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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W97H

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00893

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245205**
2.STATE VENDOR OR MEDICAID NO.
(L2) **261960100**

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

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

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

6. DATE OF SURVEY **12/08/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, Supervisor 12/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 12/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/08/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5205

Electronically Delivered: December 19, 2014

Mr. Doug Dolinsky, Administrator
Anoka Rehabilitation and Living Center
3000 - 4th 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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective December 2, 2014 the above facility is certified for:

120 - Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 12, 2014

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

RE: Project Number S5205025

Dear Mr. Dolinsky:

On November 4, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 23, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 19, 2014 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 October 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 2, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 23, 2014, effective December 2, 2014 and therefore remedies outlined in our letter to you dated November 4, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245205	A. Building B. Wing	12/8/2014

Name of Facility	Street Address, City, State, Zip Code
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/02/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/02/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/02/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **12/02/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **12/02/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/02/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/02/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/02/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	12/12/2014	29249	12/8/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/23/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245205	A. Building B. Wing 02 - ANOKA CARE & REHAB CENTER	11/19/2014

Name of Facility	Street Address, City, State, Zip Code
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	10/24/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/KJ	Date: 12/12/2014	Signature of Surveyor: 28120	Date: 11/19/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/23/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: W97H

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

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(L1) **245205**

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

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

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

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

6. DATE OF SURVEY **10/23/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

B. Not in Compliance with Program
X Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
LoAnne DeGagne, HFE NE II 11/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 12/08/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 4, 2014

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

RE: Project Number S5205025

Dear Mr. Dolinsky:

On October 23, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

<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.

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
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7365
Fax: (320)223-7365

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 December 2, 2014, 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 December 2, 2014 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred

between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 23, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 23, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	10/23/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to use respectful, person centered terminology when referencing residents who required eating assistance and failed to provide a dignified dining experience, related to standing while feeding residents, for 2 of 2 residents (R162 and R184) who required assistance with eating. The facility also failed to respond to 1 of 1 resident (R177) whose request for an additional serving at mealtime was ignored. Findings include: R162's quarterly Minimum Data Set (MDS) dated 10/14/14, identified her cognition was severely	F 241	F000:Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continually improve quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facilities allegation of compliance.	12/2/14

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

Electronically Signed | 11/12/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245205	A. BUILDING _____ B. WING _____	10/23/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 impaired, required extensive assistance of one staff to eat, and her meals were mechanically altered. R184's quarterly MDS dated 9/9/14, indicated his cognition was severely impaired and required supervision with set up for eating. During observation of the breakfast meal on 10/21/14, at 10:12 a.m. nursing assistant (NA)-E referred to R162 and R184 as "feeders," while she assisted R162 to a dining room table. NA-E brought R184 coffee and stated she was going to help him eat so there would be no spilling today. R184 was observed as able to eat without assistance, however, NA-E stood between R162 and R184, assisting both with eating their meal. NA-E remained standing throughout the entire meal, while she continued to provide eating assistance to both R162 and R184. During interview on 10/21/14, at 10:40 a.m. NA-E confirmed she referred to R162 and R184 as "feeders." NA-E stated she was aware the term "feeders" was not to be used. NA-E also confirmed she remained standing while she assisted R162 and R184 with eating. During interview on 10/22/14, at 8:21 a.m. registered nurse (RN)-A stated staff were expected to sit next to residents when they assisted with meals. RN-A stated residents were not to be referred to as "feeders" because it was unacceptable terminology. The facility's Feeding a Resident policy dated 2006, directed staff to position a chair where it was convenient for both them and the resident, in order to remain seated while providing eating	F 241	F241: It is the policy of Anoka Rehabilitation and Living Center to promote care for residents in a manner and in an environment that maintains or enhances each resident□s dignity and respect in full recognition of his or her individuality. To correct the deficient practice for Residents 162,184, and 177, all staff will be educated on the use of appropriate dignified language and correct response in addressing resident requests for additional food. This will be done at the mandatory POC in-service held 11/20, 11/21, 11/24 and 11/25. The policy and procedure on the Feeding of Residents will also be reviewed with all staff at the in-service. All residents in the facility have the potential to be effected by the same deficient practice. Dining room audits to ensure that the policy and procedure regarding the feeding of residents is being followed will be completed at every meal once a week for four weeks, then each meal will be observed once a month for two months. The Director of Nursing or designee will ensure compliance and report the audit results to facility QA for three months and then as needed.	

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F 241	Continued From page 2 assistance. R177's care plan dated 8/18/14, identified a history of weight loss and directed staff to offer him his favorite foods. R177's discharge (return anticipated) MDS dated 9/12/14, included diagnoses of dementia and anemia. The MDS identified R177 had clear speech, had no chewing or swallowing problems, and was independent with eating after staff set up. A Brief Interview for Mental Status (BIMS) assessment completed on 9/20/14, identified R177 had no cognitive impairment. R177's current physician orders dated 10/23/14, directed a regular texture diet with thin liquids. During observation of the evening meal on 10/20/14, at 5:25 p.m. R177 was seated at a table in the dining room, eating supper. At 5:29 p.m. R177 finished his meal and asked NA-D if there was more spaghetti available. NA-D stated she did not know and continued assisting another resident with their meal. NA-D did not approach the kitchen to request an additional helping of food and no action was taken to respond to his request. At 5:39 p.m., R177 left the dining area with no response to his request for more food. During interview on 10/20/14, at 5:34 p.m. dietary aide (DA)-A stated the steam table containing the food served to the residents had been returned to the kitchen, however, more food could be obtained from another unit if a resident requested additional servings. During interview on 10/22/14, at 12:34 p.m. NA-C stated sandwiches were available in the facility	F 241		

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F 241	Continued From page 3 kitchenettes for residents who were still hungry after finishing their meal. During interview on 10/23/14, at 12:38 p.m. registered dietician (RD) stated all staff were to offer residents a second helping at meals. RD stated if the steam table was removed from the unit, staff could have called the kitchen to request additional servings. During interview on 10/23/14, at 1:18 p.m. the clinical administrator (CA) and director of nursing (DON) stated they expected staff to respond to all resident requests and to provide additional helpings at mealtimes when requested.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		12/2/14

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F 280	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to update the resident's plan of care to reflect current for range of motion (ROM) services, for 1 of 3 residents (R68) who was to receive passive range of motion (PROM) per assessed recommendations from occupational therapy (OT). Findings include: R68's care plan dated 9/23/14, directed staff to complete PROM to his right wrist daily on the morning shift and as needed. R68's quarterly Minimum Data Set (MDS) dated 10/7/14, identified diagnoses including traumatic brain injury. The MDS identified R68 had moderately impaired cognition, required extensive staff assistance with all activities of daily living (ADLs), and had an upper extremity impairment to one side of his body. A progress note dated 10/8/14, at 4:29 p.m. from occupational therapy (OT) recommended nursing to provide passive range of motion (PROM) to R68's wrist each shift to, "keep control of his contracture." The note added, "Nurse manager and staff development director present for information relay and setting up of PROM for his [R68] wrist..." Although OT recommended R68 recieved PROM each shift, the facility did not update R68's care plan to direct staff of this change. During interview on 10/22/14, at 1:24 p.m. physical therapist (PT)-A stated R68 received therapy services from 7/8/14, through 8/4/14. PT-A confirmed OT recommended PROM services for extension and flexion of R68's right	F 280	It is the policy of Anoka Rehabilitation and Living Center that every resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. To correct the deficient practice for R68, he was re-evaluated by the Occupational Therapist on 10/23/14. His Care Plan, Kardex, and Treatment sheet in Point Click Care for nurses and Point of Care for nursing assistants was updated to reflect the order for range of motion. Other residents who may be affected by this deficient practice were identified by the Therapy Dept. Physical Therapy will screen all residents upon admission, quarterly, or with significant change for ROM and decline in physical function. A communication system was established between the Therapy Dept. and nursing to ensure orders for ROM will be completed and implemented. Any residents identified to have a decline in physical function or ROM will be reported to the Nurse Manager by the therapist. The Nurse Manager will ensure that the Care Plan, Kardex, treatment sheet, and Point of Care are revised to reflect identified a change in treatment.	

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F 280	Continued From page 5 fingers and wrist on 10/8/14. On 10/23/14, at 9:26 a.m. nursing assistant (NA)-F verified she assisted R68 with morning cares on 10/22/14, and 10/23/14, but did not provide PROM. NA-F stated she was not aware R68 was supposed to receive range of motion services. NA care sheet and care plan, NA-F reviewed R68's care plan and stated it appeared the resident was to receive PROM to his upper extremities, daily. NA-F was not aware of OT's recommendation for R68 to receive PROM each shift. Although OT recommended R68 recieved PROM on each shift, the facility did not update R68's care plan to direct staff of this change.	F 280	Residents receiving ROM will be reviewed in IDT weekly with the IDT minutes given to the Director of Nursing weekly for review. The Director of nursing or designee will ensure compliance and report results to facility QA for 3 months and then as needed.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure each resident's personal hygiene plan of care was followed for routine shaving, for 1 of 3 residents (R63) who were observed with unwanted facial hair. Findings include: R63's care plan dated 9/29/14, directed staff to re-approached the resident if he refused cares. The care plan also identified R63 required set up	F 282	It is the policy of Anoka Rehabilitation and Living Center that the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident□s written plan of care. The care plan for R63 was reviewed and updated by the interdisciplinary team to ensure care needs and personal preferences are met at all times. The	12/2/14

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F 282	Continued From page 6 assistance and supervision with grooming activities. R63's admission Minimum data set (MDS) dated 9/24/14, identified diagnoses including dementia. The MDS identified R63 had severe cognitive impairment and required extensive assistance for personal hygiene. During the evening meal on 10/20/14, at 5:25 p.m. R63 was observed in the facility dining room. R63 was noted with very thick facial hair to his neck, upper lip, and chin. During the breakfast meal on 10/21/14, at 10:20 a.m. R63 was observed in the facility dining room. R63's thick facial hair was again noted to his neck, upper lip, and chin. During a third observation on 10/22/14, at 11:35 a.m. R63's thick facial hair remained and was approximately a quarter inch in length. R63 was interviewed at the time of this observation and stated he usually did not wear a beard. During interview on 10/22/14, at 12:34 p.m. NA-C confirmed R63 had long facial hair. During interview on 10/22/14, at 1:21 p.m. registered nurse (RN)-A stated residents should have been offered shaving on a daily basis. During interview on 10/23/14, at 10:37 a.m. family (F)-B stated R63 had been clean-shaven while residing in the community, prior to living at the facility, and had not had a beard in the past. During interview on 10/23/14, at 1:19 p.m. the clinical administrator (CA) and director of nursing	F 282	shaving task was added to the Point of Care NAR daily documentation. All residents have the potential to be affected by the deficient practice. The Point of Care system was revised to reflect grooming routines/shaving per residents care needs and personal preferences. To ensure that the deficient practice will not re-occur, the policy and procedure regarding Activities of Daily Living and Daily Life Functions will be reviewed at the mandatory POC in-service held 11/20, 11/21, 11/24 and 11/25. Grooming audits will be completed by Nurse Manager or designee two times per week for one month, one time a week for the following two months, then randomly as needed. The Director of nursing or designee will ensure compliance and report audit results to facility QA for 3 months and then as needed.	

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F 282	Continued From page 7 (DON) stated residents were to be shaved as directed by the care plan and as needed to ensure a clean appearance. The facility's Activities of Daily Living (ADL) (Daily Life Functions) policy dated 2006, lacked direction related to the facility's expectations for grooming or shaving frequency.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents who required assistance with grooming were appropriately shaved, for 2 of 3 residents (R63 and R29) who were observed with unwanted facial hair. Findings include: R63's admission Minimum data set (MDS) dated 9/24/14, identified diagnoses including dementia. R63 had severe cognitive impairment, required extensive assistance for personal hygiene, and had no behavioral symptoms including rejection of care. R63's care plan dated 9/29/14, directed staff to re-approached R63 if he refused cares. The care plan also directed staff R63 required set up assistance and supervision with grooming	F 311	It is the policy of Anoka Rehabilitation and Living Center to ensure residents are given the appropriate treatment and services to maintain or improve his or her abilities. The care plans for R63 and R29 were reviewed and updated by the interdisciplinary team to ensure care needs and personal preferences are met at all times. The shaving task was added to the Point of Care NAR daily documentation. All residents have the potential to be affected by the deficient practice. The Point of Care system updated to record shaving being offered every day for all residents.	12/2/14

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F 311	Continued From page 8 activities. During the evening meal on 10/20/14, at 5:25 p.m. R63 was observed in the facility dining room. R63 was noted with very thick facial hair to his neck, upper lip, and chin. During the breakfast meal on 10/21/14, at 10:20 a.m. R63 was observed in the facility dining room. R63's thick facial hair was again noted to his neck, upper lip, and chin. During a third observation on 10/22/14, at 11:35 a.m. R63's thick facial hair remained and was approximately a quarter inch in length. R63 was interviewed at the time of this observation and stated he usually did not wear a beard. R63 stated he was not able to shave because he did not have a razor, however, a package containing 11 disposable razors was observed in a basin, on the counter in R63's bathroom. During interview on 10/22/14, at 12:10 p.m. nursing assistant (NA)-A stated R63 was sometimes uncooperative with cares. NA-A verified she was aware R63 had disposable razors in his room. During interview on 10/22/14, at 12:34 p.m. NA-C confirmed R63 had long facial hair. During interview on 10/22/14, at 1:21 p.m. registered nurse (RN)-A stated residents should be offered shaving on a daily basis, regardless of whether they had been resistive with cares in the past. During interview on 10/23/14, at 10:37 a.m. family (F)-B stated she noticed R63 had not been	F 311	To ensure the deficient practice will not reoccur, the policy and procedure regarding Activities of Daily Living and Daily Life Functions will be reviewed at the mandatory POC in-service held 11/20, 11/21, 11/24 and 11/25. Grooming audits will be completed by the Nurse Manager or designee two times per week for one month, one time a week for the following 2 months, then randomly as needed. The Director of nursing or designee will ensure compliance and report audit results to facility QA for 3 months and then as needed.	

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F 311	Continued From page 9	F 311		

shaved on Monday, 10/20/14, so she brought in disposable razors. F-B stated she planned to approach staff later that day about shaving R63. She stated that if he was not shaved, she was going to shave him herself. She stated, "[I'll] shave him myself if I have to." F-B stated R63 had been clean-shaven while residing in the community prior to living at the facility and had not had a beard in the past.

R29's quarterly MDS dated 10/22/14, indicated the resident had diagnoses including dementia. The MDS identified R29 had severe cognitive impairment, required extensive assistance for personal hygiene tasks, and had no behavior symptoms including rejection of cares.

During the evening meal on 10/20/14, at 5:25 p.m. R29 was observed in the facility dining room with long facial hair.

During a second observation on 10/22/14, at 11:47 a.m. R29 was again noted to have long facial hair. No razors for shaving were observed in R29's room.

During interview on 10/22/14, at 12:10 a.m. NA-A confirmed R29 did typically shave. NA-A stated she thought R29 had been shaved on 10/20/14, and she was going to offer R29 assistance with shaving after lunch.

During interview on 10/22/14, at 12:34 p.m. NA-C confirmed R29 had long facial hair.

During interview on 10/22/14, at 1:21 p.m. RN-A stated residents were to be offered shaving daily. RN-A confirmed R29 was usually cooperative with cares.

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F 311	Continued From page 10 During interview on 10/23/14, at 1:19 p.m. the clinical administrator (CA) and director of nursing (DON) stated residents were to be shaved as often as they allowed, as directed by the care plan, and as needed to ensure a clean appearance. The facility's Activities of Daily Living (ADL) (Daily Life Functions) policy dated 2006, lacked direction related to the facility's expectations for grooming or shaving frequency.	F 311		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide passive range of motion (PROM) services, for 1 of 3 residents (R68) per the assessed occupational therapy recommendation. Findings include: R68's care plan dated 9/23/14, directed staff to complete PROM daily to R68's right wrist on the morning shift, and as needed. R68's quarterly Minimum Data Set (MDS) dated 10/7/14, identified diagnoses including traumatic	F 318	It is the policy of Anoka Rehabilitation and Living Center to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. To correct the deficient practice for R68, he was re-evaluated by the Occupational Therapist on 10/23/14. His Care Plan, Kardex, and Treatment Sheet in Point	12/2/14

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F 318	Continued From page 11 brain injury. The MDS identified R68 had moderate cognitive impairment, required extensive staff assistance with all activities of daily living (ADLs), and had an upper extremity impairment to one side of his body. A progress note dated 10/8/14, at 4:29 p.m. from occupational therapy (OT) recommended nursing provide range of motion (ROM) to R68's wrist each shift to keep control of his contracture. The note added, "Nurse manager and staff development director present for information relay and setting up of ROM for his wrist..." During observation on 10/21/14, at 10:03 a.m. R68 was seated in his wheelchair in his resident room. R68 was able to move his right hand digits a small degree on his own, with his right wrist flexed towards his right forearm. During interview on 10/21/14, at 11:41 a.m. registered nurse (RN)-A stated R68 received PROM to his right hand, and R68 needed encouragement to do PROM with staff. The facility's documentation history for nursing assistant tasks indicated R68 received PROM one time on 10/21/14, and two times on 10/22/14. There was no further documentation for the month of October 2014, to indicate R68 received or was offered any PROM services. During interview on 10/22/14, at 1:24 p.m. physical therapist (PT)-A stated R68 received therapy services from 7/8/14, through 8/4/14. PT-A confirmed OT recommended PROM services every shift for extension and flexion of R68's right fingers and wrist on 10/8/14. On 10/23/14, at 9:26 a.m. nursing assistant (NA)-F stated she assisted R68 with morning cares on 10/22/14, and 10/23/14, but did not provide PROM. NA-F stated she had not offered the PROM services to R68 because she was not aware the resident was to receive them.	F 318	Click Care for nurses and Point of Care for nursing assistants was updated to reflect the order for range of motion. Other residents who may be affected by this deficient practice are identified by the Therapy Dept. Physical Therapy screens all residents upon admission, quarterly, or with significant change for PROM and decline in physical function. A communication system was established between the Therapy Dept. and nursing to ensure orders for PROM will be completed and implemented. Any residents identified to have a decline in physical function or PROM will be reported to the Nurse Manager by the therapist. The Nurse Manager will ensure Care Plan, Kardex, treatment sheet, and Point of Care is revised to reflect an identified change in treatment. The Therapy Dept. will present and demonstrate PROM exercises at the mandatory POC in-service held 11/20, 11/21, 11/24 and 11/25. A binder will be established for each neighborhood that will outline individualized PROM exercises for those residents requiring them. Residents receiving ROM will be reviewed in IDT weekly. To ensure ongoing compliance the IDT minutes will be given to the DON weekly for review. The Director of nursing or designee will ensure compliance and report results to facility QA for 3 months and then as needed.	

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	245205	A. BUILDING _____ B. WING _____	10/23/2014

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

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F 318	Continued From page 12 Although OT had assessed and recommended R68 was to receive PROM each shift beginning on 10/8/14, the facility failed to update staff to ensure the PROM was being completed as assessed by OT.	F 318		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		12/2/14

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F 431	Continued From page 13 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Fentanyl (narcotic analgesic) patches were destroyed in a manner to prevent potential diversion for 1 of 1 resident (R138) reviewed with prescribed Fentanyl patches. Findings include: R138's physician order dated 9/4/14, contained a medication order for a 75 microgram (mcg) per hour Fentanyl Patch to be applied transdermally (on the skin) every 72 hours for pain. On 10/22/14, at 7:33 a.m. during medication room review on the Cornerstone unit registered nurse (RN)-B stated when removing a used Fentanyl patch from a resident the nurse would fold it up and put it in the sharps containers which were located in the residents room. RN-B stated used Fentanyl patch removal was not documented nor witnessed by two staff. RN-B was unsure if the facility had a specific Fentanyl policy to direct staff on disposal and documentation of used Fentanyl patches. On 10/22/14, at 11:32 a.m. during medication room review of the Reflections unit, licensed practical nurse (LPN)-A stated when removing a used Fentanyl patch from a resident the nurse would fold it up and put it in the sharps container which were located in the residents room. LPN-A	F 431	It is the policy of Anoka Rehabilitation and Living Center to employ or obtain the services of a licensed pharmacist who established a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The facility stores all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility provides separately locked, permanently affixed compartments for storage of controlled drugs listed in schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, expect when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a mission dose can be readily detected. Resident 138 no longer resides in the	

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F 431	Continued From page 14 stated used Fentanyl patch removal was not documented nor witnessed by two staff. LPN-A was unsure if the facility had a specific Fentanyl policy to direct staff on disposal and documentation of used Fentanyl patches. Review of R138's medication administration record (MAR) for the month of 10/14, revealed the following dates lacked documentation of proper destruction and/or two nurse witness signatures/initials of the used Fentanyl patches per facility policy: 10/2/14, 10/5/14, 10/8/14, 10/11/14, 10/14/14, 10/17/14, and 10/20/14. During interview on 10/23/14, at 12:54 p.m. director of nursing (DON) and the clinical administrator (CA) verified the findings and stated they were not aware nursing staff was not following the facility policy regarding 2 nurses documenting when a Fentanyl patch was removed from a resident. The DON and CA stated the facility did not have a procedure in place for accurate reconciliation and accounting of the used Fentanyl patches to prevent diversion after removing from a resident. The CA stated the facility policy only addressed when a medication was discontinued, however, CA stated the policy gave direction to waste the medication into the toilet which would be witnessed by two licensed staff and staff should be following the same principles when removing a used Fentanyl patch, which would include 2 nurses witnessing the destruction of it after removing it from a resident. A facility policy was requested for Fentanyl Patch destruction. A policy titled Disposal/Destruction of Expired or Discontinued Medications dated 1/1/13, was provided. The policy indicated the facility should destroy discontinued or out dated	F 431	facility. There are currently no other residents in the facility receiving a fentanyl patch. A Policy and Procedure was written titled Administration and Disposal of Fentanyl Patches. The policy and procedure will be reviewed with all nurses at the mandatory POC in-service held 11/20, 11/21, 11/24 and 11/25. The documentation of fentanyl patch administration, removal and destruction, per VOA policy, in bound narcotic book will be demonstrated when policy and procedure is reviewed at POC in service. When a resident admits with an order for a fentanyl patch, the Nurse Manager will audit the bound narcotic book for correct destruction per Administration and Disposal of Fentanyl Patches policy and procedure. The Director of Nursing will determine the duration of the individual audit. The new Policy and Procedure will be reviewed with the facility Medical Director at the facility QA meeting on 11/13/14.	

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F 431	Continued From page 15 medications in the presence of a registered nurse and a licensed professional in accordance with Facility Policy or Applicable Law and document on the controlled medication count sheet. CA stated although the policy lacked specific direction related to destroying used Fentanyl patches, the staff should be applying the destruction of discontinued or out of date medication method when disposing of the used patches, such as having two staff witness the destruction of the Fentanyl patches when they are removed from a resident.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		12/2/14

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F 441	Continued From page 16 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff followed proper hand hygiene techniques for 1 of 1 residents (R184) observed for personal cares, and 2 of 2 residents (R162 and R184) who were observed receiving assisted with dining and staff did not perform proper hand hygiene techniques while assisting with dining. Findings include: R184's quarterly Minimum Data Set (MDS) dated 9/9/14, identified R184 had severe cognitive impairment, required staff supervision with eating, and required assistance with tray set up. The group 1 sheet, which was identified as what the nursing assistants used to provide cares to residents, undated, indicated R184 required assistance of a total mechanical lift for transfers from surface to surface. An observation on 10/22/14, at 9:19 a.m.	F 441	It is the policy of Anoka Rehabilitation and Living Center to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. To correct the deficient practice for residents 162 and 184, NA-F and NA-E have been re-educated on proper infection control practices per facility policy and procedure. All residents could be affected by this deficient practice. The policies for Hand Washing, Hand Hygiene, and Glove Technique will be reviewed at the mandatory POC in-service held 11/20, 11/21, 11/24 and 11/25.	

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F 441	Continued From page 17 revealed nursing assistant (NA)-F put gloves on to assist with R184's morning cares. NA-F raised the bed and provided upper torso cares, and then lowered the front of R184's incontinent product and provided perineal care. R184 was rolled onto the side and the incontinent product, which was soiled with bowel movement (BM), was removed. NA-F wiped R184's rectal area. Without removing the soiled gloves, NA-F put the clean incontinent product on R184, pulled up the residents pants, and placed the soiled incontinent product in the garbage. Without the same soiled gloves, NA-F opened the linen cabinet and placed the soiled linens in the linen bag in the cabinet. NA-F then removed the gloves and put on R184's socks. NA-F then washed her hands. During interview on 10/22/14, at 9:34 a.m. NA-F stated she should have changed gloves and washed her hands after removing the soiled incontinent product and cleaning R184. NA-F stated gloves should be changed after washing residents' face and upper body, also. During interview on 10/22/14, at 12:23 p.m. registered nurse (RN)-A stated gloves should have been changed after the soiled incontinent product was taken off and the resident was cleaned up. The facility policy Hand Washing and Hand Hygiene dated 2006, directed staff to perform hand hygiene after touching bodily fluid, secretion, excretions, and contaminated items; immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment, and/or the environment.	F 441	Hand washing and glove audits will be completed two times per week for one month to observe glove use during care and hand hygiene during dining times. Audits will be done weekly for the following two months, and then randomly as needed. The audit results will be reported by the Infection Control Nurse to facility QA for 3 months. The Director of Nursing or designee will be responsible for compliance.	

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F 441	Continued From page 18 Proper hand hygiene was not performed by staff while assisting residents to dine. R162's quarterly MDS dated 10/14/14, indicated R162's cognition was severely impaired. The MDS also indicated R162 required extensive assistance of one staff to eat. R184's quarterly MDS dated 9/9/14, indicated R184's cognition was severely impaired and required supervision with eating and needed tray set up. During observation in the dining room on 10/21/14, at 10:12 a.m., NA-E touched her face with her right hand and then picked up R184's coffee cup with her right uncleansed hand and fingers around the top of the cup where R184 would drink the coffee from, and gave the coffee cup to R184 to drink. At 10:27 a.m. NA-E touched her right hand on her face and then retrieved a straw for R162, removed the paper from the straw with uncleansed hands, placed it in the juice glass, and put the straw to R162's mouth to drink his juice. At 10:30 a.m. NA-E reached over the table and picked up R184's fork that he had been using and gave R184 a bite of oatmeal. NA-E set down R184's fork, and without washing her hands, picked up R162's silverware and offered more food and beverage to R162. During interview on 10/21/14, at 10:40 a.m. NA-E verified no hand sanitizer was used while the meal occurred in between providing R162 and R184 assistance with dining.	F 441		

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F 441	Continued From page 19 During interview on 10/22/14, at 8:21 a.m. RN-A stated hand sanitizer would be expected to be used between resident contact and after staff have touched their face. The facility policy titled Hand Washing and Hand Hygiene dated 2006, directed staff to perform hand hygiene after touching bodily fluid, secretion, excretions, and contaminated items; immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and/or the environment.	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the range hood, grill grates, ovens, and convection oven, in the central kitchen were maintained in a sanitary manner. This had the potential to effect all 114 residents currently residing in the facility. Findings include: During tour of the kitchen on 10/20/14, at 1:22 p.m. the following soiled kitchen appliances were observed: An uncovered stand mixer was sitting on the	F 465	It is the policy of Anoka Rehabilitation and Living Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. An in-service was given on 11-10-14 which highlighted the correct procedures for cleaning grill grates, range hoods, ovens and convection oven as well as the correct procedure for documentation of said cleaning. The corrective action to be taken to ensure compliance is that as of	12/2/14

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F 465	Continued From page 20 counter that had dried, dark sprayed substance covering the mixer. The convection oven had cooked food sprayed on both sides of the oven. The range hood was covered with grease and had visible food particles scattered across the hood. The stove oven had large, dark black splatter on the floor of the oven. The grill grates on the flat top grill had blackened food particles stuck on the grates. During interview on 10/20/14, at 1:22 p.m. registered dietician (RD)-A stated the mixer had not been used on 10/20/14, and staff was expected to clean the mixer after every use. RD-A stated the facility oven, range hood, and grill grates all required cleaning and were set up to be on a weekly cleaning schedule. During interview on 10/20/14, at 1:22 p.m. (C)-B stated all the kitchen appliances were on a weekly cleaning schedule except the grill. C-B stated she did not remember the last time the grill had been used, and the grill and mixer were both appliances that should be cleaned after each use. The facility provided a Weekly Cleaning Duties Schedule for the a.m.(morning) and p.m. (evening) shift for 9/13/14- current. The list included cleaning duties such as clean convection oven inside and out, clean front, sides and shelf on stove top oven, and clean vent hood filters. Since 9/13/14, there was no indication any of the weekly cleaning had been completed in the kitchen. The facility policy titled Cleaning Instructions: Ovens dated 11/11, instructed staff ovens will be cleaned as needed and according to the cleaning schedule.	F 465	11-10-14 weekly compliance audits will be conducted to not only ensure that cleaning has been done but to also ensure that the documentation is being signed for these cleaning tasks. All responsible staff have been educated of this policy. New dietary staff will also be in-serviced regarding proper cleaning techniques and documentation by the Dietary Director or designee. Data collected will be reviewed by facility QA team for 3 months. The team will then make recommendations for any system changes. Dietary Director or designee will perform annual documented in-service on proper cleaning techniques of kitchen appliances.	

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	245205	A. BUILDING **02 - ANOKA CARE & REHAB CENTER** B. WING _____	**10/23/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. 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 prevent a reoccurrence of the deficiency.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/12/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Anoka Care-Rehabilitation Center was constructed in 2012 and opened in 2013. It is a two story building with a basement. The construction type is determined to be Type II (111). The building is separated from the rest of the complex by 2 hour fire rated construction. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility is licensed for 120 beds and 114 were occupied at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed	K 050	It is the policy of Anoka Rehabilitation and Living Center to conduct fire drills at	10/24/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING **02 - ANOKA CARE & REHAB CENTER** B. WING _____	**10/23/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 2 to vary the times and dates of numerous fire drills in the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Findings include: On facility tour between between 9:45 AM and 11:30 AM on 10/24/2014, record review revealed that there no no PM shift fire drill for the third quarter of 2014 or Night shift fire drill for the first quarter of 2014. This deficient practice was verified by the Environmental Services Director at the time of the inspection.	K 050	unexpected times under varying conditions, at least quarterly on each shift. One fire drill per quarter per shift will be conducted and documented as required per MSFC. Bill Barth, Environmental Services Director will ensure compliance.	