DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

October 10, 2022

Administrator
Anoka-Metro Reg Treatment Ctr
3301 Seventh Ave North
Anoka, MN 55303

Re: SURVEY RESULTS
CCN: 244002
Cycle Start Date: August 9, 2022

Dear Administrator:

On September 20, 2022 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed an on-site revisit of your facility, to verify that your facility had achieved and maintained compliance with federal Conditions of Participation (CoP) with certification deficiencies issued pursuant to a substantial allegation validation survey, completed on August 9, 2022.

We presumed, based on your plan of correction, that your facility had corrected the deficiencies that found the CoP of 42 CFR 482.13, Patient Rights was in compliance. Based on our on-site revisit, we have determined that your facility has achieved substantial compliance.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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August 31, 2022

Administrator
Anoka-Metro Reg Treatment Ctr
3301 Seventh Ave North
Anoka, MN 55303

Re: SURVEY RESULTS
CCN: 244002
Cycle Start Date: August 9, 2022

Dear Administrator:

A survey was completed on August 9, 2022 for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health noted one or more deficiencies. At the conclusion of this survey, the surveyors advised you of the findings, including the fact that this facility does not meet the requirements of Section 1905(d) of the Social Security Act and the following Condition(s) of Participation (CoP) for Critical Access Hospitals (CAH).

A0167 42 CFR 482.13 Condition of Participation: Patient's Rights

We also verified on August 9, 2022 that the conditions, cited at A0167, resulted in an Immediate Jeopardy (IJ) due to non-compliance with the §42 CFR 482.13 Condition of Participation: Patient's Rights. The immediate jeopardy has been removed.

Federal certification deficiencies are delineated on the electronically attached form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC).

To be considered acceptable, your PoC must contain the following elements:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

Ordinarily, a facility will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview. If possible, please type your plan of correction to ensure legibility.

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

Please make a copy of your plan of correction for your records.

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days may result in decertification and a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action. If, upon a revisit within forty five (45) days of the survey exit date, correction is not ascertained, we will have no recourse except to recommend to the Centers for Medicare and Medicaid Services Chicago Region V Office that your certification be terminated, effective November 7, 2022.

Please feel free to call me with any questions related to this letter.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	244002	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA-METRO REG TREATMENT CTR	3301 SEVENTH AVE NORTH 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
A 000	INITIAL COMMENTS A substantial allegation investigation was conducted from 8/2/22 through 8/9/22, to investigate an alleged violation of the Conditions of Participation for hospitals participating in Medicare, specifically the Conditions of Patient Rights at 42 CFR 482.13 related to the complaints H40023504C (MN85351) and H40023570C (MN85486). The investigation resulted in an Immediate Jeopardy (IJ) at Condition of Patient Rights at 42 CFR 482.13, at A0167 Restraint and Seclusion when on 6/21/22 a safety support staff (SSS)-A responded to an incident by running across a courtyard, tackling a patient (P)-1 to the ground who was engaged with four other safety support staff to deescalate the patient's behavior impairing other interventions to meet the patient needs. On 7/18/22 when SSS-A and two other SSS were escorting P2 from the Sally Port to the admitting unit. P2 postured SSS-A who then lifted P2 off the ground with P2's feet dangling. SSS-A continued to walk forward with P2 towards the unit as P2 kicked the walls of the hallway outside of the unit and at the unit doors. SSA-A and P2 landed on the ground. The IJ began on 6/21/22 and the immediacy was removed on 8/8/22. The hospital remains out of compliance at the Condition level under the Condition of Patient Rights at 42 CFR 482.13.	A 000		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights.	A 115		

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.

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A 115	Continued From page 1 This CONDITION is not met as evidenced by: Based on interview and document review, the hospital failed to provide adequate implementation of restraints for 2 of 10 patients (P1, P2) reviewed. See A0167. An IJ was identified on 8/5/22, at 11:00 a.m. related to an improper restraint incident of (P1) and (P2) involving potential risk for injury and harm. The IJ was removed 8/8/22, at 2:13 p.m. after verification of implementation of an acceptable removal plan, but the hospital remained out of compliance at the Condition of Patient Rights. See A0167.	A 115		
A 167	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(4)(ii) [The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to identify and thoroughly investigate the use of improper resistant incidents resulting in the potential risk for serious injury and harm for 2 of 10 patients (P)-1 and P2 reviewed for patient rights. This deficient practice resulted in an immediate jeopardy (IJ) for P1 and P2. The IJ began on 6/21/22, at approximately 10:35 a.m. when a safety support staff (SSS)-A responded to an incident by running across a	A 167		

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A 167	Continued From page 2 courtyard, tackling a patient (P)-1 to the ground who was engaged with four other safety support staff to deescalate the patient's behavior impairing other interventions to meet the patient needs. On 7/18/22, when SSS-A and two other SSS were escorting P2 from the Sally Port to the admitting unit. P2 postured SSS-A who then lifted P2 off the ground with P2's feet dangling. SSS-A continued to walk forward with P2 towards the unit as P2 kicked the walls of the hallway outside of the unit and at the unit doors. SSA-A and P2 landed on the ground. In addition, neither P1 or P2 received a timely thorough initial nursing assessment nor were there timely assessments completed while P1 and P2 were in restraints as per policy and procedure guidance. The Medical Director, Director of Operations, MHSATS Executive Director, MHSATS Nurse Executive, MHSATS Quality Director, MHSATS Security Director and Training & Development Supervisor were notified of the IJ finding on 8/5/22, at 11:00 a.m. The IJ was removed on 8/8/22, at 2:13 p.m. after verification of an acceptable removal plan but noncompliance remained at the Condition level under the Condition of Patient Rights at 42 CFR 482.13. Findings include: P1 was admitted to the hospital on 6/21/22, with diagnoses of schizophrenia. On 8/3/22, at 10:48 a.m. video review revealed on 6/21/22, at approximately 10:35 a.m., P1 during the admission process ran from safety support staff out into the secure courtyard. Within 43 seconds of running, P1 had been surrounded by four SSS. At the same time, SSA-A was observed on video running up behind P1 and	A 167		

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A 167	Continued From page 3	A 167		

placing P1 in a manual basket hold, lifting P1 off the ground and into the air. SSS-A then slammed P1 down on the ground. Other SSS's then responded and secured P1's extremities in a manual hold. P1 was placed in a restraint chair and taken to Bravo unit for assessment and admission. Video review further revealed P1 had been left with security support staff for approximately seven minutes without having both a nursing initial assessment completed, and nursing staff present.

On 8/2/22, at 12:34 p.m. P1 was interviewed and stated he felt safe and denied injuries. P1 had no recollection of the incident which occurred on 6/21/22.

P2 was admitted to the hospital on 7/18/22, with diagnoses which included psychosis.

On 8/2/22, at 2:04 p.m. video review revealed on 7/18/22, at approximately 10:30 a.m., SSS-A placed P2 in a manual hold, SSS-A was observed on video lifting P2 into the air and carrying P2 approximately 15 feet down the hallway. SSS-A attempted to carry P2 through the double doors on the unit, however P2 placed his feet on the door and pushed back. SSS-A appeared to have either lost his balance or propelled P2 onto the floor where P2 was manually restrained and eventually placed in a restraint chair. Video review further revealed P2 had been placed in the restraint chair at 10:40 a.m. At 10:42, P2 was then brought to the restraint room. P2 had not been assessed by a registered nurse until 10:48 a.m., approximately 7 minutes after being placed in a restraint chair. At 11:22 a.m. P2's head dropped to his chest and appears to go unconscious. At 11:23 P2 is assessed by a

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A 167	Continued From page 4	A 167		

registered nurse (RN) and Incident Command System (ICS) was initiated.

On 8/2/22, at 12:55 p.m. P2 was interviewed and stated he felt safe and denied injuries. P2 had no recollection of the incident which occurred on 7/18/22.

On 8/4/22, at 10:41 a.m. SSS-A was interviewed and verified he had initiated a manual hold on 6/21/22, related to P1 running from other security support staff during the admission process. SSS-A stated "P1 was out in the courtyard in his underwear and there were other female patients outside, so I made the decision to place the patient in a manual hold from behind and take him down". SSS-A verified four other SSS staff where present and around P1 at the time he made the decision to initiate a manual hold. SSS-A further stated during the incident nursing staff was not present. SSS-A stated on 7/18/22 he had placed P2 in a manual hold due to physical aggression towards staff. SSA-A verified proper EASE technique was not used during the manual hold with P2 when he lifted him up from the floor in a manual hold, carried him and then brought him to the ground.

On 8/3/22, at 1:55 p.m. SSS-B was interviewed and stated she was present and observed SSS-A place P2 in a manual hold, lift him of the ground and carry him to the double door to enter the unit. SSS-B stated she witnessed SSS-A and P2 fall to the floor during the struggle. SSS-B verified lifting a patient up in the air and carrying them is not part of EASE training and facility policy and procedure related to restraints.

On 8/3/22, at 3:12 p.m. SSS-C was interviewed

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A 167	Continued From page 5 and stated she was present and observed SSS-A place P2 in a manual hold, lift him of the ground and carry him to the double door to enter the unit. SSS-C stated she witnessed SSS-A and P2 fall to the floor during the struggle. SSS-C stated physically lifting a patient up in the air and carrying them is not part of EASE training and facility policy and procedure related to restraints On 8/3/22, at 1:07 p.m. RN-A stated she had viewed the video on 7/18/22, which revealed SSS-A physically lift P2 up in the air off the ground with his feet kicking, proceed to carry him and bring him down onto the floor. RN-A stated upon viewing the video footage the incident had been reported immediately to the hospital leadership team which included Director of Nursing, Medical Director and hospital administrator due to the manual hold and incident went against facility EASE training and restraint policy and procedure. RN-A stated she was told that leadership had made the determination the incident was not a reportable incident and was not going to be reported to the state agency (SA). RN-A verified the facility policy directs that a RN completes an initial assessment when restraints are initiated followed by RN assessing the patient every 15 minutes. RN-A stated the assessment included vitals to be taken, checking for circulation and the need for continuing restraint. On 8/3/22, at 1:33 p.m. RN-B stated she had viewed the video on 7/18/22, which revealed SSS-A physically lifting P2 up in the air off the ground with his feet kicking, proceed to carry him and bring him down onto the floor. RN-B stated what she observed went against EASE training. RN-B stated upon viewing the video footage the incident had been reported immediately to the	A 167		

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A 167	Continued From page 6 hospital leadership team which included Director of Nursing, Medical Director, and hospital administrator. RN-A verified the facility policy directs that a RN completes an initial assessment when restraints are initiated followed by RN assessing the patient every 15 minutes. RN-A stated the assessment included vitals to be taken, checking for circulation and the need for continuing restraint for patient safety. RN-A verified through viewing the videos involving P1 and P2, neither patient had the required nursing assessments initiated nor had they been completed as per policy every 15 min for patient safety. On 8/4/22, at 8:44 a.m. RN-C stated she had viewed the video on 7/18/22, which revealed SSS-A physically lifting P2 up in the air off the ground with his feet kicking, proceed to carry him and bring him down onto the floor. RN-C stated what she observed went against EASE training. RN-C stated she was immediately concerned upon viewing the video footage the incident and reported immediately to the hospital leadership team which included Director of Nursing, Medical Director, and hospital administrator. RN-C verified the facility policy directs that a RN completes an initial assessment when restraints are initiated followed by RN assessing the patient every 15 minutes. RN-C stated the assessment included vitals to be taken, checking for circulation and the need for continuing restraint for patient safety On 8/4/22, at 4:26 p.m. during interview Safety Operations Supervisor (SSO) verified SSS-A had not followed EASE policy and procedure on 6/21/22, related to the manual restraint hold involving P1. SSO verified SSS-A had not	A 167		

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A 167	Continued From page 7 followed EASE policy and procedure on 7/18/22, involving the manual restraint hold involving P2. SSO stated these are not techniques we teach. SSO stated the EASE techniques are to keep patients and staff safe. SSO further stated the goal is to always use the least restrictive and de-escalation verbally should be attempted prior to a manual hold. On 8/4/22, at 5:05 p.m. Director of Operations (DO) during interview stated EASE was important to be followed for not only patient safety but also staff. DO verified EASE techniques had not been followed related to the manual holds on both 6/21/22 and 7/18/22. On 8/4/22, at 1:01 p.m. during interview Medial Director verified EASE policy and procedure developed for patient safety and staff safety related to restraints had not been followed on 6/21/22, involving SSS-A and P1. Facility Medical Director further verified that through review of video assessments, it was identified that P1 had not been assessed properly per policy with initiation of restraints which is the expectation for patient safety. Medical Director verified EASE policy and procedure developed for patient safety and staff safety related to restraints had not been followed on 7/18/22, involving SSS-A and P2. Facility Medical Director further verified that through review of video assessments, it was identified that P1 had not been assessed properly per policy with initiation of restraints which is the expectation for patient safety On 8/4/22, at 1:01 p.m. during interview MHSATS Executive Director verified EASE policy and procedure developed for patient safety and staff safety related to restraints had not been followed	A 167		

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A 167	Continued From page 8 on 6/21/22, involving SSS-A and P1. MHSATS Executive Director further verified that through review of video assessments, it was identified that P1 had not been assessed properly per policy with initiation of restraints which is the expectation for patient safety. MHSATS Executive Director verified EASE policy and procedure developed for patient safety and staff safety related to restraints had not been followed on 7/18/22, involving SSS-A and P2. MHSATS Executive Director further verified that through review of video assessments, it was identified that P1 had not been assessed properly per policy with initiation of restraints which is the expectation for patient safety. MHSATS Executive Director further stated he believed the incidents which occurred on 6/21/22 and 7/18/22 both should have been reported to the SA. The facility policy Seclusion or Restraint dated 2/2/21, directed staff provide for the safety of patients who pose an imminent risk of harm to self or others by using the least restrictive intervention available including seclusion and/or restraint. Seclusion or restraint may only be used when less restrictive interventions are ineffective for the management of aggressive, violent, or self-destructive behavior and cannot be used as a punitive action or for staff convenience. The policy further Direct care staff monitoring patient in restraints to included, continuously observe the patient during the restraint period, repeat and discuss release criteria upon request of patient and as often as necessary to facilitate patient's release, document observations and patient's behavior on the Therapeutic Observation Record (DHS 5688) at least every 15 minutes, engage with patient at a minimum of every 15 minutes to assist the patient in regaining emotional	A 167		

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A 167	Continued From page 9 regulation and safety towards their release from restraint, note presence or absence of indicators for good circulation in hands and feet as indicated by warmth, color, motion and sensitivity on observation record and inform RN immediately of absence of any indicator, take vital signs as directed by the RN, and ensure patient is in good body alignment with adequate respirations. The facility training manual titled EASE Foundations Physical Safety Strategies, A Manual for Class Instructors dated 4/9/2021, directed staff as follows: Standing Hold & Escorting with Arms Crossed in Front This hold might be used to hold a smaller adult or child in place or to move them backwards. 1. Approach the person from behind. 2. Use your forearms to push both their arms forward so that their arms cross in front of their body. 3. Grasp the person's right wrist with your left hand. 4. Move your right hand down the person's left arm to the left wrist and grasp their wrist. 5. Pull person's arms to their abdomen below their rib cage area. 6. Place one of your shoulders between the person's shoulders to minimize head butting and pull them towards you to control their balance. 7. Escorting: After securing the hold, walk backwards slowly with the person. This will help in preventing the person from seeing and using obstacles to block progress by raising the feet to door frames, tables. The immediately jeopardy that began on 6/21/22, IJ was removed on 8/8/22/22, at 2:13 p.m. when it was verified the hospital successfully	A 167		

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A 167	Continued From page 10 implemented a removal plan which included: in person education with all direct care staff during the staff's first shift related to improper use of restraint, imminent risk, patient rights concerns and reporting potential patient rights concerns but noncompliance remained at the Condition level under the Condition of Patient Rights at 42 CFR 482.13.	A 167		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 31, 2022

Ms. Rochelle Fischer, Administrator
Anoka-Metro Reg Treatment Ctr
3301 Seventh Ave North
Anoka, MN 55303

Dear Ms. Fischer:

On August 9, 2022, a sample validation survey was completed at the above facility by the Minnesota Departments of Health and Public Safety for the purpose of assessing compliance with State standards for licensure based on Minnesota Statutes §144.55, Subd. 3.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

Enclosed is your copy of the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

Thank you for your cooperation.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00004	A. BUILDING: _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA-METRO REG TREATMENT CTR	3301 SEVENTH AVE NORTH 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) COMPLETE DATE
6 000	INITIAL COMMENTS In accordance with MN State Statute 144.55 Subd 3., for the purpose of hospital licensure, the commissioner of health shall use as minimum standards the hospital certification regulations. A substantial allegation survey was conducted from 8/2/22 through 8/9/22, to investigate an alleged violation of State requirements for Hospital Licensure pertaining to Patient Rights at 42 CFR 482.13. Please refer to CMS 2567.	6 000		