Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 12, 2025

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

RE: CCN: 245205
Cycle Start Date: January 22, 2025

Dear Administrator:

On March 5, 2025, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 12, 2025

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

Re: Reinspection Results
Event ID: WS5812

Dear Administrator:

On March 5, 2025 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 survey completed on January 22, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 10, 2025

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

RE: CCN: 245205
Cycle Start Date: January 22, 2025

Dear Administrator:

On January 22, 2025, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 April 22, 2025 (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 July 22, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@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 01/22/2025

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 1/21/25 to 1/22/25, 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 complaints were reviewed with no deficiency issued. H52054261C (MN00109618), H52055401C (MN00106689), H52055402C (MN00106084), AND The following complaints were reviewed. H52055120C (MN00109815 and MN000110052), H52053622C (MN00109407), H52055400C (MN00106630) with a deficiency issued at F812. As a result of the investigation, an associated deficiency was cited at F880. 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 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		2/21/25

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

Electronically Signed | 02/11/2025

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 812	Continued From page 1 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain proper holding food temperatures for 18 of 19 residents observed to receive the noon meal on the Reflections unit. Further, the facility failed to maintain the ice machine in a sanitary manner to prevent potential food-borne illness for 39 residents who currently received ice from the ice machine in the Transitional care unit and Cardiac care unit area, and 36 residents who currently received ice from the ice machine in the Riverbend and cornerstone unit area. Findings include: FOOD TEMPERATURE	F 812	POC F812 Ice machine was cleaned, immediate education to dietary staff on appropriate serving temperatures provided, and ensured the hot cart was plugged in and kept to appropriate temp for R1, R7, and all other residents affected. All residents have the potential to be affected. A new process was implemented to ensure the ice machine and components of the ice machine are kept sanitary along with auditing to ensure process is maintained. Education was provided to dietary staff on proper serving temps per policy (Food Temperatures). Hot carts will remain plugged in and set at appropriate	

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F 812	Continued From page 2 During an interview on 1/21/25 at 1:20 p.m., family member (FM)-A stated several times when she was at the facility visiting R1, the food was cold and R1 refused to eat the food. FM-A further stated she began bringing food in for R1 to ensure R1 had food to eat. During a continuous observation on 1/21/25 at 11:49 a.m., dietary aide(DA)-A entered the Reflections unit with a covered cart of food trays in a heated cart from the second floor kitchen. DA-A plugged in the cart and left the unit. Nursing staff began removing the trays with food from the cart and placed a cover on each tray as they passed them out to each resident in the dining room. At 12:42 p.m., staff removed two of the remaining trays from the food cart and delivered them to the residents rooms. At 12:46 p.m., as the last tray was being delivered in the dining room DA-A checked the temperature of a test tray that had been stored in the food cart since the beginning of food service and the temperatures were as follows: Spaghetti noodles were 102 degrees F. Hamburger meat sauce was 114 degrees F. Peas and carrots were 115 degrees F. During an interview on 1/21/25 at 12:55 p.m., DA-A stated it was his first day of work and he was unsure of what the holding temperatures for hot food were expected to be. DA-A stated he would need to find out what the proper holding temperatures for hot food were to ensure in the future the hot food remained within the proper temperatures so residents do not become ill. During an interview on 1/21/25 at 1:05 p.m., dietary manager (DM) stated her expectation was	F 812	temps throughout entire meal service to ensure proper temps are held until served to the resident. A random meal temp audit process was implemented by Dietary Director to ensure meal serving temps are appropriate. Dietary Director or designee will conduct audits on food serving temps and ice machine cleanliness x5 per week for 4 weeks, then x5 per 1 month for 2 months. Results will be brought back to the QAPI committee to determine further need. Date of compliance: 2/21/25	

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F 812	Continued From page 3	F 812		

that holding temps for hot food would have been between 135 and 165 degrees F. DM stated it was important to maintain holding temperatures, to prevent foodborne illness and to ensure quality of food for the residents.

ICE MACHINE

R7's annual Minimum Data Set (MDS), dated 12/30/24, identified R7 had intact cognition with diagnoses of hypertension (high blood pressure) and arthritis. R7 was independent with eating after setup help from staff.

During an observation on 1/21/25 at 11:42 a.m., the ice machine located in the dining area of the Riverbend and Cornerstone unit had a white flaky substance approximately one-half an inch to three-quarters of an inch in height on both the inside and outside rim of the ice spout and water spout. The tray of the ice machine had a white flaky substance covering the entire removable tray with noticeable dripping of water from the ice spout about every one to two seconds into the tray.

During an observation on 1/21/25 at 2:10 p.m., the ice machine located in the dining area of the Transitional care unit and Cardiac care unit had a white flaky substance approximately one-half an inch to three-quarters of an inch in height on both the inside and outside rim of the ice spout and

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F 812	Continued From page 4	F 812		

water spout. The tray of the ice machine had a white flaky substance covering the entire removable tray with noticeable dripping of water from the ice spout about every one to two seconds into the tray.

During an interview on 1/21/25 at 3:42 p.m., R7 stated the ice and water tasted terrible. R7 further stated he had to discard seven glasses of water before being able to get water that tasted alright from the ice machine. R7 stated he reported the terrible ice and water taste to licensed practical nurse (LPN)-A on many occasions and the ice machine continued to be dirty with water and ice that tasted terrible.

During an interview on 1/22/25 at 10:04 a.m., LPN-A verified a resident had asked for the ice and water machine to be cleaned. LPN-A stated maintenance was notified and LPN-A did not follow up with maintenance about the ice machine after that.

During an interview on 1/22/25 at 9:14 a.m., dietary manager (DM) verified a white substance on the outside and inside of the ice and water machine spouts and identified it was calcium buildup. DM verified the white substance on the ice machine in the dining area of the Riverbend and cornerstone unit and the ice machine in the dining area of the transitional care unit and cardiac care unit. DM stated the calcium buildup could break off of the spouts and get in the ice and or water and residents could become ill. DM further stated, maintenance staff cleaned the machine and was unsure when the ice machines had been cleaned last. DM stated maintenance staff was out ill and unavailable. DM confirmed cleaning logs for the ice machines were not

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F 812	Continued From page 5 available. A facility policy titled Food Temperatures dated 2021, identified all hot food must be cooked to appropriate internal temperatures, held, and served a temperature of at least 135 degrees F. Identified hot foods may not fall below 135 degrees F. after cooking unless it is an item which was to be rapidly cooled to 41 degrees F. Further identified temperatures should have been taken periodically to assure hot foods stayed above 135 degrees F.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		2/21/25

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F 880	Continued From page 6 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 7 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for for 2 of 2 residents (R8, R9) observed for COVID-19 transmission based precautions (TBP) and for 1 of 2 residents (R10) observed for enhanced barrier precautions (EBP), (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). This deficient practice had the potential to affect all 112 residents who resided in the facility. Findings Include: Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions (EBP) included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. Review of CDC guidance dated 6/24/24, Infection Control Guidance SARS-COV-2 indicated health care professionals (HCP) who entered the room of a patient with suspected or confirmed	F 880	POC F880 Immediate education on proper PPE was provided to identified nursing assistance who were not following signage for R8, R9, R10. All residents have the potential to be affected. Education will be provided to all staff who need to enter isolation rooms on proper PPE usage/following door signage instructions. DON or designee will conduct audits on staff entering isolation rooms to ensure proper PPE usage/following signage will be completed x5 per week for 4 weeks, then x5 audits per 1 month for 2 months. Results will be brought back to the QAPI committee to determine further need. Date of Compliance: 2/21/25	

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F 880	Continued From page 8 SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Review of CDC guidance dated 5/16/23, How to Use Your N95 Respirator indicated N95 respirators must form a seal to the face to work properly. This was especially important for people at increased risk for severe disease. R8's admission Minimum Data Set (MDS) dated 1/2/25, identified R8 had moderately impaired cognition with diagnoses of hypertension (high blood pressure), heart failure, diabetes, and dementia. Identified R8 required extensive assistance of two staff with bed mobility, transfers, toileting and was independent with setup help for eating. R9's admission MDS dated 1/17/25, identified R9 had intact cognition with diagnoses of heart failure, hypertension, and end stage renal disease (ESRD). Identified R9 required limited assistance of two staff with bed mobility, transfers, toileting and was independent with setup help for eating. R10's admission MDS still in progress dated 1/26/25, identified R10 had intact cognition with diagnoses of hypertension, diabetes, chronic kidney disease, obesity, chronic obstructive pulmonary disease (COPD). The MDS lacked completion of R10's requirements of staff assistance for activities of daily living (ADL's). R8's covid test dated 1/20/25, identified positive COVID-19.	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 R9's covid test dated 1/20/25, identified positive COVID-19. R10's EBP dated 1/20/25, identified EBP through 1/28/25. During an observation on 1/21/25 at 1:34 p.m., nursing assistant (NA)-A put on a gown, N95 mask and gloves outside of R8's room and entered R8's room. NA-A was not wearing eye protection while providing cares for R8. NA-B was in R8's room observed to have on a surgical mask, gown and gloves. NA-B was not wearing eye protection or a N95 mask while providing cares for R8. NA-A and NA-B completed cares for R8, removed PPE in R8's room and exited R8's room. NA-B did not remove the surgical mask and continued to wear the surgical mask. During an interview on 1/22/25 at 9:43 a.m., NA-A verified R8 had COVID-19. NA-A stated she did not recall putting on eye protection prior to entering R8's room the previous day. NA-A stated it was important to wear all the recommended PPE including eye protection to prevent the possible spread of the disease to others. During an interview on 1/22/25 at 9:51 a.m., NA-B verified R8 had COVID-19. NA-B stated the recommendation of PPE for COVID-19 residents was a surgical mask, gown and gloves. NA-B was asked to read the precaution sign on R8's door, NA-B verified the COVID-19 precaution PPE recommendations on R8's door stated to wear a N95 mask, eye protection, gown and gloves. NA-B stated she was unaware of the PPE recommendations for COVID-19 and that it was important to follow the guidelines to prevent the	F 880		

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	245205	A. BUILDING _____ B. WING _____	C 01/22/2025

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F 880	Continued From page 10 spread of infection to others. During an observation on 1/21/25 at 3:51 p.m., NA-C was wearing a surgical mask in the hallway exiting resident room 1116. NA-C put on a gown and gloves outside of R9's room and entered R9's room. NA-C did not have eye protection on. NA-C removed the gown and gloves prior to exit of R9's room six minutes later, continued to wear the same surgical mask, put on gloves and a gown and entered R10's room. During an interview on 1/21/25 at 4:03 p.m., NA-C verified R9 was in COVID-19 precautions and R10 was in EBP. NA-C stated staff were expected to wear a N95 mask and eye protection while caring for COVID-19 positive residents to prevent the spread of infection and staff were expected to remove PPE prior to leaving an EBP or TBP resident room. NA-C stated she was aware of the recommended PPE to wear however, lacked follow through. During an interview on 1/22/25 at 10:00 a.m., LPN-A stated staff were aware of which residents were in EBP or TBP based on the sign on the resident's door and all staff received training on proper PPE use. LPN-A stated the nurse working was expected to monitor the nursing assistants to ensure proper PPE was being used. During an interview on 1/22/25 at 11:16 a.m., director of nursing (DON) stated staff were educated on proper PPE use and received daily updates on which residents were in TBP or EBP. DON verified the expectation of staff was to wear a N95 mask, eye protection, gown and gloves when working with a COVID-19 positive resident. In addition, DON indicated staff were expected to	F 880		

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F 880	Continued From page 11 remove PPE prior to exiting a EBP resident room and prior to entering another resident room. DON confirmed these practices were important for transmission reasons and to protect the staff and residents from becoming ill. A facility policy titled Infection Control and Manual for Transmission Based Precautions dated 2023, identified PPE use to Prevent Spread of Multidrug-resistant Organisms (MDROs) identified examples of high-contact resident care activities requiring gown and glove use for EBP included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. A facility policy titled Red, Yellow, Green Personal Protective Equipment, Resident Placement and Signage Supplemental Guidelines for Use related to COVID-19 revised 6/26/23, identified a positive COVID-19 (Red) guidelines included; N95 mask would be worn prior to entry of a COVID-19 resident room and removed and discarded when leaving the specific isolation unit/area or if soiled or damaged. If unable to obtain a new N95 every shift due to supply shortage, rotate at least every 72 hours and replace after 5 uses or if soiled or damaged. A face shield or goggles would be worn prior to entry of a COVID-19 resident room and would be cleaned and disinfected (or changed) if visibly soiled, including splashes and sprays or difficult to see through. A gown would be worn prior to entry of a COVID-19 resident room and changed when soiled. Gloves would be worn prior to entry of a COVID-19 resident room and would be changed per standard precautions guidelines	F 880		

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 10, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: WS5811

Dear Administrator:

The above facility was surveyed on January 21, 2025, through January 22, 2025, 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: On 1/21/25 to 1/22/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H52054261C (MN00109618), H52055401C (MN00106689), H52055402C (MN00106084) AND The following complaints were reviewed. H52055120C (MN00109815 and MN000110052), H52053622C (MN00109407), H52055400C (MN00106630) with licensing orders issued at 1015. As a result of the investigation, an associated licensing order was issued at 1385. 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/regulatio	2 000		

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2 000	Continued From page 2 n/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 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		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain proper holding food temperatures for 18 of 19 residents observed to receive the noon meal on the Reflections unit. Further, the facility failed to maintain the ice machine in a sanitary manner to prevent potential food-borne illness for 39	21015	Corrected	2/21/25

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21015	Continued From page 3 residents who currently received ice from the ice machine in the Transitional care unit and Cardiac care unit area, and 36 residents who currently received ice from the ice machine in the Riverbend and Cornerstone unit area. Findings include: FOOD TEMPERATURE During an interview on 1/21/25 at 1:20 p.m., family member (FM)-A stated several times when she was at the facility visiting R1, the food was cold and R1 refused to eat the food. FM-A further stated she began bringing food in for R1 to ensure R1 had food to eat. During a continuous observation on 1/21/25 at 11:49 a.m., dietary aide(DA)-A entered the Reflections unit with a covered cart of food trays in a heated cart from the second floor kitchen. DA-A plugged in the cart and left the unit. Nursing staff began removing the trays with food from the cart and placed a cover on each tray as they passed them out to each resident in the dining room. At 12:42 p.m., staff removed two of the remaining trays from the food cart and delivered them to the residents rooms. At 12:46 p.m., as the last tray was being delivered in the dining room DA-A checked the temperature of a test tray that had been stored in the food cart since the beginning of food service and the temperatures were as follows: Spaghetti noodles were 102 degrees F. Hamburger meat sauce was 114 degrees F. Peas and carrots were 115 degrees F. During an interview on 1/21/25 at 12:55 p.m., DA-A stated it was his first day of work and he	21015		

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21015	Continued From page 4 was unsure of what the holding temperatures for hot food were expected to be. DA-A stated he would need to find out what the proper holding temperatures for hot food were to ensure in the future the hot food remained within the proper temperatures so residents do not become ill. During an interview on 1/21/25 at 1:05 p.m., dietary manager (DM) stated her expectation was that holding temps for hot food would have been between 135 and 165 degrees F. DM stated it was important to maintain holding temperatures, to prevent foodborne illness and to ensure quality of food for the residents. ICE MACHINE R7's annual Minimum Data Set (MDS), dated 12/30/24, identified R7 had intact cognition with diagnoses of hypertension (high blood pressure) and arthritis. R7 was independent with eating after setup help from staff. During an observation on 1/21/25 at 11:42 a.m., the ice machine located in the dining area of the Riverbend and Cornerstone unit had a white flaky substance approximately one-half an inch to three-quarters of an inch in height on both the inside and outside rim of the ice spout and water spout. The tray of the ice machine had a white flaky substance covering the entire removable tray with noticeable dripping of water from the ice spout about every one to two seconds into the tray. During an observation on 1/21/25 at 2:10 p.m., the ice machine located in the dining area of the Transitional care unit and cardiac care unit had a white flaky substance approximately one-half an inch to three-quarters of an inch in height on both	21015		

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21015	Continued From page 5 the inside and outside rim of the ice spout and water spout. The tray of the ice machine had a white flaky substance covering the entire removable tray with noticeable dripping of water from the ice spout about every one to two seconds into the tray. During an interview on 1/21/25 at 3:42 p.m., R7 stated the ice and water tasted terrible. R7 further stated,he had to discard seven glasses of water before being able to get water that tasted alright from the ice machine. R7 stated he reported the terrible ice and water taste to licensed practical nurse (LPN)-A on many occasions and the ice machine continued to be dirty with water and ice that tasted terrible. During an interview on 1/22/25 at 10:04 a.m., LPN-A verified a resident had asked for the ice and water machine to be cleaned. LPN-A stated maintenance was notified and LPN-A did not follow up with maintenance about the ice machine after that. During an interview on 1/22/25 at 9:14 a.m., dietary manager (DM) verified a white substance on the outside and inside of the ice and water machine spouts and identified it was calcium buildup. DM verified the white substance on the ice machine in the dining area of the Riverbend and cornerstone unit and the ice machine in the dining area of the transitional care unit and cardiac care unit. DM stated the calcium buildup could break off of the spouts and get in the ice and or water and residents could become ill. DM further stated, maintenance staff cleaned the machine and was unsure when the ice machines had been cleaned last. DM stated maintenance staff was out ill and unavailable. DM confirmed cleaning logs for the ice machines were not	21015		

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21015	Continued From page 6 available. A facility policy titled Food Temperatures dated 2021, identified all hot food must be cooked to appropriate internal temperatures, held, and served a temperature of at least 135 degrees F. Identified hot foods may not fall below 135 degrees F. after cooking unless it is an item which was to be rapidly cooled to 41 degrees F. Further identified temperatures should have been taken periodically to assure hot foods stayed above 135 degrees F SUGGESTED METHOD OF CORRECTION: The RD or designee, could develop policy and procedures for ensuring sanitary conditions for maintaining ice machines. In addition, the RD or designee could develop policy and procedures for ensuring holding temperatures for food were within guidelines and conduct random audits to ensure food temps remain within guidelines during meal service. In addition, the RD or designee could conduct random audits to ensure proper cleaning for ice machines. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.	21385		2/21/25

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21385	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for for 2 of 2 residents (R8, R9) observed for COVID-19 transmission based precautions (TBP) and for 1 of 2 residents (R10) observed for enhanced barrier precautions (EBP), (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). This deficient practice had the potential to affect all 112 residents who resided in the facility. Findings Include: Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions (EBP) included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. Review of CDC guidance dated 6/24/24, Infection Control Guidance SARS-COV-2 indicated health care professionals (HCP) who entered the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher,	21385	Corrected	

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21385	Continued From page 8 gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Review of CDC guidance dated 5/16/23, How to Use Your N95 Respirator indicated N95 respirators must form a seal to the face to work properly. This was especially important for people at increased risk for severe disease. R8's admission Minimum Data Set (MDS) dated 1/2/25, identified R8 had moderately impaired cognition with diagnoses of hypertension (high blood pressure), heart failure, diabetes, and dementia. Identified R8 required extensive assistance of two staff with bed mobility, transfers, toileting and was independent with setup help for eating. R9's admission MDS dated 1/17/25, identified R9 had intact cognition with diagnoses of heart failure, hypertension, and end stage renal disease (ESRD). Identified R9 required limited assistance of two staff with bed mobility, transfers, toileting and was independent with setup help for eating. R10's admission MDS still in progress dated 1/26/25, identified R10 had intact cognition with diagnoses of hypertension, diabetes, chronic kidney disease, obesity, chronic obstructive pulmonary disease (COPD). The MDS lacked completion of R10's requirements of staff assistance for activities of daily living (ADL's). R8's covid test dated 1/20/25, identified positive COVID-19. R9's covid test dated 1/20/25, identified positive COVID-19.	21385		

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	00893	A. BUILDING: _____ B. WING _____	C 01/22/2025

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21385	Continued From page 9 R10's EBP dated 1/20/25, identified EBP through 1/28/25. During an observation on 1/21/25 at 1:34 p.m., nursing assistant (NA)-A put on a gown, N95 mask and gloves outside of R8's room and entered R8's room. NA-A was not wearing eye protection while providing cares for R8. NA-B was in R8's room observed to have on a surgical mask, gown and gloves. NA-B was not wearing eye protection or a N95 mask while providing cares for R8. NA-A and NA-B completed cares for R8, removed PPE in R8's room and exited R8's room. NA-B did not remove the surgical mask and continued to wear the surgical mask. During an interview on 1/22/25 at 9:43 a.m., NA-A verified R8 had COVID-19. NA-A stated she did not recall putting on eye protection prior to entering R8's room the previous day. NA-A stated it was important to wear all the recommended PPE including eye protection to prevent the possible spread of the disease to others. During an interview on 1/22/25 at 9:51 a.m., NA-B verified R8 had COVID-19. NA-B stated the recommendation of PPE for COVID-19 residents was a surgical mask, gown and gloves. NA-B was asked to read the precaution sign on R8's door, NA-B verified the COVID-19 precaution PPE recommendations on R8's door stated to wear a N95 mask, eye protection, gown and gloves. NA-B stated she was unaware of the PPE recommendations for COVID-19 and that it was important to follow the guidelines to prevent the spread of infection to others. During an observation on 1/21/25 at 3:51 p.m., NA-C was wearing a surgical mask in the hallway exiting resident room 1116. NA-C put on a gown	21385		

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21385	Continued From page 10 and gloves outside of R9's room and entered R9's room. NA-C did not have eye protection on. NA-C removed the gown and gloves prior to exit of R9's room six minutes later, continued to wear the same surgical mask, put on gloves and a gown and entered R10's room. During an interview on 1/21/25 at 4:03 p.m., NA-C verified R9 was in COVID-19 precautions and R10 was in EBP. NA-C stated staff were expected to wear a N95 mask and eye protection while caring for COVID-19 positive residents to prevent the spread of infection and staff were expected to remove PPE prior to leaving an EBP or TBP resident room. NA-C stated she was aware of the recommended PPE to wear however, lacked follow through. During an interview on 1/22/25 at 10:00 a.m., LPN-A stated staff were aware of which residents were in EBP or TBP based on the sign on the resident's door and all staff received training on proper PPE use. LPN-A stated the nurse working was expected to monitor the nursing assistants to ensure proper PPE was being used. During an interview on 1/22/25 at 11:16 a.m., director of nursing (DON) stated staff were educated on proper PPE use and received daily updates on which residents were in TBP or EBP. DON verified the expectation of staff was to wear a N95 mask, eye protection, gown and gloves when working with a COVID-19 positive resident. In addition, DON indicated staff were expected to remove PPE prior to exiting a EBP resident room and prior to entering another resident room. DON confirmed these practices were important for transmission reasons and to protect the staff and residents from becoming ill.	21385		

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21385	Continued From page 11 A facility policy titled Infection Control and Manual for Transmission Based Precautions dated 2023, identified PPE use to Prevent Spread of Multidrug-resistant Organisms (MDROs) identified examples of high-contact resident care activities requiring gown and glove use for EBP included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. A facility policy titled Red, Yellow, Green Personal Protective Equipment, Resident Placement and Signage Supplemental Guidelines for Use related to COVID-19 revised 6/26/23, identified a positive COVID-19 (Red) guidelines included; N95 mask would be worn prior to entry of a COVID-19 resident room and removed and discarded when leaving the specific isolation unit/area or if soiled or damaged. If unable to obtain a new N95 every shift due to supply shortage, rotate at least every 72 hours and replace after 5 uses or if soiled or damaged. A face shield or goggles would be worn prior to entry of a COVID-19 resident room and would be cleaned and disinfected (or changed) if visibly soiled, including splashes and sprays or difficult to see through. A gown would be worn prior to entry of a COVID-19 resident room and changed when soiled. Gloves would be worn prior to entry of a COVID-19 resident room and would be changed per standard precautions guidelines SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure infection control procedures and standards and proper use of personal protective equipment (PPE) are maintained by all	21385		

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21385	Continued From page 12 staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385		