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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XJPM

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 08/30/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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):

Post Certification Revisit by review of the facility's plan of correction to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective August 20, 2013, the facility is certified for 120 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 09/19/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen Leach, Program Specialist 12/19/2013 (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
08/27/2013 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5205 December 19, 2013

Mr. Ryan Keller, Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, Minnesota 55303

Dear Mr. Keller:

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 August 20, 2013, 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 19, 2014

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

Re: Enclosed Reinspection Results - Complaint Number H5205033

Dear Mr. Decosta:

On December 16, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Office for an abbreviated standard survey, completed on November 4, 2013. 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 January 10, 2014, the Minnesota Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on November 4, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 14, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 4, 2013, effective January 10, 2014 and therefore remedies outlined in our letter to you dated December 16, 2013, will not be imposed.

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

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

Feel free to contact 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

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	8/30/2013

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii),** LSC	Correction Completed **08/20/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/20/2013**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/20/2013**
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **08/20/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/20/2013**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **08/20/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/20/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** SG/AK	**Date:** 09/19/2013	**Signature of Surveyor:** 28589	**Date:** 08/30/2013
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/11/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 19, 2013

Ms. Leah Killian-Smith, Administrator
Anoka Rehabilitation & Living Center
3000 - 4th Avenue
Anoka, Minnesta 55303

RE: Project Number S5205023

Dear Ms. Killian-Smith:

On July 25, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 11, 2013. 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 August 30, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 11, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 20, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 11, 2013, effective August 20, 2013 and therefore remedies outlined in our letter to you dated July 25, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: 612-201-4124 Fax: 651-215-9697

Enclosure
cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XJPM

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

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

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

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

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

6. DATE OF SURVEY **07/11/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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: 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):
At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HFE NEII 08/12/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 08/22/2013 (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
ML
Posted 8/27/2013

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

Certified Mail # 7012 3050 0000 4830 7871

July 25, 2013

Ms. Leah Killian-Smith, Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, Minnesota 55303

RE: Project Number S5205023 & H5205032

Dear Ms. Killian-Smith:

On July 11, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 11, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5205032, which was found to be substantiated.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc
Minnesota Department of Health
Midtown Square
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (320) 223-7365

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 August 20, 2013, 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 August 20, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 11, 2013 (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 January 11, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7365 Fax: (320) 223-7348

Enclosure

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 _____	C 07/11/2013

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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. A complaint investigation had been completed at the time of the standard recertification survey. Investigation of complaint H5205032 had been completed and has been substantiated. Deficiency has been issued as a result of the substantiated findings at F353.	F 000	**F000** It is the policy of Anoka Rehabilitation & Living Center to follow all federal, state, and local guidelines, laws, regulations, and statutes. This plan of correction will serve as our credible allegation of compliance but does not constitute an admission of deficient practice. RECEIVED AUG 06 2013 MN Dept of Health St.Cloud	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225	F225 Abuse Prohibition It is the policy of Anoka Rehabilitation & Living Center to ensure all alleged violations involving possible mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property are reported immediately to the Administrator and to other officials in accordance with state law through established procedures including the state survey and certification agency.	

OK 8/12/13 SO

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Leah M Smith ✓	Interim Executive Director	8/5/13 ✓

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	C 07/11/2013

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

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F 225	Continued From page 1 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse, neglect and injuries of unknown origin were reported to the administrator immediately, reported to state agency as indicated and thoroughly investigated for 5 of 13 residents (R77, R247, R290, R117 and R68), reviewed in the sample for abuse. Findings include: R77's quarterly Minimum Data Set (MDS), completed on 4/18/13, indicated R77 was cognitively intact. She needed supervision of one staff for personal hygiene and needed extensive	F 225	For Residents #: 77, 247, 290, 68, and 117 each concern was immediately reported to the administrator upon notification. The concerns were reported to the OHFC and investigated according to the abuse prohibition policy and procedure. A review of the concerns reported was completed by the interdisciplinary team. The results of the investigation will be reported to the resident and/or responsible party. Corresponding updates will be made to the plan of care. For all other residents who may be affected by this practice, the concern forms will be reviewed by the interdisciplinary team to ensure all reportable events are sent in to OHFC per policy and that the Administrator is notified immediately. Education will be provided for staff members on the abuse prohibition policy and procedures. Audits regarding reportable events, notification, investigation, and staff member knowledge of the abuse prohibition policy will be completed	

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F 225	Continued From page 2 assistance of one facility staff with toileting and dressing. She needed physical assistance of one staff for bathing. R77 reported on 7/9/13, at 8:47 a.m. of an incident that occurred 3 weeks prior, when a nursing assistant, whom resident named, was rough with her. She reported he "yanked me around " and when I complained to him about the treatment "he told me he could do whatever he wanted to do with me." She reported "the staff know all about the incident " and also indicated that she had told registered nurse (RN)-B about the incident. She stated that RN-B reassured her the nursing assistant would not assist her again. RN-B was interviewed on 7/10/13, at 2:10 p.m. and denied R77 had reported any incident of rough treatment by any staff to him. R77 was interviewed for a second time on 7/10/13, at 3:34 p.m. R77 continued to report a male nursing assistant had been rough with her about 3 weeks prior. She reported for a second time she had "told the staff about it " and was able to identify specifically a nursing assistant (NA)-C, she had discussed the incident with. An interview with NA-C on 7/10/13, at 3:36 p.m. was completed. NA-C reported R77 had reported a nursing assistant had been rough with her when he gave her a shower. NA-C indicated R77 did not tell her the name of the nursing assistant, but NA-C reported R77 had indicated it was a male. NA-C was unable to identify when the allegation had been made and also indicated that she thought she had informed licensed practical nurse (LPN)-C about R77's allegation.	F 225	three times per week for two weeks, weekly for four weeks, and as needed to ensure compliance. The results will be reported to the Quality Assurance Committee for review and further recommendations. The Director of Social Services or her designee will be responsible for compliance. Date of Correction: August 20, 2013	

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F 225	Continued From page 3 An interview with LPN-C was completed on 7/10/13, at 3:46 p.m. LPN-C reported R77 had told her about an incident with an unidentified male nursing assistant, who had been rough with her and the resident assigned to the adjacent room. LPN-C reported R77 and her female neighbor did not want the male nursing assistant to work with them again but he had worked with them since then without any further incident. She indicated she forwarded the information to the next shift but did not report any further. An interview on 7/10/13, at 3:54 p.m. with RN-B and RN-D was completed and informed of the findings. They reported they were unaware of the allegations and would start an investigation. An interview on 7/10/13, at 4:15 p.m. was completed with the director of nursing (DON). She reported the staff failed to follow the facility's abuse prohibition plan which included a report to the state agency and a thorough investigation. She also indicated that all staff are trained to report allegations of mistreatment immediately to their supervisor, who was to then report immediately to the administrator. R247 was admitted on 5/14/13, and discharged on 5/25/13. The Admission nursing Data Collection tool completed on 5/14/13, identified the resident was alert and oriented. The data indicated R247 was having pain, which interfered with his sleep pattern. He was prescribed Oxycordone 5 milligrams (mg) in the morning and bedtime and every three hours as the resident requested. He was also prescribed Tylenol ES (extra strength) three times per day.	F 225		

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F 225	Continued From page 4 According to a written grievance reported to facility social worker on 5/24/13, R247 reported he had requested pain medication at 4:30 a.m. and did not receive the medication for pain until 9:30 a.m. (five hours after his request). The grievance report indicated R247's medication "had run out and there were none to give to him." The report was signed by the administrator on 5/19/13, five days after the allegation was made. An interview on 7/11/13, at 8:15 a.m. was completed with the DON. The DON reported this should have been treated as an abuse allegation due to the excessive waiting time for pain management and their policy and plan had not been followed. She noted the administrator and the state regulatory agency had not been informed. R290 was admitted on 5/2/13, and discharged on 5/5/13. Upon admission, the resident was assessed as alert and oriented to person, place and time. A cognition status assessment was completed on 5/5/13, and noted the resident had no long or short term memory impairment, was independent with decision making and had no signs or symptoms of delirium. According to a written grievance report of 5/3/13, written by the facility social worker (SW), R290 complained of how she had been treated on the night of her admission. She (R290) reported she needed "a lot of assistance with walking and moving around". She reported when she got to her assigned room at the facility, she wanted to have her "stuff put away" and the "NAR [nursing assistant] just looked at her and stared out the	F 225		

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F 225	Continued From page 5 window." R290 reported to the SW when she (R290) "realized she wasn't going to get any help, she started putting her stuff away in the drawers. As she put her stuff away, she started having some pain, so she left the dresser drawers open and tried to make it to the bed to sit down." She (R290) asked the NAR if she could put her suitcase up on the bed so she could "try to throw the clothes from the bed into the drawer." R290 reported after the suitcase was on the bed, she began to "throwing her clothes in the drawer and the nursing assistant started to laugh at what she (R290) was doing but didn't ask if she wanted help. Not laughing like she was making fun of her, but laughing because she thought it was silly." R290 furthermore reported to the SW, after her clothing was put away she requested the nursing assistant move the dinner tray that was on her bedside stand, so that she could put her belonging on this area. R290 indicated the nursing assistant took the tray out of the room and did not return with her evening meal. R290 also alleged that she smelled alcohol on the nursing assistant's breath and informed the SW that "she told other staff on 5/2/13" about the odor. According to the report, the SW talked to staff, who reported that R290 "appeared to have delirium from pain meds", the accused nursing assistant had "normal demeanor" with no odor of alcohol noted and the building had taken five admissions that day and they did the best they could. The report was signed by the administrator on 5/21/13, which was eighteen days after the allegation. An interview on 7/11/13, at 8:15 a.m. was completed with the DON. She reported that facility staff failed to follow their policy regarding	F 225		

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F 225	Continued From page 6 allegations of abuse. She reported the allegations should have been reported to the administrator and the state agency, which had not been done. She also reported that a comprehensive investigation should have been done and was not. R117 was admitted on 4/9/13, and discharged on 4/24/13 with diagnosis that included a fracture of the hip. Upon his admission R117 was considered to be alert and oriented to person, place and time. An assessment completed on 4/10/13, noted R117 was cognitively intact. An admission MDS was completed on 4/16/13, indicated R117 needed extensive assistance of two staff with bed mobility, transfers, dressing, toilet use, and personal hygiene. A written complaint was made on 4/12/13, by the resident's daughter in regards to NA-D and a second unidentified nursing assistant, who were rough with her father. She reported they had transferred him "hasty" and they had not given him a chance to bear weight on his own. She reported that the nursing assistants "just pulled him up and put him in the chair." The facility staff talked to the involved nursing assistants and they denied the concern. The report was signed by the administrator on 4/17/13, five days after the concern was reported. An interview on 7/11/13, at 8:15 a.m. was completed with the DON. She reported that facility staff failed to follow their policy regarding allegations of abuse. She reported the allegations should have been reported to the administrator and the state agency, which had not been done. She also reported that a	F 225		

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F 225	Continued From page 7 comprehensive investigation should have been done. R68's admission MDS, completed on 1/14/13, indicated she was cognitively intact. The quarterly MDS, completed on 4/9/13, noted cognition had declined to moderately impaired and needed extensive assistance of two staff for bed mobility, toilet use, and transfers. She needed extensive assistance of one staff for locomotion on and off the unit, dressing, eating and personal hygiene. According to a written grievance of 3/28/13, R68's daughter reported her mother had told her that a male nursing assistant was rough with her when he used a transfer belt. R68 had told her daughter the belt was too tight. Staff talked to R68 , who described the nursing assistant and verified the nursing assistant had the transfer belt on her too tight and he had not loosened it when she complained. R68 was unable to specify the date, day or time of the incident. According to the grievance report, the unit nurse manager and DON were informed. The established plan for resolution was that the nurse manager was to follow up with the nursing assistant, re-educate the nursing assistant on the use of the transfer belt and listen to the resident. The report was signed by the administrator on 4/11/13, An interview on 7/11/13, at 8:15 a.m. was completed with the DON. She reported the facility staff failed to follow their policy regarding allegations of abuse. She reported the allegations should have been reported to the administrator and the state agency, which had not been done. She also reported that a	F 225		

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F 225	Continued From page 8 comprehensive investigation should have been done. The facilities policy, Resident Protection Policy and Procedure, implemented June, 2009; specified allegations of abuse were to be reported to immediately to the supervisor or the building supervisor. The supervisor or reporter was to contact immediately the administrator and DON. The policy also specified if suspicion of abuse had occurred, it was to be reported to state regulatory agencies. The policy specified that upon receipt of a complaint of alleged maltreatment, the administrator, DON and director of social services would coordinate an investigation, which would include completion of witness statements. When a specific staff member was implicated in the alleged event, they were to be removed from the resident care area immediately and suspended until the investigation was completed.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement an abuse prohibition policy which required allegations of abuse, neglect and injuries of unknown origin were immediately reported the administrator and to the	F 226	F226 Abuse Prohibition It is the policy of Anoka Rehabilitation & Living Center to develop and implement policies and procedures regarding abuse prohibition that include screening, training, prevention, identification, investigation, protection, and reporting/response. For Residents #: 77, 247, 290, 68, and 117 each concern was immediately reported to the administrator upon notification.	

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F 226	Continued From page 9 state agency and a thorough investigation was completed (SA) for 5 of 13 residents (R77, R247, R290, R117 and R68), reviewed in sample for abuse prohibition. Findings include: The facilities policy, Resident Protection Policy and Procedure, implemented June, 2009; specified allegations of abuse were to be reported to immediately to the supervisor or the building supervisor. The supervisor or reporter was to contact immediately the administrator and DON. The policy also specified if suspicion of abuse had occurred, it was to be reported to state regulatory agencies. The policy specified that upon receipt of a complaint of alleged maltreatment, the administrator, DON and director of social services would coordinate an investigation, which would include completion of witness statements. When a specific staff member was implicated in the alleged event, they were to be removed from the resident care area immediately and suspended until the investigation was completed. R77's quarterly Minimum Data Set (MDS), completed on 4/18/13, indicated R77 was cognitively intact. She needed supervision of one staff for personal hygiene and needed extensive assistance of one facility staff with toileting and dressing. She needed physical assistance of one staff for bathing. R77 reported on 7/9/13, at 8:47 a.m. of an incident that occurred 3 weeks prior, when a nursing assistant, whom resident named, was rough with her. She reported he "yanked me	F 226	The concerns were reported to the OHFC and investigated according to the abuse prohibition plan. A review of the concerns reported will be completed by the interdisciplinary team. The results of the investigation will be reported to the resident and/or responsible party. Education will be provided for staff members regarding the abuse prohibition policy and procedures. For all other residents who may be affected by this practice, the concern forms will be reviewed by the interdisciplinary team to ensure all reportable events are sent in to OHFC per policy and that the Administrator is notified immediately. Education will be provided for staff members on the abuse prohibition policy and procedures. The Medical Director and the interdisciplinary team will review the policy and procedure for abuse prohibition to ensure current practices meet the standards set forth by state law and federal regulation. Audits regarding reportable events, notification, investigation, and staff	

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F 226	Continued From page 10 around " and when I complained to him about the treatment "he told me he could do whatever he wanted to do with me." She reported "the staff know all about the incident " and also indicated that she had told registered nurse (RN)-B about the incident. She stated that RN-B reassured her the nursing assistant would not assist her again. RN-B was interviewed on 7/10/13, at 2:10 p.m. and denied R77 had reported any incident of rough treatment by any staff to him. R77 was interviewed for a second time on 7/10/13, at 3:34 p.m. R77 continued to report a male nursing assistant had been rough with her about 3 weeks prior. She reported for a second time she had "told the staff about it " and was able to identify specifically a nursing assistant (NA)-C, she had discussed the incident with. An interview with NA-C on 7/10/13, at 3:36 p.m. was completed. NA-C reported R77 had reported a nursing assistant had been rough with her when he gave her a shower. NA-C indicated R77 did not tell her the name of the nursing assistant, but NA-C reported R77 had indicated it was a male. NA-C was unable to identify when the allegation had been made and also indicated that she thought she had informed licensed practical nurse (LPN)-C about R77's allegation. An interview with LPN-C was completed on 7/10/13, at 3:46 p.m. LPN-C reported R77 had told her about an incident with an unidentified male nursing assistant, who had been rough with her and the resident assigned to the adjacent room. LPN-C reported R77 and her female neighbor did not want the male nursing assistant	F 226	member knowledge of the abuse prohibition policy will be completed three times per week for two weeks, weekly for four weeks, and as needed to ensure compliance. The results will be reported to the Quality Assurance Committee for review and further recommendations. The Director of Social Services or her designee will be responsible for compliance. Date of Correction: August 20, 2013	

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F 226	Continued From page 11	F 226		

to work with them again but he had worked with them since then without any further incident. She indicated she forwarded the information to the next shift but did not report any further.

An interview on 7/10/13, at 3:54 p.m. with RN-B and RN-D was completed and informed of the findings. They reported they were unaware of the allegations and would start an investigation.

An interview on 7/10/13, at 4:15 p.m. was completed with the director of nursing (DON). She reported the staff failed to follow the facility's abuse prohibition plan. She indicated that all staff are trained to report allegations of mistreatment immediately to their supervisor, who was to then report immediately to the administrator and to report to the state agency.

R247 was admitted on 5/14/13, and discharged on 5/25/13. The Admission nursing Data Collection tool completed on 5/14/13, identified the resident was alert and oriented. The data indicated R247 was having pain, which interfered with his sleep pattern. He was prescribed Oxycordone 5 milligrams (mg) in the morning and bedtime and every three hours as the resident requested. He was also prescribed Tylenol ES (extra strength) three times per day.

According to a written grievance reported to facility social worker on 5/24/13, R247 reported he had requested pain medication at 4:30 a.m. and did not receive the medication for pain until 9:30 a.m. (five hours after his request). The grievance report indicated R247's medication "had run out and there were none to give to him." The report was signed by the administrator on

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F 226	Continued From page 12 5/19/13, five days after the allegation was made. An interview on 7/11/13, at 8:15 a.m. was completed with the DON. The DON reported this should have been treated as an abuse allegation due to the excessive waiting time for pain management and their policy and plan had not been followed. She noted the administrator and the state agency had not been informed. R290 was admitted on 5/2/13, and discharged on 5/5/13. Upon admission, the resident was assessed as alert and oriented to person, place and time. A cognition status assessment was completed on 5/5/13, and noted the resident had no long or short term memory impairment, was independent with decision making and had no signs or symptoms of delirium. According to a written grievance report of 5/3/13, written by the facility social worker (SW), R290 complained of how she had been treated on the night of her admission. She (R290) reported she needed "a lot of assistance with walking and moving around". She reported when she got to her assigned room at the facility, she wanted to have her "stuff put away" and the "NAR [nursing assistant] just looked at her and stared out the window." R290 reported to the SW when she (R290) "realized she wasn't going to get any help, she started putting her stuff away in the drawers. As she put her stuff away, she started having some pain, so she left the dresser drawers open and tried to make it to the bed to sit down." She (R290) asked the NAR if she could put her suitcase up on the bed so she could "try to throw the clothes from the bed into the drawer." R290 reported after the suitcase was on the bed,	F 226		

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F 226	Continued From page 13 she began to "throwing her clothes in the drawer and the nursing assistant started to laugh at what she (R290) was doing but didn't ask if she wanted help. Not laughing like she was making fun of her, but laughing because she thought it was silly." R290 furthermore reported to the SW, after her clothing was put away she requested the nursing assistant move the dinner tray that was on her bedside stand, so that she could put her belonging on this area. R290 indicated the nursing assistant took the tray out of the room and did not return with her evening meal. R290 also alleged that she smelled alcohol on the nursing assistant's breath and informed the SW that "she told other staff on 5/2/13" about the odor. According to the report, the SW talked to staff, who reported that R290 "appeared to have delirium from pain meds", the accused nursing assistant had "normal demeanor" with no odor of alcohol noted and the building had taken five admissions that day and they did the best they could. The report was signed by the administrator on 5/21/13, which was eighteen days after the allegation. An interview on 7/11/13, at 8:15 a.m. was completed with the DON. She reported that facility staff failed to follow their policy regarding allegations of abuse. She reported the allegations should have been reported to the administrator and the state agency, which had not been done. She also reported that a comprehensive investigation should have been done and was not. R117 was admitted on 4/9/13, and discharged on 4/24/13 with diagnosis that included a fracture of the hip. Upon his admission R117 was	F 226		

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F 226	Continued From page 14 considered to be alert and oriented to person, place and time. An assessment completed on 4/10/13, noted R117 was cognitively intact. An admission MDS was completed on 4/16/13, indicated R117 needed extensive assistance of two staff with bed mobility, transfers, dressing, toilet use, and personal hygiene. A written complaint was made on 4/12/13, by the resident's daughter in regards to NA-D and a second unidentified nursing assistant, who were rough with her father. She reported they had transferred him "hasty" and they had not given him a chance to bear weight on his own. She reported that the nursing assistants "just pulled him up and put him in the chair." The facility staff talked to the involved nursing assistants and they denied the concern. The report was signed by the administrator on 4/17/13, five days after the concern was reported. An interview on 7/11/13, at 8:15 a.m. was completed with the DON. She reported that facility staff failed to follow their policy regarding allegations of abuse. She reported the allegations should have been reported to the administrator and the state agency, which had not been done. She also reported that a comprehensive investigation should have been done. R68's admission MDS, completed on 1/14/13, indicated she was cognitively intact. The quarterly MDS, completed on 4/9/13, noted cognition had declined to moderately impaired and needed extensive assistance of two staff for bed mobility, toilet use, and transfers. She needed extensive assistance of one staff for	F 226		

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F 226	Continued From page 15 locomotion on and off the unit, dressing, eating and personal hygiene. According to a written grievance of 3/28/13, R68's daughter reported her mother had told her that a male nursing assistant was rough with her when he used a transfer belt. R68 had told her daughter the belt was too tight. Staff talked to R68 , who described the nursing assistant and verified the nursing assistant had the transfer belt on her too tight and he had not loosened it when she complained. R68 was unable to specify the date, day or time of the incident. According to the grievance report, the unit nurse manager and DON were informed. The established plan for resolution was that the nurse manager was to follow up with the nursing assistant, re-educate the nursing assistant on the use of the transfer belt and listen to the resident. The report was signed by the administrator on 4/11/13, An interview on 7/11/13, at 8:15 a.m. was completed with the DON. She reported the facility staff failed to follow their policy regarding allegations of abuse. She reported the allegations should have been reported to the administrator and the state agency, which had not been done. She also reported that a comprehensive investigation should have been done.	F 226		
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.	F 241	F241 Dignity It is the policy of Anoka Rehabilitation & Living Center to promote care for residents in a manner and in an environment that maintains or enhances each	

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F 241	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that personal care and services were provided in a dignified manner for 2 of 3 residents (R77 & R30) who were reviewed in the sample for dignity. Findings include: On 7/9/13, at 9:13 a.m. a soiled incontinence product was observed lying on R77's unmade bed. R77 had diagnoses which included severe bladder spasms following urinary suprapubic catheter placement and neurogenic bladder with urinary retention. R77 had surgery on her right shoulder on 7/5/13, and wore a sling on the affected arm. The quarterly Minimum Data Set (MDS), completed on 4/18/13, indicated R77 was cognitively intact and needed extensive assistance of one facility staff to toilet. The MDS noted R77 needed supervision of one staff with personal hygiene. An interview was completed with R77 on 7/9/13, at 9:13 a.m. R77 reported she had been independent with her cares prior to a surgery on her right shoulder and now needed assistance from the staff for personal hygiene and dressing. R77 indicated the nursing assistant (NA)-A was, "Rushed this morning " when R77 was assisted with personal hygiene and dressing. She reported NA-A did not take the time to straighten out her	F 241	resident's dignity and respect in full recognition of his or her individuality. For Resident #30 a concern report was completed and an investigation initiated by the interdisciplinary team. The resident and family members were both interviewed regarding the concern of the delayed mealtime. The culinary manager investigated the concern and the employee responsible for the delay was counseled. The results of the investigation and correction will be reported to the resident and responsible party. For other residents who may be affected by this practice, the workflow for dining will be reviewed and revised to ensure that meals are served timely. Staff members responsible for meals will be educated on the proper protocols for meal preparation and service. The interdisciplinary team will review resident rights policy and update as needed. Dining audits will be completed three times per week for two weeks, two times per week for two	

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F 241	Continued From page 17 room or make her bed before she was wheeled to breakfast. An interview with NA-A was completed on 7/9/13, at 9:25 a.m. She reported that she was rushed when cares were provided to R77 on this date and did not take time to straighten the room, make the bed or dispose of the used incontinence product, which she verified was left on the bed. She reported she was in a hurry to get the resident to breakfast and had planned to return to the R77's room after she got all the other residents to breakfast. NA-A reported when she returned to the R77's room to clean it, a volunteer (A) was with R77 and was observed to provide healing touch to R77 and NA-A was unable to remove the incontinent product from the bed or straighten out the room. An interview with the registered nurse (RN)-B was completed on 7/10/13, at 2:10 p.m. He reported it was not acceptable to leave the resident's bedroom in "disarray" nor was it acceptable to leave a used incontinence product on the bed. He verified it was not dignified. An interview with the director of nursing (DON) was completed on 7/11/13, at 7:15 a.m. She reported that a used incontinence product that was left on the bed where it could potentially be viewed by visitors or consultants was not acceptable and felt it was a dignity issue. A second interview with R77 was done on 7/11/13, at 9:30 a.m. She reported that she saw the incontinence product lying on her bed on 7/9/13, and it bothered her. She reported that volunteer-A was in her room, and provided	F 241	weeks, and then weekly as needed to ensure compliance. The interdisciplinary team will review the protocols and meet with direct care staff weekly for four weeks to review and revise the workflow for each dining area. For Resident #77 the personal undergarment was put away out of public view upon notification. For other residents who may be affected by this practice, resident right to dignity and privacy will be reviewed with all staff responsible for resident care. Dignity and privacy audits will be completed two times per week for two weeks and then weekly as needed to ensure compliance. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendation. The Culinary Services Director or his designee will be responsible for meal time accuracy. The Director of Nursing or her designee will be responsible for maintaining privacy of resident undergarments. Date of Correction: August 20, 2013	

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F 241	Continued From page 18 healing touch that morning and when R77 saw the incontinence product lying on her bed and it upset her. R30 reported that on 7/6/13, she waited for breakfast from 7:00 a.m. to 9:15 a.m. and breakfast was not served. A quarterly MDS completed on 4/4/13, indicated R30 was cognitively intact. She needed extensive assistance of one staff for areas that included transfers, dressing and personal hygiene. She was independent with meals after staff served her the meal. An interview with R30's family member (FM-A) was completed on 7/8/13, at 5:21 p.m. FM-A reported she was very upset in regards to the care given to R30. She reported she had talked R30 in that morning and R30 was very upset and crying. She reported that she was told by R30 that on 7/6/13, she was not served breakfast. FM-A reported R30 told her that she went to the dining room at 7:00 a.m. and planned to have coffee until breakfast was served at 7:30 a.m. R30 reported that she sat at her table until 9:15 a.m., when she left the dining room to go to the bathroom. R30 reported to FM-A that during the 2 hour and 15 minute wait, no breakfast was served to her or any of the residents that sat in the dining room. FM-A reported R30 was so upset that when NA-E assisted her to the bathroom, R30 told the NA about this and he went to the kitchen, made her some toast/coffee and brought the food to her room. An interview with R30 was completed on 7/9/13, at 9:31 a.m. R30 verified the report from FM-A.	F 241		

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F 241	Continued From page 19 She cried when she discussed the incident. She stated she was still upset about the incident and felt so vulnerable that had to sit there for such a long time, and no one served her breakfast. She indicated no staff person said anything to her, or any other resident, who sat in the dining room while their waited for their meal, as to why breakfast was not served. She indicated she did not know if any of the other residents got their meal or not. An interview with the DON on 7/11/13, at 7:15 a.m. was completed. The DON reported the dietary staff person who would have served breakfast had called in ill on 7/6/13, and as a result the breakfast meal was served very late. The DON reported she was not aware that no one had not told the residents of the reason for the delay and someone should have done so.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide resident preferences for bathing frequency for 1 of 3 residents (R68) reviewed for personal choices.	F 242	F242 Resident Choice It is the policy of Anoka Rehabilitation & Living Center that residents have the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to each resident.	

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F 242	Continued From page 20 Findings include: The admission Minimum Data Set (MDS) completed on 1/18/13, noted R68 was cognitively intact and that it was very important to R68 to be involved with choices for bathing. During an interview on 7/8/13, at 6:35 p.m. R68 reported that she did not get to choose how often she gets a bath. R68 reported that when she was admitted she was told when her bath would be given and it would be done once per week. R68 further reported that prior to her admission to the facility, she bathed on a daily basis. Furthermore, R68 stated that she would like to be involved in the decisions that involved the frequency of her baths. An interview was completed with nursing assistant (NA)-B on 7/10/13, at 10:15 a.m. NA-B reported that she worked with R68 but had not bathed her as she was bathed in the evening. NA-B reported that if a resident asked for additional baths, she would inform the nurse about this request. An interview with registered nurse (RN)-B was completed on 7/10/13, at 2:15 p.m. He reported upon admission, residents are informed of their bathing schedule and asked about their personal preferences. A request for documentation of this discussion with the resident was made and none were provided. RN-B indicated on 7/11/13, at 11:00 a.m. that he talked with R68 and she indicated she wanted more frequent baths, RN-B reported it would be addressed.	F 242	For Resident #68 the resident was interviewed regarding bathing preferences and those preferences added to the plan of care. For other residents who may be affected by this practice, preferences will be reviewed at the care conferences to ensure personal preferences are honored. Education will be provided for staff members regarding residents' rights to choose and their preferences. The interdisciplinary team will review the protocols for interviewing residents and/or responsible parties for preferences and choices and make revisions as needed. Audits regarding resident choice will be completed weekly for four weeks and then monthly as needed to ensure compliance. The audit results will be reported to the Quality Assurance Committee for review and further recommendations. The Director of Nursing or her designee will be responsible for compliance. Date of Correction: August 20, 2013	

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and monitor the care and treatment related to toe pain, ingrown toenails and an ongoing fungal infection 1 of 1 resident (R170) reviewed in the sample for skin conditions, non pressure related. Findings include: R170's quarterly Minimum Data Set (MDS) completed on 4/24/13, noted he was cognitively intact. The MDS indicated R170 was generally cooperative and did not reject personal cares. According to the MDS, R170 needed extensive assistance of one staff for transfers, dressing and locomotion off the unit. He was independent with personal hygiene and eating. He had no scheduled pain management and no non-medication interventions were identified for pain management. He received medication as needed for pain management. According to the MDS R170 had no identified skin conditions. R170's plan of care, last reviewed on 5/7/13, noted R170 had great toe pain related to	F 309	F309 Quality of Care and Life It is the policy of Anoka Rehabilitation & Living Center to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. For Resident #170 a new assessment will be completed regarding his foot condition to ensure the current treatment plan meets the needs of the resident. The primary physician will be informed of the assessment results and a review of the current physician orders will be completed. Corresponding updates will be made to the plan of care. Education on assessment and treatment of non-pressure skin alterations will be provided for staff members responsible. For other residents who may be affected by this practice, an audit of all non-pressure skin alterations will be completed, to ensure	

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F 309	Continued From page 22 peripheral vascular disease and ingrown nails. The interventions on the care plan included a referral to the podiatrist if the resident had thick nails, corns or calluses and monitor/document and report to physician any signs or symptoms of skin problems related to peripheral vascular disease. The resident was identified at risk for alteration of skin integrity due to peripheral vascular disease, left great toe pain, and a history of fungal infection of both feet. The care plan interventions included a nurse to monitor R170's skin integrity when bathed and report any changes. A review of the medical record lacked any evidence the resident's skin/feet were assessed at weekly baths. The pain assessment completed with the quarterly MDS on 4/24/13, did not identify pain as an issue. A Braden and skin risk data assessment was completed on 4/22/13, and the status of the R170's feet was not discussed on the assessment. R170 was seen by a podiatrist on 4/5/13. The podiatrist's report identified R170 presented for evaluation and treatment of a painful digital nail deformity. It indicated R170 was unable to provide nail care for himself due to the length and thickness of the nails, which caused him pressure and limited R170's ability to walk in shoes without pain. The podiatrist assessed an onychomycosis (fungal infection), signs of PVD (peripheral vascular disease), pain in limb, hammertoes, calluses, onychogryphosis (thickening and nail curvature), and keratoderma (development of calluses). The podiatrist debrided (cut) the nails, removed thickened toenail material around the nail edges and cut a skin lesion.	F 309	assessments are accurate, up to date, physician orders are current, and treatment plan meets current needs of residents. Audits of skin alterations will be completed weekly for four weeks and then monthly as needed to ensure continued compliance. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendations. The Director of Nursing or her designee will be responsible for compliance. Date of Correction: August 20, 2013	

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F 309	Continued From page 23 A medical progress note, written on 4/10/13, by the nurse practitioner noted a diagnosis of great toe pain and fungal infection of resident's feet. She documented the resident complained of bilateral great toe pain and the toe pain caused a decrease in resident's ability to walk. Both toes had erythema (redness of the skin) and were painful to touch. The left great toe had a blackened area around the toe nail bed. A review of the R170's treatment record noted a physician order, written on 12/11/12, that Lotrimin AF cream 1% (an antifungal cream) was to be applied at bedtime after foot soaks. The May treatment record indicated R170 received the foot soaks and antifungal cream 3 of 31 opportunities. The June treatment record indicated R170 received the foot soaks and antifungal cream 13 of 30 opportunities and the July treatment record (July 1 to July 10) indicated he received the treatment and cream 2 of 10 opportunities. R170 was observed and interviewed on 7/9/13, at 8:36 a.m. He sat in a recliner chair and his feet were uncovered. He reported that it hurt to wear shoes and socks so he did not wear them. His toes were observed to be red. His toes nails were thickened and wavy in appearance. R170 reported the pain in his left toe woke him up the night before but he did not take any medication or tell any staff about the toe pain. R170 was interviewed a second time on 7/11/13, at 1:25 p.m. He again reported he did not wear shoes and socks because it hurt his feet. He reported any pressure on his feet caused pain. R170 was observed to walk in his room with a	F 309		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 24 four wheeled walker without any shoes or socks on his feet. An interview with nursing assistant (NA)-B on 7/10/13, at 9:18 a.m. was completed. She reported that she cared for R170 on this date and previously. She reported the resident normally wore shoes and socks and was not aware that he did not have them on. An interview on 7/10/13, at 9:31 a.m. with NA-A was completed. NA-A reported R170 refused to wear shoes and socks a lot of the time. She indicated she did not know why R170 did not want to wear shoes and assumed it was just his personal preference. An interview on 7/10/13, at 10:01 a.m. with registered nurse (RN)-C was completed. She reported R170 consistently refused to wear shoes and socks. She did not know the rationale for the resident's decision to do so. She indicated she did not complete an assessment his skin or feet on her shift. She reported the evening shift did this as he was to have foot soaks and ointment to his feet on "their shift." An interview with registered nurse (RN)-B on 7/10/13, at 1:49 p.m. was completed. RN-B reported he had assisted the resident to the facility store earlier in the day and the resident ambulated with a four wheeled walker and did not have any covering on his feet. He indicated he did not know why R170 did not wear any foot covering and thought it was his personal preference. The treatment records for the foot soaks with the antifungal cream for June and July, 2013 were reviewed with RN-B. He	F 309		

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F 309	Continued From page 25 reported was unaware the resident did not receive this medication and the foot soaks as ordered and the staff should have informed the physician and himself about this. A request was made for evidence of skin/feet assessment, skin monitoring, physician notification of refusal of foot soaks/medication, pain assessment and any discussion with R170 in regards to the risks vs benefits of not wearing any foot covering. No further information was provided.	F 309		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	F353 Sufficient Staffing It is the policy of Anoka Rehabilitation & Living Center to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Anoka Rehabilitation & Living Center meets or exceeds the state and federal requirements for nursing staffing ratios. For Residents #: 30, 47, 33, 77, 282, 170, 289, 39, 105, 68, 246, 8, and 4, call light audits will be completed to ensure that resident requests are honored timely according to policy.	

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F 353	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to ensure sufficient nursing staff to provide nursing and related services at the highest practicable level to ensure that the physical, mental, and psychosocial well-being of each resident, as evidenced by 2 of 4 families (R30 and R82) interviewed and 12 of 31 resident complaints (R30, R47,R33, R77, R170, R68, R246, R8, R4, R282, R289, and R39). Findings include: Family-A, Family B, and Family C expressed concerns of insufficient staffing within the facility. During an interview on 7/8/13, at 5:21 p.m. Family (F)-A (family of R30) verbalized she was upset in regards to the short staffing at the facility and how it affected her parent. F-A reported she frequently visited her mother and felt there had been a decline in the past five months in the staffing pattern. She felt the care for her parent had declined. She reported she had talked R30 in the morning (7/8/13) and R30 was very upset and crying. She reported that she was told by R30 that on 7/6/13, she was not served breakfast. She reported R30 told her that she went to the dining room at 7:00 a.m. and planned to have coffee until breakfast was served at 7:30 a.m. R30 reported that she sat at her table until 9:15 a.m., when she left the dining room to go to the bathroom. R30 reported to F-A that during the 2 hour and 15 minute wait, no breakfast was served to herself or any of the residents that sat in the dining room. F-A reported R30 was so upset that when NA-E assisted her to the bathroom, R30	F 353	The families of Residents #: 82 and 30 will be interviewed and concerns investigated by the interdisciplinary team for follow up with results reported back to the residents and/or responsible parties. The location of staff and perceptions will be discussed at the next resident council and family council meetings with concerns brought back to the interdisciplinary team for review and action. An audible call system has been ordered and installation is pending for the transitional care households. For all other residents who may be affected by this practice, call light audits and resident interviews will be completed to ensure compliance with response time. The interdisciplinary team will review the workflow for the households to ensure that staff members are available to answer call lights timely and that break times are staggered for direct caregivers. The method of medication administration was reviewed and the auto-tear system was replaced with bubble packs on	

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F 353	Continued From page 27 told the NA about this and he went to the kitchen, made her some toast/ coffee and brought the food to her room. F-A reported that it seemed as though residents had to spend excessive time to wait for their meals as there was insufficient help in the dining room. She also reported call light response was "extremely poor". She reported that she was on the phone with R30 and had timed the call light response when R30 needed to go to the bathroom. She indicated a lot of the time, it was over a half an hour for the nursing assistant to respond and sometimes longer. F-A also reported R30 was upset about the administration of her medications. She indicated that due to staff shortage, R30 did not get her medication at breakfast as she had requested and the medication may be administered anywhere between 10:00 a.m. to noon. She reported at times, R30 will have to remind the staff about needing the medication. During an interview on 7/9/13, at 1:49 p.m. F-B (family of R82) reported the facility was very short of staff. F-B indicated she visited R82 almost daily. She indicated staff are "quitting all the time" and then new staff are hired but the consistency of the care suffers. She indicated when she visits R82 and she has a question or a care need is noted, she no longer used the call light. She reported it takes too long for the staff to respond, so F-B will hunt down a staff member to have issues addressed. She indicated she felt this irritated the staff but she needed to ensure he was taken care of. F-B reported that she constantly has had to look behind staff to ensure	F 353	7/26/13. The staffing patterns for each household were reviewed and staffing adjustments made to accommodate resident care needs. Audits regarding resident wait times for assistance will be completed three times per week for two weeks, two times per week for two weeks and then weekly as needed to ensure compliance. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendations. The Director of Nursing or her designee will be responsible for compliance. Date of Correction: August 20, 2013	

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they had done what they were supposed to do. She also reported that she worries about the care given when she was not there.

R30, R47, R33, R77, R105, R170, R68, R246, R8, R4, R282, R289 and R39 expressed concerns in regards to insufficient staff within the facility.

R30's quarterly Minimum Data Set (MDS) was completed on 4/4/13, and indicated R30 was cognitively intact. She needed extensive assistance of one staff for toileting, bed mobility, transfers, walking in room/corridor, dressing and personal hygiene.

An interview was conducted on 7/9/13, at 9:31 a.m. and R30 reported she did not feel there was sufficient staff to give her the care she needed. R30 again verified her concerns on a second interview on 7/11/13, at 10:05 a.m. She reported that she did not get her medication on a regularly scheduled basis due to staff shortage. She indicated she preferred to get her medications with her breakfast and had told staff about this but due to shortages of staff will get medications before or after lunch. She reported she had to remind staff many times she needed her medications and they tell R30 " they are running behind " .

R30 reported she frequently had to wait half an hour for assistance to use the bathroom and then will wait another 20 minutes for help to get out of the bathroom. She reported had episodes of urinary incontinence as staff are not able to respond quickly enough and has just "resigned" to this.

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F 353	Continued From page 29 R30 also reported had to consistently wait over a half an hour to forty five minutes for staff to serve meals. She indicated the evening meal on 7/8/13, she had "never seen so many staff in the dining room" and their meal was served quickly. She reported a recent incident when several residents got frustrated over the extended wait time for the meal and started to bang on their dishes, chiming, "We want our food." R30 reported on 7/6/13, she went to breakfast at 7:00 a.m. with the expectation the staff would start serving breakfast at 7:30 a.m. She was not served her meal and at 9:15 a.m., she had to use the bathroom and so went back to room. A nursing assistant (NA)-E assisted her and then asked if she was going back to dining room. She reported she refused to return to the dining room as she needed to get ready for a birthday party so the NA-E went to kitchen and got some toast and coffee. She reported the dietary department is also short of staff. Dietary staff were present during the incident on 7/6/13 but did not serve breakfast or provide explanation as to the delay. R30 cried when she discussed the incident. She reported felt very vulnerable and felt uncomfortable. R47's admission MDS dated 4/5/13, revealed R47's cognition was intact. He required extensive assistance for locomotion and was independent with with eating. During an interview on 7/8/13, at 6:16 p.m., R47 reported the facility did not have enough staff available for the meal times to ensure timely service and assistance. He reported that he typically had to wait 15 to 30 minutes in the dining	F 353		

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F 353	Continued From page 30 room to be waited on. R47 added, "There's meals we've sat there for about an hour and still there's no one whose come and waited on you." During a follow-up interview on 7/10/13, at 9:50 a.m., R47 verified his statements. He indicated insufficient staffing concerns during all meal times, breakfast, lunch and dinner. R33's quarterly MDS dated 4/2/13, revealed R33's cognition was intact and she needed extensive assistance of two staff for bed mobility, dressing, toileting and eating. She was totally dependent on two facility staff for all transfers. During an interview on 7/8/13, at 7:13 p.m. R33 voiced concern in regards to inadequate staff. She reported had to wait at times over 30 minutes and "sometimes I just give up." She also revealed she had episodes of urinary incontinence as staff don't respond to her requests in a timely fashion. She reported she felt really bad when this happened. R77's quarterly MDS, dated 4/18/13, revealed R77's cognition was intact and she needed extensive assistance of one staff for dressing and toileting. She needed limited assistance of one staff for bed mobility and walking in her room and supervision with personal hygiene and transfers. She was independent eating. During an interview on 7/9/13, at 9:13 a.m., R77 reported she did not feel there were sufficient staff to assist her and other residents. She reported the primary shortage was in the morning as "they just did not have enough staff to get everyone up and to breakfast in a timely fashion." She also reported there were not enough staff in	F 353		

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the dining room for meals. R77 reported she had been independent with her cares prior to a surgery on her right shoulder and now needed assistance from the staff for personal hygiene and dressing. R77 indicated the nursing assistant (NA-A) was really rushed "this morning" when she was assisted with personal hygiene and dressing and did not take the time to straighten out her room, make her bed or remove a soiled incontinence product that was lying on top of her bed. A second interview was completed on 7/11/13, at 9:30 a.m. R77 verified her statements and also reported that it really bothered her that the nursing assistant left the incontinence product "lying on the bed."

R170's quarterly MDS dated 4/24/13, revealed the resident was cognitively intact. He needed supervision with toileting and locomotion on the unit.

During an interview with R170 on 7/9/13, at 8:25 a.m., he reported he had concerns in regards to staffing. He stated he felt the facility was very short of staff. He indicated when he used the call light would have to wait for at least a half an hour for assistance and had waited for over 1 hour and 20 minutes for pain medication. He reported that sometimes nursing assistants will walk by his room when his call light was on and " just ignore it."

R68's admission MDS, dated 1/14/13, revealed R68 was considered cognitively intact and the quarterly MDS, dated 4/9/13 noted cognition had declined to moderately impaired. The quarterly MDS noted R68 needed extensive assistance of two staff for bed mobility, toilet use, and transfers.

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F 353	Continued From page 32 During an interview on 7/8/13, at 6:48 p.m. R68 reported she felt the facility did not have enough staff. She reported she had requested of staff to be taken to the bathroom before the evening meal and they still have not had time to assist me. She reported this was a " big problem" at the facility. R246's MDS dated 5/24/13, revealed R246 was cognitively intact, he required set up to limited assistance for most activities of daily living. During an interview on 7/9/13, at 10:30 a.m., R246 reported the facility did not provide enough staffing to assist during meal times. R246 stated that he had waited unacceptable lengths of time for service in the dining room. He added, "Just not enough aides in there to wait on everybody." R8's quarterly MDS, dated 5/28/13, identified R8 was cognitively intact and needed extensive assistance of two facility staff with bed mobility, transfers, dressing, and toileting. During an interview on 7/9/13, at 11:14 a.m., R8 reported she had concerns in regards to staffing. She reported "they just don't have enough help and I will have to wait a long time for them to help me." She indicated at times will have to wait an hour or so for help and indicated she should not have to wait to so long. She reported she had incidents of wetting herself as the staff could not "get to me in time " . R4's quarterly MDS dated 4/22/13, revealed R4's cognition was moderately intact and she required extensive assistance with activities of daily living,	F 353		

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F 353	Continued From page 33 including toileting. During an interview on 7/9/13, at 2:36 p.m., R4 reported that she typically had to wait between five to 30 minutes for transfer and/or toileting assistance. During follow-up interview on 7/11/13, at 12:50 p.m., R4 added that she had to wait unacceptable lengths of time for response to the use of her call light. She stated, "It takes too long." R282 was admitted on 6/27/13 from an acute care hospital and was identified to make her needs known. During an interview on 7/8/13, at 7:01 p.m., she reported she had to wait a couple of hours for assistance with toileting. "It's gotten to where they put this pad on me, so I just go." She indicated she knew when she needed to use the toilet but just could not wait for the staff because they take so long. R289 was admitted on 4/12/13 and discharged to a private home on 4/19/13. Upon admission, R289 was alert and oriented to person, place and time. According to a written grievance report of 4/12/13, R289's daughter, who was in tears, stated "I am going to take my mother out here. She is on the cardiac unit. I think she is on the wrong unit, no one has told us anything." "No pillow or tray table in room." "Someone dropped off a walker." "Seems like q (every) time she rings the call light, aides act like they are inconvenienced" and identified nursing assistant (NA)-D. The report indicated R289 was admitted	F 353		

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F 353	Continued From page 34 around the time another resident had a medical emergency and was sent to local emergency room. R39's admission MDS, dated 4/24/13, revealed R39 was cognitively intact and needed extensive assistance with bed mobility, transfers, dressing and toileting. During an interview with R39 on 7/11/13, at 10:14 a.m., she reported she was concerned about staffing shortages. She indicated she had to wait a "very long time" for staff to answer her call light. She reported episodes of urinary incontinence but placed responsibility on herself. She stated " I know it takes them a long time to answer the call light and so if I don't put on my call light soon enough, I will end up wetting myself." Employee interviews verified concerns of insufficient staffing. During an interview on 7/11/13, at 7:24 a.m., licensed practical nurse (LPN)-G verified that she was aware of resident complaints of long call light waits. She also verified that the NAs expressed frustration due to not having enough time to complete their tasks and assignments. LPN-G verified knowledge of residents who did not receive assistance with all cares as indicated in their plan of care and this was due to lack of time by NAs to complete the cares. During an interview on 7/9/13, at 8:31 a.m., NA-A reported she did not feel that there was enough staff to provide the care for residents. She indicated two nursing assistants were responsible	F 353		

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F 353	Continued From page 35 to get 20 residents up in the morning and to breakfast before 9:00 a.m. She indicated residents complain that they have to wait so long for assistance She reported she was aware that residents have to wait 30 minutes for assistance to go to the bathroom and if a resident is a two person assist, they may have to wait longer, possibly an hour. She indicated she had expressed concern to the registered nurse manager (RN)-B and RN-E. She reported was told they did not need more staff and staff needed to learn how to work hard. NA-A reported she would skip breaks to get the work done and reported management was aware of this. NA-A indicated that yesterday (7/8/13) when she first came to work she had a resident who complained of chest pain and spent 45 minutes with the resident and assisted the nurse. NA-A indicated that as a result, she got behind in her work and was more hurried than normal. NA-A also indicated there was no one to call if we need help. During an interview on 7/9/13, at 9:42 a.m. NA-B reported she did not feel here was enough help at the present. She reported residents complained they have to wait a long time for help. She reported the nurse on the unit tried to help but she had other things to do. Indicated that both she will skip her breaks, and this included her lunch breaks just to get all the work done before she leaves work. During an interview on 7/9/13 at 10:14 a.m., RN-E reported she was aware of staff shortage. She reported the nursing assistants do the best they can but there are just not enough. Indicated she had talked to a manager about the shortage of nursing assistants but it had not done any	F 353		

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F 353	Continued From page 36 good. During an interview with the director of nursing (DON) on 7/9/13, at 8:30 a.m. she reported the call light audits were done formally when a complaint was issued in regards call light response time. She reported she does random call light audits but does not document them. Documentation of call light audits completed were received. The audits were done on 6/12/13, at 5:05 p.m. and 6/4/13, at 1:26 p.m. The longest call light response was nine minutes. During a follow up interview with the DON on 7/11/13, at 7:15 a.m., she discussed the facility was in a transition phase in which they were moving from a traditional nursing home environment to the non-traditional household environment and some of the staff were having problems adjusting to the new work environment. She indicated this transition started about five months ago and they had not done any customer service audits to determine the effectiveness of the new concept. She reported that was not aware of any resident or family concerns in regards to the staffing.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 It is the policy of Anoka Rehabilitation & Living Center to procure food from sources approved or considered satisfactory by Federal, State, and/or local authorities; and store, prepare, distribute and serve food under sanitary conditions. The missing temperature for the dish machine was taken upon	

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	245205	A. BUILDING _____ B. WING _____	C 07/11/2013

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

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F 371	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper hand hygiene was followed during meal services, which had the potential to affect 20 of 20 residents who reside on the Reflections Memory Care unit and 17 of 19 residents who reside on the Seasons Memory Care unit. The facility failed to ensure the dish washer temperatures were monitored to ensure safe cleaning temperatures with the potential to affect 111 of 114 residents who resided in the facility. In addition, the facility failed to ensure pureed food items were checked for appropriate temperature prior to serving food for 3 of 3 residents (R74, R204, R114) who required altered diets. Findings include: On 7/8/13, at 5:24 p.m. during observation of the evening meal service on the Reflections memory care unit, dietary aid (DA)-E donned gloves, pulled glasses out of pocket, grabbed a hamburger bun out of the bag and carried it across the kitchen to put it on a plate. DA-E then put a hamburger on the bun and walked back to the center island with the plate. With the same gloved hands, DA-E then tore a piece of lettuce, grabbed a slice of tomato and placed them on the hamburger. DA-E proceeded to the toaster, grabbed a slice of toast, buttered it while it was in her same gloved hands, placed it on the serving counter top, sliced it in half and put it on plate. DA-E continued to serve with the same gloved hands and DA-E was observed to touch the refrigerator handles at 5:31 p.m. and 5:34 p.m. DA-E again returned to the pattern to touch the	F 371	notification. Education will be provided for staff members on the policy for taking dish machine temperatures. Staff members were counseled and reminded of glove use with preparing and serving food upon notification. Education will be provided for staff members on the proper use of gloves when preparing and serving food. The steam table pan temperatures were taken upon notification. The plate temperatures for R74, R204, and R114 were also taken to ensure proper temperatures. Education will be provided for staff members responsible for taking food temperatures. For other residents who may be affected by this practice, a review of hygiene practices, dish machine sanitation, food temperatures, and food preparation & distribution practices will be completed to ensure compliance with current standards of practice.	

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F 371	Continued From page 38 buns, lettuce and tomatoes and did not change her gloves. At 5:41 p.m. after being handed a bag of ketchup packets, DA-E was told to change gloves by the director of culinary services. On 7/8/13, at 5:32 p.m. nursing assistant (NA)-F was observed to remove the top hamburger bun for a resident in the dining room with bare hands. NA-F removed the top of the bun and applied ketchup to the hamburger. Then with bare hands, NA-F placed the lettuce, tomato and top bun back on the hamburger. NA-F then held the hamburger with one hand and cut it down the middle with a knife in the other hand. Again, at 5:47 p.m. during the same meal service, NA-F was observed to remove the top bun of another resident's hamburger, apply ketchup and place the bun back on top all with bare hands. During an interview on 7/8/13, at 6:10 p.m. DA-E explained how she used to work in laundry when she worked in the old building, but since laundry is not done in the new building, she started to work in the kitchen. DA-E stated she didn't know what was okay to touch and what wasn't okay to touch during meal service and felt she hadn't had much training in that area. Also, during the same interview, dietary director (DD) stated she would expect a staff person who serves a meal to remove gloves after contact with potentially contaminated surfaces prior to touching ready to eat foods again. During an observation of the evening meal on 7/8/13, at 5:40 p.m. in the Seasons dining area, dietary aide (DA)-F had gloves on, opened cupboards, took dishes out, opened twist tie on loaf of bread, handled trays, and then used the same gloved hands to place tomatoes and lettuce	F 371	The protocols and practices for hygiene, dish machine sanitation, food temperatures, and food preparation & distribution practices will be reviewed by the interdisciplinary team and revised as needed. A review of policies by the Medical Director will be completed to ensure compliance. Audits for hygiene, dish machine sanitation, and food preparation & distribution will be completed 3 times per week for 2 weeks, 2 times per week for two weeks, and then weekly as needed to ensure continued compliance. The results will be reported to the Quality Assurance Committee for review and further recommendations. The Director of Culinary Services or his designee will be responsible for compliance. Date of Correction: August 20, 2013	

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F 371	Continued From page 39 on the hamburgers. During an interview on 7/8/13, at 6:05 p.m. DA-F stated, "I usually change my gloves when I touch things like the fridge handles. I usually have my plates and bowls ready, but tonight I didn't have time." DA-F reported she didn't know if it was wrong to touch cupboard handles with her gloves on and then touch ready to serve food without changing her gloves. DA-F further stated she puts lettuce and tomatoes on the hamburgers with her hands, rather than using utensils, because she had to, "Tear the hard parts off." During an interview on 7/11/13, at 7:40 a.m. director of culinary services (DCS) stated gloves should be changed if surfaces like refrigerator doors were touched while serving food. During an observation of the evening meal on 7/8/13, at 5:30 p.m. in the Seasons dining area, licensed practical nurse (LPN)-A assisted residents to put condiments on their hamburger. LPN-A offered to help residents that needed assistance with opening single use ketchup and mustard packets. After putting the condiments on the hamburger, LPN-A picked up the bun with her bare hand, and placed it on the hamburger. During an interview on 7/11/13, at 1:30 p.m. RN-A stated she saw LPN-A touch the hamburger bun and stopped her right away and told her not to touch food with bare hands. RN-A verified that ready to serve food should never be touched with bare hands during dining service. During an interview on 7/11/13, at 2:10 p.m. DCS verified gloves should be worn when touching	F 371		

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F 371	Continued From page 40 ready to serve food. Review of the dining room standards pocket guide (no date) revealed servers must use tongs/single use disposable gloves when handling food without a utensil. Review of the dietary department infection control policy dated 2013, indicated dietary staff would practice proper food handling procedures including but not limited to hand washing, no bare hand contact with food, wearing disposable gloves to perform certain food handling tasks, and discarding gloves upon completion of the task The facility did not ensure the dishwasher temperatures were monitored to ensure safe cleaning temperatures which had the potential to affect 111 of 114 residents who resided in the facility. During the initial tour of the kitchen on 7/8/13, at 1:10 p.m. with the DCS, dishwashing temperatures were reviewed for the dishwasher in the main kitchen, which serviced the three dining areas on the main level, and the two separate dishwashers on the second level. A green binder in each dining area contained logs from 6/21/13 through 7/8/13, which included an area to document dishwashing temperatures for the wash and rinse cycle for each meal. During review of the dishwashing logs, there were 265 dishwashing temperatures that should have been recorded. Of those, 149 were left blank. Also, 33 of the documented temperatures were below the 150 degrees minimum wash temperature, and/or the 180 degree minimum rinse temperature required per the facility's policy.	F 371		

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F 371	Continued From page 41 During an interview on 7/8/13, at 1:25 p.m. DCS indicated he had in-serviced the staff on documenting the dishwashing temperatures and had even given out warnings when temperatures were not documented. DCS reported the documentation logs prior to 6/21/13, "Are worse than that" and stated, "It is what it is." When asked about the dishwashing temperatures documented that were below the minimum requirement, DCS indicated the staff should notify maintenance immediately. To his knowledge, these were not reported to maintenance. During an interview on 7/11/13, at 3:40 p.m. dietary aide (DA)-D stated the wash cycle temperature, "Should be at least 150." When asked what the rinse temperature should be, DA-D stated "170." When asked what she would do if the temperature did not meet the required level, she stated she would call maintenance right away. During an interview on 7/11/13, at 4:02 p.m. DA-B stated, "I would let the supervisor know if temperatures were not where they needed to be," but also indicated she did not know what the required temperature should be. DA-B indicated she would know what the temperature was supposed to be when she recorded the temperature, "Because it's in the book." During an interview on 7/11/13, at 4:50 p.m. DA-A stated, "I think the temp needs to be around 200." When asked what he would do if it didn't reach the required temperature, he stated, "Well I'd let it warm up." When asked if he documents the temperatures anywhere, DA-A stated, "No, I've never been told that we have to. I document the	F 371		

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F 371	Continued From page 42 food and the refrigerator temps." Review of the Dishwashing Temperature Monitoring Logs policy undated, identified the wash and rinse temperatures or parts per million (PPM), would be observed and logged every meal by the operator during the dishwashing process. The policy also indicated temperatures and/or PPM that were below the required levels should be reported to the Food Service Director (FSD) immediately for correction of the problem before continuing procedures. Finally, the policy identified it was the responsibility of the FSD to monitor daily completion of the dishwashing temperature logs. Review of the Dishwashing Procedures policy revised 12/11/08, revealed the temperature of the water would be maintained at 150 degrees Fahrenheit (F) or above for the washing cycle and at 180 degrees F for the rinsing and sanitizing cycle and if temperatures were below the minimum standard, immediate action would be taken. The policy also identified that if the final rinse temperature on the dish machine read below 180 degrees F, the temperature should be checked using a holding thermometer or temperature strips to test that the surface contact point was at 160 degrees F to ensure proper operation of the dish machine. Further, maintenance would be notified and all dishwashing would be halted as soon as the problem was identified and dishwashing could resume as soon as standard temperatures were again being maintained. The facility also failed to ensure pureed food items were checked for appropriate temperature	F 371		

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F 371	Continued From page 43 prior to serving food for 3 of 3 residents (R74, R204, R114) who required altered diets. During an observation of the morning meal in the Seasons dining area, on 7/11/13, at 7:20 a.m. the cart that contained the food was brought into the serving area. DA-C placed the large and small containers of food onto the steam table. DA-C used the thermometer to test each of the food items in each of the large containers, and recorded the temperature on the log. DA-C reported temperatures for hot foods should be between 160-185. Foods between 140-145 degrees were in the "Danger zone." DA-C set the thermometer on the table behind him. When asked if he was finished checking the temperatures on the food in the steam table, DA-C stated, "Yes." DA-C reported the pureed foods in the smaller containers did not have to be checked because, "They are the same," while pointing to the food in the larger containers. When asked if he thought the temperature should be checked because they were in different containers, DA-C stated, "No, they are the same. I don't have to check them." After the question, DA-C checked the temperature of each of the containers with pureed foods and found the ground meat temperature to be 133.4 degrees. DA-C stated, "I gotta take this back over there." DA-C brought the container to the kitchen. During an interview on 7/11/13, at 7:35 a.m. DCS stated, "Every container with food needs to be temped." DCS reminded DA-C that every food item on the steam table needed to have the temperature checked and documented. Review of the Service Temperatures policy	F 371		

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F 371	Continued From page 44 revised May 2008, revealed staff should take temperatures of all hot foods as soon as they were put on the serving line. Review of the Preparing and Cooking Hot Foods policy, undated, revealed temperatures of all potentially hazardous hot foods would be taken during preparation and service to ensure safety of food. The policy further directed the use of a calibrated thermometer to take the temperatures of all food products.	F 371		

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	245205	A. BUILDING **02 - NEW BUILDING** B. WING _____	07/10/2013

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K 000	INITIAL COMMENTS Surveyor: 03005 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Anoka Rehab & Living Ctr.was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. Anoka Care-Rehabilitation Center was constructed in 2012 and opened in 2013. It is a two story building with a basement. The construction type is determined to be Type II (111). The building is separated from the rest of the facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire doors. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility is licensed for 120 beds and 115 were occupied at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

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