Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 15, 2024

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

RE: CCN: 245205
Cycle Start Date: March 26, 2024

Dear Administrator:

On April 12, 2024, we notified you a remedy was imposed. On May 10, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 2, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 27, 2024 be discontinued as of May 2, 2024. (42 CFR 488.417 (b))

In our letter of April 12, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 27, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 15, 2024

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

Re: Reinspection Results
Event ID: U95X12 and KU4P12

Dear Administrator:

On May 9, 2024 and May 10, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on March 26, 2024 and April 22, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 1, 2024

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

RE: CCN: 245205
Cycle Start Date: March 26, 2024

Dear Administrator:

On April 12, 2024, we informed you of imposed enforcement remedies.

On April 22, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the surveyfindings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 27, 2024.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 27, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 27, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of April 12, 2024, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting

Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 27, 2024.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 September 26, 2024 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A

copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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://forms.web.health.state.mn.us/form/NHDisputeResolution

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:
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,

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

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 04/22/2024

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 4/19/24 and 4/22/24, a standard abbreviated survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H52053223C (MN00102464) with no deficiencies cited. However, as a result of the investigation, a deficiency was cited at F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		5/2/24

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

Electronically Signed | 05/01/2024

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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F 686	Continued From page 1 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assessed and/or care-planned interventions for pressure ulcer care were implemented for 1 of 3 residents (R3) reviewed for heel pressure ulcers, who were at risk for additional, and/or worsened, pressure ulcers. Findings include: R3's significant change Minimum Data Set (MDS), dated 3/25/24, indicated R3 was cognitively intact, and he required substantial/maximal assistance with mobility. R3's diagnoses included Parkinson's Disease, diabetes, coronary artery disease, and age-related physical debility. The MDS identified R3 was at risk for pressure ulcers with an identified stage 3 pressure ulcer and an unstageable pressure ulcer with suspected deep tissue injury in evolution. R3 was provided pressure ulcer care. An Incident-Post Incident Review form, dated 3/19/24, identified the medical provider noticed a left heel ulcer that was open that day. Root cause of the ulcer "appear[ed] to be a pressure sore." An Incident - IDT (interdisciplinary team) Initial Post Investigation Review, dated 3/20/24,	F 686	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. The facility immediately reviewed R3's comprehensive assessment and assured the preventative measures were care planned and implemented, to assure no further risk of additional, and/or worsened pressure ulcers. b. Offloading boots immediately placed on resident, and on-the-spot education provided to the nurse, and aide on importance of following the treatment administration record. Updated care plan, treatment administration record, tasks tab - Kardex, and POC charting to indicate the requirement of the offloading boots. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. Residents with care planned interventions for pressure ulcers to have the potential to be affected by the deficient practice. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a. Education on the importance of implementing interventions, reading, and	

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F 686	Continued From page 2 indicated the left heel ulcer was a "pressure injury." An Incident-Post Incident Review form, dated 3/21/24, indicated a right heel blister was identified that day. A root cause was documented as " ...continus [sec] placing the heel on the foot rest." R3's care plan, reviewed 4/19/24, identified R3 had a potential for skin breakdown due to impaired mobility and indicated he had a stage 3 pressure injury to his left heel, a deep tissue injury to his right heel, and a diabetic wound on his right calf. The goal was to show no complications in skin integrity. An intervention, initiated on 3/21/24, directed heel protecting boots to be applied when he was in bed and in the wheelchair to protect his feet and heels. An Incident - IDT Initial Post Investigation Review, dated 3/22/24, identified the root cause of the right heel blister was "Pressure to heels from foot pedals on wheelchair." R3's Braden Scare for Predicting Pressure Sore Risk, dated 3/22/24, identified a score of 16 (at risk) related to slightly limited sensory perception, occasionally moist skin, chairfast activity status, slightly limited mobility, and a potential problem with friction and shearing. An Incident-Post Incident Review form, dated 3/25/24, indicated a blister on R3's left heel. The form identified, after review, R3 stayed up in his wheelchair all day as he disliked the recliner chair and thus his feet rested on the foot pedals all day. R3's April 2024 Treatment Administration Record	F 686	following care plans. All pressure ulcer risk management interventions, and wound meeting wound interventions will be care planned, added to NAR task tab - Kardex, POC, and treatment administration records. Mangers were educated on all pressure ulcer interventions that are derived from our IDT and wound meeting for pressure ulcers, need to be implemented on the group sheet, task tab which will trigger into POC, the care plan and treat administration record. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a. Using the audit tool, the DON or designee will conduct random audits x5 per week for x4 weeks with results brought back to the QAPI committee.	

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F 686	Continued From page 3 (TAR), identified on 3/25/24, a treatment order was initiated for R3 to have heel managers on while up and while in bed. The frequency of documented completion was once during the day, evening, and night shifts. An Incident - IDT Initial Post Investigation Review, dated 3/26/24, identified R3's right heel "PI" (pressure injury) required the following interventions: heel manager (boot), supplements to promote wound healing, and a vascular consult as it was suspected R3 had vascular problems that contributed to his lower extremity wounds. An Incident - IDT Initial Post Investigation Review, dated 3/28/24, identified an intervention to only use foot pedals for transport and to wear protective boots while up in the wheelchair or in bed as R3 applied "most pressure to heels while sitting in wheelchair." The root cause was related to "Pressure." R3's comprehensive care plan, reviewed 4/19/24, lacked a directed intervention to keep R3's feet off the foot pedals unless he was being transported. R3's April 2024 TAR, identified on 4/10/24, the 3/25/24 order was discontinued, and a new order was initiated that directed R4 to have heel protecting boots on while up and while in bed, and that his feet were not to be resting on the foot pedals unless he was being transported. The frequency of documented completion was once during the day, evening, and night shifts. Two Wound Evaluations, each dated 4/19/24, at 10:01 a.m., identified that morning the stage 3 pressure ulcer on R3's left lateral heel and the	F 686		

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F 686	Continued From page 4 deep tissue pressure injury on his right heel were assessed. R3's TAR Administration Details report, dated 4/19/24, identified LPN-A signed off R3's boot and foot pedal task at 11:13 a.m. as completed. On 4/19/24, at 12:10 p.m., R3 was observed seated in his wheelchair at a dining room table. He wore blue gripper type socks and his feet rested on the wheelchair pedals. No protective boots were observed on R3's feet. During an interview on 4/19/24, at 12:12 p.m., R3's nurse, licensed practical nurse (LPN)-A, identified R3 had a wound on his right calf and his left heel. She did not think he had an ulcer on his right heel. Initially, LPN-A was unsure of R3's ulcer treatments and/or interventions other than for a daily dressing and a twice a week treatment. Upon review of the TAR, she identified he was to have a boot on his left heel when he was up in the wheelchair and when in bed. She stated, "He should have it on ...it is in the orders." Immediately after, LPN-A went to the dining room and identified R3 did not have boots on his feet. She asked, "Do you want me to put it on?" She was directed to do whatever the facility expected her to do. She stated she would have someone bring it. She expected she would have seen it on to "protect the foot;" however, she explained when staff toileted R3 the boot was removed but she expected staff reapplied it when finished. On 4/19/24, at 12:17 p.m., LPN-A approached R3 with the heel boots and applied them. Once on, she placed his boot covered feet back onto the wheelchair pedals.	F 686		

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F 686	Continued From page 5 When interviewed on 4/19/24, at 12:20 p.m., NA-A stated this was the first time she worked with R3 and was unsure about any alterations in his skin integrity; however, she assumed he had concerns as he wore heel boots when she got him up that morning. Despite this assumption, when she assisted him with morning cares, she took the boots off and placed the blue grippy socks on and did not replace the boots. She identified she "got him up for lunch" and did not put the boots on as he still had on the grippy socks. She was unaware of R3's care planned preventative skin/pressure ulcer interventions as she did not review resident care plans, or Kardexes (NA care plan) despite a response she was expected to follow the care plan/Kardex for resident safety and the prevention of pressure ulcers. She explained she just followed the resident group sheets she carried with her. In addition, she did not ask staff about any additional interventions for R3 that morning. NA-A's group sheet was reviewed and lacked an intervention for the boots. R3's Kardex was reviewed after NA-A opened it and she identified the Kardex directed the boots. She stated, "I did not know he was supposed to have the boots on in his wheelchair." During interview on 4/19/24, at 12:37 p.m., with the clinical assistant LPN-B, she stated NAs were updated about resident skin statuses during the daily huddles. She expected the care plan to be followed, especially as the group sheets lacked enough room to add all the interventions to it. The nurse was responsible to ensure skin/pressure ulcer interventions were implemented as setup, thus the reason why such interventions were placed on the TAR. She provided examples of boots and off-loading (repositioning). LPN-B	F 686		

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F 686	Continued From page 6 stated one of R3's pressure ulcer interventions included boots on when he was up in his wheelchair to assist with pressure reduction. If staff failed to follow this, "We are going to cause more injury to what is going on with his heels ...it is going to get worse." LPN-B declined knowledge R3 ever declined the boots. On 4/19/24, a copy of the aide group sheet was requested; however, was not provided that date. During an observation and interview on 4/19/24, at 1:02 p.m., with R3 and his family member (FM)-A, R3 sat in his wheelchair with his boot covered feet on the wheelchair pedals. R3 stated he had sores on both his heels and his ankle. The heel sores were identified "about a month or so" ago and he was unsure of the cause. He identified all of them were healing. He explained the NAs placed the boots on "a couple times a day" and he wore them to bed. He stated he did not always wear the boots when up. FM-A stated she saw them on "most of the time" but confirmed there were extended periods of time when they were not on when he was up. FM-A felt R3 did not have the boots on that morning prior to them being placed when he ate lunch. Both denied they removed the boots prior to lunch. FM-A stated R3 disliked the recliner and thus he spent most of his day seated in his wheelchair "just like he is now." He and FM-A stated he was up in the wheelchair since he got up that morning and had not laid down. When interviewed on 4/19/24, at 2:36 p.m., the director of nursing (DON), stated NAs were updated on pressure ulcers during their huddles and thus those residents with pressure ulcers were not specifically identified on the group	F 686		

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F 686	Continued From page 7 sheets. In addition, not all interventions were placed on the group sheet as the group sheets only reflected "tidbits" and "highlights" from the care plan. He expected staff to follow what was on the group sheets and what was identified on the Kardex/care plan. In addition, if an intervention was identified on the TAR, it was the nurse's responsibility to ensure the setup/ordered intervention was followed. The DON explained the importance of ensuring R3's boots were on centered around pressure injury prevention. He was aware of the 12:10 p.m. observation and responded, "It is disappointing" and expected LPN-A would have ensured the boots were on, especially as R3 was prone to skin breakdown. On 4/22/24, at 9:21 a.m., 1:23 p.m., and 3:08 p.m., R3 was observed seated in his wheelchair with blue gripper socks and protective boots; however, feet rested on the wheelchair pedals. A Prevention and Treatment of Pressure Ulcers/Pressure Injury policy, dated 11/22/22, identified the facility implemented preventative measures and provided appropriate treatment modalities for wounds according to professional standards of care.	F 686		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 1, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: U95X11

Dear Administrator:

The above facility was surveyed on April 19, 2024 through April 22, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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 _____	04/22/2024

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	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: On 4/19/24 and 4/22/24, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed this order and	2 000		

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2 000	Continued From page 1 identify the date when it will be completed. The following complaint was reviewed. H52053223C (MN00102464) with no licensing orders issued. However, as a result of the investigation, a licensing order was issued at 0900. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assessed and/or care-planned interventions for pressure ulcer care were implemented for 1 of 3 residents (R3) reviewed for heel pressure ulcers, who were at risk for additional, and/or worsened, pressure ulcers.	2 900	corrected	5/2/24

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2 900	Continued From page 3 Findings include: R3's significant change Minimum Data Set (MDS), dated 3/25/24, indicated R3 was cognitively intact, and he required substantial/maximal assistance with mobility. R3's diagnoses included Parkinson's Disease, diabetes, coronary artery disease, and age-related physical debility. The MDS identified R3 was at risk for pressure ulcers with an identified stage 3 pressure ulcer and an unstageable pressure ulcer with suspected deep tissue injury in evolution. R3 was provided pressure ulcer care. An Incident-Post Incident Review form, dated 3/19/24, identified the medical provider noticed a left heel ulcer that was open that day. Root cause of the ulcer "appear[ed] to be a pressure sore." An Incident - IDT (interdisciplinary team) Initial Post Investigation Review, dated 3/20/24, indicated the left heel ulcer was a "pressure injury." An Incident-Post Incident Review form, dated 3/21/24, indicated a right heel blister was identified that day. A root cause was documented as " ...continus [sec] placing the heel on the foot rest." R3's care plan, reviewed 4/19/24, identified R3 had a potential for skin breakdown due to impaired mobility and indicated he had a stage 3 pressure injury to his left heel, a deep tissue injury to his right heel, and a diabetic wound on his right calf. The goal was to show no complications in skin integrity. An intervention, initiated on 3/21/24, directed heel protecting boots to be applied when he was in bed and in the	2 900		

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2 900	Continued From page 4 wheelchair to protect his feet and heels. An Incident - IDT Initial Post Investigation Review, dated 3/22/24, identified the root cause of the right heel blister was "Pressure to heels from foot pedals on wheelchair." R3's Braden Scare for Predicting Pressure Sore Risk, dated 3/22/24, identified a score of 16 (at risk) related to slightly limited sensory perception, occasionally moist skin, chairfast activity status, slightly limited mobility, and a potential problem with friction and shearing. An Incident-Post Incident Review form, dated 3/25/24, indicated a blister on R3's left heel. The form identified, after review, R3 stayed up in his wheelchair all day as he disliked the recliner chair and thus his feet rested on the foot pedals all day. R3's April 2024 Treatment Administration Record (TAR), identified on 3/25/24, a treatment order was initiated for R3 to have heel managers on while up and while in bed. The frequency of documented completion was once during the day, evening, and night shifts. An Incident - IDT Initial Post Investigation Review, dated 3/26/24, identified R3's right heel "PI" (pressure injury) required the following interventions: heel manager (boot), supplements to promote wound healing, and a vascular consult as it was suspected R3 had vascular problems that contributed to his lower extremity wounds. An Incident - IDT Initial Post Investigation Review, dated 3/28/24, identified an intervention to only use foot pedals for transport and to wear protective boots while up in the wheelchair or in bed as R3 applied "most pressure to heels while	2 900		

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2 900	Continued From page 5 sitting in wheelchair." The root cause was related to "Pressure." R3's comprehensive care plan, reviewed 4/19/24, lacked a directed intervention to keep R3's feet off the foot pedals unless he was being transported. R3's April 2024 TAR, identified on 4/10/24, the 3/25/24 order was discontinued, and a new order was initiated that directed R4 to have heel protecting boots on while up and while in bed, and that his feet were not to be resting on the foot pedals unless he was being transported. The frequency of documented completion was once during the day, evening, and night shifts. Two Wound Evaluations, each dated 4/19/24, at 10:01 a.m., identified that morning the stage 3 pressure ulcer on R3's left lateral heel and the deep tissue pressure injury on his right heel were assessed. R3's TAR Administration Details report, dated 4/19/24, identified LPN-A signed off R3's boot and foot pedal task at 11:13 a.m. as completed. On 4/19/24, at 12:10 p.m., R3 was observed seated in his wheelchair at a dining room table. He wore blue gripper type socks and his feet rested on the wheelchair pedals. No protective boots were observed on R3's feet. During an interview on 4/19/24, at 12:12 p.m., R3's nurse, licensed practical nurse (LPN)-A, identified R3 had a wound on his right calf and his left heel. She did not think he had an ulcer on his right heel. Initially, LPN-A was unsure of R3's ulcer treatments and/or interventions other than for a daily dressing and a twice a week treatment.	2 900		

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2 900	Continued From page 6 Upon review of the TAR, she identified he was to have a boot on his left heel when he was up in the wheelchair and when in bed. She stated, "He should have it on ...it is in the orders." Immediately after, LPN-A went to the dining room and identified R3 did not have boots on his feet. She asked, "Do you want me to put it on?" She was directed to do whatever the facility expected her to do. She stated she would have someone bring it. She expected she would have seen it on to "protect the foot;" however, she explained when staff toileted R3 the boot was removed but she expected staff reapplied it when finished. On 4/19/24, at 12:17 p.m., LPN-A approached R3 with the heel boots and applied them. Once on, she placed his boot covered feet back onto the wheelchair pedals. When interviewed on 4/19/24, at 12:20 p.m., NA-A stated this was the first time she worked with R3 and was unsure about any alterations in his skin integrity; however, she assumed he had concerns as he wore heel boots when she got him up that morning. Despite this assumption, when she assisted him with morning cares, she took the boots off and placed the blue grippy socks on and did not replace the boots. She identified she "got him up for lunch" and did not put the boots on as he still had on the grippy socks. She was unaware of R3's care planned preventative skin/pressure ulcer interventions as she did not review resident care plans, or Kardexes (NA care plan) despite a response she was expected to follow the care plan/Kardex for resident safety and the prevention of pressure ulcers. She explained she just followed the resident group sheets she carried with her. In addition, she did not ask staff about any additional interventions for R3 that morning.	2 900		

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2 900	Continued From page 7 NA-A's group sheet was reviewed and lacked an intervention for the boots. R3's Kardex was reviewed after NA-A opened it and she identified the Kardex directed the boots. She stated, "I did not know he was supposed to have the boots on in his wheelchair." During interview on 4/19/24, at 12:37 p.m., with the clinical assistant LPN-B, she stated NAs were updated about resident skin statuses during the daily huddles. She expected the care plan to be followed, especially as the group sheets lacked enough room to add all the interventions to it. The nurse was responsible to ensure skin/pressure ulcer interventions were implemented as setup, thus the reason why such interventions were placed on the TAR. She provided examples of boots and off-loading (repositioning). LPN-B stated one of R3's pressure ulcer interventions included boots on when he was up in his wheelchair to assist with pressure reduction. If staff failed to follow this, "We are going to cause more injury to what is going on with his heels ...it is going to get worse." LPN-B declined knowledge R3 ever declined the boots. On 4/19/24, a copy of the aide group sheet was requested; however, was not provided that date. During an observation and interview on 4/19/24, at 1:02 p.m., with R3 and his family member (FM)-A, R3 sat in his wheelchair with his boot covered feet on the wheelchair pedals. R3 stated he had sores on both his heels and his ankle. The heel sores were identified "about a month or so" ago and he was unsure of the cause. He identified all of them were healing. He explained the NAs placed the boots on "a couple times a day" and he wore them to bed. He stated he did not always wear the boots when up. FM-A stated	2 900		

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2 900	Continued From page 8 she saw them on "most of the time" but confirmed there were extended periods of time when they were not on when he was up. FM-A felt R3 did not have the boots on that morning prior to them being placed when he ate lunch. Both denied they removed the boots prior to lunch. FM-A stated R3 disliked the recliner and thus he spent most of his day seated in his wheelchair "just like he is now." He and FM-A stated he was up in the wheelchair since he got up that morning and had not laid down. When interviewed on 4/19/24, at 2:36 p.m., the director of nursing (DON), stated NAs were updated on pressure ulcers during their huddles and thus those residents with pressure ulcers were not specifically identified on the group sheets. In addition, not all interventions were placed on the group sheet as the group sheets only reflected "tidbits" and "highlights" from the care plan. He expected staff to follow what was on the group sheets and what was identified on the Kardex/care plan. In addition, if an intervention was identified on the TAR, it was the nurse's responsibility to ensure the setup/ordered intervention was followed. The DON explained the importance of ensuring R3's boots were on centered around pressure injury prevention. He was aware of the 12:10 p.m. observation and responded, "It is disappointing" and expected LPN-A would have ensured the boots were on, especially as R3 was prone to skin breakdown. On 4/22/24, at 9:21 a.m., 1:23 p.m., and 3:08 p.m., R3 was observed seated in his wheelchair with blue gripper socks and protective boots; however, feet rested on the wheelchair pedals. A Prevention and Treatment of Pressure Ulcers/Pressure Injury policy, dated 11/22/22,	2 900		

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2 900	Continued From page 9 identified the facility implemented preventative measures and provided appropriate treatment modalities for wounds according to professional standards of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		