CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: J2K9

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STATI	STATE SURVEY AGENCY Facility ID: 00893			
MEDICARE/MEDICAID PROVIDER No. (L1) 245205 2.STATE VENDOR OR MEDICAID NO.	0.	3. NAME AND ADD (L3) ANOKA REP (L4) 3000 4TH AV	HABILITATION		NG CENTER		4. TYPE OF ACTION: 1. Initial	7 (L8) 2. Recertification
(L2) 261960100		(L5) ANOKA, MN			(L6)	55303	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 11/01/2012	NERSHIP	7. PROVIDER/SUP	PPLIER CATEGOR'	Y 09 ESRD	<u>02</u> (L7)	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 02/11 , 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) — (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 120 (L37) (L38) 16. STATE SURVEY AGENCY REMARK	120 (L18) 120 (L17) 19 SNF (L39)	B. Not in Comp Requirements a ICF (L42)	nce With quirements Based On: cceptable POC pliance with Program and/or Applied Waiv IID (L43)		2. Techi 3. 24 H 4. 7-Da 5. Life:	nical Personnel our RN y RN (Rural SNF) Safety Code A* EETS	Following Requirements: 6. Scope of Serv. 7. Medical Direc 8. Patient Room 9 9. Beds/Room (L12)	tor
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	YEY AGENCY APP	PROVAL	Date:
Austin Fry, HFl	E NE II		02/11/2016	(L19)	Kate J	ohnsTon, Pr	ogram Specialist	02/29/2016 (L20)
	PART II - TO	BE COMPLETEI	D BY HCFA RI	EGIONAL	OFFICE OR S	INGLE STATI	E AGENCY	
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible			PLIANCE WITH C ITS ACT:	IVIL	2. O		al Solvency (HCFA-2572) tterest Disclosure Stmt (HCF/	\-1513)
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	ENT	26. TERMINAT	ION ACTION:	(L30)
OF PARTICIPATION 02/07/1976	BEGINNING	DATE	ENDING DAT	E	VOLUNTARY 01-Merger, Closur	re	05-Fail to M	eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction 03-Risk of Involun	W/ Reimbursemen	t 06-Fail to M	eet Agreement
25. LTC EXTENSION DATE: (L27)	A. Suspension of	of Admissions:	(L44)		04-Other Reason fo		OTHER 07-Provider 00-Active	Status Change
	B. Rescind Sus	pension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
	(1.28)	00320		(I 21)				
31. RO RECEIPT OF CMS-1539	(L28) 32	. DETERMINATION C	DF APPROVAL DA	(L31) TE	Posted 04/1	1/2016 Co.		
	(L32)	02/05/2016		(L33)	DETERMINA	TION APPROV	/AL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245205 February 29, 2016

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 January 18, 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.

Anoka Rehabilitation And Living Center February 29, 2016 Page 2

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 29, 2016

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

RE: Project Number S5205026

Dear Mr. Dolinsky:

On December 29, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 10, 2015. 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 February 11, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 1, 2016 the Minnesota Department of Public Safety 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 December 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 18, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 10, 2015, effective January 18, 2016 and therefore remedies outlined in our letter to you dated December 29, 2015, 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.

Anoka Rehabilitation and Living Center February 29, 2016 Page 2

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

POST-CERTIFICATION REVISIT REPORT

	1 001 0EIXIII 10AI101	TILL TION INC. OIL		
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245205 _{Y1}	B. Wing	Y2	2/11/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
ANOKA REHABILITATION AND L	IVING CENTER	3000 4TH AVENUE		
		ANOKA, MN 55303		
	,	and/or Clinical Laboratory Improvement Amendments nent of Deficiencies and Plan of Correction, that have	been	

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).

ITEI	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0205 483.12(b)(1)&(2)		Correction	ID Prefix	F0279 483,200	d), 483.20(k)(1)	Correction	ID Prefix	F0282 483.20(k)(3)(ii)		Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC			01/18/2016	LSC			01/18/2016	LSC			01/18/2016
ID Prefix	F0309		Correction	ID Prefix	F0312		Correction	ID Prefix	F0314		Correction
Reg. #	483.25		Completed	Reg. #	483.25(a)(3)	Completed	Reg.#	483.25(c)		Completed
LSC			01/18/2016	LSC			- 01/18/2016 -	LSC			01/18/2016
ID Prefix	F0315		Correction	ID Prefix	F0318		Correction	ID Prefix	F0329		Correction
Reg.#	483.25(d)		Completed	Reg. #	483.25(e)(2)	Completed	Reg.#	483.25(I)		Completed
LSC			01/18/2016	LSC			- 01/18/2016 -	LSC			01/18/2016
ID Prefix	F0356 483.30(e)		Correction	ID Prefix	F0441 483.65		Correction	ID Prefix	_		Correction
Reg. #			Completed	Reg. #			Completed –	Reg. #			Completed
LSC			01/18/2016	LSC			01/18/2016	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg.#			Completed
LSC				LSC			_	LSC			
REVIEWE		REVIEWE		DATE		SIGNATURE OF S	URVEYOR			DATE	
STATE AG	BENCY	(INITIALS	JS/KJ	02/29/2	2016		3.	3925		02/	11/2016
REVIEWE CMS RO	D BY	REVIEWE (INITIALS		DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/10/2015		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?				YES NO					

POST-CERTIFICATION REVISIT REPORT

CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON 12/9/2015								
REVIEWE		<u> </u>	(INITIALS) TL/KJ	02/29/20 DATE	016 тіті		19251	02/01/2016 DATE
REVIEWE			REVIEWED BY	DATE	SIGI	NATURE OF SURVEYOR	<u> </u>	DATE
LSC				LSC			LSC	
Reg. #			Completed	Reg.#		Completed	Reg. #	Completed
ID Prefix			Correction	ID Prefix		Correction	ID Prefix	Correction
LSC				LSC			LSC	
Reg. #			Completed	Reg. #		Completed	Reg. #	Completed
ID Prefix			Correction	ID Prefix		Correction	ID Prefix	Correction
LSC				LSC			LSC	
Reg.#			Completed	Reg. #		Completed	Reg. #	Completed
ID Prefix			Correction	ID Prefix		Correction	ID Prefix	Correction
LSC				LSC			LSC	
Reg. #			Completed	Reg. #		Completed	Reg. #	Completed
ID Prefix			Correction	ID Prefix		Correction	ID Prefix	Correction
LSC	K0029		01/18/2016	LSC	K0050	01/08/2016	LSC	
Reg. #	NFPA 10	1	Completed	Reg. #	NFPA 101	Completed	Reg. #	Completed
ID Prefix			Correction	ID Prefix		Correction	ID Prefix	Correction
Y4			Y5	Y4		Y5	Y4	Y5
program corrected provision	to show d and the n number ey report	those of date su and the	leficiencies previously rep uch corrective action was	oorted on the accomplished	CMS-2567, S d. Each defic	icaid and/or Clinical Laborato Statement of Deficiencies an ciency should be fully identific CMS-2567 (prefix codes sho	d Plan of Correction, ed using either the re	that have been gulation or LSC
ANOKA	REHABIL	ITATIO	N AND LIVING CENTER			3000 4TH AVENUE ANOKA, MN 55303		
	FACILITY		'			STREET ADDRESS, CI	TY, STATE, ZIP CODE	1
	R / SUPPI CATION N			STRUCTION - ANOKA CA	RE & REHA	B CENTER		DATE OF REVISIT 2/1/2016 y ₃



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 29, 2016

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

Re: Reinspection Results - Project Number S5205026

Dear Mr. Dolinsky:

On February 11, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 10, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

STATE FORM: REVISIT REPORT											
	MULTIPLE CONSTRUCTION		DATE OF REVISIT								
IDENTIFICATION NUMBER	A. Building		2/11/2016								
00893 _{Y1}	B. Wing	Y2	2/11/2016 _Y	′3							
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE									
ANOKA REHABILITATION AND LI	VING CENTER	3000 4TH AVENUE									
		ANOKA, MN 55303		_							
		reported that have been corrected and the date such ng either the regulation or LSC provision number and									

identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEI	M		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20560		Correction	ID Prefix	20565		Correction	ID Prefix	20830		Correction
Reg.#	MN Rule 4658.04 Subp. 2	105	Completed	Reg.#	MN Rul Subp. 3	e 4658.0405	Completed	Reg. #	MN Rule 4658.0520 Subp. 1)	Completed
LSC			01/18/2016	LSC			01/18/2016	LSC			01/18/2016
ID Prefix	20895		Correction	ID Prefix	20900		Correction	ID Prefix	20910		Correction
Reg.#	MN Rule 4658.05 Subp. 2.B	525	Completed	Reg. #	MN Rul Subp. 3	e 4658.0525	Completed	Reg. #	MN Rule 4658.0525 Subp. 5 A.B	5	Completed
LSC			01/18/2016	LSC			01/18/2016	LSC			01/18/2016
ID Prefix	20920		Correction	ID Prefix	21390		Correction	ID Prefix			Correction
Reg.#	MN Rule 4658.05 Subp. 6 B	525	Completed	Reg. #	MN Rul Subp. 4	e 4658.0800 · A-I	Completed	Reg.#			Completed
LSC			01/18/2016	LSC			01/18/2016	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			-	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			_	LSC			
REVIEWE STATE AG		REVIEWE (INITIALS	3)	DATE		SIGNATURE OF S				DATE	
			JS/KJ	02/29/2	016	TITLE	3392	25			/11/2016
CMS RO	D BY □	REVIEWE (INITIALS		DATE		TITLE				DATE	
12/10/20	JP TO SURVEY CO	OMPLETED	ON			ANY UNCORRECTE				YE	в 🔲 по
									E) (E) IT ID		

Page 1 of 1 EVENT ID: J2K912

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: J2K9

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART I -	TO BE COMPLETED BY	THE STA	TE SURVEY AGENCY	Facility ID: 00893			
MEDICARE/MEDICAID PROVIDER NO. (L1) 245205 2.STATE VENDOR OR MEDICAID NO. (L2) 261960100	3. NAME AND ADDRESS OF FAC (L3) ANOKA REHABILITATI (L4) 3000 4TH AVENUE (L5) ANOKA, MN		LIVING CENTER (L6) 55303	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint			
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 11/01/2012	7. PROVIDER/SUPPLIER CATEO 01 Hospital 05 HHA	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY 12/10/2015 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TIC 2 AOA 3 Other	02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 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 A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC X B. Not in Compliance with Pro Requirements and/or Applied	gram	And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 6. Scope of Services Limit 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size 5. Life Safety Code 9. Beds/Room * Code: B* (L12)				
14. LTC CERTIFIED BED BREAKDOWN 18 SNF	ICF IID (L42) (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)			
16. STATE SURVEY AGENCY REMARKS (IF APPLICA	ABLE SHOW LTC CANCELLATION	DATE):					
17. SURVEYOR SIGNATURE	Date :		18. STATE SURVEY AGENCY	APPROVAL Date:			
Austin Fry, HFE NE II	01/13/2016	(L19)	Kate JohnsTon, P	rogram Specialist 02/04/2016 (L20)			
PART II - TO BE	COMPLETED BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY			
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WIT RIGHTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:			
22. ORIGINAL DATE 23. LTC AGREE OF PARTICIPATION BEGINNING 02/07/1976 (L24) (L41)			26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburs	INVOLUNTARY 05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement			
A. Suspensio	VE SANCTIONS n of Admissions: (L44) uspension Date: (L45)		03-Risk of Involuntary Terminatic 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active			
28. TERMINATION DATE: 29). INTERMEDIARY/CARRIER NO.		30. REMARKS				
(L28)	00320	(L31)					
31. RO RECEIPT OF CMS-1539 32	2. DETERMINATION OF APPROVAL	LDATE					
(L32)		(L33)	DETERMINATION APP	ROVAL			



Electronically delivered December 29, 2015

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

RE: Project Number S5205026

Dear Mr. Dolinsky:

On December 10, 2015, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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>Electronic 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.

Anoka Rehabilitation And Living Center December 29, 2015 Page 2

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:

Jessica Sellner, Unit Supervisor Minnesota Department of Health Licensing & Certification Health Regulation Division Midtown Square 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (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 January 19, 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 January 19, 2016 the following remedy will be imposed:

• Per instance civil money penalties. (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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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

Anoka Rehabilitation And Living Center December 29, 2015 Page 4

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 March 10, 2016 (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 June 10, 2016 (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 Anoka Rehabilitation And Living Center December 29, 2015 Page 5

> 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 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. Tom Linhoff, Interim Supervisor Health Care Fire Inspections State Fire Marshal Division Email: tom.linhoff@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

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

PRINTED: 01/13/2016 FORM APPROVED OMB NO. 0938-0391

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTE			E SURVEY MPLETED
		245205	B. WING			12/	10/2015
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F 000	as your allegation of Department's acceenrolled in ePOC, at the bottom of the form. Your electron be used as verificated Upon receipt of an on-site revisit of your validate that substate regulations has been your verification. 483.12(b)(1)&(2) New POLICY BEFORE/ Before a nursing fathospital or allows a leave, the nursing fathospital or allows a leave, the nursing fathospital representation of the bed-hold polduring which the reand resume residenthe nursing facility's periods, which must (b)(3) of this section return. At the time of transhospitalization or the facility must provide member or legal rewinch specifies the described in parage.	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with OTICE OF BED-HOLD UPON TRANSFR acility transfers a resident to a resident to go on therapeutic facility must provide written resident and a family member tive that specifies the duration icy under the State plan, if any, esident is permitted to return nce in the nursing facility, and is policies regarding bed-hold at be consistent with paragraph n, permitting a resident to after of a resident for nerapeutic leave, a nursing e to the resident and a family representative written notice of duration of the bed-hold policy raph (b)(1) of this section.	F 0				1/18/16
LABORATOR'	Y DIRECTOR'S OR PROVII	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

Electronically Signed 01/07/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	` '	ROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	` '		E CONSTRUCTION (SURVEY PLETED
		245205	B. WING			12/1	0/2015
NAME OF PROVIDER OR SUF	PLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0, _ 0 10
ANOKA REHABILITATIO	N AND LIVI	NG CENTER			000 4TH AVENUE		
				А	NOKA, MN 55303		
PREFIX (EACH DEF	CIENCY MUST	T OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 205 Continued Fr	. •	and made as a Managar	F 2	:05			
This REQUIF by: Based on int facility failed to representative bed hold police of 1 residents transfer, disconstraints in transfer in tran	erview and oprovide the written not by at the time (R53) review arge. Ide: I	document review, the re resident or legal tification of the facility's e of hospitalization for 1 ewed for admission, atted the resident was 1 - 11/9/15. The medical ation that written bed hold policy was family or legal 8/15, at 12:20 p.m. atted no notice of the bed when R53 was 10/15, at 11:40 a.m. atted no notification was 853 was transferred to there was nothing in hold when R53 was 0/15, at 2:18 p.m. ostated the social worker or their legal not their bed held if they tal, and they should also old policy on admission. information was			Preparation, submission and implementation of this Plan of Corre does not constitute an admission of, agreement with the facts and conclu in the statement of deficiencies. Thi of Correction is prepared and execura means to continuously improve the quality of care, to comply with all applicable state and federal regulator requirements and it constitutes the facility's allegation of compliance. It is policy of Anoka Rehabilitation and Li Center to provide notice to the reside and/or designated decision maker be transfer to the hospital or therapeutic leave. All residents receive bedhold information upon admission. All resident or their designated or legal representative will be given a bed ho form for signature upon transfer to the hospital or go on leave of absence p state guidelines. Bedhold policy per state guidelines here in the policy per state guidelines here reviewed by the interdisciplinar team on 12/31/15 to ensure that bed and readmission notice information is provided to all residents who transfer or leave facility (hospital, Leave of absence). The policy and procedure for bed horeadmission notification was reviewed the interdisciplinary team on 12/31/1 Staff members were trained as it related to their respective roles and responsibilities regarding the bedhold responsibilities regarding the perfective responsibilities regarding the	or usions is Plan ted as e ory is the iving ent efore c policy dent old he per as ry d hold is er and old and ed by 5. ates	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		245205	B. WING			12/ ⁻	10/2015
	PROVIDER OR SUPPLIER	D LIVING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE 000 4TH AVENUE NOKA, MN 55303		
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F 279 SS=D	hospital. When interviewed cassistant executive service staff are reshold policy with the representative. AE transferred to the heand signed by the restated this was to b verbally. The facility policy tit Policy dated 8/2011 work or designee w responsible party w hospitalization to asheld. 483.20(d), 483.20(k COMPREHENSIVE A facility must use to develop, review a comprehensive plan. The facility must deplan for each reside objectives and time medical, nursing, an needs that are idem assessment.	on 12/10/15, at 2:26 p.m. director (AED) stated social sponsible for reviewing the bed resident and/ or legal D stated any time a resident is ospital, the form is discussed esident or designee, and AED e done in writing and not just led Minnesota Bed Hold, identified the assigned social ill contact the resident or the ithin one business day after a sk if they wish to have a bed E)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's	F 2		monthly x3 and quarterly x2. Upon staff education will be implemented indicated by a prescribed corrective plan. The Director of Nursing/Clinical Services/Finance Director/Business Manager or designee will be responder compliance.	I if action S Office asible	1/18/16
	psychosocial well-b	physical, mental, and eing as required under ervices that would otherwise					

	IENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING COMP		E SURVEY PLETED			
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F 279	Continued From particle be required under due to the resident §483.10, including under §483.10(b)(4). This REQUIREME by: Based on observareview, the facility comprehensive play precautions for 1 of for dialysis, and for interventions for 1 for emotional well-Findings include: R132's admission dated 11/5/15, ider cognitive impairmed an outside facility. R132's care plan of was a new admission, and was curred However, the care	age 3 §483.25 but are not provided 's exercise of rights under the right to refuse treatment 4). NT is not met as evidenced ation, interview and document failed to develop a an of care to include fistula f 1 residents (R132) reviewed behavioral symptoms and of 2 residents (R210) reviewed	F 2	DEFICIENCY)	d of Correction sion of, or d conclusions es. This Plan d executed as rove the h all regulatory es the ance. It is the n and living ervices by nce with each e. re plan was \$1/2015.	
	monitoring resulted	estrictions for blood pressure d from R132's shunt site.		changes have been made to family and physician. Resident # 132 discharged 1	2/9/15For	
	was seated at the dialysis shunt visib	on 12/8/15, at 4:42 p.m. R132 dining room table. R132 had a le in his right upper arm, and dialysis three times a week.		other residents who may be this practice, review and revi upon admission, significant of quarterly. Individualized care reflect resident's current stat	se careplan change and plan will	
	nursing assistant (on 12/8/15, at 5:46 p.m. NA)-C stated the NA staff		staff will update the careplan policy. The policy for comprehensive	per facility	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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F 279	when interviewed registered nurse (plan was used to residents, and the from the resident oreference for the pressures were not right arm because information should plan and NA care R132's undated N indicated R132 reguide did not identicated R132 reguide did not identicated, or not to right arm. When observed a on 12/8/15, at 6:2's wheelchair in his rhave any signage dialysis shunt, or a obtain R132's block several staff, incluicated the care plate for that particular plate information about on R132's right art treatment records	on 12/8/15, at 6:05 p.m. RN)-D stated the resident care direct the care and needs of NA care guides were created care plan and was to be a NA staff. RN-D stated blood of to be obtained using R132's of his dialysis shunt, and that it be identified on R132's care	F 2	279	was reviewed by the interdisciplina on 12/31/15. Staff members were the as it relates to their respective roles responsibilities regarding the care policy and procedures on January & 6th 2016. The Director of Nursing or designe be responsible for compliance. Care plan audits will be completed for 3 weeks, monthly for 3 months, quarterly. Staff education will be priffundicated by audits.	rained s and olan 4th, 5th e will weekly then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245205	B. WING			12/	10/2015
	PROVIDER OR SUPPLIER REHABILITATION ANI	D LIVING CENTER		STREET ADDRESS, 3000 4TH AVENUE ANOKA, MN 553			
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F 279	identified her cognitand required extens activities of daily lividentified R210 den behaviors. The care plan dated had Lewy Body den the following intervedementia care, beh Anticipate needs; e carefully; observe hody language; observed to sensory where to express feelimake her wants an use short and directive explain activities/caprovide one directive feelings when appropression, bring her for psychosocial well be manner; avoid arguitates and the same propression of the same plan also lacked staff supervision the addition, the care propression individualized in the same propression of the same plan also lacked staff supervision the addition, the care propression individualized in the same plan also lacked staff supervision the addition, the care propression in the same plan also lacked staff supervision the addition, the care propression in the same plan also lacked staff supervision the	change MDS dated 11/18/15, tion was moderately impaired sive assistance for most ing (ADLs). The MDS monstrated wandering d 11/25/15, identified R210 mentia. The care plan directed entions for communication, aviors and elopement: incourage socialization; listen fer facial expressions and serve for sad/anxious mood loss; provide opportunity for ings regarding her inability to dineeds known; speak clearly, the phrases; communicate at yourself at each interaction; are prior to beginning them; are prior to beginning them; are at a time; validate her opriate; allow time for her to to activities to promote her eing; approach her in a calming with her; redirect her for each as needed; praise her for my distract her from wandering to diversions of activity, food, on; involve her in activities as and ensure her Wanderguard care plan did not address into other resident rooms. The end direction for the increased at was required for R210. In alan lacked specification of end interests and successful fied through the facility's	F 2	79			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 279	another resident ap (RN)-J and reported room. RN-J and not entered the room at this other resident's room). R210 was a required weight bear RN-J and NA-K to swheelchair. R210 wand did not appear happening to her. I during the transfer at toward the bed. R2 some of these thing forearm area tightly noted to comment, her to transfer back replied to R210 stat with my arm,,, [will let go of NA-K's arm transfer to her wheer room, rubbing her did hurt her arm du she pinched her arm pinches." At 12:36 wandering into a diffunct her own room), assisted R210 out of down another hallw in the direction of her com, seat bathroom. RN-J coon R210 and found her toilet. R210 had and a small void of	ge 6 s on 12/9/15, at 12:27 p.m., proached registered nurse d she needed help in her ursing assistant (NA)-K and R210 was observed lying in a bed (this was not R210's alert, but not oriented and aring assistance from both stand and transfer back to her was resistive to the transfer to understand what was Most of R210's body was limp and/or R210 was leaning back 210 stated, "I'm scared of gs," and grabbed NA-K's and held it. R210 was also "That hurts," as they assisted to her wheelchair. NA-K ting, "Well that's hurting me, you] let go please?" R210 did in and then they completed the elchair. As NA-K left the forearm. She reported R210 ring the transfer, specifically, in. NA-K stated, "Yeah, she p.m., R210 was observed if erent resident's room (again, RN-J alerted NA-K and NA-K of the room and brought her any where she began to propel er own resident room. At was observed in her own red on the toilet in her onfirmed NA-K had checked in she had self-transferred to d a medium bowel movement urine. RN-J commented that been trying to communicate	F 2	279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 279	and anxious-like been buring interview on stated R210 had liv approximately one demonstrated multi including pinching, wandering into other feet into the flow her feet into the flow her in her wheelchainterventions she fowith R210: Providing warm blanket over right after each men her pain was well mattend activities. R couple of other resinot tolerant of R210 RN-J stated, "That' close eye on her." into other resident reach shift. She ide all of the staff to be at all times and to resident's doors cloof entering their rocinterventions found communicated to sonce weekly behav R210's nursing profincluded specific bestaff. RN-J stated identified during the the care plans bein the behavior rounds RN-J identified werher a cup of coffee in the staff of the staff.	bathroom by her wandering chavior. 12/9/15, at 12:09 a.m. RN-J red on that unit for month. RN-J reported R210 ple behavior concerns tugging at others' clothing, er resident rooms and planting or when someone is propelling pair. RN-J reported the following bund as successful in her working her with snacks, using a her shoulders, toileting her al, providing 1:1's ensuring managed, encouraging her to N-J added, there were a dents on the unit, who were D's wandering into their room. Is why we have to keep such a She stated R210 wandered rooms one, to two times during ntified that it was important for cognizant of where she was make every effort to keep other used, to minimize her likelihood	F 27	79			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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F 279	should add that wa plan]." During interview on stated behavior interview on paper with interventions were the time. NA-K state in the behavior round opportunity to share other had found to was the time of day more fidgety. She waiting and re-appreffective. She repolikely a result of her something to the stand routinely wanded. During interview on licensed social wor facility's behavior rounding to the stated the NAs and behaviors observed shared successful and/or suggested in R210. LSW-C reported and successful facility is director (A recorded and su	rm blanket in there [the care 12/9/15, at 12:49 p.m. NA-K erventions for R210 included arm banked, or a marker to . She added R210's current effective approximately 50% of ted the NAs routinely took part nds, where they were given the einterventions which each be effective. NA-K stated this when R210 typically became added, other interventions of roaching R210 were somewhat orted R210's behaviors were attempting to communicate aff. NA-K reported R210 did er into other resident's rooms. 12/9/15, at 2:27 p.m. ker (LSW)-C, stated the ounds took place at least once more frequently than this. He other staff discussed any new distince the prior meeting and interventions implemented essful interventions should that between himself and AD)-A, meeting minutes were essful interventions should the care plan. LSW-C at aware that R210 had been er resident rooms and did not ussing this subject during the	F 2	79		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245205	B. WING		12/	/10/2015
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F 279	earlier that day. He engaged as much interventions of enproviding 1:1 assistimes weekly and a he tried to have R2 activities per week always participate parallel with the oth coffee to drink. At the behavior round that he took notes meetings, but thou interventions should plan by the facility's confirmed he did not the behavior round of care. AD-A state the behavior round other staff via a coother staff	ring into other resident rooms, e stated, "We try to have her as possible." AD-A identified gaging her in activities and tance with them three to four as needed. AD-A reported that 210 participate in three to four. He added, R210 did not in activities, but would sit her residents, if given a cup of D-A confirmed he routinely led as on R210's unit. He stated of the discussion at the ght that any suggested and have been added to the care is nursing department. He ot typically enter the findings of as into a resident's written planed the interventions shared at as were communicated to all mmunication book and/or via to the care plan. In 12/10/15, at 4:31 p.m. the (DON) stated, any behavior thy observed by staff, should don the care plan, with a plan the behavior. Ity's Care Plan Policy and /12/15, directed individualized ritten to help residents meet are plan was to be updated or eeds changed and any as were to be added to the re plan if no resolution was met e interdisciplinary team was to belopment of the care plan, in	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245205	B. WING		12/	10/2015
	PROVIDER OR SUPPLIER	D LIVING CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 000 4TH AVENUE ANOKA, MN 55303		
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F 279 F 282 SS=E	Continued From pa self-determination a 483.20(k)(3)(ii) SEI PERSONS/PER CA	and participation. RVICES BY QUALIFIED	F 279 F 282			1/18/16
	must be provided by accordance with eactore. This REQUIREMED by: Based on observareview, the facility for care was followed for presidents (R211, R2)	ded or arranged by the facility y qualified persons in ach resident's written plan of the NT is not met as evidenced tion, interview, and document ailed to ensure the plan of or 2 of 2 residents (R208, pressure ulcers, 2 of 2 (208)) reviewed for urinary or 1 of 3 residents (R208) of motion services.		Preparation, submission and implementation of this Plan of Corredoes not constitute an admission of agreement with the facts and concl in the statement of deficiencies. The facility has appealed the deficiencies licensing violations. This Plan of Correction is prepared and execute	f, or usions ne es and	
	orders) dated 12/2/including dementia cancer, chronic obsand acute and chrophysician orders diminimize R208's risher current pressure of new pressure uldaily Tefla dressing in Kerlix; Elevating off bed at all times with no pressure or wheelchair and no	Review Report (physician 15, identified diagnoses depression, anxiety, lung structive pulmonary disease onic respiratory failure. The rected interventions to sk for further progression of e ulcers and the development cers. These orders included sto both heel sores, wrapping her bilateral heels and Achilles using a Heel Lift Manager, in her heels while up in her shoes to be worn; and Placing half-way onto her feet and not due to wounds.		means to continuously improve the of care, to comply with all applicable and federal regulatory requirements constitutes the facility is allegation compliance. It is the policy of Anoka Rehabilitatic living center to provide care and se by qualified persons in accordance each resident is written plan of care. Resident # 208 a comprehensive reassessment was conducted to inc ADLs, range of motion, bowel and bladder assessment, positioning, transfers, skin/body audit assessment, hospid pharmacy consultant medication management review, MD/NP consultant medication.	e state s and it of on and rvices with e. clude; pain, ce plan,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	` '	E SURVEY PLETED
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ANOKA	REHABILITATION AN	ID LIVING CENTER		3000 4TH AVENUE ANOKA, MN 55303		
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F 282	R208's care plan of following interventing pressure ulcers: Staff to keep heelst times, assuring heanything. R208 required two any major repositions and alternative bed, a pressure reacushion to float in the care plan note tendency to remove manager or off the when up in the Broand assistance to R208's significant (MDS) dated 9/30/impairment, requir for activities of daistage two pressure ulcers single Observations of Resource of R208's and assistance to R208's significant (MDS) dated 9/30/impairment, requir for activities of daistage two pressure ulcers single Observations of Resource observed around in the station. She had we shoes on both feet observed around in the station. On 12/8/15, at 7:1-1 lying in her bed, or 12/9/15, at 7:1-1 lying in her left for 12/9/15, at 7:1-1 lying in her left for 12/9/15, at 7:1-1 lying in her left for 12/9/15, at 7:1-1 lying in	dated 10/2/15, directed the ions to minimize the risk for selevated on pillows at all rheels were not touching staff to boost up in bed or with oning. Itiple pressure relieving devices ating pressure mattress for her ducing device for her chair and	F 28	The careplan was reviewed and by the interdisciplinary team on The corresponding updates hav made to Kardex and careplan. It reviewed resident nutritional surfor skin integrity. The notification been to resident family and phys 1/5/16 met with family & hospicareview concerns, the bowel and assessment was revised and up again on 1/5/16 to reflect reside elimination status which will be and change upon rising, after mediand change upon rising, after mediand change as needed during the rupon request. For resident #211 personalized careplan was revised to reflect of toileting plan of toilet after meals and change as need at night. The careplan and Kardex have been and revised by the Quality Asseteam Resident #19 was reassessed of weekly wound rounds on 12/14/wound on right buttock healed. Fairbaim observed area on 12/1 Nurse Practitioner Melissa Sore and family notified. R19 was reast by Nurse Manager on 12/24/15 01/05/16 and skin remains into A Comprehensive reassessment conducted to include; ADLs, Brabowel and bladder assessment, positioning, transfers, pain, skin audit assessment. For other residents who may be	12/31/15. e been Dietician plement is have sician. e team to bladder idated ints current o check eals, at hight and colleting current s, check he reviewed ssment uring 2015 and Dr. 4/15, nson, NP ssessed and t. t was iden,	

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245205	B. WING			12/1	10/2015
	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE 000 4TH AVENUE NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	no pillows or device and both heels wer She wore regular, of feet. Her right, low with gauze, but the R208's bilateral heem attress. On 12/10/15, at 8:0 lying in her bed in hor devices were in was wearing regular white gauze was oblower ankle/ heel a cushion was obsernightstand and the NA-H entered R208 eating her breakfast the bed to approxin remained lying flat blades resting at the of her bed and both bilateral feet and to footboard of her bed pressed into the may were in place to flow on 12/10/15, at 9:5 completed R208's is shoes and socks of care plan directed to During interview on confirmed she was was responsible for plan interventions, were to be floated whenever she was	es in place to float her heels be observed resting on the bed. White socks to her bilateral er ankle area was wrapped left was not. NA-I confirmed els were resting on the 55 a.m. to 9:40 a.m., R208 was her resident room. No pillows place to float her heels. She ar, white socks to both feet and observed around only her right rea. A black heel floating ved, tucked between the wall to R208's right side. B's room to assist her with st. NA-H raised the head of nately 60 degrees. R208 on her back, with her shoulder e crease from the raised head in knees bent. The balls of her les were pressed against the led, with her bilateral heels attress. No pillows or devices	F 2	282	by this practice, the nurse manager MDS coordinator reviewed and revicareplans and updated as needed. Other residents whose clinical concare at risk for impaired skin integrity. Licensed staff to implement preven measures such as Braden assessnin order to provide appropriate treat modalities for wounds according to industry standards of care. After reupdates will be made as appropriate each resident identified. All residents will have a plan of care Kardex that reflects individual care based on assessments. These assessments will be conducted and reviewed upon admission, significal change and quarterly. Individualized careplan and Kardex will reflect resident is current status. Licensed will update the careplan per facility. Each resident will have an individual careplan that reflects their care need based on assessment. The nurse managers will review periodically to ensure that the careplan and Kardeup to date. The policy for compreh care plans was reviewed by the interdisciplinary team on 12/31/15. members were trained as it relates respective roles and responsibilities regarding the careplan policy and procedures on January 4th, 5th & 62016. The Director of Nursing or designed.	ditions y tative nents tment eview e for e and needs distaff policy. Alized eds ex are ensive Staff to their seth	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245205	B. WING			12/ ⁻	10/2015
	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE 000 4TH AVENUE NOKA, MN 55303		
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F 282		ige 13 d it may had fallen off.	F 2	82	be responsible for compliance.		
	During interview on director of nursing (12/10/15, at 4:35 p.m. the (DON) stated staff should sident's care plan and to follow			So respendible for compilation		
	(MDS) dated 9/30/1 was severely impai extensive to total as living, including extension The MDS identified	change Minimum Data Set 15, identified R208's cognition red and she required ssistance for activities of daily ensive assistance for toileting. R208 was not on a toileting llways incontinent of both					
	offer toileting to R2 bedtime, as needed request. The care assist R208 with the provide her with as- toilet. R208 was to	o o					
	7:00 p.m. R208 wa for the supper mea nurse's station area hallway throughout	s on 12/8/15, from 5:30 p.m. to s assisted to the dining room I and then brought back to the a, where she remained in the the evening. R208 was not a bedpan or toileting ng to her care plan.					
	nursing assistant (Note that morning cares with	on 12/10/15, at 9:50 a.m. NA)-H and NA-I completed R208, during which her ct was changed. NA-I					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(SURVEY PLETED
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F 282	confirmed R208 has medium bowel movurine. R208 was nor toileting assistant. During interview on confirmed she was shift. NA-H reported and changed on a revery three hours. morning, she did not until her morning caunaware of when shout confirmed it was (approximately three During interview on director of nursing implementing each R208's significant of identified R208's coand she required eactivities of daily live had a functional liminer upper extremity (CAA) dated 9/30/1 hospice, expected resident participate able Requires lift weight bear with rigaddress PROM or R208's care plan dato both upper extremity	and been incontinent, with a evement and a small void of ot offered the use of a bedpannee. In 12/10/15, at 1:45 p.m. NA-H R208's primary NA on the day at R208 was to be checked routine basis, approximately NA-H confirmed earlier this of check and change R208 ares at 9:50 a.m. and she was he was changed prior to that, is prior to 6:30 a.m. are and a half hours prior). In 12/10/15, at 4:35 p.m. the (DON) stated staff should be a resident's care plan. In the MDS dated 9/30/15, and some severely impaired extensive to total assistance for ring. The MDS identified R208 hitation in ROM to one side of the Care Area Assessment 5, noted, "Resident on to decline over time. Have a fin activities of daily living] as for transfers; not able to ght arm" The CAA did not exercises. In the Care Area PROM mities (UE) and lower	F 2	282			
	during morning car directed, "ROM pro	ith three repetitions each, es. The care plan also ogram for both UB [upper body] once per day following					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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F 282	worksheets in her of R208's closet, as reincluded the following. An Upper Extremit (undated) directed fingers, wrists, elborepetitions to each This form was signitherapy assistant, lifthe Lower Extremit 8/4/15, directed PR ankles, knees, legs repetitions, one time was directed by phy (PTA)-A. During a telephone p.m. family member concerns of her more had been ordered to R208's Documenta 9/1/15, through 12/17 regarding provision In 9/15, R208 receil lower extremities do no PROM noted on remaining three day In 10/15, R208 receil for the one In 11/15, R208 receil and the significant of the one In 11/15, R208 receil and the significant of the one In 11/15, R208 receil and the significant of the one In 11/15, R208 receil and the significant of the one In 11/15, R208 receil and the significant of the one In 11/15, R208 receil and the significant of the one In 11/15, R208 receil and the significant of the one In 11/15, R208 receil and the significant of the one In 11/15, R208 receil and the significant of the one In 11/15, R208 receil and the significant of the signi	closet" The worksheets in eferenced in the care planing: y ROM Program form PROM exercises to R208's ws, and shoulders, with 20 area, one to two times daily. ed by certified occupational censed (COTA/L)-A. ty ROM Program form dated OM exercises to R208's and hips, with five to 10 e daily. This exercise program ysical therapy assistant interview on 12/8/15, at 8:54 r (FM)-B stated she had other not receiving PROM as by therapy. tion Survey Report from 19/15, detailed the following of her ROM services. Wed PROM to her upper and uring 21 out of 30 days, with six days and no data for the tys. eived PROM during eight out PROM noted on 22 days and	F 2	282		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING		_	12/10/2015
	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		STREET ADDRESS, CITY, STA 3000 4TH AVENUE ANOKA, MN 55303	TE, ZIP CODE	
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F 282	R208's morning ca and NA-I. As the N during cares, holding push and/or pull he observed to moan NA-H and NA-I corhistorical for R208 during cares. R206 indications of pain of both her UE and sweatshirt, while as arms into each slee her face and moan with lifting each legany other exercises her morning cares. During interview or stated R208 was she is so painful, yeshe's 'owe, owe." demonstrated thes discomfort wheneveliegs and when turn NA-H reiterated she with R208 because seemed to result. These observations extremities to her states that she was not probecause of this pain developing care plaimplementation. U whether R208 was	res were observed with NA-H JAs turned R208 side-to-side ng her hips and shoulders to er to either side, she was and say, "Owe, owe, owe." nfirmed this was typical and to made such vocalizations also demonstrated and discomfort with dressing LE. During application of her esisting her with putting her eve, she held her hand over ed. She also vocalized "owe" into her pants. No PROM or swere provided to R208 during 12/10/15, at 1:45 p.m. NA-H apposed to receive ROM, "but but move her arm and then NA-H added, R208 e indications of pain/ er she moved her feet, arms ing her side-to-side in bed. e did not do ROM exercises e of the pain/ discomfort which NA-H denied having reported of pain with movements of her supervisors and/or reporting roviding ROM exercises n. 12/10/15, at 2:15 p.m. RN)-A confirmed she was ager and was responsible for	F 2	282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING			12 /	10/2015
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F 282	orders and stated sidirect ROM. She awere in place, were resident's closet do document the exer medical record sysbeen informed of a concerns of care pimplemented for Riburing interview or director of nursing expectation for staticare plan. R19's quarterly MDR19 had moderate extensive assistant frequently incontine pressure ulcer, but pressure ulcers, armattress and whee included diagnoses vascular accident (indicated R19 was R19's care plan was 12/8/15, the care pfor alteration of skiincontinence and pneeded more assis Interventions included the mattress on bed, pchair, inspect skin two hours and cheet on 12/9/15, at 7:10 was observed sleet.	she was not seeing anything to added, any ROM programs that e typically placed inside each for and NAs were prompted to cises in the facility's electronic tem. RN-A denied having my pain concerns and/or any lanned exercises not being 208. In 12/10/15, at 4:35 p.m. the (DON) reported that it was his if to implement each resident's as dated 10/29/15, indicated cognitive impairment, required the for bed mobility, was ent, was at risk for developing did not have any current and had a pressure reducing elchair cushion. The MDS is of heart failure, cerebral CVA) and depression, and receiving hospice care. Is observed electronically on lan included R19 was at risk in integrity due to bladder eriods of lethargy where she stance with mobility. It is ded: alternating pressure ressure relieving device in daily with cares, and turn every	F 2	182			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING _		12	/10/2015	
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F 282	not observed repormake any change during this period On 12/9/15, at 9:1 room with a break R19's head of the not relieved from I tray table with R19 NA-A set up R19's room without provassistance. R19 position eating break positioned F shift at 7:00 a.m. It when interviewed RN-B stated R19 and the aids are to regardless if she is when interviewed stated that the car R19 had a two hor relieve pressure. When interviewed DON stated his expollowing the resid turning and repositions.	sitioning R19, nor did R19 is in her position by herself of time. 6 a.m. NA-A entered R19's fast tray for R19 and raised bed, however, pressure was R19's buttocks. NA-A placed the B's breakfast in front of R19. Is breakfast tray and left the iding any repositioning was observed in the same eakfast until 9:54 a.m. In 12/9/15, at 9:57 a.m. NA-A signed to care for R19 for the ent was to be repositioned however, NA-A stated she had 19 since the beginning of her because she had, "Forgot." In 12/10/15, at 9:55 a.m. needed help being repositioned on help her every two hours, is sleeping. In 12/10/15, at 2:02 p.m. RN-A e plan on 12/9/15 indicated our repositioning schedule to on 12/10/15, at 3:01 p.m. the spectation was staff should be ents individualized care plan for	F 28	32			
		ognition, required extensive ileting, and was frequently					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING		_ 12	/10/2015	
NAME OF PROVIDER OR SUPPLIER ANOKA REHABILITATION AND LIVING CENTER							
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F 282	incontinent of bladd R211's care plan da was incontinent of b "Toilet upon rising, [hour of sleep and p R211's undated nur identified, "Toilet up [sic], HS and prn" During observation 7:05 a.m. nursing a get dressed in bed, wheelchair. NA-E a and helped him bru hair, then assisted for breakfast. R21' toileting after rising care. When interviewed o stated R211 should "Like every two hou was saturated with woke him up. NA-E toileting to R211 tha his care planning d thought R211 would because his beddir During interview on registered nurse (R should be used as, care," and staff wer plan of care." Furth toileting program an	der. ated 12/7/15, identified R211 bladder, and directed staff to, before and after meals, HS brn [as needed]." rsing assistant (NA) care guide bon rising [,] before after meals	F 2	282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245205	B. WING _		12 /-	10/2015
	PROVIDER OR SUPPLIER	D LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282		Plan Policy and Procedure	F 28	32		
F 309 SS=D	the resident the ap maintain or attain t practicable function policy directed the necessary care for measurable goals	ed, "The care plan will ensure propriate care required to he resident's highest level of a possible." Furthermore, the care plan would serve to direct residents, including to determine progress. CARE/SERVICES FOR SEING	F 30	09		1/18/16
	provide the necess or maintain the hig mental, and psych	t receive and the facility must cary care and services to attain hest practicable physical, osocial well-being, in e comprehensive assessment				
	by: Based on observareview the facility for were aware of speresidents (R132) redialysis. In addition individualized demorovided for 1 of 1 behavioral and em Findings include: R132's admission dated 11/5/15, ider cognitive impairments.	tion, interview, and document ailed to ensure all nursing staff cialized care required for 1 of 1 eviewed who was receiving n, the facility failed to ensure entia care interventions were residents (R210) reviewed for otional status. Minimum Data Set (MDS) atified R132 had moderate ent, and had received dialysis at while a resident in the facility.		Preparation, submission and implementation of this Plan of Corre does not constitute an admission of agreement with the facts and concl in the statement of deficiencies. The of Correction is prepared and exect a means to continuously improve the quality of care, to comply with all applicable state and federal regulate requirements and it constitutes the facility is allegation of compliance. It is the policy of Anoka rehabilitation living Center to provide each residencessary care and services to attain maintain the highest practicable physical process.	f, or usions usions plan uted as ne cory on and ent the ain or	

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		245205	B. WING			12/	10/2015
NAME OF	PROVIDER OR SUPPLIE	R		STREE	T ADDRESS, CITY, STATE, ZIP CODE		
ANIOKA	DELIABILITATION AL	ND LIVING CENTER		3000 4	TH AVENUE		
ANOKA	REHABILITATION A	ND LIVING CENTER		ANOK	(A, MN 55303		
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F 309	was a new admissiport, and was curroutside facility. He where R132's dialongoing care instrany restrictions for related to R132's. During observation was seated at the dialysis shunt visil stated he goes to. When interviewed nursing assistant checked R132's whowever, NA staff days. NA-C state restrictions for col R132, and was not not be taken on the color believed blood problem arm with his dinot receive any tracare of a dialysis she took to become when interviewed registered nurse (used to direct the and the NA care of a dialysis she took to direct the and the NA care of a direct the and the NA care of the NA care o	dated 10/30/15, identified R132 sion to the facility, had a dialysis rently receiving dialysis at an owever, the care plan lacked lysis port was located, any ructions for the shunt site, or r blood pressure monitoring	F3	Responding and acceptance and acceptance acc	ental, and psychosocial well-be cordance with the comprehens sessment and plan of care. If Resident # 210 the interdiscipal arreassessed the interest need dividualized the plan of careplaintex to reflect interest and erventions. These updates includer a cup of coffee, 1:1 visit, eso tivity to observe and suggestions ist staff in understanding behasist staff in understanding behasist ended and implemented buding: coordination of dialysis are developed and implemented buding: coordination of dialysis under include shunt site location, alysis, and location of dialysis under include whisten receive dialysis, transport of phone number, no blood drawntral line dialysis port, no blood essure or blood draws from spending from the staff to notify docted actitioner if no thrill or bruit, applied pressure if there is a bleed ling 911 other residents have been revisioned in the dialysis developed. Stanting has been developed.	blinary eds and n and ude; cort to an ns to avior and /9/15. e has d care days of nit/phone at days rtation ws from ecific arm specific tor/nurse blying and iewed to or and aff each	

PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 22 F 309	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ANOKA REHABILITATION AND LIVING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 22 F 309 STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303 (X5) (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) F 309 Continued From page 22 F 309			245205	B. WING _		12 /-	10/2015	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 22 F 309			D LIVING CENTER		3000 4TH AVENUE			
	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
collected in R132's right arm because of his dialysis shunt and that information should be identified on R132's care plan and the NA care guide. RN-D stated if float staff were to assist R132 and didn't know him, they use the information on the care plan and the NA care guide as a reference to provide resident cares. R132's undated NA care guide identified the resident was receiving dialysis, however, the care guide did not identify the location of R132's dialysis shunt, any care instructions or monitoring required, or not to collect blood pressures in his right arm. When observed and interviewed on 12/8/15, at 6:27 p.m. R132's room did not have any sign displayed to alert staff to his dialysis shunt, or any instructions on how to obtain R132's blood pressure. R132's stated several staff, including NA's, had attempted to obtain blood pressures in his right arm (with his shunt) before, and he has had to stop them. During interview on 12/9/15, at 1:30 p.m. RN-E stated information about not collecting blood pressures on R132's right arm was identified on the nurses treatment records, but the NA staff did not have access to those and stated this information should have been on the care plan. A facility policy on dialysis care was requested, but none was provided. R210's significant change MDS dated 11/18/15,	F 309	RN-D stated blood collected in R132's dialysis shunt and tidentified on R132's guide. RN-D stated R132 and didn't know information on the das a reference to possible to a resident was received guide did not identificated	pressures should not be right arm because of his that information should be a care plan and the NA care diffloat staff were to assist ow him, they use the care plan and NA care guide rovide resident cares. A care guide identified the ving dialysis, however, the care fy the location of R132's care instructions or monitoring collect blood pressures in his and interviewed on 12/8/15, at as seated in his wheelchair in from did not have any sign that to obtain R132's blood atted several staff, including and to obtain blood pressures in his shunt) before, and he has an 12/9/15, at 1:30 p.m. RN-E in is used to, "Individually care attent." RN-E stated not collecting blood pressures in was identified on the nurses but the NA staff did not have did stated this information on the care plan. Chialysis care was requested, ded.	F 30	care was reviewed by the team on 12/31/2015. Staff trained as it relates to their roles and responsibilities in Dementia care and Dialysis policy and procedures on a 5th, and 6th of 2016. On a nurse managers will review resident for specialized ca including behavior program dialysis. Dementia care plan audits completed weekly x 3 weemonths, then quarterly for ensure compliance with reto the QA/QI Committee for further recommendations. Dialysis Care Plan audits women completed weekly x 3 weemonths, and quarterly for ensure compliance with reto the Quality Assurance Coreview and further recommendations.	f members were respective respective regarding the is care plan January 4th, admission the wany new re needs mming and will be eks, monthly x 3 2 quarters to esults reported or review and will be eks, monthly x3 2 quarters to esults reported committee for nendations.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245205	B. WING		1:	2/10/2015
_	PROVIDER OR SUPPLIER	D LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP 3000 4TH AVENUE ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE
F 309	identified diagnose dementia. R210 ha cognition, required activities of daily liv physical behavioral symptoms directed behaviors. R210's care plan dhad Lewy Body der the following intervedementia care, behavicipate needs; ecarefully; observe hody language; observed to express feelimake her wants an use short and directed to sensory lher to express feelimake her wants an use short and directed eye level; introduce explain activities/ cprovide one directive feelings when approximate approximate the provide one directive feelings when approximate and re-approximate finding her own rood by offering pleasan fluids or conversatimuch as possible; was in place. The R210's wandering it also lacked direct supervision that wat addition, the care proximate in the care p	s including aphasia and ad moderately impaired extensive assistance for mosting (ADLs), demonstrated symptoms, other behavioral toward others, and wandering atted 11/25/15, identified R210 mentia. The care plan directed entions for communication, naviors and elopement: encourage socialization; listen per facial expressions and serve for sad/anxious mood oss; provide opportunity for ings regarding her inability to ad needs known; speak clearly, at phrases; communicate at eyourself at each interaction; are prior to beginning them; and time; and the proposed her in a calm and the proposed to the prop	F3	09		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING			12/	10/2015
	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 3000 4TH AVENUE ANOKA, MN 55303	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 309	R210 was seated in room table eating heaten less than 100 began to self proper encouraged R210 to referred to the residence, sweetie, and responsive to RN-J wheeling away from another resident as she needed help in entered the room at the other resident's room). R210 was a required weight bear RN-J and NA-K to swheelchair. R210 and appeared conf was limp during the leaning back towar scared of some of NA-K's forearm are replied to R210 stawith my arm,,, [will let go of NA-K's arr transfer to her whe room, rubbing her hurt her arm during pinched her arm. In pinches." At 12:36 wandering into a dinot her own room). NA-K assisted R21 her down another her propel in the direction At 12:42 p.m., R21	s on 12/9/15, at 12:04 p.m. In her wheel chair at the dining per lunch meal. R210 had for her meal, when she have for a round for her meal, when she have for a round for her meal, when she have for a round for her meal, when she have for a round for her meal, when she have for a round for her meal, when she have for a round for her was not her round for her round	F 3	09			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245205	B. WING		12	2/10/2015	
	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP O 3000 4TH AVENUE ANOKA, MN 55303			
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F 309	bathroom. RN-J co on R210 and found her toilet. R210 had and a small void of R210 had been tryi to use the bathroor anxious-like behavious behavious like like like like like like like like	onfirmed NA-K had checked in she had self-transferred to d a medium bowel movement urine. RN-J stated perhaps ng to communicate her need n by her wandering and or.	F3	09			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245205	B. WING _		1:	2/10/2015
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F 309	RN-J stated interversely staff were to be shift reports and durounds, and should residents care plan believed R210's in have included specidentified by staff, a identified were to know cup of coffee, and stated, "I don't thin should add that waplan]." During interview or stated behavior into offering coffee, a widraw on paper. Nainterventions were the time. NA-K stain the behavior rou opportunity to shar other had found to afternoon was the typically became in behaviors were like communicate som. During interview or social worker (LSW behavior rounds to but could be more LSW-C stated the any new resident be prior meeting and simplemented and/of attempt with R210. himself and activiti	entions found to be successful communicated to staff through uring once weekly behavior of than be added to the and th	F 30	09		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP 3000 4TH AVENUE ANOKA, MN 55303	CODE		
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F 309	plan. LSW-C state been wandering int not recall the staff of the behavior round: During interview on stated he had just to behavior of wander earlier that day. He R210 in activities a stated he tried to hat to four activities penot always participal have the resident sersidents and would drink. AD-A stated meeting, however, update the resident new behaviors/ intestated the intervent rounds were communication bodupdates to the care. During interview on stated he was a pri routinely worked wi often went into other just done so about "She went into that have to watch her attention." NA-J staresidents, but had on R210 was actually facility did not do the other residents ofter R210's wandering in	d have been added to the care d he was not aware R210 had o other resident rooms and did discussing this subject during s. 12/10/15, at 4:15 p.m. AD-A been informed of R210's ing into other resident rooms at stated staff try to engaged as much as possible. AD-A ave R210 participate in three or week, and although R210 did ate in activities, staff would atte in activities, staff would it parallel with the other digive her a cup of coffee to he led the behavior round nursing was responsible to the swritten plan of care with any erventions discussed. AD-A ions shared at the behavior unicated to all other staff via a bk and/or via the nurses	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245205	B. WING _		12/	10/2015
	PROVIDER OR SUPPLIER	D LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303		
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F 309	stated any behavior should be included intervention on how DON stated all resid however, he was no other resident room resident on that unit Review of the facilit Support Programs a directed the program person-centered me whole person, incluemotional, intellectu	12/10/15, at 4:31 p.m. DON consistently observed by staff on the care plan including the to address the behavior. The dent's on that unit wandered, of aware R210 wandering into its any more than any other t. y's Guidelines for Memory and Services dated 2/15,	F 30	09		
F 312 SS=D	Procedure dated 3/ interventions be writheir goals. The cachanged as care not temporary problems comprehensive carwithin 30 days. The be involved in deveorder to promote auself-determination at 483.25(a)(3) ADL CODEPENDENT RES	and participation. ARE PROVIDED FOR	F3	12		1/18/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245205	B. WING		12/1	10/2015
	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 4TH AVENUE ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From page	age 29	F 312			
	by: Based on observareview, the facility care and services directed by the plat (R208) reviewed with toileting. Findings include: R208's Medication 12/2/15, identified lung cancer, respired was severely imparextensive to total aliving including ext. The MDS identified program, but was abowel and bladder. R208's Care Area 9/30/15, identified included end stage restricted mobility, urine, urgency and toileting. The CAP toileting/or to be chapted to provide pericare [incontinence]. Ha [incontinence]." A MDS assessment.	ation, interview, and document failed to provide the necessary related to incontinece care as n of care for 1 of 4 residents who required staff assistance. Review Report signed diagnoses including dementia, ratory failure and chronic pain. Change Minimum Data Set 15, indicated R208's cognition ired and she required assistance for activities of daily ensive assistance for toileting. If R208 was not on a toileting always incontinent of both. Assessment (CAA) dated R208 had diagnoses which expected and changed. Continue to also noted, "Continue to offer necked and changed. Continue after each incontency after each incontency after the cooresponding dated 9/30/15, indicated R208 ing program, the CAA directed		Preparation, submission and implementation of this Plan of Corridoes not constitute an admission of agreement with the facts and conclinate the statement of deficiencies. The of Correction is prepared and exect a means to continuously improve the quality of care, to comply with all applicable state and federal regular requirements and it constitutes the facility is allegation of compliance. It is the policy of Anoka Rehabilitati Living Center to ensure that a resid who is unable to carry out activities daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hy Resident # 208 a comprehensive reassessment was conducted to in ADLs, range of motion, bowel and bladder assessment, positioning, transfers, skin/body audit assessment, hospic pharmacy consultant medication management review, MD/NP consultant medication m	f, or usions usions nis Plan uted as ne cory on and lent of /giene. clude; r pain, ce plan, ult vised 31/15. een ician ement blace;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	the resident was to Any additional boy completed on R20 were provided. R208's care plant offer toileting to R20 bedtime, as neederequest. The care assist R208 with the provide her with a toilet. During observation 7:00 p.m. R208 with the supper menurse's station are hallway throughout provided check are offer use of a bed R208's care plant and During continuous 7:14 a.m. through bed in her room. Funtil 8:34 a.m., who briefly entered her moving her legs in R208's room. Chenot observed to be not offered the use assistance. At 8:5 alone in her room checked/changed entire observation.	vel and bladder assessments as were requested, but none dated 10/2/15, directed staff to 208 upon rising, after meals, at ed during the night and upon a plan directed staff to either the bed pan or to have two staff ssistance to transfer to the as assisted to the dining room all and then brought back to the ear, where she remained in the at the evening. R208 was not and change services nor did staff can or toileting assistance as and CAA directed. To observation on 12/9/15, from 8:55 a.m. R208 was lying in R208 continued to lie in bed, are a facility nursing assistant aroom, and assisted with a bed and immediately exited and change services were a offered or provided. R208 was as of a bedpan or toileting 55 a.m., R208 remained in bed, R208 had not been nor offered toileting for the	F3	312	appropriateness. 1/5/16 met with far hospice team to review concerns, to bowel and bladder assessment was revised and updated again on 1/5/1 reflect residents current elimination which will be to check and change rising, after meals, at bedtime, as reduring the night and upon request. It was determined by the interdiscipteam the resident skin integrity issumavoidable due to decline in healt status and quality of life choice to wishoes. For other residents who may be affected by this practice, nurse manager and coordinator revised care plans and updated as needed. All residents was a care plan and kardex that reflects individualized care needs based on and bladder assessment. Bowel and bladder assessments as reviewed upon admission, during significant change, annually and as needed if a change in elimination is Bowel and bladders assessment wormunicated to nurses and nursi assistants via careplan, and kardex. Upon this review, care plan staff education will be implemented if incon January 4th, 5th, & 6th 2016. The policy for Activities of Daily Lividependent care was reviewed by the interdisciplinary team on 12/31/15. members were informed to follow to individualized comprehensive carepand Kardex.	he s 6 to status upon leeded olinary lee was he wear ected d MDS ill have s bowel re s noted. Ill be ng c dicated ng lee Staff he	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	D LIVING CENTER		30	000 4TH AVENUE		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
at 9:50 a.m. and wa changed prior to the 6:30 a.m. (approxim prior). During interview on registered nurse (R offered the bed panbrief. RN-A was un on a toileting prograshould have been obasis and with care. During interview on director of nursing (expectation for staff care plan. A facility policy addrurinary incontinence was provided. 483.25(c) TREATM PREVENT/HEAL P Based on the compresident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores recesservices to promote prevent new sores for this REQUIREMENTS.	as unaware of when she was at, but confirmed it was prior to nately three and a half hours 12/10/15, at 2:15 p.m. N)-A stated R208 was to be and utilized an incontinence sure as to whether R208 was am, but confirmed the bed pan offered to her on a regular s. 12/10/15, at 4:35 p.m. the DON) reported it was his at to implement each resident's ressing toileting assistance or a was requested, but none ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having gives necessary treatment and a healing, prevent infection and from developing.			to their respective roles and responsibilities regarding the policy procedures on January 4th, 5th, & 6 2016. Six Random focus Bowel and Bladd audits will be completed by Nurse manager or designee weekly x three weeks, monthly for three months a quarterly for 2 quarters to ensure continued compliance with results reported to the Quality Assurance Committee for review and further recommendation. The Director of Nursing or designed be responsible for compliance.	and 6th der ee nd	1/18/16
Daseu on observat	ion, interview and document			Freparation, submission and		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS) Continued From pa at 9:50 a.m. and wa changed prior to tha 6:30 a.m. (approxim prior). During interview on registered nurse (R offered the bed pan brief. RN-A was un on a toileting prograshould have been obasis and with care. During interview on director of nursing (expectation for staff care plan. A facility policy addrurinary incontinence was provided. 483.25(c) TREATM PREVENT/HEAL P. Based on the compresident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores received th	REHABILITATION AND LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 at 9:50 a.m. and was unaware of when she was changed prior to that, but confirmed it was prior to 6:30 a.m. (approximately three and a half hours prior). 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A facility policy addressing toileting assistance or urinary incontinence was requested, but none was provided. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility must ensure that a resident who enters the facility must ensure that a resident who enters the facility of ensure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	REHABILITATION AND LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 at 9:50 a.m. and was unaware of when she was changed prior to that, but confirmed it was prior to 6:30 a.m. (approximately three and a half hours prior). 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE	ND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 3000 4TH AVENUE ANOKA, MN 55303			
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F 314	review, the facility skin for an appropriate skin for an appropriate schedule, and fail which had been appressure ulcers fromote healing of 3 residents (R2 were identified wiresulted in actual an unstageable pof her right foot. Findings include: R208's significant (MDS) dated 9/30 impairment, requifor activities of dastage two pressurthickness loss of open ulcer with a slough), and two-(unable to measure to eschar or scab assessment. R208's Care Area 9/30/15, identified declining and that to hospice service included severe concontinence, immantidepressant m "Does have capal bed." Although the capabale of turnir individualized continence in the capabale of turnir individualized conti	refailed to assess the resident's priate turning/ repositioning led to implement interventions assessed to prevent further rom developing and/ or to of current pressure ulcers for 2 208 and R19) reviewed who the current pressure ulcers. This harm for R208, who developed ressure ulcer to the second toe of the change Minimum Data Set 10/15, identified severe cognitive ired extensive to total assistance and living, had developed one-re ulcer (defined as partial dermis presenting as a shallow red-pink wound bed without unstageable pressure ulcers are depth of pressure ulcer due bing) since the prior as Assessment (CAA) dated at R208's overall condition was at the resident had been admitted as Risk factors identified acognitive deficit, poor nutrition, mobility, and the use of edication. The CAA indicated, bility of turning side to side in the CAA indicated R208 was and in bed, there was no imprehensive assessment identified the resident was able	F 3	implementation of this Plan of does not constitute an admiss agreement with the facts and in the statement of deficiencie facility has appealed the deficilicensing violations. This Plan Correction is prepared and exmeans to continuously improve of care, to comply with all appeand federal regulatory require constitutes the facility is alleg compliance. It is the policy of Anoka Rehall Living Center to ensure that be comprehensive Assessment of a resident who enters our factories pressure sores does not deversore unless the individual is condition demonstrates that the unavoidable; and a resident himpressure sores receives necestreatment and services to protect the production of the pressure sore infection and sores from developing. Resident # 208 a comprehense reassessment was conducted ADLs, Range of motion, bowel and be assessment, positioning, transkin/body audit assessment, pharmacy consultant medicated management review, MD/NP nutrition assessment. The careplan was reviewed a by the interdisciplinary team of the corresponding updates him ade to Kardex and careplan was reviewed as the corresponding updates him and to Kardex and careplan was reviewed as the corresponding updates him and to Kardex and careplan was reviewed as the corresponding updates him and to Kardex and careplan was reviewed as the corresponding updates him and to Kardex and careplan was reviewed as the corresponding updates him and to Kardex and careplan was reviewed as the corresponding updates him and to Kardex and careplan was reviewed as the corresponding updates him and to Kardex and careplan was reviewed as the corresponding updates him and the corr	sion of, or conclusions es. The siencies and of secuted as a ve the quality blicable state ements and it pation of solilitation and based on the of a resident, ility without elop pressure clinical hey were eaving essary mote prevent new sive of to include; bladder sfers, pain, hospice plan, ion consult, and revised on 12/31/15. ave been		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 314	orders) signed 12/2 including: dementia obstructive pulmon chronic respiratory was admitted to hot a terminal diagnosis. Physician orders di minimize R208's riscurrent pressure uldevelopment of nevincluded: Alternatir mattress; Daily Tefl pressure ulcers and Barrier cream post needed; Pressure chair; Twice daily sl	Review Report (physician 2/15, identified diagnoses a, lung cancer, chronic ary disease, and acute and failure. The report noted R208 spice services on 9/21/15, with s of diastolic heart failure. rected interventions to sk for further progression of cers and to prevent the w pressure ulcers which ag pressure reduction a dressings to both heel d wrapping them in Kerlix; episodes of incontinence, as relief with pillows when up in kin checks to heels and	F3	3314	reviewed resident nutritional supple for skin integrity. The notifications I been to resident, family, and physic 1/5/16 met with family & hospice te review concerns, the bowel and bla assessment was revised and upda again on 1/5/16 to reflect residents elimination status which will be to and change upon rising, after meal bedtime, as needed during the night upon request. Initiated low airloss mattress, broda chair, and nutrition supplements. It was determined by the interdiscipteam the resident skin integrity issuunavoidable due to decline in healt status and quality of life choice to wishoes.	nave cian. am to adder ted current sheck s, at and all blinary ue was h	
	with any concerns in and Achilles off bed Manager, with no prin her wheelchair at Keeping the necrotic Achilles open to air gripper socks only locovering her heels. R208's care plan dakeep heels elevated assuring heels were staff to boost up in repositioning, R208 relieving devices in mattress for her befor her chair and a The care plan indictendency to remove	the nurse practitioner (NP) dentified; Elevating both heels I at all times using a Heel Lift ressure on her heels while up and no shoes to be worn; ic areas on her left and right to keeping them dry; Placing half-way onto her feet and not due to the pressure ulcers. ated 10/2/15, directed staff to d on pillows at all times, e not touching anything, two bed or with any major required multiple pressure cluding an alternating pressure d, a pressure reducing device cushion to float her heels. ated, "Resident does have a e her heels from the heel pillows that elevate her heels			Resident #19 was reassessed duri weekly wound rounds on 12/14/20 wound on right buttock healed. Dr. Fairbaim observed area on 12/14/1 Nurse Practitioner Melissa Sorenso and family notified. R19 was reassed by Nurse Manager on 12/24/15 and 01/05/16 and skin remains intact. A Comprehensive reassessment wound conducted to include; ADLs, Brade bowel and bladder assessment, positioning, transfers, pain, skin/boaudit assessment. For other residents whose clinical conditions are at risk for impaired sintegrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such as Brade integrity Licensed staff to implement preventative measures such a	15 and 15, 5, 5n, NP essed d vas n, dy	

manager or off the pillows that elevate her heels

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F 314	and assistance to keep and assistance to keep from 9/1/15, through following descriptions ite #1: Left heel prin-house on 9/30/18 superficial, but ope The area was not size and showed not size #2: Left Achille in-house on 9/11/18 with 100% eschar. was decreasing in sinfection. Site #3: Right Achill in-house on 9/11/18 cm, with 100% eschar was decreasing of infection. During observation was seated in her be hallway, near the not white socks and blather than the floor out in from the floor and the backs of he bumping the foot programmed the floor and the backs of he bumping the foot programmed floor or and the backs of he bumping the foot programmed floor or and the backs of he bumping the foot programmed floor and the backs of he bumping the foot programmed floor and the backs of he bumping the foot programmed floor and the backs of he bumping the foot programmed floor and the backs of he bumping the foot programmed floor and the backs of he bumping the foot programmed floor and the backs of he bumping the foot programmed floor and the backs of he bumping the foot programmed floor and the backs of he bumping the foot programmed floor and the backs of he bumping the floor and the backs of he b	da chair. Needs reminders keep heels elevated." Weekly Wound Documentation th 12/10/15, revealed the on of the pressure ulcers: pressure ulcer acquired 5, measuring 1.8 cm by 1.5 cm or area, with 100% granulation. Staged, but was decreasing in or signs of infection. The area was not staged, but size and showed no signs of les pressure ulcer acquired 5, measuring 1.5 cm by 2 cm, area was not staged, but size and showed no signs of les pressure ulcer acquired 5, measuring 1.0 cm by 1.0 har. The area was not staged, grin size and showed no signs on 12/8/15, at 7:00 p.m. R208 Broda wheelchair in the urse's station. She had on ack canvas shoes on both feet. Her wheelchair were in place, as observed resting her feet on to of the foot pedals, wheelchair. R208 stretched of her, placing her bilateral and then pulling herself forward, were heels were observed edals as she propelled. As observed around her right rea, however, there was no observed to her left foot/ ankle.	F 314	assessments in order to provide appropriate treatment modalities wounds according to industry sta care. After review updates will be as appropriate for each resident in the policy and procedure for presulter was reviewed by the interdite team on 12/30/15. Upon admit, so change, quarterly and as needed pressure area/wound has been in a skin/body audit assessment is completed by a Licensed nurse. It assistants are educated on skin of all resident daily cares. Nursing a sis required to report any noted skin changes to the nurse who review changes and will implement appropolicy of the facility. Staff members were trained as it to their respective roles and responsibilities regarding the presulter policy and procedure on Jay 4th, 5th and 6th 2016. Resident who have been identified pressure ulcers audits will be conweekly for 3 weeks, monthly for 3 and quarterly for 2 quarters. The reported to the Quality Assurance Committee for review for further recommendation. The Director of Nursing or design be responsible for compliance.	ndards of e made dentified. ssure sciplinary significant if a new dentified Nursing care with assistant in s skin opriate tocol relates ssure nuary ed with appleted a months, results	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 314	p.m. family membe concerned about R. the facility should h this risk for develop and to promote heaulcers. FM-B state turning and repositi which the facility was buring observation was lying on her lef propped on both sidno pillows or device and both heels were At 8:22 a.m., R208 and her right leg was left side of the bed. against the bed with to float her heels. A (NA)-I entered R20 in bed. NA-I stated over the side of the so she was lying flad evices were put in and they were layin had regular white scright, lower ankle as however, there was left foot/ ankle. NA were resting on the ate breakfast in bed cares until after she R208's room and d residents heels off was awake and ren no pillows or devices	ge 35 r (FM)-B stated she was 208's pressure ulcers and felt ave done more to minimize sing further pressure ulcers, aling of the current pressure ed she felt R208 needed oning at least every two hours, as not currently doing. on 12/9/15, at 7:14 a.m. R208 at side in bed with pillows des of her torso. There were see in place to float her heels ee observed resting on the bed. The remained asleep in her bed, as draped over the edge of the Her left heel remained flat an no pillows or devices in place at 8:35 a.m., nursing assistant 8's room and boosted her up R208's legs were hanging bed so they repositioned her at on her back. No pillows or to place to float R208's heels, godirectly on the bed. R208 ocks on both feet, and her rea was wrapped with gauze, and did not receive morning at ate. However, NA-I left id not attempt to float the the bed. At 8:55 a.m., R208 hained lying flat in her bed with se in place to float her heels, se still resting on the mattress.	F3	14		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 314	During observation R208 was lying in hwere no pillows or cheels. At 8:17 a.m. her back with both observed resting di wearing regular whwhite gauze was oblower ankle/ heel at the left. A black he observed tucked be wall to R208's right a.m., NA-H entered with eating her brea of the bed to approremained on her bathe balls of her feet against the footboa pressed into the ma or devices in place. During observation NA-H and NA-I con While providing car assistance from bo side-to-side while ir one side of the bed opposite side. The shoulder and hip ar and/or push her aw proceeded to provid stated they were not pressure ulcers. Breather and hip ar and/or push the socks wrapped around he exposed, dark brow Achilles tendon are red skin surrounding	on 12/10/15, at 8:05 a.m. Her bed on her back, and there devices in place to float her and the series bent and her feet were rectly on the bed. She was it e socks to both feet and eserved around only her right rea, and there was none on the floating cushion was etween the nightstand and the side in her room. At 9:40 I R208's room to assist her akfast. NA-H raised the head aximately 60 degrees and R208 ack with both knees bent and and toes were pressed rd of her bed, with her heels attress. There were no pillows	F3	114		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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F 314	observed, and ther scabbed area to the top of the second to carefully applied the wrapped around Rarea, however, she same precautions and at one point, of directly over the optendon. Once dress he need her shoes sometimes wore through the foliation of the folia	e-sized open area was e was also a small, flaky e edge of her left heel, and the oe was reddened. NA-H e right sock over the gauze 208's right lower ankle/ heel e did not appear to take the with the left ankle/ heel area ne of her fingers was observed ben area to R208's left Achilles ssed, NA-I asked NA-H, "Does s?" NA-H replied that R208 he shoes and other times did h proceeded to apply black proximately 10:45 a.m. hurse (LPN)-A entered R208's he was not very familiar with he reviewed the residents hat record and stated R208 was hatments at this time but the grown toe nail to her left great hat a topical antibacterial hemoved R208's left sock and hat that area. As he proceeded he, he was asked whether there hen areas or skin breakdown on hat a stage 2 pressure ulcer on hat a stage 3 pressure ulcer on hat a stage 4 pressure ulcer on hat a stage 5 pressure ulcer on hat a stage 6 pressure ulcer on hat a stage 7 pressure ulcer on hat a stage 8 pressure ulcer on hat a stage 8 pressure ulcer on hat a stage 9 pressure ulcer on hat a stage 1 pr	F 314				

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F 314	ulcers, "would define were not being float the nurses were exwas in place every residents electronic the nurses to sign of during every shift. It reatment record all nurse to apply dreshowever, he was nead a wrap on. Dure peatedly crossed while crossing here top foot was observo opposite ankle area R208's feet/ heels toe was possibly a documented in the however, LPN-A strome into the reside pressure ulcers. On 12/10/15, at 11 manager) and RN-R208's room to assulcers. RN-A and fulcers both R208's following results: Site #1: Left heel, co.3 centimeters (cr. Site #2: Left Achille last assessment but and was now an op 0.8 cm, with granul stage 2. Site #3: Right Achill measuring 0.8 cm.	ted the residents pressure nitely get worse," if her heels atted from the bed. He stated spected to check the cushion time R208 was in bed, and the correct treatment record prompted off this was being implemented LPN-A stated R208's less directed the evening shift asings to both R208's heels, of sure why only the right heel wing this observation, R208 I one foot over the other, and feet, the Achilles area of the active residents on the top of the active as he did not see it residents treatment record, atted he would have an RN lents room to assess the residents pressure RN-H assessed all pressure feet/ heels and reported the dry scabbed area measuring on by 0.4 cm, unstageable. The scab had since fallen off pen area measuring 0.8 cm by lation noted around edges, les, dry scabbed area by 1.0 cm, unstageable. The scab had since fallen off pen area measuring of the scab had since fallen off p	F 31	4		

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F 314	reddened surround unstageable. RN-A stated sites # from past assessmulcer to R208's righnew. RN-A stated brought new shoes had just, "had the rorder" for no shoes wear the shoes the placed the black cafoot and compared ulcer to the shoe at shoes were the cat RN-A stated she will wrap it with Kerlix, 12/11/15, and R208 in the meantime. Finad the NP removed directed the resided because family had canvas shoes about stated the facility not resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to independently michanges to her positioning scheet Review of R208's transport to the resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to independently michanges to her positioning scheet to resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to independently michanges to her positioning scheet to resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to independently michanges to her positioning scheet to resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to resident was self-put foot pedals coupressure ulcers on stated R208 did no repositioning scheet to resident was self-put foot pedals coupressure ulcers on stated R208 did no	suring 0.2 cm by 0.2 cm, with ling tissue measuring 0.3 cm, #1, #2 and #3 were improving ents, but stated the pressure at second toe (site #4) was R208's family had recently in for the resident, and she have practitioner change the son 12/9/15, so R208 could family had brought in. RN-A anvas shoe next to R208's right the newly identified pressure and stated it appeared the use of the new pressure ulcer. as going to clean the area, and have the NP look at it on B had slippers she could wear RN-A stated on 12/9/15, she at the physician order that the was not to wear shoes at brought in the new black at a week prior for R208. RN-A curses were to observe all of the east during each evening shift. It is foot pedals should have been are removed any time the ropelling in the wheelchair as all resulted in bumping the her bilateral Achilles. RN-A to require a turning or dule and the resident was able ake significant, prolonged	F3	14			

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F 314	Tefla/ non-adherer and wrap with Kerl indicated this treat routinely as ordere Starting on 9/11/15 [bilateral] heels off heels when up in vuntil resolved to Bi opens or any conc treatment was adn and no refusals we Starting on 9/17/15 daily] skin checks with any concerns prevention." The Twas administered refusals were note Starting on 9/17/15 TAR directed, "Heelevated heels and Every shift." The Twas administered refusals were note Starting on 10/2/15 TAR directed, "Pla feet only- do not conceivery shift." The Trefusals, however, administered routin Review of R208's 19/1/15, through 12. The progress note routinely refusing of pressure ulcers. The progress note	5, the TAR directed, "Apply at dressing to both heels sores ix. Change daily." The TAR ment was administered d, and no refusals were noted. If the TAR directed, "Elevate Bill bed at all times no pressure on a complete [wheelchair] daily checks and Achilles one time a day; Call if the erns." The TAR indicated this inninistered routinely as ordered are noted. If the TAR directed, "Bid [twice to heels and Achilles. Call New every day and evening shift for TAR indicated this treatment routinely as ordered and no d. If the the lift Manager on at all times to the Achilles off bed. NO SHOES. TAR indicated this treatment routinely as ordered and no d. If the the lift Manager on at all times to the control of t	F 314			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 314	wearing the black family. The progress note determine if R208 further pressure user the progress note request for R208 repositioning schemes are propriate turning R208. During interview of stated R208 requiturn her from side however, if she was taff could turn her able to turn her bound tu	risks of skin breakdown with canvas shoes provided by the estacked any assessment to a could wear shoes to prevent alcers from developing. Estacked any notation of FM-B's to have a two hour turning and edule. Estacked assessment of an grand repositioning schedule for an and repositioning schedule for the edule of th	F3	314	DEFICIENCY)			
	get dressed and L NA-H stated she I morning, and she raised the head or	staff typically assisted R208 to up in her wheelchair. However, had not repositioned R208 that boosted R208 up in bed and f the bed for her to eat						
	position. NA-H warepositioned throu unable to state ho her back, but cont hours, from 6:30 a	not turn her to a different as not sure whether R208 was ughout the night, so she was by long she had been lying on firmed it was at least three a.m. to 9:40 a.m. NA-H was not 08 had her been wearing the						

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303	, . <u>-</u>	10,2010
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F 314	black canvas shoe been more than a During interview o stated she was R2 responsible for co and the developminterventions. RN pressure ulcer to foot was an unstay which had develop shoes brought in R208 had not bee whether the shoes risk for skin break shoes. RN-A state wear the shoes so the order. RN-A state wear the shoes so the order. RN-A state wear the shoes so the order. RN-A state floated with a heel was lying in bed. manager was not they laid R208 down bilateral heels wer dressing, however feet around a lot a area could have fa RN-A stated R208 repositioning sche around independe turning and reposishe would need to determine how it were stated to state the shoes of the state of the stated R208 repositioning sche around independe turning and reposishe would need to determine how it were stated R208 repositioning sche around independe turning and reposishe would need to determine how it were stated R208 repositioning sche around independe turning and reposishe would need to determine how it were stated R208 repositioning sche around independe to determine how it were stated R208 repositioning sche around independe turning and reposishe would need to determine how it were stated R208 repositioning sche around independe turning and reposishe would need to determine how it were stated R208 repositioning sche around independe turning and reposishe would need to determine how it were stated R208 repositioning sche around independe turning and repositioning sche around all the schedules are schedules are schedules are schedules are schedule	es, but stated she knew it had	F 31	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING		12/	10/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	assist, with turning incontinence caredon't know. She reget her up and the in the Broda chair "offload" was refer when R208 was necessarily provide RN-A stated the fadeveloping a time and would provide However, at the time of assessment of repositioning schewas provided. During interview of director of nursing implement each rephysician orders, aware of R208's necessarily provided. During interview of director of nursing implement each rephysician orders, aware of R208's necessarily by the physician orders. The risks and docute abide by the physician order, however, he did not show any of were provided. During interview of 5:45 p.m. the MDS facility did not dot assessment used ability to withstand longer the standard in the results of the standard in th	age 43 v sheet, or two persons to g side-to-side in bed during s. RN-A stated, "I guess I really moves a lot herself They do ey offload her and reposition her " RN-A stated her reference to rred to the time during transfers of seated or lying, which did not e sufficient pressure relief. acility was still working on line of R208's pressure ulcers, e it once it was completed. The of survey exit on 12/10/15, R208's turning and redule or pressure ulcer timeline In 12/10/15, at 4:35 p.m. the (DON) stated staff should resident's care plan and to follow DON stated he was made ew unstageable pressure ulcer stated it was R208 and her sish for her to wear the shoes. In stated he would expected his 208's legal representative on ment the education and refusal eysician's order in the medical me stated R208's medical record reducation on wearing the shoes In 12/10/15, at approximately coordinator reported the issue tolerance testing (an to individualy assess the skins I pressure) as this was no and of practice and research uch as this were not effective in	F 314			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245205	B. WING _		12	2/10/2015
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP CO 3000 4TH AVENUE ANOKA, MN 55303		
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	determination of a of turning and repostated the facility a appropriate turning adjusting the scheresident skin was con-going basis, and to the nurse for furthe RN's adjusted schedule as needed there was no asseevaluated for an appropriate in the repositioning schere. A facility policy regrequested, but not R19's quarterly MER19 had moderate extensive assistant frequently incontincare, and was at rifulcers, but did not ulcers. The MDS is pressure reducing cushion used to pressu	resident's need for frequency positioning. MDS coordinator assessed residents for an gor repositioning schedule by dule as concerns arose, and checked with all cares on an dany concerns were reported ther assessment. She stated the turning and repositioning ed. MDS coordinator stated assment R208's skin was appropriate turning and dule. arding pressure ulcers was provided. OS dated 10/29/15, indicated a cognitive impairment, needed are for bed mobility, was ent, was receiving hospice sk for developing pressure have any current pressure ndicated the resident had a mattress and wheelchair	F 31	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 314	11/18/15, indicated assistance with be R19's electronic of 12/8/15, and the crisk for alteration of incontinence and preeded more assist Interventions inclusion mattress on bed, prochair, inspect skin reposition every two incontinence. During constant of a.m. through 9:09 sleeping on her batilted slightly to the repositioning by stochanges in position of time. On 12/9/15, at 9:1 room with a break the head of R19's relieved from R19 tray table with R19 set up R19's break without providing a time. During interview of stated her butt was little, however, R1 herself and contin	nd shearing. hly Documentation dated d R19 needed extensive	F3	.14		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245205	B. WING			12 /	10/2015
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F 314	repositioning. During interview or stated she was ass stated R19 was to hours, however, sh since the beginning because NA-A, "For R19's head of the kincontinent producilleft side. R19 grabilito roll but could not NA-A used the the assisted R19 to he needed help with rewere observed at the white cream. NA-A of R19's buttocks, areas about the size buttocks, and a quato her left inner but to her ight buttock press foam dressing as r LPN-A stated R10 to the right buttock were not communic On 12/9/15, at 10:1 room with a measure.	until 9:54 a.m. with no 12/9/15, at 9:57 a.m. NA-A signed to care for R19. NA-A be repositioned every two le had not been repositioned g of her shift at 7:00 a.m. orgot." NA-A than lowered bed, unfastened her t, and asked R19 to role to her bed the left grab bar and tried t move herself to her side. I draw sheet on the bed and or left side. NA-A stated R19 epositioning. R19's buttocks his time and was covered in a A washed the white cream off and R19 had two small open te of a dime on her right inner earter size blanchable red area tock. 17 a.m. licensed practical nurse 19's room and stated he wasn't y open areas and reviewed the d could not find documentation LPN-A looked at R19's the order section dated ructed staff to cleanse the ure ulcer, and cover with a needed and every evening. had no foam dressing in place , and R19's pressure ulcer(s)	F 3	14			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG		COMPLETED	
		245205	B. WING _		12	2/10/2015
	PROVIDER OR SUPPLIER REHABILITATION AN			STREET ADDRESS, CITY, STATE, ZIP COD 3000 4TH AVENUE ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	stated the resident facility on 12/7/15, hospice notes yet. ulcers and the upp centimeters (cm) x area measured 0.5 both area's were s and the red area o measurable as it h When interviewed 1:17 p.m. RN-B ho observed a 1 cm p buttocks on 12/7/1 the pressure ulcer during her visit, an nurse, RN-C, prior an order to cleanse a foam dressing dated 12/7/15, which open area on R19' recurrent pressure to cover the pressure to cover the pressure to cover the pressure demonstrated she independently. Alt unable to turn inde assessment continuable to relieve pressures R19's Nurse Week dated 12/9/15, inclinations and the service week detect 12/9/15, inclinations and the service week dated 12/9/15, inclinations and the service week dated 12/9/15, inclinations are serviced week dated 12/9/15, inclinations	s hospice nurse was in the but she had not reviewed the RN-A measured the pressure er area measured at 0.6 co.5 cm, and the lower open cm x 0.6 cm. RN-A stated uperficial and had no drainage, in the left buttock was not ad completely faded. via telephone on 12/9/15, at spice nurse stated she ressure ulcer on R19's right 5. RN-B stated she cleansed and applied a foam dressing d then she updated the facility to leaving the facility and wrote et the pressure ulcer and apply		4		

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	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		3000 47	ADDRESS, CITY, STATE, ZIP CODE ITH AVENUE A, MN 55303	, . <u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	and were both super R19's medical reco Tolerance and and developed pressure R19's care plan wa indicated R19 had a evidenced by two subtocks. The care want to be awakene R19 was able to turbars adequately for needed assistance. When interviewed RN-A stated she had not notified the pressure ulcer. R19 and felt that she with the use of the had also updated Fplan on 12/9/15, as to be awakened to stated she was awareposition herself a RN-A stated she discusse regarding not being however, she did not she document the roll of the pressure was awareposition in the stated she discusse regarding not being however, she did not she document the roll of the puring interview on the puring interview on the pressure was a stated she discusse regarding not being however, she did not she document the roll of the puring interview on the pressure was a stated she discusse regarding not being however, she did not she document the roll of the pressure was a stated she discusse regarding not being however, she did not she document the roll of the pressure was a stated she discussed the pressure was a stated she was a stated she discussed the pressure was a stated she was a stated she discussed the pressure w	erficial stage 2 pressure ulcers. In a lacked an updated Tissue analysis of the newly en ulcer discovered on 12/7/15. Is updated on 12/9/15, and an alteration in skin integrity as uperficial open areas on right plan indicated R19 did not end to be turned/repositioned, and from side to side using grab pressure relief, and R19 just with boosting up in bed In 12/10/15, at 8:20 a.m. and spoken to hospice RN-BN-B reported the pressure wing the visit on 12/7/15. RN-A ated the family and the pressure ulcer, however, and any other facility staff about RN-A stated she observed the had repositioned herself grab bar on her bed, and she at 19's Braden Scale and care R19 told her she did not want be be repositioned. RN-A are R19 does not always as she was weak and forgets. In an analysis of the repositioned, and she are R19 told her she did not want be be repositioned. RN-A are R19 does not always as she was weak and forgets. In an analysis of the repositioned, and the repositioned risk vs benefits were reviewed.	F3	14			

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	developed a pressuand gave a hospice foam dressing daily she processed the or notify RN-A regadevelopment. RN-I repositioning to relidence at least every sleeping. During follow up int p.m. RN-A stated the assessment lacked should be reposition RN-A further stated assessment incorred MDS nurses to detecomplete the assessment and care plan previoupdated on 12/9/15. A policy on pressur was not received. 483.25(d) NO CATI RESTORE BLADD Based on the residence as individually assessment, the faresident who enters individually catheter resident's clinical contact catheterization was who is incontinent of treatment and service.	are ulcer on her right buttocks order to cleanse and apply a rand as needed. RN-C stated order, but failed to document rding the pressure ulcer B stated R19 needed help with eve pressure, which should be two hours, regardless if she is erviewed on 12/10/15, at 2:02 ne 10/28/15, Tissue Tolerance direction on how often R19 ned while sitting and/or lying. If she could be doing the ectly and would check with the ermine the correct way to essessment should have as for repositioning for R19, as ously read before it was as the facility without an is not catheterized unless the condition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder	F 31			1/18/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 315	Continued From p	age 50	F 31	15		
	by: Based on observareview, the facility assess and impler promote continend reviewed for urina. Findings include: R211's admission dated 11/25/15, idecognition, required toileting, was not oprogram, and was bladder. R211's Nur Day 4 dated 11/21/15, ideincontinent," of blaassistance to use provided a section urinary patterns," a identify intervention incontinence which "Scheduled/Habit" "Check and Chang "Training to return and; "Prompted Voiding However, none of and were left bland analysis of the assas, "Patient [R211] occasionally inconassessment did no assessment did not	Minimum Data Set (MDS) entified R211 had intact dextensive assistance with on a scheduled toileting frequently incontinent of Post Admission assessment entified R211 to be, "Always adder and required extensive the toilet. The assessment to document, "Comments on and check mark boxes to ns to help R211 manage his in included the following options: Toileting Plan," ge Program," to previous pattern/retraining"		Preparation, submission an implementation of this Plan does not constitute an admit agreement with the facts an in the statement of deficience of Correction is prepared an a means to continuously implements and it constitut facility of care, to comply with applicable state and federal requirements and it constitut facility's allegation of complist is the policy of Anoka Reh Living Center that based on comprehensive assessment who enters the facility without indwelling catheter is not caunless the resident's clinical demonstrates that catheteriz necessary; and a resident wincontinent of bladder receiv appropriate treatment and supprevent urinary tract infection restore as much normal blad as possible. For Resident # 211 a new as Bowel and urinary incontined was review and revised on the which includes the identification type of incontinence. Corresupdates have been made to and care plan that address in programming and intervention members responsible for incontineers responsible for incontineers and procedures on the policies and procedur	of Correction ssion of, or d conclusions cies. This Plan d executed as crove the th all regulatory tes the ance. The abilitation and the resident at the terized and the terized condition cation was who is concerned and to deer function seessment for nace, care plan 12/12/2015 at of the sponding of the kardex andividualized ons. All staff continence ated on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING			12/1	10/2015
	PROVIDER OR SUPPLIEI REHABILITATION A	ND LIVING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE 00 4TH AVENUE NOKA, MN 55303	,	
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F 315	any collected patt interventions to proceed the continent of the continent	continence and Indwelling a Assessment (CAA) dated, "Res [resident] is incontinent ad bladder] unknown if his n." Further, the CAA provided a esident and family input on eeds, however this space just view." The CAA identified would be developed to slow or nes, avoid complications, and of urinary incontinence. The fy any collected patterns of erventions to promote 11. dated 12/7/15, identified R211 to bladder, and identified an oilet upon rising, before and nour of sleep] and prn [as as lying in bed, while nursing prepared a wash basin in the had on an incontinence pad with urine and stool. NA-E and 11 to his wheelchair, and NA-E into the restroom, placing him ity to brush his teeth. R211 ng cares, and was assisted to able for breakfast. No offer or 211 was provided by staff as	F3	115	5th and 6th 2016. For other residents who may be a by this practice, comprehensive rereview of bowel and bladder will completed per facility policy. Staff members were trained as it is to their respective roles and responsibilities regarding Bowel at Bladder policy and procedures on 4th, 5th and 6th 2016. Six Random focus Bowel and Bladaudits will be completed by Nurse manager or designee weekly is in weeks, monthly for three months quarterly for 2 quarters to ensure continued compliance with results reported to the Quality Assurance Committee for review and further recommendation. The Director of Nursing or designed be responsible for compliance.	elates nd January dder ree and	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3000 4TH AVENUE ANOKA, MN 55303				
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F 315	is usually saturated "Normally wet in th NA-E stated R211" bedding were saturated stated she helped he would say he didn't be used in the NA staff do not for his voiding, but adding, at times, Replaced on it. When interviewed registered nurse (Freason R211 could void, but was unawabeing assisted with charting the NA staff were several reconvoids for R211. Replaced on the NA staff do not for his voiding, at times, Replaced on it. When interviewed registered nurse (Freason R211 could void, but was unawabeing assisted with charting the NA staff were several reconvoids for R211. Repladder assessment further documental supporting an asset finished (referencing don't know what to buring interview or stated R211 was, "bladder," and at timuse the restroom.	d with urine in the morning, e morning, every morning." s incontinence pad and rated with urine this morning im with morning cares. NA-E 211 to the bathroom, Every two offer toileting to R211 that g, despite his care plan ecause she thought R211 to thave to use it. In 12/9/15, at 9:28 a.m. NA-G ped get R211 up for the day or, and he had been, "Wet we got him up." NA-G stated assist R211 to use the toilet rather place him on a bed pan 1211 would void after being on 12/9/15, at 12:33 p.m. RN)-G stated there was no anot be placed on the toilet to vare if R211 would void after in toileting. RN-G reviewed the aff completed and stated there ded episodes of continent N-G reviewed R211's Nur Day 4 and stated there was no tion she could locate essment of R211 had been ing the blank areas identified), "I	F 31					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245205	B. WING _		12/ ⁻	10/2015
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F 318 SS=D	assisted upon rising after meals, at bedfactomprehensive assincluded a summar "Identify a pattern if RN-F stated R211 toileting schedule," should be physically bathroom during the plan because R211 and it would attempt doesn't lose his abion A facility policy on be scheduled toileting provided.	plan which included being in the morning, before and ime and as needed. R211's resement should have by of his recorded voiding to, there was one." Further, was placed on his current to be proactive," and staff by helping R211 to the retimes identified on the care was a post stroke patient, but to retrain his bladder, "So he lity." Diadder incontinence and was requested, but none was	F 31			1/18/16
55=D	Based on the compresident, the facility with a limited range appropriate treatmerange of motion and decrease in range of this REQUIREMENT by: Based on observative review, the facility frange of motion (Plexercises as directed)	orehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further of motion. NT is not met as evidenced alled to implement passive ROM) and upper extremity ed upon discharge from residents (R208) reviewed		Preparation, submission and implementation of this Plan of Corr does not constitute an admission o agreement with the facts and concl in the statement of deficiencies. The of Correction is prepared and exect a means to continuously improve the	f, or usions nis Plan uted as	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING			12 /1	10/2015
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
ANOKAI	REHABILITATION AN	D LIVING CENTER			000 4TH AVENUE		
7.1.01.01.				Α	NOKA, MN 55303		
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F 318	Findings include:		F 3	18	quality of care, to comply with all applicable state and federal regulat	ory	
	(MDS) dated 9/30/ was severely impa	change Minimum Data Set 15, identified R208's cognition ired, required extensive to total vities of daily living, and had a			requirements and it constitutes the facility s allegation of compliance. It is the policy of that a resident with	ı a	
	functional limitation upper extremity.	n in ROM to one side of her			limited range of motion receives appropriate treatment and services increase range of motion and/or to	to	
	R208's Care Area Assessment (CAA) dated 9/30/15, indicated, "Resident on hospice, expected to decline over time. Have resident participate [in activities of daily living] as able				prevent further decrease in range o motion. For resident #208. A ROM screen w		
	Requires lift for tra	nsfers; not able to weight bear he CAA did not address			performed in the presence of the su on 12/10/15. The resident presente functional range of motion in all plan actively and with active assistance to	urveyor ed with nes	
	orders) signed 12/3 including dementia failure, chronic pai	Review Report (physician 2/15, identified diagnoses I, lung cancer, respiratory In, major depression, anxiety Ing. The report noted R208 was			the therapist. Patient presented as able to go beyond 100 degrees of shoulder flexion and beyond 90 degof bilateral shoulder abduction. RO within functional range of motion re-	ented as being rees of and 90 degrees tion. ROM is	
	diagnosis of diasto directed no weight extremity and note	services with a terminal lic heart failure. The orders bearing to her upper right d, "PRECAUTIONS FOR R every shift for PREVENTION			to perform and participate in activitic daily living. Patient denied pain throughout all ROM on both upper a lower extremities. The resident was deemed to not require a ROM programmer.	and s	
	no reaching pushir may do finger and physician progress	or pulling lifting with right arm wrist motion." Review of a note dated 11/2/15, identified ilateral upper and lower			and the order was discontinued on day. A review of all ROM programs for residents were reviewed and complete.	that	
	extremity fractures infections. The no	and recurrent urinary tract te specified, "Closed fracture of outine healing. Closed fracture			on 1/8/16. For other residents who may be affered to the control of the control		
	of left hip with rout displaced greater t Closed fracture of s/p ORIF [status-p	ine healing- minimally rochanteric avulsion fracture right hip with routine healing ost open reduction and internal rocedure)]. Closed fracture of			by this practice a comprehensive re review of Activity of Daily Living fundand Range of Motion will be comple quarterly and as needed. After reviupdates will be made as appropriate	ecord ction eted ew	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245205	B. WING		12/1	10/2015
	PROVIDER OR SUPPLIER	D LIVING CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 000 4TH AVENUE ANOKA, MN 55303	, . – .	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	proximal end of righthealing." R208's care plan do to both upper extreextremities (LE), with during morning cardirected, "ROM proand LB [lower body worksheets in her of R208's closet, as reincluded the following An Upper Extremity (undated) directed fingers, wrists, elborepetitions to each This form was significant the Lower Extremit 8/4/15, directed Prankles, knees, legs repetitions, one time was directed by phy (PTA)-A. A letter dated 12/8/team by family mer representative) indifor about 6 [six] we was not progressint to long term care.	ht humerus with routine ated 10/2/15, directed PROM mities (UE) and lower ith three repetitions each, es. The care plan also ogram for both UB [upper body] once per day following closet" The worksheets in eferenced in the care plan	F 318	each resident identified. Other residents who may be affect this deficient practice were identified the Therapy department. Physical Therapy will screen all residents upadmission, quarterly, with significate change and annually. Therapy will assign range motion putter when necessary for specific reside indicated. Progressively, current ROM prograte be discussed during the weekly Interdisciplinary Team meetings. In the the therapy assessment will also be discussed if changes need to be diany program or if a resident is identified a ROM program started. Retherapy will be given as indicated. monthly review of all ROM program be done with Therapy representating present. For other residents who may be afford by this practice a comprehensive review of Activity of Daily Living fur and Range of Motion will be completed as appropriate ach resident identified.	onnot one to a similar to the core one of the core of t	
	with their commitm improve it felt like to During a telephone	ehab and it had more to do ent to helping my mom hey were giving up on her." interview on 12/8/15, at 8:54 the was concerned her mother		Other residents who may be affect this deficient practice were identified the Therapy department. Physical Therapy will screen all residents upadmission, quarterly, with significat	ed by	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING			12/ ⁻	10/2015
	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE 000 4TH AVENUE NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	felt R208 needed the R208's Documentar ROM services) from detailed the following services. In 9/15, R208 receil lower extremities 2 opportunities), with and no data for the In 10/15, R208 receil days, with no PROI data for the one reling 11/15, R208 receil days, with no PROI data for the remain In 12/15, R208 receil days, with no PROI data for the remain In 12/15, R208 receil days, with no In R208's morning carental days, with no In R208's morning carental during cares, holding push and/or pull herobserved to moan NA-H and NA-I con R208 to say this dudemonstrated indiction with dressing of both application of her swith putting her arm her hand over her for vocalized "owe" with pants. No PROM oprovided to R208 described in	M as ordered by therapy, and his to remain comfortable. Ition Survey Report (charting of m 9/1/15, through 12/9/15, and regarding her ROM Ved PROM to her upper and 1 out of 30 days (70% of no PROM noted on six days, remaining three days. Peived PROM eight out of 31 M noted on 22 days, and no maining day. Peived PROM five out of 30 M noted on 23 days, and no	F3	:18	change and annually Therapy will assign range motion p when necessary for specific reside indicated. The protocols and practices for ass residents with range of motion was reviewed and updated by the interdisciplinary team on 12/31/15. members were trained as it relates respective roles and responsibilitie regarding the Range of Motion poli procedures on 12/30/15. Range of motion will be communic nurses and nursing assistance via careplan, kardex and treatment sho Range of Motion audits will be commonthly x3 and ongoing quarterly. All residents currently receiving rar motion were reviewed on 1/4/16 th 1/8/16 and updated. Resident on r motion will be reviewed during interdisciplinary team meeting wee The Director of Nursing or designe be responsible for compliance.	Staff to their s cy and ated to eet. Inpleted arge of rough ange of kly.	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245205	B. WING			12/	10/2015
	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		STREET ADDRESS, CITY 3000 4TH AVENUE ANOKA, MN 55303	', STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD NCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	stated R208 was so she is so painful, yo she's 'owe, owe."" demonstrated thes discomfort whenevelegs, and when turn NA-H stated she has the charge nurses because of R208's staff were aware of exercises were not result. During interview or registered nurse (Final nurse manager and developing care plaimplementation. Ries was supposed to restated any ROM proverbally placed door and NAs were exercises in the fact record system. RN were evaluated via non-verbal's. She cares routinely and turning/ dressing Ries non-verbalizations being scared than stated NAs were to who was supposed not being provided reason. RN-A state R208 was not receitherapy. During observation	supposed to receive ROM, "But ou move her arm and then NA-H stated, R208 e indications of pain/ er she moved her feet, arms, ning her side-to-side in bed. ad not spoken specifically to about not providing ROM pain, however, NA-H stated all R208's pain and ROM being implemented as a 12/10/15, at 2:15 p.m. RN)-A stated she was R208's d was responsible for ans and monitoring N-A was unsure whether R208 eceive ROM services, and ograms that were in place ad inside each resident's closet a prompted to document the cility's electronic medical I-A stated R208's pain levels	F3	18			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		245205	B. WING		12/	10/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 318	seated in her whee to her. PT-A manipextremities and bild confirmed she four limitations in any e had shown no evid her discharge from reassessment, R2 symptoms of pain, the PT-A and FM-A denied any concerwith movement of R208 did not curre staff and stated RC discontinued upon However, PT-A statherapy to ensure to	age 58 ange of motion. R208 was elchair with FM-B seated next oulated R208's bilateral upper ateral lower extremities and no current functional xtremity. PT-A reported R208 lence of declined ROM since a therapies in 8/15. During this 08 demonstrated no sighs or and she communicated with A during the assessment and ns of pain upon inquiry and each extremity. PT-A stated ntly require ROM services from DM orders should have been R208's admission to hospice. Ited staff had not notified the resident did not require any continue for comfort.	F 31	8		
F 329 SS=D	director of nursing expectation for sta care plan. A facility policy whi was requested, but 483.25(I) DRUG RUNNECESSARY Exact resident's druunnecessary drugs drug when used in duplicate therapy); without adequate rindications for its uadverse conseque	EGIMEN IS FREE FROM	F 32	9		1/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING		·····	12/10/2015		
	PROVIDER OR SUPPLIE	R ND LIVING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE 100 4TH AVENUE NOKA, MN 55303	-		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		3E	(X5) COMPLETION DATE	
F 329	Based on a compresident, the facili who have not use given these drugs therapy is necess as diagnosed and record; and reside drugs receive grabehavioral intervention.	page 59 the reasons above. The reasons above.	F3	329				
	by: Based on observereview, the facility criteria for use for and anti-psychotic specific behaviors each administration medications, and non-pharmacolog prior to administrate of 3 residents (PRN psychoactive Findings include: R208's significant (MDS) dated 9/30 including dementing R208 had severe	ation, interview, and document failed to clarify indications/ as needed (PRN) anti-anxiety medications, failed to ensure sobserved were documented for on of PRN psycho-active failed to document ical interventions attempted ation of the PRN medication, for R208) reviewed who received medications.			Preparation, submission and implementation of this Plan of Corre does not constitute an admission of, agreement with the facts and concluin the statement of deficiencies. This of Correction is prepared and execula means to continuously improve the quality of care, to comply with all applicable state and federal regulator requirements and it constitutes the facility's allegation of compliance. It is the policy of Anoka Rehabilitation Living Center that each resident's driving Center that each resident's driving regimen is free from unnecessary driving For Resident # 208 a new assessment psychotherapeutic medication, cognigradual dose reduction, AIMS, was completed on 12/23/2015. For Resident	or usions is Plan lited as e orry on and rug rugs ent for littion,		

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING			12 /1	10/2015
NAME OF I	PROVIDER OR SUPPLIEF			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	•	
ANOKA	REHABILITATION AN	ID I IVING CENTER			000 4TH AVENUE		
AITORA	TETIABLETTATION AL	to civilla ocivicii		Al	NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	for one to three daperiod. The MDS not place her at signiterfere with care participation in socidentified R208 red R208's Medication directed the follow non-pharmacologion on 11/5/15, Ativar 0.25 mg/ 0.1 millility ordered to be apply wrist every four hoanxiety/ agitation. on 11/24/15. On 11/13/15, Ativar was ordered every agitation/ confusion on 11/19/15, Sero four hours as need agitation. On 11/2 order was change on 11/23/15, the capture of the progression of 11/24/15, the capture of the progression of the pr	iors not directed toward others bys during the assessment identified R208's behaviors did gnificant risk for illness or injury, s, or interfere with her cial activities. The MDS deived hospice services. In Review Report dated 10/2/15, ing medication orders and cal directives: In (an anti-anxiety medication) ter (ml), 0.25 mg gel was lied transdermally to the inner purs as needed (PRN) for This order was discontinued an solution 2 mg/ml, 0.25 mg or four hours as needed for in. In quel 25 mg was ordered every ded for restlessness and 16/15, the indication for this	F3	329	208 pharmacy consultant completed drug regimen review on 1/4/16 and recommendations were forwarded primary physician/nurse practitione review and follow up. Correspondiupdates have been made to the cakardex and communicated to the redesignated decision maker on 1/5/17. The primary physician was informe the assessment results and a reviet the current physician orders was completed on 12/23/15. Gradual dose reduction will be revion 1/4/16For other residents who naffected by this practice, record of psychotropic meds will be generate the electronic health record will be completed weekly and as needed be interdisciplinary team. The policy and procedure for psychmedications was reviewed by the interdisciplinary team on 12/31/201 members were trained as it relates respective roles and responsibilities regarding the Psychotropic policy a procedures on January 4th, 5th and 2016. Complete a Psychotropic check regunnecessary medication , pharmace regimen review, AIMS (for antipsychmedications) and Gradual Dose Reduction(GRD) audits will be comweekly, monthly for 3 months, and	the to the to the r for ng re plan, esident 16. d of w of ewed nay be ed from by the notropic 5. Staff to their s nd d 6th cort of y hotic pleted	
	staff on which PRI	n Review Report did not direct N medication to use first, nor dication which behaviors to use or.			quarterly per facility policy to ensure continued compliance. The results be reported to the Quarter Assuran Committee for review and further recommendation.	e s will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245205	B. WING			12/1	10/2015
	PROVIDER OR SUPPLIER REHABILITATION ANI	D LIVING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE 000 4TH AVENUE NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULE TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			BE	(X5) COMPLETION DATE
F 329	behaviors of trying repetitively/ self-train home repetitively, and Care planned internormal services and referrals as new services; Providing loving care; One-to requested; Acknown making supportive verbalize frustration her in a calm and refamily and allowing Discussing her fear diagnoses or treath chaplain, home hear massage therapy in tended to experient her books from a like assisting her with the for music/ videos; Whousehold or to oth environmental noise fluids such as ice of Coffering toileting and if she was resisting calm manner from assistance as need R208; Ensuring her alternative comfort Providing emotional psychotherapy as in listening and validations.	ated 10/2/15, identified target to get out of her chair nsfer unassisted, asking to go and resisting essential cares. Ventions for management of avior included the following: up visits with her psychology	F3	329	The Director of Nursing or designed be responsible for compliance.	∍ will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245205	B. WING		····	12/	10/2015
	PROVIDER OR SUPPLIER	D LIVING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE 00 4TH AVENUE NOKA, MN 55303		
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F 329	effects and docume effectiveness. Review of R208's in record (MAR) and in 11/1/15, through 12 On 11/5/15, at 5:35 (LPN)-B noted, "Rebe combative, angrhad demonstrated identified LPN-B comprovider and receiv (milligrams) of halo administered every behavior improved for 5 mg haloperide every 30 minutes undicated R208 had agitative behavior." behaviors observed interventions attem results of this administered every and ineffective. At 6:38 PRN dose of Ativar medication was adiagitation." No furth observed and/or no interventions were administration were administration were administration were undicated any description which preceded this effectiveness.	_	F3	29			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245205	B. WING		12	2/10/2015
_	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP 3000 4TH AVENUE ANOKA, MN 55303		
(X4) ID PREFIX TAG			ID PREFIX TAG		ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 329	were identified. The were noted as effect received another Pland progress notes regarding the reason and/ or non-pharma attempted prior to a this administration. On 11/8/15, at 12:1 dose of Ativan. The were noted as effect employee-A noted, NOCs [overnight stall noc [night] trying behaviors has contimined where resident kep well as her broda and then talking abher. Resident deninoted regarding paranti-anxiety me moderate relief. We nursing station with music, as well as a conversation. Resident deninoted regarding paranti-anxiety me moderate relief. We nursing station with music, as well as a conversation. Resident deninoted regarding paranti-anxiety me moderate relief. We nursing station with music, as well as a conversation. Resident dose of Haldol solution orders to be LPN-C noted she adose of Haldol solution. No furth behaviors observed interventions tried, this administration	e results of this administration ctive. At 5:45 p.m., R208 RN dose of Ativan. The MAR lacked any description oning for this administration acological interventions administration. The results of were noted as effective. 2 a.m. R 208 received a PRN e results of this administration ctive. On 11/8/15, at 1:08 p.m. "Writer had been updated by aff] that resident had been up to get out of bed. Resident inued on this a.m. shift as well, at trying to get out of bed as hair. Resident was yelling in unding and then laughung [sic] out someone coming to get es pain. No observations in. PRN [as needed] Ativan dication] administered with riter then placed resident by a nurse and played Christmas llowing the time for dent appeared to settle. Then ame, she ate lunch and then sing station for supervision and aced to hospice to update. Or Haldol PRN. Signed be faxed over." At 5:45 p.m. dministered an as needed tion for agitation and ner description of the d and/ or non-pharmacological were identified. The results of were noted as ineffective. At oted she administered an as	F3	329		

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245205	B. WING		12	/10/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303	, .=	.0/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 329	needed dose of Hagitation." No furth observed and/or rinterventions atter results of this admineffective. On 11/9/15, at 2:5 administration of I "confusion/agitation identified this adminerventions at of this antipsychology of Seroquel Progress notes are description of behinterventions attenthis medication. The were unknown. On 11/11/15, at 3: dose of Ativan. Placked any description of this administration of this administration of this administration. The confusion of this administration of this administration of this administration. The confusion of the interventions attenthis medication. The were noted as efference of the confusion of the interventions attenthis medication. The confusion of the intervention of	aldol solution for "confusion/ ner description of the behaviors non-pharmacological mpted were identified. The ninistration were noted as 9 p.m. LPN-C noted PRN dose of Haldol solution for on." The progress note ninistration was effective, but details of behaviors observed tempted prior to administration	F 329				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING	-	(X3) DATE SURVEY COMPLETED		
		245205	B. WING		_	12/	10/2015
	PROVIDER OR SUPPLIER	D LIVING CENTER		STREET ADDRESS, CITY, STA 3000 4TH AVENUE ANOKA, MN 55303	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCEI		BE	(X5) COMPLETION DATE
F 329	lacked any further observed and/or intadministration of the this administration. On 11/13/15, at 3:4 dose of Ativan. Priservices (SS)-A not continuously calling of the unit. SS-A not continuously calling of the administration were adding, "Resident rinconsolable. Cont of chair, requiring 1 all times during this on 11/15/15, at 4:4 dose of Seroquel. lacked any descript and/or interventions administration of the this administration of the description of behalinterventions atternal contents.	description of behaviors terventions attempted prior to is medication. The results of were noted as ineffective. 1 p.m. R208 received a PRN or to this administration, social ted R208 had been yout wanting to find a way out ofted staff spoke with resident, ges and brought her to a ent. However, these real approaches were results of this medication also noted as ineffective, emained agitated and inuously attempted to get out :1 [one-to-one] supervision at a shift." 1 p.m. R208 received a PRN Progress notes and the MAR tion of behaviors observed a attempted prior to is medication. The results of were noted as effective. 1 p.m. R208 received a PRN progress notes and the MAR tion of behaviors observed a sattempted prior to is medication. The results of were noted as ineffective. At eccived a PRN dose of Ativan. It the MAR lacked any viors observed and/or pted prior to administration of e results of this administration of e results of this administration	FS	329			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245205	B. WING		12/	10/2015	
	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 8000 4TH AVENUE ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE	
F 329	dose of Ativan for I of bed, twice within this administration adding R208 continuous her legs off the bed upon repositioning At 11:20 p.m., R20 Ativan. Progress of description of behavinterventions attenthis medication. The were noted as effective. On 11/19/15, at 3:4 dose of Ativan. Resident has bee wants to go home. non-pharmacologic her to speak with the telephone, spending taking and wheeling "which helped calmadministration were on 11/21/15, at 6:4 dose of Ativan for a described as continuon-coherent, yelling physically hitting stomation of the results of this administration of the results of this administration. On 11/22/15, at 9:2 on 11/22/15, at 9:2	52 a.m. R208 received a PRN peing restless with her legs out a 90 minutes. The results of were noted as unknown, mued with infrequent placing of d, but then re-settled into sleep and receiving water to drink. 8 received a PRN dose of notes and the MAR lacked any aviors observed and/or apted prior to administration of ne results of this administration	F 329				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD IE APPROPF	BE	(X5) COMPLETION DATE	
F 329	further details were interventions. The was noted as ineffer on 11/23/15, at 7:0 dose of Ativan for a Progress notes and description of beharinterventions attempthis medication. The were noted as effect on 11/24/15, at 2:2 dose of Ativan for a trying to pack, sweat facility staff visited with needs. However, "lassistance from state home." The results noted as ineffective on 11/25/15, at 5:0 dose of Ativan for a noted R208 was conthe building and go Interventions including and go Interventions. The rewas noted as ineffective on 11/28/15, at 4:1 dose of Seroquel for continually called on attending to her and returned to the continually called on attending to her and the continually called on attending to her and the continually called on the continually called on the continually called on the conti	ing to leave the building. No included to identify attempted results of this administration ective. O p.m. R208 received a PRN gitation and confusion. If the MAR lacked any viors observed and/or pted prior to administration of the results of this administration ective. 4 p.m. R208 received a PRN existency, exit seeking behavior, earing at staff. SS-A noted, the with R208 and attended to her Resident continually asking for easily the first own of this administration were existency. O p.m. R208 received a PRN gitation/ confusion. SS-A entinually calling out to leave home to her family. Its ded offering food, fluids, talking dministration of her PRN esults of this administration	F3	29				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245205	B. WING			12/10/2015	
	PROVIDER OR SUPPLIER	ND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP 3000 4TH AVENUE ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 329	dose of Ativan for was yelling and so MAR and progres non-pharmacolog the results of the On 12/5/15, at 1:5 dose of Ativan. Placked any descriand/or intervention administration of this administration for agitation/ confrout trying to take a sling. The MAR a identification of the administration of the admini	page 68 202 p.m. R208 received a PRN agitation/ confusion, noting she creaming without cause. The s notes lacked identification of ical interventions attempted and medication administration. 21 a.m. R208 received a PRN rogress notes and the MAR ption of behaviors observed as attempted prior to this medication. The results of a was noted as effective. At eceived a PRN dose of Ativan usion, noting, "Resident calling apart hoyer [mechanical lift] and progress notes lacked terventions attempted prior to this PRN medication. The ninistration was noted as	F3	329			
	dose of Ativan for noted R208 was y No further descrip or interventions at MAR or progress administration we Review of a letter survey team by fa legal representative including staff had family members in difficult her mother nothing more they family could come	agitation/ confusion. LPN-C relling out to staff to help her. retion of the behaviors observed tempted were included in the notes. The results of this re noted as effective. dated 12/8/15, submitted to the mily member (FM)-B (R208's re) indicated multiple concerns diapproached her and other nany times expressing how re was and insinuating there was recould do, and perhaps the in to be with her. FM-B stated were good, but she did not feel					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245205	B. WING		1	2/10/2015	
	PROVIDER OR SUPPLIER REHABILITATION ANI	D LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 329	needs. She added, no relationships are have any sense of some p.m. FM-B stated with her confusion and restle put her by the nurse some one's office if FM-B stated she was form to administer I medication), but demedication because were going to use it supervision. During observation was seated in her win front of the televishelp and making nowere easily audible were observed to in transported to the donce in the dining remonstrate any bewas brought to the station area. She pwheelchair until after property of the property of the station area. She pwheelchair until after property of the party of the pwheelchair until after property of the pwheelchair until after pwheelchair pwheelc	ge 69 staff to meet her mother's "The staff changes so much made and the residents don't security nor does the family." interview on 12/8/15, at 8:54 he felt the Seroquel en effective for her mother, sed she did not feel the ness and timeliness to her acceptable and indicated this mother's level of agitation, essness. She stated, "They e's station and/or put her in she has been acting out," and do not feel staff were utilizing a pharmalogical interventions. As asked to sign a consent Haldol (an antipsychotic clined to authorize this e she was fearful the staff as an alternative to staffing or on 12/8/15, at 5:00 p.m. R208 wheelchair in her resident room sion. She was calling out for on-sensical comments that from down the hall. No staff atteract with R208 until she was lining room around 5:30 p.m. from, R208 did not call out or enaviors. After supper, R208 hallway, near the nurse's propelled herself around in her fer 7:00 p.m. Aside from noted wiors and/ or agitation were	F3	29			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245205	B. WING		12	/10/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3000 4TH AVENUE ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 329	R208's morning completed by nurs R208 was alert and behaviors observed. During interview of stated R208's behaviors outside. NA-H stated around anxious behaviors outside. NA-H stated redired for R208, and she wheelchair in anot statements of war NA-H stated she had been been been been been been been bee	n on 12/10/15, at 9:40 a.m. ares were observed being sing assistant (NA)-H and NA-I. d somewhat oriented, with no	F3	29		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING		_	12/10/2015	
	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		STREET ADDRESS, CITY, STA 3000 4TH AVENUE ANOKA, MN 55303	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE
F 356 SS=C	facility's electronic she was unable to The facility's Psych Gradual Dose Red indicated, "It is the that a resident will medications includi unless non-pharma failed to sufficiently behavioral, mood opolicy directed each given to treat a clea 483.30(e) POSTEL INFORMATION The facility must post a daily basis: o Facility name. o The current date oo The total number by the following cat unlicensed nursing resident care per seigher care per seigher care per son the current date. The facility must post of the current care per seigher care per seigh	be documented within the medical record system, and locate any further information. oactive Medication Use and uction policy dated 8/13, policy of Volunteers of America not receive unnecessarying psychoactive medications, acological interventions have a modify a resident's target or sleep disturbance." The psychoactive medication be arly defined targeted condition. O NURSE STAFFING Dest the following information on the staff directly responsible for hift: preses. Sticial nurses or licensed as defined under State law). The prosted as defined under State law and the nurse staffing data a daily basis at the beginning must be posted as follows: ole format. acce readily accessible to	F3				1/18/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245205	B. WING		12/10/2015	
	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 8000 4TH AVENUE ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	make nurse staffin for review at a cos standard. The facility must m staffing data for a required by State Is. This REQUIREME by: Based on observative review, the facility posting was update actual employees thad the potential to facility, staff, and with einformation. Findings include: During observation Nursing Staffing poinside the front ent and was dated 12/identified the cens following staff work Morning shift	ppon oral or written request, g data available to the public to not to exceed the community raintain the posted daily nurse minimum of 18 months, or as aw, whichever is greater. NT is not met as evidenced ation, interview, and document failed to ensure the daily staffed on a daily basis to reflect the working for each shift. This oraffect all 118 residents in the isitors who wished to review on 12/7/15, at 9:13 a.m. the posting was displayed directly rance in a shadow box frame 5/15, 2 days prior. The posting us of 118 and identified the	F 356	Preparation, submission and implementation of this Plan of Corr does not constitute an admission o agreement with the facts and concl in the statement of deficiencies. The of Correction is prepared and exect a means to continuously improve the quality of care, to comply with all applicable state and federal regular requirements and it constitutes the facility's allegation of compliance. It is the policy of Anoka Rehabilitatic Living center to publicly post nurse staffing information at the beginning each shift and include the minimum and allow public access to posted restaffing data. The policy and practice of posting in the staffing data.	f, or usions nis Plan uted as ne tory on and g of n data nurse nours	
	a.m 3:00 p.m.	tical nurses (LPN) from 6:30 ant (NA) from 7:00 a.m 1:00		was reviewed 12/30/2015 to incluposting nursing staffing upon received current daily resident census in the morning. This will be communicate staffing and clinical leadership mee 12/31/15 For other residents who may be affect by this practice, the hours posting was received.	ving d to eting on ected	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING		12/10/2015		
	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFUL DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 356 F 441 SS=F	Three RN from 2:30 Three LPN from 2:30 One NA from 6:00 p Six NA from 3:00 p Six NA from 3:00 p Night shift Four RN from 10:30 Two LPN from 10:30 When interviewed of staffing coordinator of changing the staduring the week an she works, however just on call and does change the staffing staffing posting is not weekend. SC-A staduring the staffing staffing posting is not weekend. SC-A staduring the staffing posting is not weekend. SC-A staduring the weekend. When interviewed of director of nursing policy related to staduring the weeker responsible for ensposted daily and up aware the posting work of the weekend. 483.65 INFECTION SPREAD, LINENS The facility must estinfection Control President in the staffing was a staffing to the staffing was a staffing to the staffing to the staffing the s	O p.m 11:00 p.m. O p.m 11:00 p.m. O p.m 9:00 p.m. O p.m 10:30 p.m. O p.m 11:30 p.m. O p.m 7:00 a.m. O p.m	F 44	reviewed by the Director of Nursing designee each day before posting ensure proper listing of Nursing he including facility name, date, numbers worked in each category (Responsible to ensure compliance. The policy and procedure for nursestaffing, scheduling coordination, a posting was reviewed by the interdisciplinary team on (12/30/15 Staffing members were re-educated relates to their respective roles and procedures on January 4th,5t 6th 2016. Audits of the hours posting will be completed 3 times weekly x 3 were monthly for 3 months, and then a for 2 quarters to ensure continued compliance. The results will be reptite Quality Assurance Committee review and further recommendation. The Director of Nursing or designed be responsible for compliance.	to cours over N, LPN, on the ing hours of the ing hours of the ing hours hand eks, uarterly ported to for on.	1/18/16	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING		12/	/10/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 441	of disease and infer (a) Infection Control The facility must exprogram under who (1) Investigates, coin the facility; (2) Decides what pushould be applied (3) Maintains a reconstructions related to in (b) Preventing Sprogram (1) When the Inferd determines that a prevent the spreadisolate the resident (2) The facility must communicable discommunicable discommunica	development and transmission ection. Of Program stablish an Infection Control ich it - portrols, and prevents infections procedures, such as isolation, to an individual resident; and eard of incidents and corrective infections. The eard of Infection estion Control Program resident needs isolation to the of infection, the facility must the ease or infected skin lesions with residents or their food, if ransmit the disease. It require staff to wash their direct resident contact for which dicated by accepted	F 44				
	by: Based on intervieved facility failed to imp	NT is not met as evidenced w and document review, the blement an infection control luded consistent monitoring.		Preparation, submission and implementation of this Plan of Codes not constitute an admission			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			` '	(X3) DATE SURVEY COMPLETED	
		245205	B. WING			12/	10/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRE	SS, CITY, STATE, ZIP CODE		3, 2 3 3
				3000 4TH AVE	NUE		
ANOKA I	REHABILITATION ANI	D LIVING CENTER		ANOKA, MN	55303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOUL REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 441	Continued From page 75		F 4	41			
	transmission to other. This had the potent	sis of infections to reduce the er residents in the facility. ial to affect all 118 residents ty, staff, and visitors.		in the stat of Correct a means quality of	nt with the facts and con- tement of deficiencies. I tion is prepared and exe to continuously improve care, to comply with all e state and federal regula	This Plan cuted as the	
	Review of the facilit	y's Monthly Infection Control entified a flowsheet for staff		requireme	ents and it constitutes the allegation of compliance.		
				Living Ce infection of provide a environme developm and infect The infect reviewed	olicy of Anoka rehabilitat nter to establish and ma control program designe safe, sanitary and comfeent and to help prevent the tand transmission of tion. tion surveillance program and revised on 12/31/15 plinary team. A new infe	intain an d to ortable he disease n was by the	
	 Date culture taker Organism(s) Antibiotic resistan Antibiotic type Start date Infection definition 	t (Y/N)		summary each hous comprehe preventat January 8 For other	sheet will be implement sehold with a more ensive analysis of data a ive measures taken star	ed for nd ting ffected	
	Classification notClassification com	infected		notificatio resident(s Staff men to their re	d upon admission and in from Licensed staff of it is) with infection. In the spective roles and it is possible regarding the police.	relates	
	May 2015, through identified the reside type, antibiotic, and admit. However, it	oom number, body site, date		Audits wil weeks, m	es on infection control or lth, 5th and 6th 2016 If be completed weekly for conthly for x3 months, an x2 to ensure continued be with results reported t	or x3	

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245205	B. WING		_	12/10/2015	
	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER		STREET ADDRESS, CITY, ST. 3000 4TH AVENUE ANOKA, MN 55303	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 441	and whether or not be filled out by the tracking and trending when interviewed development (SD)-control nurse, state ordered by the physidentified when a rehospital with an infermation from the Infections are track compiled on the abquality assurance (she looks at the type the infection, is the for it, is there an interesting tracked on the resident's progress has access to.	iotic resistant, date resolved, it was isolated as directed to flowsheet to ensure accurate ng of resident infections. on 12/10/15, at 4:36 p.m. staff A, who was also infection ed cultures are not typically sician, and the organism is not esident is admitted from the ection. She also stated the empt to receive this in the hospital after admission. Seed for each household, and sove mentioned form to bring to QA) meetings. SD-A stated the of infection, the location of resident receiving treatment tervention, was it acquired at ant on admission, and is it SD-A stated the symptoms are log, but available in the shotes in the chart, which she	F 4	Quality Assurance C and further recomm The Director of Nurs be responsible for c	endations. sing or designee wi		

5205025

PRINTED: 01/13/2016 **FORM APPROVED** OMB NO. 0938-0391

DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 02 - ANOKA CARE & REHAB CENTER B. WING 12/09/2015 245205 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3000 4TH AVENUE ANOKA REHABILITATION AND LIVING CENTER **ANOKA, MN 55303** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS **FIRE SAFETY** A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division on December 09,2015. At the time of this survey Anoka Rehabilitation & Living Center was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES TO:** Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:

Marian.Whitney@state.mn.us

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

- 1. A description of what has been, or will be, done to correct the deficiency.
- 2. The actual, or proposed, completion date.
- 3. The name and/or title of the person responsible for correction and monitoring to

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

(X6) DATE

Electronically Signed

01/07/2016

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.

PRINTED: 01/13/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 2 - ANOKA CARE & REHAB CENTER	(X3) DATE SURVEY COMPLETED	
		245205	B. WING			12/0	9/2015
,	NAME OF PROVIDER OR SUPPLIER ANOKA REHABILITATION AND LIVING CENTER			30	REET ADDRESS, CITY, STATE, ZIP CODE 00 4TH AVENUE NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Anoka Care-Rehak constructed in 2012 two story building we construction type is (111). The building the complex by 2 h. The building is fully facility has a complex system, with smoke spaces open to the automatic fire departs and the transfacility is licensed froccupied at the time. The requirement at NOT MET as evident NFPA 101 LIFE SA Hazardous areas a with 8.4. The area fire-rated barrier, we without windows (in	politation Center was 2 and opened in 2013. It is a with a basement. The 3 determined to be Type II is separated from the rest of our fire rated construction. If sprinkler protected. The lete automatic sprinkler edetection in the corridors and a corridor, that is monitored for artment notification. All it is single station smoke smit to the nurses station. The lete of inspection. If 42 CFR Subpart 483.70(a) is enced by: IFETY CODE STANDARD If the protected in accordance is are enclosed with a one hour in accordance with 8.4). Doors automatic closing in		000			1/18/16
	Based on observa facility has failed to from a hazardous a deficient practice of	is not met as evidenced by: tions and staff interview, the provide proper protection area in the facility. This ould affect 40 residents, as n this room could enter the			The two 20 minute doors on room (Kitchen Storage) will be changed or exceed the 45 minute requirem stated during inspection. Bill Bart Environmental Services Director	I to meet nent :h,	

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 02 - ANOKA CARE & REHAB CENTER		SURVEY PLETED
		245205	B. WING _		12/0	9/2015
	PROVIDER OR SUPPLIER	D LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
K 029	Continued From pa corridor making it u Findings include:		K 02	9 ensure compliance.		
	on 12/09/2015, it w basement kitchen	veen 9:00 AM and 12:30 PM as observed that the dry storage room(which is over 0-minute fire rated door and e rated door.				
K 050 SS=D	Maintenance Direc NFPA 101 LIFE SA	tice was verified by the tor at the time of inspection. FETY CODE STANDARD at unexpected times under	K 05	0		1/8/16
	varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercis conducted between	at least quarterly on each shift. with procedures and is aware of established routine. lanning and conducting drills is ompetent persons who are e leadership. Where drills are in 9 PM and 6 AM a coded by be used instead of audible				
	Based on review of interview, it was de to vary the times of 12-month period. Taffect how staff rea	is not met as evidenced by: of reports, records and staff termined that the facility failed if the fire drills in the last This deficient practice could act in the event of a fire. by staff would affect the safety		It is the policy of Anoka Rehabilit Living Center to conduct fire drills unexpected times under varying conditions, at least quarterly on e Fire drills that occur on the same vary at least 1 ½ hours in time. Or drill per quarter per shift will be conducted as required per Bill Barth, Environmental Service.	at ach shift. shift will One fire onducted MSFC.	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ANOKA CARE & REHAB CENTER				(X3) DATE SURVEY COMPLETED	
		245205	B. WING				/09/2015	
	PROVIDER OR SUPPLIER	D LIVING CENTER		3000 4TH AVEN	55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
K 050	12:30 PM on 12/09 revealed that the fa Evening-Shift fire d	ween between 9:00 AM and /2015, a record review cility conducted the rills in 2015 between the hours M, 3:10 PM, 3:26 PM not	КО		vill ensure compliance).	17	
	This deficient pract Maintenance Direction.	ice was verified by the tor at the time of the						

FORM CMS-2567(02-99) Previous Versions Obsolete



Electronically submitted December 29, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5205026

Dear Mr. Dolinsky:

The above facility was surveyed on December 7, 2015 through December 10, 2015 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, Health Regulation 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute 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.

Anoka Rehabilitation And Living Center December 29, 2015 Page 2

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Jessica Sellner, Unit Supervisor at (320)223-7343.

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

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

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00002	B. WING		10/10/0015
NAME OF I		00893		CTATE ZID CODE	12/10/2015
	PROVIDER OR SUPPLIER	3000 4TH		STATE, ZIP CODE	
ANOKA	REHABILITATION ANI	ANOKA, I	MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTENTION*****				
	NH LICENSING CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Departmen	nether a violation has been			
	requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	e rule provided at the tagule number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was			
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.			
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to

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

Electronically Signed 01/07/16

TITLE

X3 PROVIDER SUPPLIER X PROVIDER OR SUPPLIER X DENTIFICATION NUMBER: B. WING 12/10/2015	Minneso	<u>ta Department of He</u>	ealth				
ANME OF PROVIDER OR SUPPLIER ANOKA REHABILITATION AND LIVING CENTEI (X4) ID PREFIX TAG (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December 7-10th, 2015, 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. 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 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 Conrection. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO Appears in the far left column entitled "ID Prefix Tag." The state statute statute FILE PREFIX TAG. **COMPLETE ADMOR SAMON S5303 **COMPLETE PREFIX PROVIDER'S PLAN OF COMPLETE DATE ACTION SHOULD BE CROSS-REFERENCED TO THE APPOPRIATE DEFICIENCY. **CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPOPRORIATE DEFICIENCY. **CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPOPRORIATE DEFICIENCY. **CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPOPRORIATE DEFICIENCY. **CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPOPRORIATE DEFICIENCY. **COMPLETE DATE: DATE ACTION SHOULD BE CROSS-	-	ND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:					
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ANOKA REHABILITATION AND LIVING CENTE ANOKA, MN 55303	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMEN			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE			SURVEY LETED
	00893		B. WING		12/1	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, M	_			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 2	2 560			
2 560			2 560			1/18/16
	Continued From page 2 MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care to include fistula precautions for 1 of 1 residents (R132) reviewed for dialysis, and for behavioral symptoms and interventions for 1 of 2 residents (R210) reviewed for emotional well-being. Findings include: R132's admission Minimum Data Set (MDS) dated 11/5/15, identified R132 had moderate cognitive impairment, and had recieved dialysis at an outside facility. R132's care plan dated 10/30/15, identified R132 was a new admission to the facility, had a dialysis port, and was currently receiving dialysis. However, the care lacked where R132's port was located, any ongoing care instructions for the shunt site, or any restrictions for blood pressure			Corrected		
	During observation	on 12/8/15, at 4:42 p.m. R132				

Minnesota Department of Health

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Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.					X3) DATE SURVEY COMPLETED	
	00893		B. WING		12/1	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, N	_			
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2 560	was seated at the ordialysis shunt visible stated he goes to do when interviewed on ursing assistant (Noteck resident block) NA-C stated she was for obtaining blood. When interviewed oregistered nurse (Replan was used to diresidents, and the Note of the Not	dining room table. R132 had a e in his right upper arm, and ialysis three times a week. In 12/8/15, at 5:46 p.m. NA)-C stated the NA staff od pressures on bath days. as unaware of any restrictions pressures on R132. In 12/8/15, at 6:05 p.m. IN)-D stated the resident care arect the care and needs of NA care guides were created are plan and was to be a A staff. RN-D stated blood to be obtained using R132's of his dialysis shunt, and that be identified on R132's care	2 560			
		12/9/15, at 1:30 p.m. RN-En is used to, "Individually care				

Minnesota Department of Health

STATE FORM 5699 J2K911 If continuation sheet 4 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00893			B. WING		12/1	0/2015
ANOKA REHABILITATION AND LIVING CENTER 3000 4TH				STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 560	for that particular painformation about non R132's right arm treatment records, access to those add the care plan." R210's significant of identified her cognition and required extension activities of daily living identified R210 dembehaviors. The care plan dated had Lewy Body dementia care, behand Lewy Body dementia care, behanticipate needs; ecarefully; observe hody language; observed to express feeling make her wants and use short and directive explain activities/caprovide one directive feelings when approximately and re-approximately and re-app	ge 4 atient." RN-E stated ot collecting blood pressures is was identified on the nurses but the NA staff did not have ding, "It should have been on change MDS dated 11/18/15, ition was moderately impaired sive assistance for most ing (ADLs). The MDS nonstrated wandering d 11/25/15, identified R210 nentia. The care plan directed entions for communication, aviors and elopement: ncourage socialization; listen her facial expressions and serve for sad/anxious mood loss; provide opportunity for high regarding her inability to d needs known; speak clearly, t phrases; communicate at hyourself at each interaction; are prior to beginning them; her at a time; validate her hopriate; allow time for her to to activities to promote her her eing; approach her in a calm hing with her; redirect her for high activities as high redirect her for my distract her from wandering to diversions of activity, food, hor; involve her in activities as hand ensure her Wanderguard her plan did not address hand other resident rooms. The				

Minnesota Department of Health

STATE FORM J2K911 If continuation sheet 5 of 62

Minnesota Department of Health

AND BLAN OF CORRECTION (IDENTIFICATION NUMBER)		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		A. DOILDING.					
00893		B. WING		12/	10/2015		
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTE	3000 4TH	_			
			ANOKA, I	MN 55303			
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2 560	Continued From pa	ige 5		2 560			
2 560	staff supervision the addition, the care property individualized interventions identified behavior rounds property of the proof of the	at was required for Folan lacked specificated interests and successed interests and success. Is on 12/9/15, at 12:20 peroached registered desired through the facility ocess. Is on 12/9/15, at 12:20 peroached registered desired and registered desired assistant (NA) and R210 was observed bed (this was not Folalert, but not oriented aring assistance from stand and transfer bed was resistive to the tounderstand what Most of R210's body and/or R210 was leaded and the stand of R210 was observed and the stand of R210 was ob	tion of cessful ity's 27 p.m., I nurse in her look of lying in lect to her ransfer was was limp aning back ed of look of assisted NA-K ting me, R210 did look of lect the led R210 ecifically, ah, she served om (again,				
	assisted R210 out down another hallw in the direction of h 12:42 p.m., R210 w	RN-J alerted NA-K of the room and brouvay where she begar er own resident room was observed in her otted on the toilet in he	ught her n to propel n. At own				
		onfirmed NA-K had o					

Minnesota Department of Health

STATE FORM 5899 J2K911 If continuation sheet 6 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00893		B. W	B. WING			0/2015
	PROVIDER OR SUPPLIER	300	EET ADDRES	,	TATE, ZIP CODE		
ANOKA	REHABILITATION ANI	AN	OKA, MN 5	5303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;		ID REFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	on R210 and found	she had self-transferred		560			
	and a small void of perhaps R210 had	d a medium bowel mover urine. RN-J commented been trying to communicate bathroom by her wander havior.	that ate				
	stated R210 had liv approximately one	month. RN-J reported Ra					
	including pinching, wandering into other	ple behavior concerns tugging at others' clothing or resident rooms and pla or when someone is prop	nting				
	interventions she for with R210: Providing	air. RN-J reported the follo bund as successful in her ng her with snacks, using her shoulders, toileting he	work a				
	right after each mea her pain was well m	al, providing 1:1's ensuring the all, providing 1:1's ensuring he nanaged, encouraging he N-J added, there were a	ng				
	not tolerant of R210 RN-J stated, "That's	dents on the unit, who we o's wandering into their ro s why we have to keep su	om. ıch a				
	into other resident reach shift. She ide	She stated R210 wander rooms one, to two times on ntified that it was importa cognizant of where she want cognizant of where she want cogniz	luring nt for				
	at all times and to n resident's doors clo of entering their roo	nake every effort to keep sed, to minimize her likel oms. RN-J stated	other ihood				
	communicated to so	to be successful, were to taff through shift reports a ior rounds. She also beli	and				
	included specific be staff. RN-J stated i	gress notes should have ehavior concerns identific nterventions were to be ese reports and rounds, w					
	the care plans being	g updated by the leaders g aroup. Other intervention	of				

Minnesota Department of Health

STATE FORM 5899 J2K911 If continuation sheet 7 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00893		B. WING		12/10/2015		
	PROVIDER OR SUPPLIER REHABILITATION ANI	DLIVING CENTER 3000 4TH	, ,	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 560	RN-J identified were her a cup of coffee, stated, "I don't think should add that war plan]." During interview on stated behavior interventions were at the time. NA-K stating the behavior rour opportunity to share other had found to was the time of day more fidgety. She waiting and re-appreffective. She repolikely a result of her something to the stand routinely wanded. During interview on licensed social world facility's behavior rour monthly, but often restated the NAs and behaviors observed shared successful it and/or suggested in R210. LSW-C report activities director (Arecorded and succession in the succession	ge 7 e keeping her busy, offering sitting next to her. RN-J a she likes to be alone I rm blanket in there [the care 12/9/15, at 12:49 p.m. NA-K erventions for R210 included arm banked, or a marker to She added R210's current effective approximately 50% of ted the NAs routinely took part ands, where they were given the einterventions which each be effective. NA-K stated this when R210 typically became added, other interventions of oaching R210 were somewhat arted R210's behaviors were attempting to communicate aff. NA-K reported R210 did ar into other resident's rooms. 12/9/15, at 2:27 p.m. ker (LSW)-C, stated the bunds took place at least once more frequently than this. He other staff discussed any new disince the prior meeting and interventions implemented afterventions to attempt with orted that between himself and another care plan. LSW-C at aware that R210 had been ar resident rooms and did not ussing this subject during the				

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00893	B. WING		12/1	0/2015
	PROVIDER OR SUPPLIER REHABILITATION ANI	DILIVING CENTER 3000 4TH	DDRESS, CITY, S AVENUE MN 55303	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	During interview on stated that he had j behavior of wander earlier that day. He engaged as much a interventions of eng providing 1:1 assist times weekly and a he tried to have R2 activities per week. always participate in parallel with the oth coffee to drink. AD the behavior rounds that he took notes of meetings, but though interventions should plan by the facility's confirmed he did not the behavior rounds of care. AD-A state the behavior rounds of the restaff via a conther staff via a conthe nurses updates. During interview on director of nursing (that was consistent have been included for how to address.) Review of the facility Procedure dated 3/ interventions be writheir goals. The cachanged as care not emporary problems comprehensive car within 30 days. The	12/10/15, at 4:15 p.m. AD-A ust been informed of R210's ing into other resident rooms, e stated, "We try to have her as possible." AD-A identified paging her in activities and ance with them three to four s needed. AD-A reported that 10 participate in three to four He added, R210 did not n activities, but would sit er residents, if given a cup of A confirmed he routinely led son R210's unit. He stated of the discussion at the 10 ght that any suggested did have been added to the care nursing department. He 10 typically enter the findings of 10 is into a resident's written planted the interventions shared at 12 were communicated to all numunication book and/or via 12 to the care plan.				

Minnesota Department of Health

STATE FORM J2K911 If continuation sheet 9 of 62

Minnesota Department of Health

AND BUAN OF CORRECTION IDENTIFICATION AND RE					SURVEY PLETED	
00893			B. WING		12/1	0/2015
	PROVIDER OR SUPPLIER	DLIVING CENTER 3000 4TH	DDRESS, CITY, S I AVENUE MN 55303	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa order to promote au self-determination a	utonomy, dignity,	2 560			
	director of nursing (inservice nursing st	THOD OF CORRECTION: The (DON) or designee could aff to the development of a e plan, then audit to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			1/18/16
		omprehensive plan of care personnel involved in the				
	by: Based on observati review, the facility facare was followed f R19) reviewed for presidents (R211, R2	ent is not met as evidenced on, interview, and document ailed to ensure the plan of or 2 of 2 residents (R208, pressure ulcers, 2 of 2 (208)) reviewed for urinary or 1 of 3 residents (R208) of motion services.		corrected		
	Findings include:					
	orders) dated 12/2/	Review Report (physician 15, identified diagnoses , depression, anxiety, lung				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
00893 B. WING	12/10/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ANOKA REHABILITATION AND LIVING CENTEI 3000 4TH AVENUE ANOKA, MN 55303	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	SHOULD BE COMPLETE
cancer, chronic obstructive pulmonary disease and acute and chronic respiratory failure. Physician orders directed interventions to minimize R208's risk for further progression of her current pressure ulcers and the development of new pressure ulcers. These orders included daily Tefla dressings to both heel sores, wrapping in Kerlix; Elevating her bilateral heels and Achilles off bed at all times using a Heel Lift Manager, with no pressure on her heels while up in her wheelchair and no shoes to be worn; and Placing gripper socks only half-way onto her feet and not covering her heels due to wounds. R208's care plan dated 10/2/15, directed the following interventions to minimize the risk for pressure ulcers: Staff to keep heels elevated on pillows at all times, assuring her heels were not touching anything. R208 required two staff to boost up in bed or with any major repositioning, R208 required multiple pressure relieving devices including an alternating pressure mattress for her bed, a pressure reducing device for her chair and a cushion to float her heels. The care plan noted, "Resident does have a tendency to remove her heels from the heel manager or off the pillows that elevate her heels when up in the Broda chair. Needs reminders and assistance to keep heels elevated." R208's significant change Minimum Data Set (MDS) dated 9/30/15, identified severe cognitive impairment, required extensive to total assistance for activities of daily living, had developed onestage two pressure ulcers and two unstageable pressure ulcers since the prior assessment.	

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00893	B. WING		12/1	0/2015
	PROVIDER OR SUPPLIER	D LIVING CENTER 3000 4TH	DRESS, CITY, S AVENUE MN 55303	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	On 12/8/15, at 7:00 Broda wheelchair ir station. She had w shoes on both feet. observed around he However, no gauze her left foot. On 12/9/15, at 7:14 lying in her bed, on propped on either sno pillows or device and both heels were She wore regular, w feet. Her right, lowe with gauze, but the R208's bilateral heemattress. On 12/10/15, at 8:0 lying in her bed in hor devices were in pwas wearing regula white gauze was oblower ankle/ heel are cushion was observinghtstand and the NA-H entered R208 eating her breakfasthe bed to approxim remained lying flat of her bed and both bilateral feet and to footboard of her bed pressed into the may were in place to floaters.	p.m. R208 was seated in her the hallway, near the nurse's hite socks and black, canvas A gauze dressing was er right lower ankle/ heel area. or dressing was observed to a.m. to 8:55 a.m., R208 was her left side, with pillows ide of her torso. There were is in place to float her heels e observed resting on the bed. white socks to her bilateral er ankle area was wrapped left was not. NA-I confirmed is were resting on the 5 a.m. to 9:40 a.m., R208 was her resident room. No pillows olace to float her heels. She r, white socks to both feet and observed around only her right rea. A black heel floating red, tucked between the wall to R208's right side. It is noom to assist her with to R208's right side. It is noom to assist her with the result of hately 60 degrees. R208 on her back, with her shoulder e crease from the raised head is knees bent. The balls of her es were pressed against the d, with her bilateral heels aftress. No pillows or devices				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00893	B. WING		12/1	0/2015
	PROVIDER OR SUPPLIER	3000 ATH		STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTEI ANOKA, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From page 12		2 565			
	completed R208's morning cares and placed shoes and socks on the resident, although the care plan directed the resident not to wear shoes.					
	confirmed she was was responsible for plan interventions. were to be floated whenever she was R208's bilateral hee	n 12/10/15, at 2:15 p.m. RN-A R208's nurse manager and r the development of her care RN-A stated R208's heels with a heel lift manager lying in bed. RN-A stated els were to be wrapped with a d it may had fallen off.				
	During interview on 12/10/15, at 4:35 p.m. the director of nursing (DON) stated staff should implement each resident's care plan and to follow physician orders.					
	R208's significant change Minimum Data Set (MDS) dated 9/30/15, identified R208's cognition was severely impaired and she required extensive to total assistance for activities of daily living, including extensive assistance for toileting. The MDS identified R208 was not on a toileting program and was always incontinent of both bowel and bladder.					
	offer toileting to R2 bedtime, as needed request. The care assist R208 with th provide her with as toilet. R208 was to					
		s on 12/8/15, from 5:30 p.m. to s assisted to the dining room				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 20.25 (6.			
		00893	B. WING	· · · · · · · · · · · · · · · · · · ·	12/1	0/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ANOKA	REHABILITATION ANI	D LIVING CENTEI 3000 4TH ANOKA, I	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 13	2 565			
	nurse's station area					
	nursing assistant (N morning cares with incontinence production confirmed R208 hat medium bowel move	on 12/10/15, at 9:50 a.m. NA)-H and NA-I completed R208, during which her ct was changed. NA-I d been incontinent, with a rement and a small void of ot offered the use of a bedpance.				
	During interview on 12/10/15, at 1:45 p.m. NA-H confirmed she was R208's primary NA on the day shift. NA-H reported R208 was to be checked and changed on a routine basis, approximately every three hours. NA-H confirmed earlier this morning, she did not check and change R208 until her morning cares at 9:50 a.m. and she was unaware of when she was changed prior to that, but confirmed it was prior to 6:30 a.m. (approximately three and a half hours prior).					
	director of nursing (12/10/15, at 4:35 p.m. the (DON) stated staff should be resident's care plan.				
	identified R208's co and she required ex activities of daily live had a functional lime her upper extremity (CAA) dated 9/30/1 hospice, expected to resident participate	change MDS dated 9/30/15, agnition was severely impaired ktensive to total assistance for ing. The MDS identified R208 itation in ROM to one side of the Care Area Assessment 5, noted, "Resident on to decline over time. Have [in activities of daily living] as for transfers; not able to				

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NAME OF PROVIDER OR SUPPLIER ANOKA REHABILITATION AND LIVING CENTEI (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
ANOKA REHABILITATION AND LIVING CENTEI (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			00893	B. WING		12/	10/2015
			D LIVING CENTER 3000 4	H AVENUE	STATE, ZIP CODE		
	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
weight bear with right arm" The CAA did not address PROM or exercises. R208's care plan dated 10/2/15, directed PROM to both upper extremities (LE) and lower extremities (LE), with three repetitions each, during morning cares. The care plan also directed, "ROM program for both UB (upper body) and LB (lower body) once per day following worksheets in her closet" The worksheets in R208's closet, as referenced in the care plan included the following: -An Upper Extremity ROM Program form (undated) directed PROM exercises to R208's fingers, wrists, elbows, and shoulders, with 20 repetitions to each area, one to two times daily. This form was signed by certified occupational therapy assistant, licensed (COTAL)-A. The Lower Extremity ROM Program form dated 8/4/15, directed PROM exercises to R208's ankles, knees, legs and hips, with five to 10 repetitions, one time daily. This exercise program was directed by physical therapy assistant (PTA)-A. During a telephone interview on 12/8/15, at 8:54 p.m. family member (FM)-B stated she had concerns of her mother not receiving PROM as had been ordered by therapy. R208's Documentation Survey Report from 9/1/15, through 12/9/15, detailed the following regarding provision of her ROM services. In 9/15, R208 received PROM to her upper and lower extremities during 21 out of 30 days, with no PROM noted on six days and no data for the remaining three days. In 10/15, R208 received PROM during eight out	2 565	weight bear with rig address PROM or extremities (LE), widuring morning card directed, "ROM proand LB [lower body worksheets in her or R208's closet, as reincluded the followir-An Upper Extremit (undated) directed fingers, wrists, elborepetitions to each This form was significant therapy assistant, lithe Lower Extremit 8/4/15, directed PR ankles, knees, legs repetitions, one timwas directed by phy (PTA)-A. During a telephone p.m. family membe concerns of her mohad been ordered by R208's Documenta 9/1/15, through 12/9 regarding provision In 9/15, R208 receillower extremities dino PROM noted on remaining three day	ght arm" The CAA did not exercises. ated 10/2/15, directed PROMmities (UE) and lower ith three repetitions each, es. The care plan also orgam for both UB [upper book) once per day following closet" The worksheets in eferenced in the care plan ing: ty ROM Program form PROM exercises to R208's ows, and shoulders, with 20 area, one to two times daily. ed by certified occupational icensed (COTA/L)-A. Ity ROM Program form dated and hips, with five to 10 in edaily. This exercise program is a daily. This exercise program is a daily is a day, with a six days and no data for the days.	y]			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00893		B. WING		12/	10/2015
	PROVIDER OR SUPPLIER REHABILITATION ANI	O LIVING CENTEL	STREET ADI 3000 4TH ANOKA, N	AVENUE	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	In 11/15, R208 reces 30 days (17% of op noted on 23 days a two days. In 12/15, R208 recenine days, with no F During observation R208's morning car and NA-I. As the N during cares, holdin push and/or pull he observed to moan a NA-H and NA-I con historical for R208 t during cares. R208 indications of pain a of both her UE and sweatshirt, while as arms into each sleet her face and moand with lifting each leg any other exercises her morning cares. During interview on stated R208 was su she is so painful, yo she's 'owe, owe.'" I demonstrated these discomfort wheneve legs and when turn NA-H reiterated she with R208 because seemed to result. N these observations extremities to her s	sived PROM during fix portunities), with no Find no data for the rendered PROM during or PROM noted on eight on 12/10/15, at 9:50 ares were observed with As turned R208 sideling her hips and should reduce to either side, she wand say, "Owe, owe, of firmed this was typicate on made such vocalized and discomfort with drace. During application is sisting her with putting eye, she held her hand eye. She also vocalized into her pants. No Play were provided to R20 are provided to R20 are she moved her feeting her side-to-side in the did not do ROM execution of pain with movement of pain with movement poviding ROM exercises and/or repoviding ROM exercises and reduced a	PROM naining ne out of days. a.m. th NA-H to-side ders to as owe." al and ations ressing on of her g her dover to dover to dover to down the deriver of the down the deriver of the derive	2 565			

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Minnesota Department of Health

-	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00893	B. WING		12/1	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, I	AVENUE MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	During interview on registered nurse (R R208's nurse manadeveloping care plaimplementation. U whether R208 was services. She brief orders and stated sirect ROM. She awere in place, were resident's closet do document the exermedical record sysbeen informed of a concerns of care plaimplemented for R2 During interview on director of nursing expectation for staff care plan. R19's quarterly MD R19 had moderate extensive assistant frequently incontine pressure ulcer, but pressure ulcers, and mattress and whee included diagnoses vascular accident (indicated R19 was R19's care plan was 12/8/15, the care plan for alteration of skir incontinence and pieceded more assis Interventions included included incontinence and pieceded more assis Interventions included incontinence included incontinence and pieceded more assis Interventions included incontinence included incontinence and pieceded more assis Interventions included incontinence included	a 12/10/15, at 2:15 p.m. aN)-A confirmed she was ager and was responsible for ans and monitoring pon inquiry, RN-A was unsure supposed to receive ROM fly reviewed R208's physician she was not seeing anything to dded, any ROM programs that a typically placed inside each for and NAs were prompted to cises in the facility's electronic tem. RN-A denied having my pain concerns and/or any anned exercises not being 208. 1 12/10/15, at 4:35 p.m. the (DON) reported that it was his f to implement each resident's sent, was at risk for developing did not have any current d had a pressure reducing lichair cushion. The MDS of heart failure, cerebral CVA) and depression, and receiving hospice care.		DEL ROLLING TY		

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00893	B. WING		12/1	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, M	_			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 17	2 565			
	chair, inspect skin daily with cares, and turn every two hours and check brief.					
	was observed sleep her upper body tilte not observed repos	a.m. through 9:09 a.m. R19 bing on her back in bed, with d slightly to the left, staff were bitioning R19, nor did R19 in her position by herself f time.				
	On 12/9/15, at 9:16 a.m. NA-A entered R19's room with a breakfast tray for R19 and raised R19's head of the bed, however, pressure was not relieved from R19's buttocks. NA-A placed the tray table with R19's breakfast in front of R19. NA-A set up R19's breakfast tray and left the room without providing any repositioning assistance. R19 was observed in the same position eating breakfast until 9:54 a.m.					
	stated she was ass shift and the reside every two hours, ho not repositioned R1	12/9/15, at 9:57 a.m. NA-A igned to care for R19 for the nt was to be repositioned owever, NA-A stated she had 9 since the beginning of her ecause she had, "Forgot."				
	RN-B stated R19 n	on 12/10/15, at 9:55 a.m. eeded help being repositioned help her every two hours, sleeping.				
	stated that the care	on 12/10/15, at 2:02 p.m. RN-A plan on 12/9/15 indicated repositioning schedule to				
	DON stated his exp	on 12/10/15, at 3:01 p.m. the pectation was staff should be ents individualized care plan for				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		E SURVEY PLETED
		00893	B. WING		12/	10/2015
	PROVIDER OR SUPPLIER	D LIVING CENTEL 3000 4TH	DDRESS, CITY, S' AVENUE MN 55303	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 565	turning and repositi R211's admission M R211 had intact cog assistance with toil incontinent of bladd R211's care plan da was incontinent of M "Toilet upon rising, [hour of sleep and p R211's undated nur identified, "Toilet up [sic], HS and prn" During observation 7:05 a.m. nursing a get dressed in bed, wheelchair. NA-E a and helped him bru hair, then assisted for breakfast. R21 toileting after rising care. When interviewed of stated R211 should "Like every two hou was saturated with woke him up. NA-E toileting to R211 tha his care planning d thought R211 would because his beddir During interview on	oning. MDS dated 11/25/15, identified gnition, required extensive eting, and was frequently der. ated 12/7/15, identified R211 bladder, and directed staff to, before and after meals, HS orn [as needed]." rsing assistant (NA) care guide on rising [,] before after meals of morning care on 12/9/15, at assistant (NA)-E helped R211 and transferred him into his assisted him into the restroom, ash his teeth and comb his him to the dining room table I was not offered or provided as directed by his plan of the assisted with toileting, ars," and added R211's bed urine this morning when they at morning upon rising, despite it morning staff to, because she disay he didn't have to use it ag was wet with urine.				
	should be used as,	N)-F stated R211's care plan "An individualized plan of e expected, "To follow the				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00893	B. WING		12/1	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
ANOKA	REHABILITATION ANI	D LIVING CENTEI 3000 4TH ANOKA, I	AVENUE MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 19	2 565			
	toileting program ar	ner, R211 was on a scheduled and should have been assisted sing as directed by his care				
	dated 3/12, indicate the resident the approximation or attain the practicable function policy directed the conecessary care for	Plan Policy and Procedure ed, "The care plan will ensure propriate care required to me resident's highest level of a possible." Furthermore, the care plan would serve to direct residents, including o determine progress.				
	director of nursing (inservice nursing st of a residents care compliance.	THOD OF CORRECTION: The (DON) or designee could aff regarding implementation plan, then audit to ensure				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			1/18/16
	receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ang home resident must be out possible unless there is a he attending physician that the in in bed or the resident				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00893	B. WING		12/1	0/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, N	_			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830 Continued From pa	ige 20	2 830			
This MN Requirem by: Based on observat review the facility fawere aware of specresidents (R132) redialysis. In addition individualized demonstrated for 1 of 1 behavioral and emore an outside facility with the facility with the facility with the facility. However, and was curred outside facility with the facility on going care instructions for related to R132's significant to the facility with the fa	ent is not met as evidenced ion, interview, and document ailed to ensure all nursing staff cialized care required for 1 of 1 eviewed who was receiving a, the facility failed to ensure entia care interventions were residents (R210) reviewed for otional status. Minimum Data Set (MDS) tified R132 had moderate and had received dialysis at while a resident in the facility. Lated 10/30/15, identified R132 on to the facility, had a dialysis ently receiving dialysis at an wever, the care plan lacked sis port was located, any octions for the shunt site, or blood pressure monitoring		corrected		

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00893	B. WING		12/1	0/2015
	PROVIDER OR SUPPLIER REHABILITATION ANI	D LIVING CENTER 3000 4TH	DDRESS, CITY, S I AVENUE MN 55303	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	days. NA-C stated restrictions for colle R132, and was not not be taken on the During interview on stated the NA staff when he receives helieved blood preshis arm with his dia not receive any traicare of a dialysis pashe took to become When interviewed or registered nurse (Rused to direct the cand the NA care gucare plan to be a reknow about special RN-D stated blood collected in R132's dialysis shunt and tidentified on R132's guide. RN-D stated R132 and didn't known information on the cas a reference to provide the resident was received guide did not identification.	she was unaware of any octing blood pressures on aware blood pressures could arm with the dialysis access. 12/8/15, at 5:55 p.m. NA-D will check R132's vital signs is baths. NA-D stated she sture should not be checked in lysis shunt, but added she did ning from the facility in the atient only from, "The test," an ursing assistant. on 12/8/15, at 6:05 p.m. N)-D stated a care plan was are and needs of the resident, ides were created from the ference for the NA staff to ized individual resident cares. pressures should not be right arm because of his hat information should be acre plan and the NA care diffloat staff were to assist ow him, they use the care plan and NA care guide rovide resident cares. I care guide identified the ing dialysis, however, the care for the location of R132's care instructions or monitoring collect blood pressures in his				
	6:27 p.m. R132 was his room. R132's re	d interviewed on 12/8/15, at s seated in his wheelchair in oom did not have any sign aff to his dialysis shunt, or any				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00893	B. WING		12/10/2015	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		0,2010
ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, I	AVENUE MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	instructions on how pressure. R132 sta NA's, had attempte his right arm (with had to stop them. During interview on stated the care plar for that particular prinformation about non R132's right arm treatment records, access to those and should have been of but none was provided activities of daily living physical behavioral symptoms directed behaviors. R210's care plan da had Lewy Body der the following interved dementia care, behaviors. R210's care plan da had Lewy Body der the following interved dementia care, behaviors.	to obtain R132's blood ated several staff, including d to obtain blood pressures in his shunt) before, and he has 12/9/15, at 1:30 p.m. RN-E in is used to, "Individually care atient." RN-E stated to collecting blood pressures in was identified on the nurses but the NA staff did not have d stated this information on the care plan.	2 830			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		D	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00893	B. WIN	IG		12/1	0/2015
	PROVIDER OR SUPPLIER	DILIVING CENTER 30	REET ADDRESS, 00 4TH AVENU NOKA, MN 553	JE	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION		FIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	provide one directive feelings when approvide one directive feelings when approvenession of the psychosocial well be manner; avoid argues afety and re-approfinding her own rood by offering pleasant fluids or conversation much as possible; awas in place. The conversation of the provided in the care possible of the provided intervention of the provided interventions identified behavior rounds provided interventions in the provided interventions in the provided interventions in the provided int	re at a time; validate her opriate; allow time for he to activities to promote heing; approach her in a cling with her; redirect hele tach as needed; praise hem; distract her from want diversions of activity, for involve her in activities and ensure her Wanderg care plan did not addresento other resident rooms ion for the increased states required for R210. In lan lacked specification and interests and successied through the facility's	er to ler calm r for her for her for ldering lood, les as guard s s, and ff of fiful m. dining d RN-J ed h., led h.,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVE COMPLETED			
		00893	B. WING		12/	10/2015
	PROVIDER OR SUPPLIER	D LIVING CENTEL 3000 4TH	DDRESS, CITY, S' I AVENUE MN 55303	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	scared of some of the NA-K's forearm are replied to R210 star with my arm,,, [will let go of NA-K's arritransfer to her where room, rubbing her hurt her arm during pinched her arm. In pinches." At 12:36 wandering into a dinot her own room). NA-K assisted R21 her down another hyropel in the direction At 12:42 p.m., R210 resident room, seat bathroom. RN-J coon R210 and found her toilet. R210 had and a small void of R210 had been tryi	these things," and grabbed at tightly and held it. NA-K ting, "Well that's hurting me, you] let go please?" R210 did n and then they completed the elchair. As NA-K left the forearm, she stated R210 did the transfer, specifically, she NA-K stated, "Yeah, she [R210] p.m., R210 was observed fferent resident's room (again, RN-J alerted NA-K, and 0 out of the room and brought allway where she began to on of her own resident room. O was observed in her own ted on the toilet in her onfirmed NA-K had checked in she had self-transferred to d a medium bowel movement urine. RN-J stated perhaps ng to communicate her need n by her wandering and				
	stated R210 had liv approximately one demonstrated multi including pinching, wandering into othe her feet onto the flo propelling her in the R210 seemed to be people and was alw approached by othe stated the following successful in her w behaviors: Providi	12/9/15, at 12:09 a.m. RN-J red on that unit for month, and stated R210 ple behavior concerns tugging at others' clothing, er resident rooms, and planting for when someone was e wheelchair. RN-J stated e generally suspicious of ways on guard when er staff and residents. RN-J interventions she found were ork with R210 during ng her with snacks, using a her shoulders, toileting her				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		00893	B. WING		12/1	0/2015
	PROVIDER OR SUPPLIER	OLIVING CENTEL 3000 4TH		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	right after each meaner pain was well meaner pain was well meaner to attend activities. Couple of other resion to tolerant of R210 and stated, "That's close eye on her." into other resident reach shift, and it was to be cognizant of wand to make every doors closed to mire entering their rooms typically lie down or and if she were to lie would need to check RN-J stated interverby staff were to be shift reports and durounds, and should residents care plan believed R210's nuhave included specidentified by staff, a identified were to ke cup of coffee, and stated, "I don't think should add that was plan]."	ge 25 al, providing 1:1's, ensuring hanaged, and encouraging her RN-J stated there were a dents on the unit who were 0's wandering into their room why we have to keep such a She stated R210 wandered from one to two times during as important for all of the staff where she was at all times, effort to keep other resident's himize her likelihood of s. RN-J stated R210 did not take a nap in the afternoon, he down in her room, the staff k on her every few minutes. Intions found to be successful communicated to staff through ring once weekly behavior than be added to the sursing progress notes should iffic behavior concerns and other interventions RN-J peep R210 busy, offering her a sitting next to her. RN-J as she likes to be alone I arm blanket in there [the care	2 830			
	draw on paper. NA interventions were of the time. NA-K state in the behavior rour opportunity to share other had found to be a state of the state of	-K stated R210's current effective approximately 50% of ted the NAs routinely took part and they were given the einterventions which each be effective. NA-K stated the time of day when R210				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING: COMPLET				
		00893	B. WING		12/1	0/2015
	PROVIDER OR SUPPLIER	3000 4TH	AVENUE	STATE, ZIP CODE		
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2 830	typically became m behaviors were like communicate some During interview on social worker (LSW behavior rounds too but could be more of LSW-C stated the Nany new resident be prior meeting and simplemented and/of attempt with R210. himself and activities minutes were recorrinterventions should plan. LSW-C stated been wandering interventions could be behavior rounds. During interview on stated he had just be behavior of wander earlier that day. He R210 in activities as stated he tried to have the resident since the resident since the resident since the resident since we behaviors/ intervent rounds were communicated the intervent rounds were communicated to meeting, however, update the intervent rounds were communicated the intervent rounds were communicated the some side of the stated the intervent rounds were communicated the some side of the stated the intervent rounds were communicated the some side of the stated the side of the stated the side of the stated side of the side	ore fidgety, and R210's ly a result of her attempting to ething to the staff. 12/9/15, at 2:27 p.m. licensed ')-C, stated the facility's ok place at least once monthly often to meet resident needs. NAs and other staff discussed ehaviors observed since the hared successful interventions r suggested interventions to LSW-C stated between es director (AD)-A, meeting ded and successful dhave been added to the care dhe was not aware R210 had to other resident rooms and didiscussing this subject during section of R210's ing into other resident rooms as stated staff try to engaged as much as possible. AD-A ave R210 participate in three r week, and although R210 did ate in activities, staff would it parallel with the other digive her a cup of coffee to he led the behavior round nursing was responsible to 's written plan of care with any erventions discussed. AD-A ions shared at the behavior unicated to all other staff via a ok and/or via the nurses	2 830			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00893	B. WING		12/1	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, M	_			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	During interview on stated he was a pri routinely worked wi often went into othe just done so about "She went into that have to watch her attention." NA-J st residents, but had R210 was actually facility did not do the other residents ofter R210's wandering ir routinely wandered door. During interview on stated any behavior should be included intervention on how DON stated all resignation however, he was nother resident room resident on that unitary aperson-centered may be written to the facility of th	in 12/10/15, at 4:20 p.m. NA-J mary staff on the unit and he th R210. NA-J stated R210 per resident's rooms and had 10 minutes prior. He stated, room and stood up so [we] . she really need[s] one-to-one ated R210's locked unit had 20 only two aides. NA-J stated a one to one resident but the last type of care. NA-J stated an became annoyed with into their rooms and she into any room with an open on the care plan including the value to address the behavior. The dent's on that unit wandered, of aware R210 wandering into the sany more than any other it.	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00893	B. WING		12/1	0/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA I	REHABILITATION ANI	D LIVING CENTEI 3000 4TH ANOKA, N				
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2 830	within 30 days. The be involved in deve order to promote at self-determination a SUGGESTED MET director of nursing (inservice nursing st standards of practice).	re plan if no resolution was met to interdisciplinary team was to elopment of the care plan, in utonomy, dignity, and participation. THOD OF CORRECTION: The (DON) or designee could taff regarding the current ce for care of a dialysis, and I residents, then audit to	2 830			
2 895	ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. MN Rule 4658.0525 Subp. 2.B Rehab - Range of		2 895			1/18/16
	Motion Subp. 2. Range of that is directed towathrough positioning implemented and not comprehensive resof nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the tursing care plan which				
	receives appropriat	th a limited range of motion to treatment and services to notion and to prevent further of motion.				
	This MN Requirements	ent is not met as evidenced				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVE COMPLETED				
		00893	B. WING		12/1	0/2015
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2 895	Based on observation review, the facility frange of motion (Pfexercises as directed therapies, for 1 of 1 for range of motion) Findings include: R208's significant of (MDS) dated 9/30/1 was severely impaint assistance for active functional limitation upper extremity. R208's Care Area Area Area Area Area Area Area A	on, interview, and document ailed to implement passive ROM) and upper extremity ed upon discharge from residents (R208) reviewed (ROM). Change Minimum Data Set 5, identified R208's cognition red, required extensive to total ities of daily living, and had a in ROM to one side of her Assessment (CAA) dated "Resident on hospice, e over time. Have resident ties of daily living] as able Insfers; not able to weight bear the CAA did not address		corrected		

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ige 30	2 895			
	of left hip with routing displaced greater to Closed fracture of the s/p ORIF [status-position] fixation (surgical proproximal end of right healing."	outine healing. Closed fracture ne healing- minimally rochanteric avulsion fracture right hip with routine healing ost open reduction and internal ocedure)]. Closed fracture of ht humerus with routine				
	R208's care plan dated 10/2/15, directed PROM to both upper extremities (UE) and lower extremities (LE), with three repetitions each, during morning cares. The care plan also directed, "ROM program for both UB [upper body] and LB [lower body] once per day following worksheets in her closet" The worksheets in R208's closet, as referenced in the care plan included the following: An Upper Extremity ROM Program form (undated) directed PROM exercises to R208's fingers, wrists, elbows, and shoulders, with 20 repetitions to each area, one to two times daily. This form was signed by certified occupational therapy assistant, licensed (COTA/L)-A.					
	The Lower Extremity ROM Program form dated 8/4/15, directed PROM exercises to R208's ankles, knees, legs and hips, with five to 10 repetitions, one time daily. This exercise program was directed by physical therapy assistant (PTA)-A.					
	A letter dated 12/8/15, submitted to the survey team by family member (FM)-B (R208's legal representative) indicated, "[R208] was in rehab for about 6 [six] weeks and then we were told she was not progressing and would have to transition to long term care. We asked for ongoing PROM which has not occurred. We had some concerns about her care in rehab and it had more to do					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00893	B. WING		12/1	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	DAINING CENTER 3000 4TH	AVENUE			
ANOKA	REHABILITATION AND	ANOKA, I	IN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 31	2 895			
	with their commitme	ent to helping my mom ney were giving up on her."				
	During a telephone interview on 12/8/15, at 8:54 p.m. FM-B stated she was concerned her mother not receiving PROM as ordered by therapy, and felt R208 needed this to remain comfortable.					
	R208's Documentation Survey Report (charting of ROM services) from 9/1/15, through 12/9/15, detailed the following regarding her ROM services.					
	In 9/15, R208 received PROM to her upper and lower extremities 21 out of 30 days (70% of opportunities), with no PROM noted on six days, and no data for the remaining three days. In 10/15, R208 received PROM eight out of 31 days, with no PROM noted on 22 days, and no data for the one remaining day. In 11/15, R208 received PROM five out of 30 days, with no PROM noted on 23 days, and no data for the remaining two days. In 12/15, R208 received PROM during one out of nine days, with no PROM noted on eight days.					
	R208's morning car and NA-I. The NAs during cares, holding push and/or pull he observed to moan a NA-H and NA-I con R208 to say this du demonstrated indice with dressing of bot application of her se with putting her arm her hand over her f	on 12/10/15, at 9:50 a.m. res were observed with NA-H is turned R208 side-to-side ag her hips and shoulders to r to either side, R208 was and say, "Owe, owe, owe." If irmed this was typical for ring cares. R208 also ations of pain and discomfort the her UE and LE. During weatshirt, while assisting her as into each sleeve, she held ace and moaned. She also h lifting each leg into her				

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00893 B. WING 12/10/201	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	ME OF PROVIDER OR SUP
ANOKA REHABILITATION AND LIVING CENTEI 3000 4TH AVENUE ANOKA, MN 55303	NOKA REHABILITATIO
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPARISON OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPARISON OF CORRECTION (X6) (EACH CORRECTION SHOULD BE COMPARISON OF CORRECTION (REFIX (EACH DEFI
2 895 Continued From page 32 pants. No PROM or any other exercises were provided to R208 during her morning cares. During interview on 12/10/15, at 1:45 p.m. NA-H stated R208 was supposed to receive ROM, "But she is so painful, you move her arm and then she's 'owe, owe." NA-H stated, R208 demonstrated these indications of pain/ discomfort whenever she moved her feet, arms, legs, and when turning her side-to-side in bed. NA-H stated she had not spoken specifically to the charge nurses about not providing ROM because of R208's pain, however, NA-H stated all staff were aware of R208's pain and ROM exercises were not being implemented as a result. During interview on 12/10/15, at 2:15 p.m. registered nurse (RN)-A stated she was R208's nurse manager and was responsible for developing care plans and monitoring implementation. RN-A was unsure whether R208 was supposed to receive ROM services, and stated any ROM programs that were in place were typically placed inside each resident's closet door and NAs were prompted to document the exercises in the facility's electronic medical record system. RN-A stated R208's pain levels were evaluated via observation of her non-verbal's. She indicated she watched resident cares routinely and during her observations of turning' dressing R208, she felt the moans and/or non-verbalizations observed had more to do with being scared than with concerns of pain. RN-A stated NAs were to report to nursing if a resident who was supposed to receive ROM services was not being provided with the services for any reason. RN-A stated she had not been informed R208 was not receiving ROM as directed by	pants. No PF provided to R. During interviors stated R208 with she is so paint she's 'owe, own demonstrated discomfort whilegs, and when NA-H stated so the charge numbecause of R. staff were away exercises were result. During intervior registered number managed developing call implementation was supposed stated any RC were typically door and NAs exercises in the record system were evaluated non-verbal's. cares routined turning/ dress non-verbalizated non-verba

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY		
		00893		B. WING		12/1	10/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTEI	3000 4TH ANOKA, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 895	Continued From page 33			2 895			
	3:30 p.m. physical raseated in her whee to her. PT-A manip extremities and bila confirmed she foun limitations in any exhad shown no evide her discharge from reassessment, R20 symptoms of pain, the PT-A and FM-A denied any concern with movement of R208 did not currer staff and stated RC discontinued upon However, PT-A statemany to ensure the PROM services to During interview on director of nursing expectation for staff care plan.	and interview on 12, therapist (PT)-A reas ange of motion. R20 Ichair with FM-B sea oulated R208's bilate ateral lower extremiting and current function attermity. PT-A report ence of declined RO therapies in 8/15. Days demonstrated not and she communicated during the assessments of pain upon inquite ach extremity. PT-Antly require ROM serom orders should have R208's admission to the staff had not not in the resident did not recontinue for comfort. In 12/10/15, at 4:35 p. (DON) stated it was if to implement each addressed ROM serom provided.	sessed 8 was sted next ral upper es and nal ted R208 M since During this sighs or ted with sent and ry and A stated vices from we been hospice. fied equire any . m. the his resident's				
	SUGGESTED MET director of nursing si inservice nursing st of the care plan to	FHOD OF CORREC (DON) or designee of taff regarding implent include completing re and then audit to er	ould nentation ange of				
	TIME PERIOD FOI (21) days.	R CORRECTION: TV	venty-one				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00893	B. WING	B. WING		0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a nursing services development of a nursing services development of a nursing services that: A. a resident who without pressure sure sores unle condition demonstrate authenticates, that B. a resident was received necessary.	sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and tho has pressure sores y treatment and services to revent infection, and prevent veloping.	2 900			1/18/16
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the resident's skin for an appropriate turning/ repositioning schedule, and failed to implement interventions which had been assessed to prevent further pressure ulcers from developing and/ or to promote healing of current pressure ulcers for 2 of 3 residents (R208 and R19) reviewed who were identified with current pressure ulcers. This resulted in actual harm for R208, who developed an unstageable pressure ulcer to the second toe of her right foot. Findings include: R208's significant change Minimum Data Set (MDS) dated 9/30/15, identified severe cognitive			corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		00893	B. WING		12/1	0/2015
-	PROVIDER OR SUPPLIER REHABILITATION ANI	3000 4TH	AVENUE	STATE, ZIP CODE		
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2 900	impairment, require for activities of daily stage two pressure thickness loss of dopen ulcer with a reslough), and two-u (unable to measure to eschar or scabbi assessment. R208's Care Area A 9/30/15, identified F declining and that to hospice services included severe cogincontinence, immorantidepressant med "Does have capabil bed." Although the capabale of turning individualized comprompleted which id to turn without staff R208's Medication orders) signed 12/2 including: demential obstructive pulmonatornoric respiratory was admitted to hose a terminal diagnosis Physician orders di minimize R208's riscurrent pressure ulcers and barrier cream post	ed extensive to total assistance of living, had developed one- ulcer (defined as partial permis presenting as a shallow ed-pink wound bed without enstageable pressure ulcers a depth of pressure ulcer due eng) since the prior Assessment (CAA) dated R208's overall condition was the resident had been admitted. Risk factors identified entitive deficit, poor nutrition, obbility, and the use of dication. The CAA indicated, lity of turning side to side in CAA indicated R208 was in bed, there was no orehensive assessment entified the resident was able	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		o. ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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2 900	chair; Twice daily sl Achilles, contacting with any concerns is and Achilles off bed Manager, with no pin her wheelchair at Keeping the necroti Achilles open to air gripper socks only be covering her heels. R208's care plan dakeep heels elevated assuring heels were staff to boost up in repositioning, R208 relieving devices in mattress for her befor her chair and a The care plan indictendency to remove manager or off the when up in the Broand assistance to keep heels elevated assuring heels were staff to boost up in repositioning, R208 relieving devices in mattress for her befor her chair and a Review of R208's Ward from 9/1/15, through following descriptions on 9/30/15, superficial, but open the area was not size and showed not size an	kin checks to heels and the nurse practitioner (Nodentified; Elevating both I at all times using a Heeressure on her heels whind no shoes to be worn; ic areas on her left and rito keeping them dry; Planalf-way onto her feet and due to the pressure ulcer ated 10/2/15, directed standard on pillows at all times, enot touching anything, the dor with any major required multiple pressure ulcuring an alternating preducing an alternating preducing an alternating preducing an alternating preducing the heels from the heel pillows that elevate her heal chair. Needs reminded heep heels elevated." Weekly Wound Documenth 12/10/15, revealed the nof the pressure ulcers: ressure ulcer acquired for measuring 1.8 cm by 1 no area, with 100% granulataged, but was decreasing the standard for the pressure ulcareasing taged, but was decreasing the standard for the pressure ulcareasing taged, but was decreasing the standard for the pressure ulcareasing taged, but was decreasing the standard for the pressure ulcareasing taged, but was decreasing the standard for the pressure ulcareasing taged, but was decreasing the standard for the pressure ulcareasing taged, but was decreasing the standard for the pressure ulcareasing taged.	heels I Lift le up ght cing d not s. Iff to wo ure essure evice s. re a eels ers tation .5 cm ation. ng in d cm, d, but s of ed			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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2 900	cm, with 100% escl but was decreasing of infection. During observation was seated in her Enallway, near the number of the foot pedals to however, R208 was the floor out in front self-propelling her wher feet out in front heels to the floor ar and the backs of he bumping the foot pegauze dressing was lower ankle/ heel ar gauze or dressing of During a telephone p.m. family membe concerned about R the facility should he this risk for develop and to promote head ulcers. FM-B state turning and repositi which the facility was During observation was lying on her lef propped on both sign op pillows or device and both heels were At 8:22 a.m., R208 and her right leg was left side of the bed. against the bed with	nar. The area was not staged, in size and showed no signs on 12/8/15, at 7:00 p.m. R208 Broda wheelchair in the urse's station. She had on ack canvas shoes on both feet, her wheelchair were in place, is observed resting her feet on	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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ANOKA	REHABILITATION ANI	ANOKA,	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	(NA)-I entered R20in bed. NA-I stated over the side of the so she was lying flat devices were put in and they were layinhad regular white siright, lower ankle as however, there was left foot/ ankle. NAwere resting on the ate breakfast in becares until after she R208's room and diresidents heels offit was awake and remopillows or device and both heels were of her bed. During observation R208 was lying in hwere no pillows or cheels. At 8:17 a.m. her back with both lobserved resting directions.	ge 38 8's room and boosted her up R208's legs were hanging bed so they repositioned her it on her back. No pillows or to place to float R208's heels, g directly on the bed. R208 ocks on both feet, and her rea was wrapped with gauze, in odressing in place on the -I stated R208's bilateral heels mattress, and R208 typically d and did not receive morning e ate. However, NA-I left id not attempt to float the the bed. At 8:55 a.m., R208 nained lying flat in her bed with es in place to float her heels, e still resting on the mattress on 12/10/15, at 8:05 a.m. er bed on her back, and there devices in place to float her , R208 continued to lay flat on knees bent and her feet were rectly on the bed. She was ite socks to both feet and				
	white gauze was ob- lower ankle/ heel ar the left. A black he	oserved around only her right rea, and there was none on el floating cushion was etween the nightstand and the				
	wall to R208's right a.m., NA-H entered with eating her brea of the bed to approx remained on her ba the balls of her feet against the footboa	side in her room. At 9:40 I R208's room to assist her akfast. NA-H raised the head ximately 60 degrees and R208 ack with both knees bent and and toes were pressed rd of her bed, with her heels attress. There were no pillows				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, N	_			
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2 900	Continued From page 39		2 900			
	During observation NA-H and NA-I con While providing car assistance from bo side-to-side while ir one side of the bed opposite side. The shoulder and hip ar and/or push her aw proceeded to provid stated they were not pressure ulcers. Brace and around he exposed, dark brown Achilles tendon are red skin surrounding the top of her second tendon area, a dime observed, and there scabbed area to the top of the second to carefully applied the wrapped around Race and at one point, or directly over the optendon. Once dress she need her shoes sometimes wore the not, however, NA-H canvas shoes.	on 12/10/15, at 9:50 a.m. impleted R208's morning cares. res, R208 required extensive with NA-H and NA-I to turn from in bed, with NA-H standing on I and NA-I stood to the regret by each braced R208's reas to pull her toward them way from them as they de cares. NA-H and NA-I of aware R208 had any current of the NAs proceeded to change and R208 had gauze right foot rested below an winder by black scab to her right rea. A scabbed area, with deeping the area was observed to indice. On her left Achilles resized open area was reddened. NA-H regist sock over the gauze 208's right lower ankle/ heel reddened in the of her fingers was observed in the left ankle/ heel area in the of her fingers was observed in the left ankle/ heel area in the seed, NA-I asked NA-H, "Does is "NA-H replied that R208 re shoes and other times did in the proceeded to apply black proximately 10:45 a.m. in the left in the left ankle/ here area to R208's in the left ankle/ here area to R208's left Achilles researched to apply black proximately 10:45 a.m. in the left ankle/ here area to R208's and other times did in the proceeded to apply black proximately 10:45 a.m. in the left ankle/ here area and the regret register and the regret R208's and other times did in the proceeded to apply black and the register and register and regret R208's a				
	room and stated he R208, however, he	e was not very familiar with reviewed the residents at record and stated R208 was				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA I	REHABILITATION ANI	O LIVING CENTEI 3000 4TH ANOKA, I	_			
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2 900	not due for any treat resident had an in-quitoe, which required ointment. LPN-A reapplied ointment to to re-apply the sock were any other opethe left foot. LPN-A gloved hand over the left foot. LPN-A gloved hand over the left foot. LPN-A gloved hand over the left heel, and Right heel lift manager," prevent further presente black heel floating R208's nightstand a cushion was to be in was in bed and statulcers, "would define were not being floating every residents electronicate the nurses were expected white crossing her foot was observed proposite ankle area R208's feet/ heels at the later than the later and the later and a wrap on. Dure peatedly crossed while crossing her foot was observed proposite ankle area R208's feet/ heels at the later and th	treatments at this time but the grown toe nail to her left great a topical antibacterial emoved R208's left sock and that area. As he proceeded to he was asked whether there in areas or skin breakdown on a examined the foot running his to back of her foot when he is on her Achilles area. Upon electronic treatment record, if a stage 2 pressure ulcer on 208 was supposed to have a at all times when in bed to esure, which he confirmed was and cushion tucked between and the wall. LPN-A stated the in place at all times while R208 ed the residents pressure itely get worse," if her heels ed from the bed. He stated bected to check the cushion time R208 was in bed, and the treatment record prompted off this was being implemented LPN-A stated R208's so directed the evening shift sings to both R208's heels, of sure why only the right heel ring this observation, R208 one foot over the other, and eet, the Achilles area of the ed resting on the top of the LPN-A inspected both and stated the area to her right new area as he did not see it	2 900	DEFICIENCY		
	however, LPN-A sta	residents treatment record, sted he would have an RN ents room to assess the				

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pressure ulcers.

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2 900	Continued From page 41		2 900				
	manager) and RN-R208's room to assulcers. RN-A and Fulcers both R208's following results: Site #1: Left heel, co.3 centimeters (cn. Site #2: Left Achille last assessment buand was now an opo.8 cm, with granul stage 2. Site #3: Right Achill measuring 0.8 cm I Site #4: Right seco scabbed area measuring assumers.	21 a.m. RN-A (nurse H (wound nurse) entered sess the residents pressure RN-H assessed all pressure feet/ heels and reported the dry scabbed area measuring n) by 0.4 cm, unstageable. s, was a scabbed area upon at the scab had since fallen off ben area measuring 0.8 cm by ation noted around edges, dry scabbed area by 1.0 cm, unstageable. It is, dry scabbed area by 1.0 cm, unstageable. It is, dry scabbed area by 1.0 cm, unstageable. It is in the scab had since fallen off ben area measuring 0.2 cm, with ing tissue measuring 0.3 cm,					
	RN-A stated sites #1, #2 and #3 were improving from past assessments, but stated the pressure ulcer to R208's right second toe (site #4) was new. RN-A stated R208's family had recently brought new shoes in for the resident, and she had just, "had the nurse practitioner change the order" for no shoes on 12/9/15, so R208 could wear the shoes the family had brought in. RN-A placed the black canvas shoe next to R208's right foot and compared the newly identified pressure ulcer to the shoe and stated it appeared the shoes were the cause of the new pressure ulcer. RN-A stated she was going to clean the area, wrap it with Kerlix, and have the NP look at it on 12/11/15, and R208 had slippers she could wear in the meantime. RN-A stated on 12/9/15, she had the NP remove the physician order that directed the resident was not to wear shoes because family had brought in the new black						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA,	AVENUE MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	stated the facility not R208's pressure and RN-A stated R208's turned away and/or resident was self-pithe foot pedals coupressure ulcers on stated R208 did not repositioning scheet to independently michanges to her positioning scheet to independently michanges to her positioning scheet to independently michanges to her positioning scheet (TAR) from 9/1/15, the following: Starting on 10/16/1 Tefla/ non-adherent and wrap with Kerli indicated this treatmoutinely as ordered Starting on 9/11/15 [bilateral] heels off heels when up in with until resolved to Bil opens or any concentreatment was admiand no refusals we Starting on 9/17/15 daily] skin checks twith any concerns a prevention." The Twas administered refusals were noted Starting on 9/17/15 TAR directed, "Hee elevated heels and Every shift." The Tax directed in the Tax and Every shift." The Tax and	at a week prior for R208. RN-A curses were to observe all of eas during each evening shift. It is foot pedals should have been removed any time the ropelling in the wheelchair as ld resulted in bumping the her bilateral Achilles. RN-A trequire a turning or dule and the resident was able aske significant, prolonged aitioning. Treatment administration record through 12/10/15, identified 5, the TAR directed, "Apply transing to both heels sores and the resident was administered and no refusals were noted. The t				

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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, N	_			
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2 900	TAR directed, "Place feet only- do not conceivery shift." The Trefusals, however, administered routing Review of R208's manual shifts of R208's manual	d., and ending on 12/9/15, the ce gripper socks 1/2 way onto over heels due to wounds. AR noted a few, sporadic overall this treatment was lely as ordered. Sursing progress notes from 10/15, identified the following: a lacked evidence of R208 ares or treatments of the calcade are shoes provided by the canvas shoes provided by the could wear shoes to prevent cers from developing. In a lacked any notation of FM-B's on have a two hour turning and	2 900			
	stated R208 require turn her from side-t however, if she was staff could turn her able to turn her bot pressure independe aware of any curren NA-H stated she ty stated she was no	12/10/15, at 1:45 p.m. NA-H ed two staff to reposition and to-side while lying in bed, is lying on a draw sheet, one NA-H stated R208 was not tom side-to-side to offload ently. NA-H stated she was not nt pressure ulcers for R208. pically repositioned R208, but the directed to do this, but justing that should be done. NA-H				

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ANOKA	REHABILITATION ANI	D LIVING CENTEI 3000 4TH ANOKA, I	AVENUE MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	stated she typically between 6:30 a.m. 10:30 a.m., when siget dressed and up NA-H stated she hamorning, and she braised the head of the breakfast, but did in position. NA-H was repositioned througunable to state how her back, but confir hours, from 6:30 a.s sure how long R208 black canvas shoes been more than a vibrated she was R20 responsible for comand the developme interventions. RN-A pressure ulcer to R foot was an unstage which had develope shoes brought in by R208 had not been whether the shoes risk for skin breakd shoes. RN-A stated wear the shoes so the order. RN-A stated wear the shoes so the order. RN-A stated on this unit in 9/15. area to her left heel 9/30/15, and stated floated with a heel I was lying in bed. R	repositioned R208 one time when her shift started, and taff typically assisted R208 to in her wheelchair. However, ad not repositioned R208 that costed R208 up in bed and he bed for her to eat ot turn her to a different of turn her to a different of turn her to a different of some sure whether R208 was hout the night, so she was a long she had been lying on med it was at least three m. to 9:40 a.m. NA-H was not a had her been wearing the some should be she was a long she had she knew it had week.	2 900			

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2 900	bilateral heels were dressing, however, feet around a lot an area could have fal RN-A stated R208 repositioning sched around independent turning and reposition she would need to determine how it wanot require a turning RN-A stated she waperson with a draw assist, with turning incontinence cares. don't know. She more get her up and they in the Broda chair." "offload" was referr when R208 was nonecessarily provide RN-A stated the fact developing a timeling and would provide in However, at the time no assessment of Frepositioning sched was provided. During interview on director of nursing (implement each resphysician orders. It aware of R208's net to her toe, and he selegal guardian's wis However, the DON staff to educate R2	n in bed. RN-A stated R208's to be wrapped with a she stated R208 moved her ad the dressing to her left heel len off throughout the night. It was not on a turning and lule, and she felt R208 moved atly and did not require a oning schedule. RN-A stated review R208's assessments to as determined the resident did g and repositioning schedule. The as unaware R208 required one sheet, or two persons to side-to-side in bed during. RN-A stated, "I guess I really oves a lot herself They do offload her and reposition her RN-A stated her reference to ed to the time during transfers t seated or lying, which did not sufficient pressure relief. Ellity was still working on the of R208's pressure ulcers, it once it was completed.				

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ANOKA	REHABILITATION ANI	O LIVING CENTE! 3000 4TH ANOKA, M				
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2 900	to abide by the physrecord, however, he did not show any edwere provided. During interview on 5:45 p.m. the MDS facility did not do tis assessment used to ability to withstand plonger the standard suggested tests suddetermination of a rof turning and reposstated the facility as appropriate turning adjusting the sched resident skin was congoing basis, and to the nurse for furt the RN's adjusted the schedule as needed there was no assesse valuated for an aprepositioning sched. R19's quarterly MD R19 had moderate extensive assistand frequently incontine care, and was at risulcers, but did not hulcers. The MDS in pressure reducing resided.	sician's order in the medical estated R208's medical record ducation on wearing the shoes 12/10/15, at approximately coordinator reported the sue tolerance testing (an individually assess the skins pressure) as this was no of practice and research that as this were not effective in resident's need for frequency sitioning. MDS coordinator assessed residents for an or repositioning schedule by the as concerns arose, and hecked with all cares on an and any concerns were reported ther assessment. She stated the turning and repositioning the d. MDS coordinator stated sment R208's skin was propriate turning and	2 900			
	10/28/15, included a Braden and Skin Ri	erly Data Collection dated a Tissue Tolerance and sk Data Collection. The assessment lacked direction on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, I	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	how often R19 shor sitting, and the assiable to make freque bodily positions ind assistance with ma Skin Risk Data Colrisk for developing frequently incontine mobility, friction, and R19's Nurse Month 11/18/15, indicated assistance with bed R19's electronic ca 12/8/15, and the carisk for alteration of incontinence and preded more assis Interventions include mattress on bed, prochair, inspect skin or reposition every two incontinence. During constant ob a.m. through 9:09 as sleeping on her bactilted slightly to the repositioning by stachanges in position of time. On 12/9/15, at 9:16 room with a breakfathe head of R19's breakfathe head of R19's breakfathe with R19's et up R19's breakfathe breakfathe with R19's breakfathe head with R19's breakfathe with R19's breakfather with R19's br	uld be repositioned lying or essment indicated R19 was ent and minor changes in ependently, but required staff jor changes. The Braden and lection indicated R19 was at pressure ulcers due to being ent, chairfast, slightly limited in ad shearing.	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00893	B. WING		12/	10/2015
	PROVIDER OR SUPPLIER REHABILITATION AN	D LIVING CENTER 3000 4TH	DDRESS, CITY, S I AVENUE MN 55303	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	time. During interview on stated her butt was little, however, R19 herself and continu was continuously of the same position of the beginning because NA-A, "For R19's head of the beginning because NA-A, "For R19's head of the beginning to roll but could not NA-A used the the assisted R19 to her needed help with rewere observed at the white cream. NA-A of R19's buttocks, a areas about the siz buttocks, and a quator her left inner button of the open areas. The treatment record in 12/7/15, which instright buttock pression of the same disaller of the same position.	12/9/15, at 9:36 a.m. R19 sore and needed to move a did not attempt to reposition ed to eat her breakfast. R19 bserved eating breakfast in intil 9:54 a.m. with no 12/9/15, at 9:57 a.m. NA-A igned to care for R19. NA-A be repositioned every two e had not been repositioned of her shift at 7:00 a.m. rgot." NA-A than lowered bed, unfastened her, and asked R19 to role to her bed the left grab bar and tried move herself to her side. draw sheet on the bed and reft side. NA-A stated R19 epositioning. R19's buttocks his time and was covered in a a washed the white cream off and R19 had two small open e of a dime on her right inner arter size blanchable red area	t 📗			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B. WING			
		00893			12/1	0/2015
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S I AVENUE	STATE, ZIP CODE		
ANOKA	REHABILITATION ANI	DIIVING CENTEL	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	to the right buttock, were not communic. On 12/9/15, at 10:1 room with a measure not aware R19 had stated the residents facility on 12/7/15, hospice notes yet. ulcers and the upper centimeters (cm) x area measured 0.5 both area's were sured the red area or measurable as it has when interviewed to 1:17 p.m. RN-B hosposerved a 1 cm probuttocks on 12/7/15 the pressure ulcer and during her visit, and nurse, RN-C, prior an order to cleanse a foam dressing data. A review of the hosposerved to cover the pressure to cover the pres	and R19's pressure ulcer(s) cated. 7 a.m. RN-A entered R19's ring tool and stated she was any pressure ulcers. RN-A is hospice nurse was in the out she had not reviewed the RN-A measured the pressure or area measured at 0.6 0.5 cm, and the lower open cm x 0.6 cm. RN-A stated uperficial and had no drainage, in the left buttock was not ad completely faded. Via telephone on 12/9/15, at spice nurse stated she ressure ulcer on R19's right 5. RN-B stated she cleansed and applied a foam dressing it then she updated the facility to leaving the facility and wrote the pressure ulcer and apply				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00893	B. WING		12/1	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From page 50		2 900			
	able to relieve pres	sure by moving independently.				
	dated 12/9/15, incluwith RN-A were in hand were both super R19's medical recorderance and and developed pressure R19's care plan was indicated R19 had evidenced by two suttocks. The care want to be awakener R19 was able to turbars adequately for	ly Wound Documentation uded the open area's observed house acquired on 12/7/15, erficial stage 2 pressure ulcers. It lacked an updated Tissue analysis of the newly erulcer discovered on 12/7/15. Is updated on 12/9/15, and an alteration in skin integrity as uperficial open areas on right plan indicated R19 did not led to be turned/ repositioned, reform side to side using grab or pressure relief, and R19 just with boosting up in bed				
	RN-A stated she had and had learned RI ulcer to RN-C follow stated she had upod physician regarding she had not notified the pressure ulcer. R19 and felt that she with the use of the had also updated F plan on 12/9/15, as to be awakened to stated she was awareposition herself a RN-A stated she discussoregarding not being	on 12/10/15, at 8:20 a.m. ad spoken to hospice RN-B N-B reported the pressure wing the visit on 12/7/15. RN-A lated the family and the goather than the pressure ulcer, however, do any other facility staff about RN-A stated she observed he had repositioned herself grab bar on her bed, and she R19's Braden Scale and care R19 told her she did not want be be repositioned. RN-A lare R19 does not always as she was weak and forgets. In the goather than the goather tha				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00893	B. WING		12/10/2015		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-		
ANOKA	REHABILITATION ANI	D LIVING CENTEI 3000 4TH ANOKA, N					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 51	2 900				
	she document the r	isk vs benefits were reviewed.					
	stated RN-B from helper developed a pressurant gave a hospice foam dressing daily she processed the or notify RN-A regardevelopment. RN-I repositioning to relied one at least every sleeping. During follow up int p.m. RN-A stated the assessment lacked should be reposition RN-A further stated assessment incorred MDS nurses to detect the assessment incorred model to the complete the assessment incorred to the complete the assessment indicated two hours the care plan previoupdated on 12/9/15	12/10/15, at 9:55 a.m. RN-C cospice had reported R19 had are ulcer on her right buttocks to order to cleanse and apply a rand as needed. RN-C stated order, but failed to document rding the pressure ulcer B stated R19 needed help with eve pressure, which should be two hours, regardless if she is erviewed on 12/10/15, at 2:02 ne 10/28/15, Tissue Tolerance direction on how often R19 ned while sitting and/ or lying. I she could be doing the ectly and would check with the ermine the correct way to ssment. RN-A stated the essessment should have a for repositioning for R19, as ously read before it was increased.					
	director of nursing (inservice staff rega plan to ensure appr	THOD OF CORRECTION: The (DON) or designee could rding implementation of a care ropriate treatment of pressure dit to ensure compliance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BUILDING.			
		00893	B. WING		12/1	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	DIVING CENTEL	I AVENUE MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	Subp. 5. Incontine have a continuous management to recunnecessary use o comprehensive reshome must ensure A. a resident without an indwellinunless the resident that catheterization B. a resident wireceives appropriate prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: the enters a nursing home of catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder the treatment and services to infections and to restore as ler function as possible.	2 910			1/18/16
	by: Based on observation review, the facility fassess and implement promote continence reviewed for urinary. Findings include: R211's admission Mated 11/25/15, ide cognition, required toileting, was not or program, and was abladder. R211's Nur Day 4 F	ent is not met as evidenced ion, interview and document ailed to comprehensively nent care plan interventions to e for 1 of 1 residents (R211) y incontinence. Minimum Data Set (MDS) ntified R211 had intact extensive assistance with a scheduled toileting frequently incontinent of Post Admission assessment ntified R211 to be, "Always		corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00893	B. WING		12/1	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD 3000 4TH	, ,	STATE, ZIP CODE		
ANOKA	REHABILITATION ANI	DIIVING CENTEL	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	assistance to use the provided a section of urinary patterns," and identify intervention incontinence which "Scheduled/Habit To "Check and Change "Training to return to and; "Prompted Voiding. However, none of the and were left blank analysis of the asseas, "Patient [R211] occasionally inconting assessment did not reversible causes of any collected patter interventions to proceed the patter interventions to proceed the patter intervention will return." Space to include resease to inc	dder and required extensive ne toilet. The assessment to document, "Comments on and check mark boxes to as to help R211 manage his included the following options: foileting Plan," he Program," o previous pattern/retraining" hese fields were completed, on the assessment. An assessment was only documented is incontinent of bladder and inent of bowel." The tidentify any potentially of R211's urinary incontinence, and of voiding, or any mote continence for R211. Intinence and Indwelling and Assessment (CAA) dated "Res [resident] is incontinent abladder] unknown if his "Further, the CAA provided a sident and family input on eds, however this space just ew." The CAA identified ould be developed to slow or es, avoid complications, and of urinary incontinence. The vany collected patterns of reventions to promote 1.	2 910			
	intervention of, "Toi	adder, and identified an let upon rising, before and our of sleep] and prn [as				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00893	B. WING		12/1	0/2015
-	PROVIDER OR SUPPLIER	3000 4TH	AVENUE	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	needed]." During observation 7:05 a.m. R211 was assistant (NA)-E prestroom. R211 ha which was soiled w NA-F assisted R21: then assisted him ir in front of the vanity finished his morning the dining room tab attempt to toilet R2 directed by his care. When interviewed a stated R211 was ty is usually saturated. "Normally wet in the NA-E stated R211's bedding were satur when she helped his stated she helps R2 hours," and did not morning upon rising directing staff to, be would say he didn't. During interview on stated she had help just a few days prio [incontinent] when we the NA staff do not for his voiding, but it adding, at times, R2 placed on it.	of morning care on 12/9/15, at solving in bed, while nursing epared a wash basin in the don an incontinence pad ith urine and stool. NA-E and 1 to his wheelchair, and NA-E nto the restroom, placing him of to brush his teeth. R211 grares, and was assisted to ble for breakfast. No offer or 11 was provided by staff as a plan. on 12/9/15, at 7:47 a.m. NA-E pically incontinent of urine, and with urine in the morning, e morning, every morning." It is incontinence pad and atted with urine this morning im with morning cares. NA-E 211 to the bathroom, Every two offer toileting to R211 that gray despite his care plan ecause she thought R211	2 910			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00893	B. WING		12/1	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANOKA	REHABILITATION AN	D LIVING CENTEI 3000 4TH ANOKA, M	_			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 910	void, but was unaw being assisted with charting the NA sta were several record voids for R211. RN bladder assessmer further documentat supporting an asse finished (referencind don't know what to During interview on stated R211 was, "bladder," and at timuse the restroom. use the toilet if gives scheduled toileting assisted upon rising after meals, at bed comprehensive assincluded a summar "Identify a pattern if RN-F stated R211 toileting schedule, should be physicall bathroom during the plan because R211 and it would attemp doesn't lose his abit A facility policy on the scheduled toileting provided. SUGGESTED MET director of nursing inservice nursing scomprehesnively as comprehesnively as comprehesnively as several records.	rare if R211 would void after toileting. RN-G reviewed the ff completed and stated there ded episodes of continent II-G reviewed R211's Nur Day 4 and and stated there was no ion she could locate assment of R211 had been ag the blank areas identified), "I tell you." 1 12/9/15, at 12:47 p.m. RN-F Frequently incontinent of the could verbalize his need to R211 was physically able to the assistance, and was on a plan which included being g in the morning, before and time and as needed. R211's sessment should have by of his recorded voiding to, and staff y helping R211 to the etimes identified on the care was a post stroke patient, but to retrain his bladder, "So he lity." Dladder incontinence and was requested, but none was a frequency for the could taff regarding how to sees and develop luce incontinence, and then	2 910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00893	B. WING		12/1	0/2015
	PROVIDER OR SUPPLIER	3000 4TH	AVENUE	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 56	2 910			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 920	MN Rule 4658.0525	Subp. 6 B Rehab - ADLs	2 920			1/18/16
	comprehensive resi home must ensure B. a resident who activities of daily livi	is unable to carry out ng receives the necessary good nutrition, grooming,				
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services related to incontinece care as directed by the plan of care for 1 of 4 residents (R208) reviewed who required staff assistance with toileting.			corrected		
	Findings include:					
	12/2/15, identified d	Review Report signed liagnoses including dementia, story failure and chronic pain.				
	(MDS) dated 9/30/1 was severely impair extensive to total as living including exte The MDS identified	hange Minimum Data Set 5, indicated R208's cognition red and she required ssistance for activities of daily nsive assistance for toileting. R208 was not on a toileting lways incontinent of both				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00893	B. WING		12/1	0/2015
	PROVIDER OR SUPPLIER	OLIVING CENTER 3000 4TH	DRESS, CITY, S AVENUE MN 55303	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 920	R208's Care Area A 9/30/15, identified Fincluded end stage restricted mobility, urine, urgency and toileting. The CAA toileting/or to be che to provide pericare [incontinence]. Has [incontinence]." Ali MDS assessment of was not on a toileting the resident was to Any additional bower completed on R208 were provided. R208's care plan do offer toileting to R208 were provided. R208's care plan do offer toileting to R208 were provided. During observations 7:00 p.m. R208 was for the supper meal nurse's station area hallway throughout provided check and offer use of a bedpa R208's care plan ar During continuous of 7:14 a.m. through 8 bed in her room. R2 until 8:34 a.m., whe	Assessment (CAA) dated R208 had diagnoses which congestive heart failure, was always incontinent of needed assistance with also noted, "Continue to offer ecked and changed. Continue after each incontency functional incontinency though the cooresponding lated 9/30/15, indicated R208 ng program, the CAA directed be offered toileting. Bel and bladder assessments were requested, but none ated 10/2/15, directed staff to 08 upon rising, after meals, at during the night and upon colan directed staff to either bed pan or to have two staff sistance to transfer to the assisted to the dining room and then brought back to the the evening. R208 was not I change services nor did staff an or toileting assistance as				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
	00893		B. WING		12/10/2015		
NAME OF PROVIDER OR SUPPLIER ANOKA REHABILITATION AND LIVING CENTEI STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 920	moving her legs in R208's room. Chech not observed to be not offered the use assistance. At 8:55 alone in her room. It checked/changed rentire observation. NA-H confirmed eacheck and changed at 9:50 a.m. and was changed prior to the 6:30 a.m. (approxim prior). During interview on registered nurse (Roffered the bed partier. RN-A was un on a toileting prograshould have been obasis and with care. During interview on director of nursing (expectation for staff care plan. A facility policy additionary incontinence was provided. SUGGESTED MET director of nursing (inservice staff regainservice staff re	bed and immediately exited k and change services were offered or provided. R208 was of a bedpan or toileting a.m., R208 remained in bed, R208 had not been for offered toileting for the arlier this morning, she did not R208 until her morning cares as unaware of when she was at, but confirmed it was prior to nately three and a half hours 12/10/15, at 2:15 p.m. N)-A stated R208 was to be and utilized an incontinence sure as to whether R208 was am, but confirmed the bed pan offered to her on a regular	2 920				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00893	B. WING		12/1	0/2015
NAME OF PROVIDER OR SUPPLIER ANOKA REHABILITATION AND LIVING CENTEI STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 920	Continued From pa TIME PERIOD FOR (21) days.	ge 59 R CORRECTION: Twenty-one	2 920			
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and com E. a resident he immunization progredefined in part 465 procedures of resid the prevention and F. the development of the prevention and F. the development of the products, including defined in part 4656 G. a system for products which affed disinfectants, antise incontinence product. I. methods for a current standards of the collection of the current standards of the collection of the control of the collection of the coll	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of policies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of lect infection control, such as eptics, gloves, and	21390			1/18/16
	Based on interview	and document review, the lement an infection control		corrected		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00893	B. WING		12/1	0/2015	
NAME OF PROVIDER OR SUPPLIER ANOKA REHABILITATION AND LIVING CENTEI ANOKA, MN 55303							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21390	program which incluted trending, and analyst transmission to other This had the potent residing in the facilit Findings include: Review of the facilit Log dated 2010, ided development (SD) to One sheet was avaithe following colument Resident name Admit date Room # - Unit Infection type Body site (cathete Date of onset Date culture taker Organism(s) Antibiotic resistant Antibiotic type Start date Infection definition Resident for 48 hour Classification com Classification com Classification head Date resolved Isolated (type)? Review of the infect May 2015, through identified the reside type, antibiotic, and admit. However, it	uded consistent monitoring, sis of infections to reduce the er residents in the facility. ial to affect all 118 residents ty, staff, and visitors. y's Monthly Infection Control entified a flowsheet for staff or record resident infections. ilable for each household, with ns: r?) met (Y/N) met (Y/N) purs or greater (Y/N) infected imunity thcare associated infection tion control flowsheets dated October 2015, typically ent name, admit date, infection if the infection was present on lacked consistent com number, body site, date					

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
00893		B. WING		12/1	12/10/2015		
NAME OF PROVIDER OR SUPPLIER ANOKA REHABILITATION AND LIVING CENTEI STREET ADDRESS, CITY, STATE, ZIP CODE 3000 4TH AVENUE ANOKA, MN 55303							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	and whether or not be filled out by the firacking and trending when interviewed of development (SD)-Acontrol nurse, stated or development by the physical with an inferior of the infections are tracked on the about the infections are tracked on the about the infection, is the for it, is there an interviewed. Further, so the facility or present the facility, but not recent the facility, but not recent the facility, but not recent the infection control facility, but not recent the infection and program, to ensure the facility of the infection and program, to other then audit to ensure the infection and program, to other then audit to ensure the infection and program, to ensure the audit to ensure the infection and program, to ensure the audit to ensure the infection and program, to ensure the audit to ensure the infection and program, to ensure the audit to ensure the infection and program, to ensure the audit to ensure the infection and program, to ensure the infection and program, to ensure the infection and program, to ensure the infection and program and pr	otic resistant, date relit was isolated as direllowsheet to ensure any of resident infection on 12/10/15, at 4:36 per	ected to ccurate ns. o.m. staff ction ically sm is not om the ed the ssion. Id, and to bring to stated ation of eatment uired at is it otoms are ne hich she ed from the edures oring of on could	21390			