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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 9XG1

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 **04/28/2014** (L34)

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

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

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

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): Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 04/21/2014, the facility is certified for 120 skilled nursing facility beds.

17. SURVEYOR SIGNATURE: Gail Anderson, Unit Supervisor — Date: 04/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL: Kate JohnsTon, Enforcement Specialist — Date: 06/26/2014 (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

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **04/30/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245205

June 26, 2014

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation And Living Center
3000 Fourth Avenue
Anoka, Minnesota 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 April 21, 2014, the above facility is certified for or for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 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 Jessica Sellner, Unit Supervisor at (320) 223-7343 if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

June 26, 2014

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

RE: Project Number S5205024

Dear Mr. Dolinsky:

On April 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 13, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 13, 2014, effective April 21, 2014 and therefore remedies outlined in our letter to you dated April 3, 2014, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact Jessica Sellner, Unit Supervisor at 320-223-7343 if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245205	A. Building B. Wing	4/28/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/21/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/21/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	06/26/2014	28034	04/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/13/2014

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

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Facility ID: 00893

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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 **03/13/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **12/31**

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From (a) :
To (b) :

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

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A. In Compliance With Program Requirements Compliance Based On:
X 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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Nicolle Marx, HFE NE II 04/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 04/24/2014 (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
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20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
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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)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5205

At the time of the standard survey completed March 13, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5076

April 3, 2014

Mr. Dennis Decosta, Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, Minnesota 55303

RE: Project Number S5205024

Dear Mr. Decosta:

On March 13, 2014, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - 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;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**
>
> **<u>Informal Dispute Resolution</u> - 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:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537

Telephone: (218) 332-5140
Fax: (218) 332-5196

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 April 22, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 June 13, 2014 (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 September 13, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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.

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

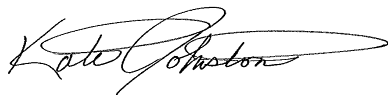
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992   Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING ______ B. WING ______	03/13/2014

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's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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	Preparation, submission and the implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth in this statement of deficiencies. This plan of correction is prepared and executed as a means to continually improve quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility did not ensure potentially hazardous foods were cooled using time and temperature controls to minimize the risk for foodborne illness. This had the potential to affect 63 of 107 residents who received a regular diet and could be served leftover turkey portions.	F 371 F371	It is the policy of Anoka Rehabilitation and Living Center to store, distribute and serve food under sanitary conditions.	04/21/2014

4/15/14 [illegible]

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	04/10/2014

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.

RECEIVED
APR 14 2014
MN Dept of Health
Fergus Falls

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 ______	03/13/2014

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 371	Continued From page 1 Findings include: During interview on 3/12/14, at 1:00 p.m. cook (C)-A and C-B were asked about the facility's process for safe cooling of leftovers. Both C-A and C-B reported that the facility did use time and temperature controls for cooling leftovers. However, neither C-A or C-B were able to relay the time frames and temperatures required for safe cooling of potentially hazardous foods. C-B also verified there were no postings in the kitchen area to guide the kitchen staff on safe time and temperature controls for cooling leftovers. C-B reported that the cooks did check the cooling temperatures of foods, but was unable to indicate the timeframes for when they took those temperatures. C-B also verified there was no documentation of these temperature checks. Upon further inquiry, she indicated she would have needed to consult with the facility's dietary manager (DM) to identify what timeframes the temperatures were to be taken and what temperatures the food items were required to drop to, in order to minimize the risk of foodborne illness. C-A and C-B verified they were typically responsible for storing and cooling leftovers after the facility's noon meal. C-A and C-B verified the facility routinely saved some food items as leftovers. C-B reported that she liked to save meats to use for making various soups. During observation and interview on 3/12/14, at 1:05 p.m. in the facility's main kitchen, dietary aide (DA)-A reported that she was not typically responsible for cooling leftovers, but verified she intermittently assisted the cooks with dishing leftovers into containers for refrigeration. DA-A was observed pushing a cart with various containers from the steam table, filled with food	F 371	All staff has been reeducated on the proper cooling methods for foods. An in-service was given on 3-12-14 and further instruction was provided on 3-25-14. As of 3-12-14 the practice of using left-overs for soups or other meals has been discontinued. All staff have been educated on this policy. New dietary staff will also be in-serviced regarding proper time and temperature controls for cooling foods. The nutritional services management team will perform compliance audits when foods are being cooled to ensure the proper cooling of foods using proper time and temperature controls to minimize the risk of foodborne illness using cooling logs. These results of the monitoring (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months and then as needed. Upon this review, revisions and staff education will be implemented as needed. The Director of Dietary or designee will be responsible for compliance.	

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 ______	03/13/2014

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 371	Continued From page 2 items from the lunch meal, into the main kitchen. DA-A reported that she typically brought the lunch leftovers to C-A and C-B for cooling. DA-A was asked how she selected container sizes for leftovers. Given the example of Turkey Dyvan (turkey breasts with a broccoli and cheese mixture), the main dish served for lunch on 3/12/14, DA-A verified that she would have selected a large container since a large amount of the dish remained. DA-A pointed out a container which held approximately five quarts. DA-A added, "[C-B] always says, the bigger the better." During observation and interview on 3/12/14, at 3:30 p.m. DM was asked to take the temperature of any meats that were saved as leftovers from the lunch meal. She went into the facility's walk-in refrigerator and presented a small container, approximately one quart in size, half-filled with Turkey Dyvan, approximately 3 servings. DM was asked to place the thermometer into one of the turkey breasts and verified a reading of 88 degrees Fahrenheit (F), two hours and twenty-five minutes after the food item was observed to be removed from the steam table and brought into the kitchen for cooling. DM verified it was her expectation that leftovers were cooled to at least 70 degrees F within two hours, to minimize the risk for foodborne illness. DM stated that she needed to verify the time the dish was removed from the steam table, but added that if it was more than two hours prior, the turkey dish would need to be discarded. During interview on 3/13/14, at 11:00 a.m. C-B verified that she had cooled the Turkey Dyvan leftovers from lunch on 3/12/14. She reported that she dished the leftovers into a plastic	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 3 container, covered and dated them, and placed them in the walk-in refrigerator. C-B estimated the Turkey Dyvan was removed from the steam table at approximately 12:30 p.m., three hours prior to the temperature finding of 88 degrees F. During interview on 3/13/14, at 11:10 a.m. DM reported the Turkey Dyvan was removed from the steam tray on 3/12/14, at approximately 1:00 p.m. DM stated she re-trained her employees that morning on cooling time and temperature controls. DM verified the leftover Turkey Dyvan was discarded. Review of the 2013 Minnesota Food Code revealed, potentially hazardous food was to be cooled §to 70 degrees F within two hours; and§ from 70 degrees F to 41 degrees F or below within four hours.§ The food code indicated that potentially hazardous food needed to pass through the first stage of cooling quickly to minimize growth. If a food item did not reach 70 degrees F within two hours, it was to be thrown out or reheated and then cooled again. The facility's Use of Leftovers policy dated 2010, directed staff to cover, label and date leftovers, then store them refrigerated or frozen, immediately after the end of the meal service. The policy indicated leftovers were to be cooled to 41 degrees F or below within four hours, or cooled to 70 degrees F within two hours and then down to 41 degrees F, within another four hours.	F 371		
F 441 SS=D	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	F 441		

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 ______	03/13/2014

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F 441	Continued From page 4 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene practices were followed to minimize the	F 441	It is the policy of Anoka Rehabilitation and Living Center to 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. The infection control practice for Resident #5745 have been reviewed by the infection control nurse. For other residents who may be affected by this practice, audits will be completed to identify any deficient infection control practices. The policies for hand washing and non-sterile glove use will be reviewed by the interdisciplinary team and revised as needed. A review of the policies by the Medical Director will be conducted	04/21/2014

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 ______	03/13/2014

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

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F 441	Continued From page 5 spread of organisms for 1 of 5 residents (R166) observed to receive care requiring hand washing. Findings include: R166 was admitted with diagnoses including diverticulitis of the colon with hemorrhage and unspecified hemorrhage of the gastrointestinal tract. R166's quarterly Minimum Data Set (MDS), dated 1/6/14, indicated R166 was cognitively intact and required limited assistance of one for transfers, walking in her room, and personal hygiene. R166 required extensive assistance of one for toileting. During an observation on 3/12/14, at 9:05 a.m., nursing assistant (NA)-A assisted R166 with morning cares while R166 sat on the toilet. When R166 indicated that she was done, NA-A assisted R166 to stand using a transfer belt. With gloved hands, NA-A used a wash cloth to clean R166's perineal area, and then used a towel to dry the area. R166 asked, "Is there any blood?" NA-A shook her head. Without removing the gloves, NA-A pushed R166's wheeled walker away from R166 touching both handles, pulled up R166's brief, adjusted R166's clothing while holding onto and adjusting the transfer belt, and then flushed the toilet. NA-A then removed the gloves, and washed her hands. During an interview on 3/12/14, at 3:05 p.m., NA-A verified that she did not remove her gloves after doing pericare for R166, and that she touched the walker, R166's clothing, and the transfer belt with the same gloves. NA-A verified that R166 has had blood in her stool in the past, but didn't see any blood today. NA-A indicated the transfer belt used for R166, is also potentially	F 441	to determine if policies meet current standards of practice. Nursing staff were reeducated as it relates to their respective roles and responsibilities for the policies and procedures on hand washing and glove usage. These results of monitoring of the corrective action (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months and then as needed. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 4/21/2014	

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	245205	A. BUILDING ______ B. WING ______	03/13/2014

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

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F 441	Continued From page 6 used for 10 residents on the Cornerstone unit that need assistance to transfer and/or ambulate. NA-A stated, "I carry the gait belt with me all day, and use it for residents that need help to walk or transfer." NA-A indicated that the transfer belt was not cleaned between residents and that the transfer belt was used on other residents during her shift, adding, "Oh, that's gross! I'm going to wash that belt tonight." During an interview on 3/13/14, at 2:10 p.m., director of nursing (DON) stated, "Gloves should be changed anytime bodily fluids are touched. Gloves should be removed after doing pericare, before touching anything else." A review of the facility's Glove Technique (Non-Sterile) policy, undated, included, "Wear clean non-sterile gloves when touching blood, body fluids, secretions, excretions, and contaminated items. Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces ... "	F 441		

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

F5205023

FORM APPROVED
OMB NO. 0938-0391

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 ______	**03/11/2014**

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

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Anoka Rehab & Living Ctr.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 facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire doors. 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 118 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

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.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5076

April 3, 2014

Mr. Dennis Decosta, Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5205024

Dear Mr. Decosta:

The above facility was surveyed on March 10, 2014 through March 13, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to Gail Anderson at Minnesota Department of Health, 1505 Pebble Lake Road #300, Fergus Falls, Minnesota 5653. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992   Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: ______ B. WING ______	03/13/2014

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

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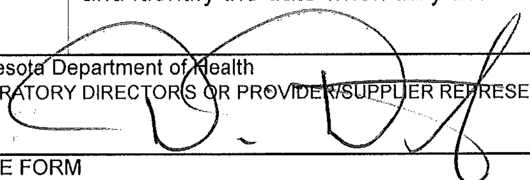
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On March 10th, 11th, 12th, and 13th, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	



Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 04/10/2014

RECEIVED
APR 14 2014
MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by:	21015		

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21015	Continued From page 2	21015		

Based on observation, interview and record review, the facility did not ensure potentially hazardous foods were cooled using time and temperature controls to minimize the risk for foodborne illness. This had the potential to affect 63 of 107 residents who received a regular diet and could be served leftover turkey portions.

Findings include:

During interview on 3/12/14, at 1:00 p.m. cook (C)-A and C-B were asked about the facility's process for safe cooling of leftovers. Both C-A and C-B reported that the facility did use time and temperature controls for cooling leftovers. However, neither C-A or C-B were able to relay the time frames and temperatures required for safe cooling of potentially hazardous foods. C-B also verified there were no postings in the kitchen area to guide the kitchen staff on safe time and temperature controls for cooling leftovers. C-B reported that the cooks did check the cooling temperatures of foods, but was unable to indicate the timeframes for when they took those temperatures. C-B also verified there was no documentation of these temperature checks. Upon further inquiry, she indicated she would have needed to consult with the facility's dietary manager (DM) to identify what timeframes the temperatures were to be taken and what temperatures the food items were required to drop to, in order to minimize the risk of foodborne illness. C-A and C-B verified they were typically responsible for storing and cooling leftovers after the facility's noon meal. C-A and C-B verified the facility routinely saved some food items as leftovers. C-B reported that she liked to save meats to use for making various soups.

During observation and interview on 3/12/14, at

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21015	Continued From page 3 1:05 p.m. in the facility's main kitchen, dietary aide (DA)-A reported that she was not typically responsible for cooling leftovers, but verified she intermittently assisted the cooks with dishing leftovers into containers for refrigeration. DA-A was observed pushing a cart with various containers from the steam table, filled with food items from the lunch meal, into the main kitchen. DA-A reported that she typically brought the lunch leftovers to C-A and C-B for cooling. DA-A was asked how she selected container sizes for leftovers. Given the example of Turkey Dyvan (turkey breasts with a broccoli and cheese mixture), the main dish served for lunch on 3/12/14, DA-A verified that she would have selected a large container since a large amount of the dish remained. DA-A pointed out a container which held approximately five quarts. DA-A added, "[C-B] always says, the bigger the better." During observation and interview on 3/12/14, at 3:30 p.m. DM was asked to take the temperature of any meats that were saved as leftovers from the lunch meal. She went into the facility's walk-in refrigerator and presented a small container, approximately one quart in size, half-filled with Turkey Dyvan, approximately 3 servings. DM was asked to place the thermometer into one of the turkey breasts and verified a reading of 88 degrees Fahrenheit (F), two hours and twenty-five minutes after the food item was observed to be removed from the steam table and brought into the kitchen for cooling. DM verified it was her expectation that leftovers were cooled to at least 70 degrees F within two hours, to minimize the risk for foodborne illness. DM stated that she needed to verify the time the dish was removed from the steam table, but added that if it was more than two hours prior, the turkey	21015		

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	00893	A. BUILDING: ______ B. WING ______	03/13/2014

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

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21015	Continued From page 4 dish would need to be discarded. During interview on 3/13/14, at 11:00 a.m. C-B verified that she had cooled the Turkey Dyvan leftovers from lunch on 3/12/14. She reported that she dished the leftovers into a plastic container, covered and dated them, and placed them in the walk-in refrigerator. C-B estimated the Turkey Dyvan was removed from the steam table at approximately 12:30 p.m., three hours prior to the temperature finding of 88 degrees F. During interview on 3/13/14, at 11:10 a.m. DM reported the Turkey Dyvan was removed from the steam tray on 3/12/14, at approximately 1:00 p.m. DM stated she re-trained her employees that morning on cooling time and temperature controls. DM verified the leftover Turkey Dyvan was discarded. Review of the 2013 Minnesota Food Code revealed, potentially hazardous food was to be cooled §to 70 degrees F within two hours; and§ from 70 degrees F to 41 degrees F or below within four hours.§ The food code indicated that potentially hazardous food needed to pass through the first stage of cooling quickly to minimize growth. If a food item did not reach 70 degrees F within two hours, it was to be thrown out or reheated and then cooled again. The facility's Use of Leftovers policy dated 2010, directed staff to cover, label and date leftovers, then store them refrigerated or frozen, immediately after the end of the meal service. The policy indicated leftovers were to be cooled to 41 degrees F or below within four hours, or cooled to 70 degrees F within two hours and then down to 41 degrees F, within another four hours. SUGGESTED METHOD OF CORRECTION: The	21015		

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21015	Continued From page 5 administrator with the director of dietary services or designee(s) could review and revise as necessary the policies and procedures regarding cooling of potentially hazardous foods. The director of dietary or designee (s) could provide training for all appropriate staff on these policies and procedures. The director of dietary or designee (s) could monitor to assure staff are cooling foods properly. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of	21390		

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products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and

I. methods for maintaining awareness of current standards of practice in infection control.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene practices were followed to minimize the spread of organisms for 1 of 5 residents (R166) observed to receive care requiring hand washing.

Findings include:

R166 was admitted with diagnoses including diverticulitis of the colon with hemorrhage and unspecified hemorrhage of the gastrointestinal tract. R166's quarterly Minimum Data Set (MDS), dated 1/6/14, indicated R166 was cognitively intact and required limited assistance of one for transfers, walking in her room, and personal hygiene. R166 required extensive assistance of one for toileting.

During an observation on 3/12/14, at 9:05 a.m., nursing assistant (NA)-A assisted R166 with morning cares while R166 sat on the toilet. When R166 indicated that she was done, NA-A assisted R166 to stand using a transfer belt. With gloved hands, NA-A used a wash cloth to clean R166's perineal area, and then used a towel to dry the area. R166 asked, "Is there any blood?" NA-A shook her head. Without removing the gloves, NA-A pushed R166's wheeled walker away from R166 touching both handles, pulled up R166's brief, adjusted R166's clothing while holding onto and adjusting the transfer belt, and

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then flushed the toilet. NA-A then removed the gloves, and washed her hands.

During an interview on 3/12/14, at 3:05 p.m., NA-A verified that she did not remove her gloves after doing pericare for R166, and that she touched the walker, R166's clothing, and the transfer belt with the same gloves. NA-A verified that R166 has had blood in her stool in the past, but didn't see any blood today. NA-A indicated the transfer belt used for R166, is also potentially used for 10 residents on the Cornerstone unit that need assistance to transfer and/or ambulate. NA-A stated, "I carry the gait belt with me all day, and use it for residents that need help to walk or transfer." NA-A indicated that the transfer belt was not cleaned between residents and that the transfer belt was used on other residents during her shift, adding, "Oh, that's gross! I'm going to wash that belt tonight."

During an interview on 3/13/14, at 2:10 p.m., director of nursing (DON) stated, "Gloves should be changed anytime bodily fluids are touched. Gloves should be removed after doing pericare, before touching anything else."

A review of the facility's Glove Technique (Non-Sterile) policy, undated, included, "Wear clean non-sterile gloves when touching blood, body fluids, secretions, excretions, and contaminated items. Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces ... "

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21390	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise the policies and procedures regarding hand hygiene and infection control and provide additional education to all involved staff. A designated staff member could perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21390		