DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 16, 2021

Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

RE: CCN: 245205
Cycle Start Date: July 14, 2021

Dear Administrator:

On August 11, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
July 28, 2021

Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

RE: CCN: 245205
Cycle Start Date: July 14, 2021

Dear Administrator:

On July 14, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 14, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by January 14, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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 07/14/2021

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 On 7/12/21-7/14/21 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5205130C and H5205129C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with	F 661		8/6/21

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

Electronically Signed | 08/03/2021

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F 661	Continued From page 1 the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately complete reconcilliation of medications upon discharge for 1 of 1 residents (R1) reviewed for discharge practices. Findings include: R1's Admission Record identified admission to facility on 5/20/21 and discharge on 6/30/21 R1's Order summary report included allergies to amlodipine, codeine, indomethacin, Niacin, Oxycodone, sulfamethaxazole/trimethoprim, sulfasalazine, sulfa antibiotics, adhesive tape, latex. R1's discharge summary data collection, completed by registered nurse (RN)-A and effective 6/29/21, indicated discharge on 6/30/21 at 1:15 p.m. included a recapitulation of stay. Diagnoses, allergies and functional data was	F 661	It is the policy of Anoka Rehabilitation and Living Center to develop a discharge summary, with the resident/representative□s participation, that is a recapitulation of a resident□s stay, including but not limited to, diagnosis, course of illness, treatment, therapy, pertinent labs, radiology and consultation results and reconciliation of pre- and post-discharge medications. The summary will also contain information about where the resident will reside and arrangements for medical and non-medical follow-up care. With the resident□s permission, a copy of the discharge summary is released to authorized persons or agencies for post-discharge care. The Transfer and Discharge Planning Policy and Procedure was reviewed and revised, including the reconciliation of all	

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F 661	Continued From page 2 completed. Further, the summary stated medications sent with the resident included: Eliquis, diltiazem, Albuterol Sulfate, Insulin Aspart, Cetirizine, Potassium Chloride, Vitamin B + C complex, Flovent, Celecoxib, Serevent, furosemide, Lopressor, Senokot, Victoza, Levothyroxine, acetaminophen, Fluocinonide, caltrate, miglitol, pantoprazole, pepcid, fluticasone, potassium chloride ER (listed twice), Wellbutrin SR and Flovent. During an interview on 7/8/21, at 4:22 p.m. the complainant stated R1 was sent home with another resident's medications. A picture was provided to confirm another residents name appeared on the prescription for amlodipine besylate 10 mg tablet. The complainant indicated there were 2 pills punched out the medication card. However, the complainant confirmed R1 knew the pills weren't her, that she had an allergy toward this medication and would not injest them. During an interviw on 7/13/21, at 3:22 p.m. the director of nursing (DON) stated the nurse was to complete a summary when a resident discharged the facility. Further, the process included a full head to toe assessment, printed medication list and physician orders. DON stated his expectation was the RN would compare the medications orders to the medications being sent home with the resident and review them. DON was not able to determine how the complainant would have a picture of another residen'ts medication and stated "most likely, the nurse did not verify the medications upon discharge." The facility's Transfer and Discharge Planning Summary policy, dated 5/2019, included Procedure 3. Include a list of medications with	F 661	pre-discharge medications with the post discharge medications including over the counter. The discharging nurse will verify current medications with physician orders. A second nurse will verify the medication list with current physician orders and sign the discharge summary. All nurses were educated on the Transfer and Discharge Policy and Procedure, including the revised procedure for reconciliation of all pre-discharged medications with the post discharge medications including over the counter. Education started on 7/30/2021 Unit Managers will complete audits on all discharges X 2 weeks then audits will be completed weekly on 3 discharged residents X 3 months. Results will be reported at QAPI and the need for continued audits will be determined and added to the QAPI Surveillance Data and Schedule until sustained compliance is in effect. Director of Nursing is responsible for compliance. Date of compliance: 8/6/2021	

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F 661	Continued From page 3 instructins in simple terms. Do not use medical terms or abbreviations, including a reconciliation of all pre-discharge medications with the post discharge medications including over the counter.	F 661		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure medication was appropriately stored for 4 of 8 residents (R2, R4, R5 & R6) reviewed for storage and expired	F 761	It is the policy of this Anoka Rehabilitation and Living Center to label and store drugs and biologicals according to State and Federal rules and regulations. Deficiency	8/3/21

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F 761	Continued From page 4 medications. Findings include: Review of R2's Prehospital Care Report, date of service 05/08/21 at 2:30 p.m. revealed R2's chief complaint was stabbing chest pain and primary impression was chest pain (non-cardiac), pain was made worse by palpation and inspiration. R2 had revealed to emergency medical services (EMS) "staff had administered one of her prescribed nitro (nitroglycerin) tablets. When EMS evaluates bottle, it was discovered the bottle was prescribed in 2003. EMS communicates with staff and informs them that the medication is expired." R2's admission record indicated a diagnosis of chronic diastolic (congestive) heart failure with an onset date of 02/04/2021. However, R2's order summary report lacked evidence of orders for amlodipine (medication used to treat high blood pressure) or nitroglycerin (medication used to treat or prevent chest pain or pressure). R4's admission record indicated a diagnosis of essential (primary) hypertension with an onset date of 4/30/21 and was enrolled in hospice on 4 /30/21. Further, R4's order summary report indicated orders for Metoprolol tartrate (medication used for high blood pressure) give 0.5 tablet (12.5mg) by mouth one time a day. Review of R4's blood pressure revealed it was within normal limits. During an observation and interview on 7/12/20, at 1:58 p.m. registered nurse (RN)-A opened R4's locked medication cabinet. RN-A removed medications and confirmed orders according to the electronic health record (EHR). RN-A	F 761	of practice was that the wrong medication was in the wrong cupboard of 4 residents. Resident R2, R4, R5, R6 medication cupboards were audited for expired medications and correct medications. Residents throughout the facility are at risk of the alleged deficient practice. Medication audits of all medicine cupboards have been completed for having the correct medication for the resident in their cupboard. The policy and procedure for storage of drugs and biologicals was reviewed and continued to meet regulatory requirements. All nurses were re-educated on the procedure for storage of drugs, biologicals and expired medications on 7/23/21. Daily auditing by floor nurse will be in effect immediately to ensure that the correct medication is in the cupboard. Upon receiving the medication from the pharmacy, it is the responsibility of the floor nurse to ensure the medication is in the appropriate medication cupboard for the resident. Medication cupboards will be audited by the Unit Manager for compliance of having the correct medication in the correct resident's medication cupboard. This will occur X 2 per week for 2 months and then every other week X 2 months. Issues will be addressed when they are identified. The trends will be reported at QAPI and the need for continued audits will be determined and added to the QAPI Surveillance Data and Schedule until sustained compliance is in effect.	

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F 761	Continued From page 5 removed a medication card for Metoprolol Tartrate 25 mg, 1/2 tab by mouth BID, however, R5's name was on the label. RN-A removed the card from the cabinet and stated the medication was not in the correct cabinet and confirmed there were 17 doses punched out of the card. RN-A continued the process of reconciling medications stored in R2's locked cabinet to the EHR. RN-A revealed Amlodipine Besylate 5mg for R6 was in the wrong medication cabinet and had zero pills punched out. RN-A removed R6's medication card from R2's cabinet. Further, RN-A confirmed R2 did not have an order for nitro nor were there any in the locked cabinet. RN-A stated residents with orders for nitro had the bottle taped to the locked medication cabinet door for easy access. RN-A stated staff were expected to do 3 checks before administering medications and likely staff were not reading or looking at the name on the label. Medication cabinets for R4 and R5 were reviewed. No further issues were noted. During an observation on 7/13/20, at 9:13 a.m. RN-B reviewed 4 additional medication cabinets and no issues were noted. On 7/13/21, at 10:47 a.m. a list of all residents with an order for nitro was provided. DON and surveyor verified each medication cabinet contained a bottle of nitro that was not expired. During an interview on 7/13/21, at 12:46 p.m. pharmacist consultant (PC) stated after review of medications replaced in the Omnicell (emergency medication storage unit), nitro was not dispensed on 5/8/21 for R2 and documentation was provided. Further, she stated if expired nitro had been administered, it would not be effective.	F 761	The Director of nursing will be responsible for correction. Compliance date 8/6/2021	

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F 761	Continued From page 6	F 761		

During an interview on 7/13/21, at 2:37 p.m. RN-D stated on 5/8/21 he was called to assist when R2 had reported chest pain to help with the paperwork. RN-D stated the nurse had realized the nitro was expired prior to administering and got it from downstairs, indicating the Omnicell.

During an interview on 7/13/21, at 2:47 p.m. RN-C stated on 5/8/21, R2 complained of chest pain and protocol required her to call for help from the supervising nurse, RN-D. RN-C stated RN-D entered R2's room and produce a bottle of nitro. RN-C stated together, they checked the expiration date, seeing it was not expired, it was administered. RN-C stated R2 received 1 nitro tablet prior to EMS arriving. RN-C stated there were still pills in the bottle so it was returned to the "transparent envelope taped inside the medication cabinet door".

During an interview on 7/13/21, at 3:22 p.m. director of nursing (DON) stated RN-A had reported medications stored in the wrong resident's medication cabinets. DON stated the RN receiving the medication was responsible to make sure it was placed in the correct resident room and when not done correctly, it placed the resident at risk for medication errors. Further, DON stated he was not aware of any medication errors related to expired nitro. Further, DON stated the review of medication cabinets, revealed the lack of a good process or procedure to where to find nitro in an emergency.

The facility policy 5.1 Delivery and Receipt of Routine Deliveries, last revised 1/1/2013, indicated "After taking delivery, Facility should place medications in the appropriate location for

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F 761	Continued From page 7 use.	F 761		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 28, 2021

Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

Re: Event ID: IFXW11

Dear Administrator:

The above facility survey was completed on July 14, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is 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 feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted on 7/12/21-7/14/21 to investigate complaint H5205130C and H5205129C As a result the following was identified: The complaints were found to be substantiated: H5205130C and H5205129C with NO licensing	2 000		

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

Electronically Signed | 08/03/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	C 07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	**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) COMPLETE DATE
2 000	Continued From page 1 orders issued The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		