425	It is the policy of Anoka Rehabilitation and Living Center to accurately transcribe medication orders. R 416: The medication was reviewed and corrected to read as prescribed by the hospital MD. The MD, dialysis, and responsible party were notified. No adverse event occurred due to the missed doses. The process for transcription of orders was reviewed and revised as necessary on 10/20/16. A staff will transcribe all orders as ordered by the MD. The order will have a second check by a licensed nurse to ensure that the orders are as written in the order.	

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F 425	Continued From page 30 Further, the MAR identified the order was given twice per day, starting the evening of 10/12/16, and ending the morning of 10/20/16, for a total of sixteen administrations. The order failed to indicate the medication was to be provided with food. R416's hospital discharge record dated 10/12/16, indicated an order for calcium acetate 667 mg. take two tablets by mouth three times daily with meals. During interview on 10/20/16, at 12:40 p.m. registered dietician (RD) stated this medication is typically given with food. The process at the facility was for nursing to process the orders. During interview on 10/20/16, at 12:49 p.m. ESRD-RD stated the order for the phosphate binder was initiated at dialysis. This medication was to be administered with meals. The order was for two tablets three times a day to be administered with meals. During interview on 10/20/16, at 12:57 p.m. clinical manager (CM)-A stated on admission R416's medication orders came from the hospital for the calcium acetate to be given with food. He verified the orders at the facility read to give twice a day, and failed to indicate to be given with food. CM-A verified this was an error. During interview on 10/21/16, at 12:23 p.m. assistant director of nursing (ADON) stated orders are transcribed by the health unit coordinators or a nurse, and a second check was always done by a nurse. ADON verified the calcium acetate was administered sixteen times	F 425	Follow-up per policy with staff members involved occurred on 10/20 and 10/21, 2016. Staff members were trained as it relates to their respective roles and responsibilities regarding medication transcription on 11/9, 11/10, 11/11 2016. Medication transcription audit will be conducted by the Nurse Manager or designee weekly x three weeks, monthly for three months and quarterly for 2 quarters. Results will be reported to the Quality Assurance Committee for review and further recommendation. The Director of Nursing or designee will be responsible for compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 31 incorrectly, and eight doses were missed. Facility policy related to medication transcription was requested but not provided.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist identified medication irregularities for 1 of 5 residents (R47) reviewed for unnecessary medication use. Findings include: R47's Admission Record dated 7/26/16, indicated R47's diagnoses included chronic obstructive pulmonary disease, diabetes, and major depression. A quarterly Minimum Data Set (MDS) dated 9/22/16, indicated R47's cognition was intact. R47's patient health questionnaire (PHQ-9) (depression score) indicated less than mild	F 428	It is the policy of Anoka Rehabilitation and Living Center that each resident□s drug regimen is reviewed and is free from unnecessary drugs. R47: A gradual dose reduction was initiated on October 22, 2016 after the MD assessed and spoke to the patient. The Prozac was reduced from 40mg to 20mg on a trial basis and will be reviewed at the next GDR date. The pharmacy consultant and interdisciplinary team completed a drug regimen review (GDR) on November 4th and 7th 2016 to identify any other resident that may benefit from a gradual dose	11/30/16

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	245205	A. BUILDING _____ B. WING _____	10/21/2016

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F 428	Continued From page 32 depression. A physician order dated 9/1/16, indicated R47 had an order for Prozac 40 milligrams (mg) by mouth in the morning, which was started on 9/7/14. A review of R47's pharmacy Consultation Reports dated from 11/5/15 through 8/2/16, lacked recommendations for tapering the dosage of Prozac since the start date of 9/7/14. During interview on 10/21/16, at 4:00 p.m. the assistant director of nursing (ADON) stated there was no attempt at a dosage reduction of the Prozac for R47. On 10/21/16, at 4:32 p.m. a telephone call was made to the pharmacy consultant and voice message was left. No return call was received. A policy was requested and none provided.	F 428	reduction. Affected residents, had a comprehensive gradual dose reduction review on 11/8 through 11/9, 2016. Residents on psychotropic medication will be reviewed weekly at IDT and then discussed with the ACP team as needed. Staff were trained as it relates to their respective roles and responsibilities regarding the Psychotropic Medication policy and procedures on November 9th, 10th 11th, 2016. The consultant pharmacist will continue to complete Drug Regimen Reviews and make necessary recommendations to the clinical team. Random GDR audits will be completed once weekly x 3 weeks, monthly x 3 then quarterly for 2 quarters. Audit results will be reported to Quality Assurance Committee for review and further recommendations. The Director of Nursing responsible for compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431		11/30/16

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F 431	Continued From page 33 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were accurately labeled with current physician orders for 1 of 7 residents (R47) observed receiving medication. Findings include:	F 431	It is the policy of Anoka Rehabilitation and Living Center that medications are accurately labeled to reflect changes in physician orders. R47: A See Direction Change sticker was applied to the medication label to reflect	

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F 431	Continued From page 34 1. During a medication observation on 10/20/16, at 2:02 p.m. with licensed practical nurse (LPN)-B revealed R47's prescribed Neurontin 100 milligram (mg) capsule medication label directed staff to give 1 capsule TID (three times a day). R47's physician orders dated 10/12/16, indicated discontinue Neurontin 100 mg TID. Neurontin 200 mg in morning, Neurontin 100 mg every afternoon, and Neurontin 200 mg every bed time. During interview on 10/20/16, at 2:02 p.m. licensed practical nurse (LPN)-B stated the Neurontin should have had a change of direction sticker on the medication card. 2. During a medication observation on 10/21/16, at 4:09 p.m. with LPN-C revealed R47's Novolog vial directed staff to administer 20 units subcutaneous (SQ) TID. R47's physician orders dated 10/10/16, indicated discontinue Novolog insulin today and on 10/14/16, restart Novolog 10 units SQ TID with meals. During interview on 10/21/16, 4:09 p.m. LPN-C stated there should be a label indicating there was an order change for the Novolog. LPN-C stated the Novolog insulin order had changed about two weeks prior. During interview on 10/21/16, at 4:27 p.m. the assistant director of nursing (ADON) stated there should be a change of direction sticker on the vial of Novolog for staff to know that the order had changed.	F 431	the change to the physician order. The medication storage areas were audited on November 10, 2016 to ensure all labels matched the physician order or had a See Direction Change sticker applied to the label. Licensed Nursing staff was trained as it relates to their respective roles and responsibilities regarding the change in direction and labelling policy on November 9th, 10th 11th, 2016. Audits will be completed once weekly x 3 weeks, monthly x 3 then quarterly for 2 quarters. Audit results will be reported to Quality Assurance Committee for review and further recommendations. The results will be reported to Quarter Assurance Committee for review and recommendation. The Director of Nursing or designee will be responsible for compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16.	

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F 431	Continued From page 35 A policy was requested and none received.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		11/30/16

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F 441	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an infection control program that tracked signs and symptoms of potential and actual infections as well as obtain culture results consistently for urinary tract infections (UTI) to be able to effectively monitor, trend and analyze infections to reduce the potential transmission to other residents in the facility. This had the potential to affect all 120 residents residing in the facility. In addition, the facility failed to ensure appropriate hand hygiene was completed after glove removal during resident care for 1 of 3 residents (R322) observed during personal cares. Findings include: The facility form used to track resident infections titled Anoka Rehab and Living Center Monthly Infection Control Log, separated by unit, were reviewed from July 2016 to September 2016, the following information was tracked: - Resident Name - Admit Date - Room Number - Unit - Type - Site - Date of Onset - Date Culture Taken - Organism - Antibiotic Resistance - Type of Antibiotic	F 441	It is the policy of Anoka Rehab and Living Center to provide an Infection Prevention and Control Program that provides a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The policy and procedures for infection control were reviewed and revised as necessary on 11/11/16. The Staff Development Coordinator / Infection Control Nurse will update the procedures based on the policy/procedure review to ensure that signs and symptoms of potential and actual infections along with required lab results will be monitored, tracked and trended. Data will be distinguished between community acquired and healthcare acquired infections (HAI□s). Nurses will be provided information regarding this process and their role in the process of surveillance, reporting, and tracking infections. The individual staff involved was re-educated on the process of glove use and hand hygiene during cares on 11/11/16. Ongoing teaching of staff to review the procedure for glove use and hand hygiene during cares.	

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F 441	Continued From page 37 - Start of Antibiotic - Infection Definition Met Y/N - Resident for Greater than 48 Hours - Not Infected - Community Acquired - HAI [Healthcare Associated Infection] - Date Resolved - Isolated/ Type The Anoka Rehab and Living Center Monthly Infection Control Logs consistently did not track signs or symptoms of infections or possible infections for HAIs. The logs also did not consistently contain culture results for UTIs. The July 2016, Anoka Rehab and Living Center Monthly Infection Control Logs identified: - The CCU had 23 infections, 14 infections were community acquired and 8 were HAI. Two infections did not identify if they were community acquired or HAI. Signs and symptoms were not tracked for any of the infections. The CCU had six UTIs of them only 1 listed culture results. The other five UTIs did not indicate a culture was obtained. Four UTIs were treated with antibiotics. - The TCU had 15 infections, 9 infections were community acquired and 3 infections were HAI. Three infections did not identify if they were community acquired or HAI. Signs and symptoms were not tracked for any of the infections. - The TCU 2 had 20 infections, 15 were community acquired and 5 were HAI. Signs and symptoms were not tracked for any of the infections. The TCU 2 had five UTIs of them only two had cultures results listed. The other three	F 441	Audits will be completed once weekly x 3 weeks, monthly x 3 then quarterly for 2 quarters. Audit results will be reported to Quality Assurance Committee for review and further recommendations. The Infection Control Nurse is responsible for compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16.	

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F 441	Continued From page 38 UTIs did not indicate a culture was obtained. All UTIs were treated with antibiotics. - Reflections had two infections that were HAI. There were no signs or symptoms tracked for either infection. - Riverbend had six infections all were HAI none of which had signs and symptoms tracked. There were two UTI's and neither listed culture results or if a culture was obtained. Both UTIs were treated with antibiotics. - Cornerstone had one infection with no signs or symptoms listed, treated with an antibiotic, however, was listed as not infected. The August 2016, Anoka Rehab and Living Center Monthly Infection Control Logs identified: - The CCU had 20 infections, 12 were community acquired and 2 were HAI. Six infections did not identify if they were community acquired or HAI. Signs and symptoms were not tracked for any of the infections. The CCU had three UTIs that did not have cultures listed or whether a culture was obtained, all three UTIs were treated with antibiotics. - The TCU had 21 infections, 10 were community acquired, 5 were HAI. Six infections did not identify if they were community acquired or HAI. Signs and symptoms were not tracked for any of the infections. The TCU had six UTIs, two that were cultured. The other four UTIs did not indicate whether a culture was obtained. Five UTIs were treated with antibiotics	F 441		

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F 441	Continued From page 39 - The TCU 2 had 20 infections, 14 were community acquired, 2 were HAI. Six did not identify whether the infections were community acquired or HAI. Signs and symptoms were not tracked for any of the infections. The TCU had eight UTIs, two were cultured. The other six did not indicate if a culture was obtained. Antibiotics were prescribed for all eight UTIs. - Reflections did not have any infections. - Riverbend had three infections all were HAI and the were no signs and symptoms documented. - Cornerstone had one infection that was community acquired and did not identify any signs or symptoms. The September 2016, Anoka Rehab and Living Center Monthly Infection Control Logs identified: - The CCU had 18 infections, 11 were community acquired and 1 was HAI. Six infections did not identify if they were community acquired or HAI. Signs and symptoms were not tracked for any of the infections. The CCU had one UTI that did not indicate a culture was obtained and an antibiotic was prescribed. - The TCU had 18 infections, six were community acquired and eight were HAI. Ten infections did not identify if they were community acquired or HAI. Signs and symptoms were not tracked for any of the infections. The TCU had seven UTIs, four UTIs identified culture results. Three UTI's did not indicate a culture was obtained. All eight UTIs were treated with an antibiotic. - The TCU 2 had 24 infections, 16 were	F 441		

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F 441	Continued From page 40	F 441		

community acquired and three were HAI. Five infections did not identify if they were community acquired or HAI. Signs and symptoms were not tracked for any of the infections. The TCU 2 had eight UTIs, four had culture results listed. Four UTIs did not indicate a culture had been obtained. All eight UTIs were treated with antibiotics.

- Reflections did not have any infections.

- Riverbend had six infections all were HAI. Signs and symptoms were not tracked for any of the infections.

- Cornerstone had two infections, both were HAI. Signs and symptoms were not tracked for any of the infections. Cornerstone had one UTI that did not indicate a culture had been obtained and was treated with an antibiotic.

During interview on 10/20/16, at 11:04 a.m. registered nurse (RN)-A stated that the forms are used to track antibiotic use and that suspected infections are not tracked but are discussed daily. RN-A further stated that the facility is not tracking signs and symptoms of HAI or potential infections. RN-A stated that the purpose to tracking infections, was to be able to identify trends and put into place any education needed, if any trends are identified. RN-A stated that cultures are not routinely obtained, especially if the resident was admitted with an UTI, because RN-A did not have access to the hospital or clinic records. RN-A did not routinely contact an outside facility for culture results. RN-A further stated that culture results identify the organism and stated the end of the month analyses are as accurate as they can be without culture results.

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F 441	Continued From page 41 The facility Infection Control Program dated 2015, indicated the infection control program investigates, controls and prevents infections in the facility. The infection control preventionist was to review microbiology culture and sensitivity reports on a regular basis to identify types of organisms causing infections, monitor for antibiotic resistance and identify potential transmission of organisms between residents. R322's significant change Minimum Data Set (MDS) dated 7/14/16, included diagnosis of Alzheimer's disease. The MDS identified that R322 was severely cognitively impaired and needed assistance from staff with activities of daily living (ADLs). During an observation on 10/19/16, 8:52 a.m. nursing assistant (NA)-A was assisting R322 with personal morning cares. NA-A put gloves on NA-A's hands and cleansed R322's perineal area which was visibility soiled with a large bowel movement. NA-A removed the soiled gloves and without using hand sanitizer or washing hands put on clean gloves. NA-A washed R322's perineum and removed soiled gloves. NA-A did not wash hand or use hand sanitizer and put on clean gloves and dried R322's perineum. NA-A removed soiled gloves and without hand sanitizer or hand washing NA-A placed a clean incontinence product on R322 and secured it. NA-A proceeded to dress R322's lower portion of the body. NA-A assisted R322 into a wheelchair and undressed the upper portion of the body. With soiled gloves NA-A emptied the wash basin and rinsed it then put more water in the basin to wash R322's upper body and dried areas. NA-A	F 441		

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put deodorant on R322 and then removed the soiled gloves. NA-A without washing hands or hand sanitizer put on clean gloves and dressed R322's upper body. NA-A took off soiled gloves and without washing hands or hand sanitizer left room to get a kidney basin for R322 to spit in when brushing teeth. NA-A put clean gloves on and assisted R322 to brush teeth. R322 opened the mouth and NA-A brushed R322's teeth. R322 took a drink of water offered from NA-A, rinsed mouth and spit into the kidney basin. NA-A wiped R322's mouth dry. NA-A with soiled gloves combed R322's hair. NA-A then removed the sheets from R322's bed and placed in linen hopper. NA-A took off soiled gloves and washed hands with soap and water.

During interview on 10/19/16, at 9:29 a.m. NA-A stated hands should be washed when leaving residents' rooms and when changing gloves. NA-A stated, "I did not wash my hands today when I left [R322's] room and came back." NA-A stated, "I could have used hand sanitizer but did not" and added should have washed hands each time changed gloves and after wiping R322's bowel movement. NA-A stated, "I was busy and it slipped my mind."

During interview on 10/20/16, at 11:52 a.m. RN-A stated when removing gloves, hand hygiene must be done before putting on new gloves if they are needed.

A facility policy Infection Control Standard Precautions, dated 2015 indicated to perform hand hygiene when entering and exiting a residents room, when hands are visibly soiled, before and after assisting a resident with personal cares, and before and after assisting a resident

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F 441	Continued From page 43 with toileting (hand washing with soap and water).	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain kitchen equipment in a clean and sanitary manner. In addition, the facility failed to provide maintenance services and ongoing repairs, and a clean and sanitary environment in 8 of 30 resident rooms (room 1140, 1142, 1144, 1148, 2125, 2129, 2135, and 2143) and 1 of 4 kitchenettes reviewed for environmental concerns. Findings include: During the kitchen tour on 10/17/16, at 12:47 p.m. the following sanitation concerns were observed and confirmed by the culinary services director (CSD). - a two row plastic beige cart next to the food preparation area was observed to have approximately 8 inches half circle area which appeared to have been melted from a hot kettle, which would make sanitation difficult. The cart was melted through completely. The cart also had an approximately 3 inch L shaped area which was cracked. CSD stated the cart is cleaned with	F 465	It is the policy of Anoka Rehab and Living Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. All vents were inspected and cleaned by 10/24/16. RM. 2135- light bulb was replaced on 10-20-16. RM.2143- walls were patched and painted on 10-24-16. Common space and resident room ceiling vents are to be dusted daily by housekeeping. They are also to be cleaned by maintenance staff bi-annually. Re-education on housekeeping staff expectations of dusting ceiling vents daily provided 10-20-16 to 10-24-16. Vents will be audited monthly to ensure compliance. Kitchen hoods/ filters are professionally cleaned bi-annually. Kitchen hood filters are cleaned quarterly by maintenance staff. Kitchen hood filters will be checked/ cleaned monthly going forward. Kitchen hood/filter cleaning will be audited monthly to ensure compliance.	11/30/16

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 _____	10/21/2016

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
F 465	Continued From page 44 a sprayer. - vents above the stove appeared dusty, with a continuous layer of dust noted on the entire span of the vents. CSD stated the vents were last cleaned in May, and next due in November, and maintenance has a company from outside come in to clean them. Further, CSD stated she "can see visible dust". - steam kettle used for soups was noted to have a build up of splattered dark brown substance on the metal behind the kettle, ranging from splatter to solid. CSD described this as "burnt on splatter of some sort." - large mixer, had plastic bunched up toward the back of the machine. Brown crumb like debris was noted behind the bowl. CSD stated the mixer is to be clean and covered when not in use. When interviewed at this time, CSD stated the kitchen equipment was to be cleaned on a weekly basis. Follow-up kitchen tour and interview on 10/20/16, at 8:36 a.m. with CSD revealed the vents above the stove had been cleaned, and no dust was visible, and CSD stated maintenance took the vents down and sprayed them off. Facility form titled: Lunch Cook, updated date 4/27/16, identified under weekly cleaning duties, on Friday to scrub down the mixer and make sure it is covered up with a bag. Review of the forms titled AM Cook and PM Cook did not identify cleaning schedule for the vents or the steam kettle.	F 465	Affected food transport cart with damage was removed from main kitchen and only used for trash purposes. Food transport carts will be checked weekly to ensure that there is no damage present. Steam kettle is cleaned weekly and after each use by dietary staff. Steam kettle and cleaning sheets will be audited weekly to ensure proper cleaning of kettle and compliance. Mixer is cleaned weekly and after each use by dietary staff. Mixer and cleaning sheets will be audited weekly to ensure proper cleaning of Mixer and compliance. A building wide maintenance inspection was completed by 11/9/16 to identify any additional areas of concern. Work orders will be completed on all identified areas. Monthly environmental rounds will be made by the Environmental Services Director. All findings from Environmental Service Director rounds will be entered into the work order system and reported to Quality Assurance Committee for review and further recommendations. Environmental Services Director & Culinary Services Director will ensure compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 11/30/16	

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 _____	10/21/2016

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 465	Continued From page 45	F 465		

Facility policy titled: Cleaning Instructions indicated, Mixer dated 11/15, indicated staff are to completely wipe off down the mixer with an appropriate cleaning agent making sure to remove any debris from behind where the mixing bowl sits.

Facility policy titled: Cleaning Instructions: Hoods, dated 11/15, indicated only stove hoods and filters are to be cleaned professionally bi-annually.

Facility policy titled: Sanitation of Dining and Food Service Areas, 2010, identified the food service staff will maintain the sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule.

On 10/20/16, at 12:39 p.m. a tour of the facility with the environmental services director (ESD) identified the following concerns:

On the first floor rooms 1140, 1142, 1144, and 1148 the bathroom ceiling fans had gray fuzzy dust particles on the fans.

On the Riverbend unit the kitchenette sink vent was covered with gray fuzzy dust particles.

On the second floor rooms 2125, 2129, and 2135 the bathroom ceiling fans had gray fuzzy dust particles on the fans.

In room 2135 the bathroom light was burnt out.

In room 2143 there were multiple large and small gouges exposing the sheet rock behind the recliner.

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 _____	10/21/2016

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 465	Continued From page 46 During an interview on 10/20/16, at 1:03 p.m. with the ESD stated the vents were cleaned biannually. The EDS stated the housekeepers should clean the bathroom ceiling vents with a wand that extends to clean them. ESD stated they patch and paint all the walls in residents' rooms when they get a work order to complete. ESD stated all the computers in the facility have an icon for a work order on the computer and staff need to complete the form, then it will get put on our maintenance list to complete. During interview on 10/20/16, at 1:26 p.m. housekeeper-A stated housekeeping does not clean the bathroom ceiling vents but maintenance did clean the bathroom ceiling vents. A policy was requested and none was provided.	F 465		

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 _____	**10/19/2016**

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 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 19, 2016. At the time of this survey Anoka Rehabilitation & Living Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. Anoka Care-Rehabilitation Center was constructed in 2012 and opened in 2013. It is a two story building with a basement. The construction type is determined to be Type II (111). The building is separated from the rest of the complex by 2 hour fire rated construction. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility is licensed for 120 beds and 109 were occupied at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

Electronically Signed | 11/12/2016

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.