DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 10, 2022

CMS Certification Number (CCN): 245205

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 18, 2022 the above facility is certified for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 120 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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May 10, 2022

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

RE: CCN: 245205
Cycle Start Date: February 17, 2022

Dear Administrator:

On March 8, 2022, we notified you a remedy was imposed. On April 8, 2022 the Minnesota Department(s) of Health and Public Safety 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 March 18, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 7, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 8, 2022, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 7, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 18, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
March 8, 2022

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

RE: CCN: 245205
Cycle Start Date: February 17, 2022

Dear Administrator:

On February 17, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 7, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 7, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 7, 2022.

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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 7, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Anoka Rehabilitation And Living Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 7, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. 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.

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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 August 17, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	02/17/2022

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
E 000	Initial Comments On 2/14/22 - 2/17/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/14/22 - 2/17/22, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must--	F 582		3/18/22

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

Electronically Signed | 03/17/2022

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 582	Continued From page 1 (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually	F 582		

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F 582	Continued From page 2 resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 2 of 2 residents (R47, R54) reviewed whose Medicare Part A coverage ended and then remained in the facility. Findings include: R47's notice for Notice of Medicare Non-Coverage (CMS-10123) form identified his last day of Medicare coverage was on 1/7/22. R47 signed the form on 1/5/22 that he was aware coverage was ending. R47's census list, undated, identified R47's payer source changed to private pay on 1/8/22, and remained in the facility. R47's progress note dated 1/5/22, at 16:10 (4:10 p.m.) indicated CMS-10123 with LCD (last covered day) of 1/7/22 was issued. The progress note had no documentation of the SNFABN form had been issued. R47's medical record was reviewed and lacked	F 582	F582- The facility must inform residents of their last covered day of Medicare skilled stay utilizing a Notice of Non-Medicare Coverage form two days prior to skilled services stopping. If the resident is staying in the facility they need to give an ABN SNF to see if they would like to have their bill submitted to Medicare for payment. It is policy of the facility to follow all Medicare guidelines. Resident R-54 and R-47 were issued ABN-SNF for the completion of their Medicare A skilled stay. All residents with a Medicare A stay in the past six months have been reviewed, and an ABN-SNF was given to those residents or their representatives if required. All residents that are utilizing their Medicare A benefit will be monitored weekly in the IDT meeting to ensure proper Medicare guidelines are being followed when issuing a Notice of Non-Medicare Coverage and ABN-SNF. Staff that will be trained on the new process is the MDS nurses and business office to ensure proper Medicare	

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F 582	Continued From page 3 any evidence a SNFABN had been provided to explain the estimated cost per day or provide rationale or explanation of the extended care services or items to be furnished, reduced, or terminated. R54's CMS-10123 form identified her last day of Medicare coverage was on 10/26/21. R54's representative signed the form on 10/22/21 indicating she had been notified. R54's census list, undated, indicated R54's payer source changed to Medicaid on 10/27/21, and remained in the facility. R54's medical record was reviewed and lacked any evidence a SNFABN had been provided to explain the estimated cost per day or provide rationale or explanation of the extended care services or items to be furnished, reduced, or terminated. When interviewed on 2/16/22, at 8:03 a.m. registered nurse (RN)-A stated the SNFABN forms should have been provided to R47 and R54 since they stayed in the facility. When interviewed on 2/16/22, at 8:29 a.m. the director of nursing (DON) stated the SNFABN forms were not issued and should have been. Policy titled Medicare Advance Beneficiary Notice (SNFABN) (Denial Notices) dated 2012, indicated the facility should issue timely and appropriate ABN (Advance Beneficiary Notice) to the Medicare beneficiary informing him/her of changes in Medicare coverage based on facility adherence to federal regulations.	F 582	guidelines are being followed. This process will ensure that all residents covered under their Medicare A benefit are able to receive the proper notice when skilled services end. All residents that remain in the facility after their Medicare A benefits stop will be given an ABN-SNF on the same day that the Notice of Non-Medicare Coverage was given to the resident or their representative. The policy and procedure were reviewed and continues to be up to date. A binder will be kept in the business office to keep all notices and logs to see if the appropriate notice was given. During the Medicare Interdisciplinary Team meeting the log will be updated with all current information with the resident who is coming off of their Medicare A stay. If it is determined that the resident requires an ABN SNF it will be given with the Notice of Non-Medicare Coverage for the resident or their representative to sign. Audits will be completed three times per week for one month, weekly for one month and then monthly for two months to maintain compliance. The audits will be completed by the Director of Nursing or designee with results reported to the QAPI Committee for review and recommendations for further monitoring. The Director of Nursing or designee will be responsible for compliance.	

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F 684	Continued From page 4	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a respiratory infection was adequately monitored to promote continuity of care and reduce the risk of complication for 1 of 1 resident (R84) reviewed who had a productive cough and signs of respiratory infection. Findings include: R84's significant change Minimum Data Set (MDS) dated 1/29/22, identified R84 had moderate cognitive impairment and required, at minimum, limited assistance to complete most of his activities of daily living (ADLs). Further, the MDS outlined R84 had asthma, chronic obstructive pulmonary disease (COPD) or another chronic lung diease (e.g., chronic bronchitis); however, R84 demonstrated no shortness of breath at rest or with exertion. R84's care plan, dated 2/8/22, identified R84 had COPD and listed a goal which read, " [R84] will be free of s/sx [signs and symptoms] of respiratory infections," and listed two	F 684	F684- All residents having respiratory symptoms that indicate a change of condition will have a complete lung assessment. The lung assessment will include PO2 levels, respiratory rate, any accessory muscles being used and lung sounds. A resident showing signs of a change of respiratory status will be placed on every shift charting and assessments to monitor condition, if appropriate. Resident R84 was put on every shift charting with appropriate respiratory assessment to be completed by license staff. The care plan was updated with current conditions and treatments. The policy and procedure were reviewed and continues to be up to date. Information regarding completing a respiratory assessment and appropriate follow up was provided during a nurses/NAR meeting on 3/1/22, 3/2/22, and 3/4/22. Audits will be completed daily for one month, then weekly for one month and then monthly for two months. The audits will be completed by the Infection	3/18/22

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F 684	Continued From page 5 interventions to help R84 meet this goal which included monitoring and recording any anxiety, and reminding R84 to monitor himself for difficulty breathing and to "not push beyond endurance." R84 was listed as being at potential nutrition risk due to a history of respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions). R84 was listed as having a regular diet with puree texture and nectar thick liquids; however, was receiving a regular texture diet with thin liquids due to a waiver being completed for them. However, the care plan lacked any direction or guidance on how the facility would monitor R84 for potential respiratory infection despite being identified as having COPD and consuming a regular texture diet and thin liquids as a result of a dietary waiver. On 2/14/22, at 9:36 a.m. R84 was observed laying in bed while in his room. R84 had an audible wet-sounding cough which he explained he had "for awhile," however, seemed to worsen a few days ago. The cough was productive and R84 showed the surveyor a standard 16 oz. Styrofoam cup on his bedside table which he was spitting the phlegm into. The cup was approximately 1/2 filled with a frothy, white and light-yellow colored phlegm. R84 denied being short of breath at this time and stated he "couldn't tell you" if he was currently taking an antibiotic or other treatment for his cough. Further, R84 stated staff were only asking him about his respiratory status and checking his lung sounds "every now and then." On 2/15/22 at 12:40 p.m., R84 was seated in his wheelchair while in his room and continued with a wet-sounding cough. R84 stated he was "still alive" and reiterated only a few staff had been	F 684	Preventionist or designee with results reported to the QAPI Committee for review and recommendations for further monitoring. The Director of Nursing or designee will be responsible for compliance.	

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listening to his lung sounds and described it as "not consistent."

R84's progress notes were reviewed and identified the following recorded entries:

On 2/11/22, R84 was recorded as wheezing (high-pitched whistling sound made with breathing). The provider was contacted and orders were received for a chest x-ray and as-needed nebulizer treatments. R84 was rapid-tested for coronavirus and was negative.

On 2/12/22, R84 had the ordered x-ray completed and R84 endorsed an occasional cough which was productive of yellow-colored phlegm. The note identified R84 denied feeling short of breath, however, did feel weak. Later on 2/12/22, R84's x-ray results were received and orders for an antibiotic were received with directions to update R84's primary physician on 2/14/22.

On 2/13/22, R84 refused his scheduled shower as he was recorded as being tired and a shower would "wipe him out." R84 continued with an occasional, productive cough of yellow-colored phlegm but denied being short of breath.

There were no recorded progress note(s) describing or indicating R84 had a cough, either productive or non-productive, in the week period prior to 2/11/22.

R84's corresponding Respiration Summary, dated 2/1/11 to 2/28/22, outlined the recorded respirations for R84 which were obtained by the nursing staff. This identified only one recorded respiration vital sign on 2/12/22 which was 20 breaths per minute. There were no recorded

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respirations for R84 on 2/13/22 or 2/14/22, despite antibiotic therapy being initiated on 2/13/22, and R84 demonstrating objective signs of respiratory infection. Further, R84's medical record was reviewed and lacked any evidence the facility had implemented routine comprehensive monitoring, including respiration monitoring and lung sounds, to ensure the developed respiratory condition was adequately monitored and assessed to ensure adequate healing despite the developed symptoms which required antibiotic therapy treatment.

On 2/15/22, at 2:53 p.m. registered nurse (RN)-F was interviewed and explained any completed respiratory monitoring, including lung sounds and respirations, would be recorded in the progress notes or "vital portion" of the medical record. RN-F stated R84 was diagnosed with pneumonia. Respiratory monitoring, including lung sounds and respirations, should be assessed and recorded "three times a day" or more if R84 had shortness of breath or "discomfort with breathing." RN-F reviewed R84's medical record and acknowledged the lack of comprehensive respiratory monitoring for R84 despite his developed symptoms and antibiotic use. She stated she felt it was being done just not documented as the nurses "need somewhere to write [record] them." RN-F stated these completed assessments and monitoring should be recorded in the medical record "so that the next nurse can know" R84's condition and if changes are happening rather than relying solely on verbal shift-to-shift report.

When interviewed on 2/17/22, at 10:05 a.m. registered nurse manager (RN)-B stated R84 moved up to the long-term care (LTC) unit in

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January 2022 after he had signed a waiver for thin liquids and regular texture meals despite speech language pathology (SLP) having made different recommendations. This placed him at risk of silent aspiration, however, R84 had not sustained an episode of pneumonia until 2/11/22, which RN-B voiced "there's a good chance" it stemmed from aspiration. RN-B described a comprehensive respiratory assessment and monitoring to include lung sounds, respirations, oxygen saturations and the patient's subjective perception of breathing (i.e., short of breath, heavy chest) and voiced any completed assessment should be recorded in the progress notes. RN-B continued and explained any developed infection should have a completed "infection note" which was done, at minimum, on a daily basis to help ensure infection symptoms and the corresponding monitoring were completed. RN-B reviewed R84's medical record and voiced an "infection note" had not been started for R84 when he was diagnosed with pneumonia and should have been which would have helped ensure lung sounds and respiratory status were better monitored. Further, RN-B stated it was important to ensure R84's respiratory condition and status was monitored on a routine, ongoing basis to ensure his condition improved timely and to help reduce risk of hospitalization.

A facility provided Respiration Assessment, Long-Term Care policy, printed 2/17/22, identified four measures were necessary to accurately assess the adequacy of respirations including the rate of respiration, rhythm, depth, and sound (i.e., lung sounds). The policy continued and outlined a respiratory assessment was "an important component of care," however, lacked any specific

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F 684	Continued From page 9 guidelines or directions on how often these should be conducted outside of "periodically," or if any special and/or increased monitoring was needed if the resident contracted pneumonia or other respiratory impairment.	F 684		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs	F 755		3/18/22

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F 755	Continued From page 10 is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physician ordered medications were re-ordered timely to prevent delay in administration and reduce the risk of complication for 1 of 5 residents (R88) observed to receive medication during the survey. Findings include: During observation of medication administration on 2/16/22, at 8:46 a.m. licensed practical nurse (LPN)-A entered R88's room on the transitional care unit (TCU) and removed four separate punch-pack style medication cards from a locked cabinet to prepare and administer to R88. These included Sotalol (an antiarrhythmic medication), diltiazem (an antihypertensive medication), Losartan (an antihypertensive medication), and Vitamin D. LPN-A then turned to the surveyor and stated "literally every card [punch pack] is empty" and she would have to go to the Omnicell (a machine used to stock emergency medication supplies) and retrieve them. LPN-A returned and stated she was unable to administer R88's scheduled once-a-day Sotalol and diltiazem as there was no supply in the Omnicell. As a result, she would contact the dispensing pharmacy and have them "stat it over." LPN-A explained the medications for R88 likely had not been re-ordered, and she added the pool agency nurses did not always re-order medications timely which had caused similar situations in the recent past. LPN-A stated she had reported this concern to past nurse manager, however, added she was unaware if management knew of the concern or not. Further, LPN-A stated it was "hard to say"	F 755	F755- All residents cabinets have been checked to ensure a minimum of one weeks supply of medication. This was completed before the beginning of the audit cycle. Resident R88 received scheduled medications as ordered per the physician. It is policy of the facility to order medications when a week's supply is left in the card or bottle. The policy and procedure were reviewed and continue to be current. Education was provided to licensed staff on 3/1/22, 3/2/22 and 3/4/22 regarding re-ordering the medications when a week's supply is left in the card or bottle. Auditing will be done by the unit managers of the medication cabinet for correct medications in the cabinet for the resident, no empty cards, and to see if the medications were ordered per policy. Auditing will be conducted daily on six cabinets on day shift and evening shift for one month, then weekly on day shift and evening shift for one month and then monthly on day shift and evening shift for two months. The audits will be completed by the Director of Nursing or designee with results reported to the QAPI Committee for review and recommendations for further monitoring. The Director of Nursing or designee will be responsible for compliance.	

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how often the issue was occurring but added when the nursing home employed staff, including herself, returned from a few days of absence, was when the issue seemed to happen most.

During follow up interview on 2/16/22, at 2:21 p.m. LPN-A verified Omnicare, the dispensing pharmacy, had been able to provide the medications for R88 so they were administered; however, they were provided well-past the scheduled administration time.

When interviewed on 2/16/22 at 2:23 p.m. the current registered nurse manager (RN)-N stated she had only been in her role as manager for a few weeks; however, had "anecdotally" heard of the pool agency staff not re-ordering medications timely. RN-N explained the TCU used punch-pack style medication cards which had a red box to indicate a warning they needed to be re-ordered, and when the staff remove medication and come to the red box, then they needed to "put in a re-order request" to the pharmacy to get them replaced. RN-N stated she "can't speak for them" on if management was aware of the issue or not, nor what actions, if any, management had implemented to correct the issue but confirmed medications should be reordered timely "so they [residents] don't run out."

During an interview on 2/17/22, at 9:44 a.m. the director of nursing (DON) stated he was unaware of any concerns or issues with the pool agency nurses not reordering medications timely causing potential delays in administration. The DON stated the pool agency nurses were educated when they started on the process of ordering medications so they "should be" doing so. The

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F 755	Continued From page 12 DON stated reordering medications timely was important "so you have medications when they're due" and don't have missed administrations. When interviewed on 2/17/22, at 11:53 a.m. the consulting pharmacist (CP) verified she worked for the dispensing pharmacy, and stated she was not aware of any concerns or issues regarding medications not being reordered timely at the nursing home. CP stated "stat orders" can cause "a log jam" at the pharmacy and if there had been repeated concerns, the pharmacy likely would have contacted her which had not happened thus far. However, CP acknowledged medications needed to be reordered timely which was important "so they don't run out." A facility provided Reordering, Changing, and Discontinuing Orders policy, dated 1/1/22, identified the nursing home was encouraged to reorder medication electronically or via fax machine when possible. The policy added, "Facility staff should select needed refills orders from a list of residents and medications due for refill."	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		3/18/22

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F 756	Continued From page 13 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were acted upon and addressed for 1 of 5 residents (R31) reviewed for unnecessary medication use. Findings include: R31's completed pharmacy Consultation Report with recommendation date 1/4/22, noted R31's	F 756	F756- Resident R31 was addressed by the MD/NP with changes made as ordered. All resident pharmacy reviews were reviewed by the Director of Nursing to ensure they were acted upon timely. This process was implemented prior to the auditing beginning. Pharmacy consults are completed on all new admissions and then monthly on the long-term care units. The pharmacy	

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F 756	Continued From page 14 medication regimen had been reviewed by the consulting pharmacist (CP) and listed, "[R31] has PRN (as needed) analgesic medication orders for similar medications without instructions as to a sequence, pain intensity or site of pain for which these options should be administered: 1. Tramadol 25mg every 4 hours PRN pain; 2. Tramadol 50mg every 4 hours PRN pain; 3. Morphine 20mg/mL give 0.25mL every 3 hours PRN pain/shortness of breath Recommendation: Please clarify the intended administration of PRN pain medications by including a sequence, pain intensity, and site of pain in the directions for use." The recorded response from the nurse practitioner dated 2/15/22, discontinue 50mg tramadol. Tramadol 25mg for pain rated 3-6 and morphine for pain rated 7-10 or shortness of breath (24 or greater with respiratory discomfort). R31's completed pharmacy Consultation Report with recommendation date 1/4/22, noted R31's medication had been reviewed by the CP and listed, "[R31] has a PRN order for an antipsychotic without a stop date: Olanzapine 2.5mg every 6 hours PRN nausea/agitation (12/17/21). Recommendation: Please discontinue the PRN olanzapine. If to continue, an in person assessment and new order is required every 14 days for PRN ANTIPSYCHOTICS for ALL nursing home residents per CMS (Centers for Medicare and Medicaid Services)." The recorded response from the nurse practitioner, accepting the recommendations as written, was dated 2/15/22. R31's medical record lacked evidence the CP's recommendations for both the PRN pain medications and the PRN antipsychotic had been	F 756	consultant will audit a specific resident at the request of the facility due to but not limited to, change of condition, falls, or other medical concerns. The policy and procedure were reviewed and remains current for the facility. Staff were educated on the reason and need for completing the pharmacy consults. When we receive the pharmacy consults two will be printed off and one will be given to the Unit Manager for processing the current recommendation. The other copy will be kept in a binder in the Director of Nursing's office. Once a response from the MD/NP is received, the consult will be scanned into the resident's record and given to the Director of Nursing. The Director of Nursing will remove the unsigned pharmacy consult and put the signed consult in the binder. Auditing will be completed weekly by the Director of Nursing or designee for two months and then monthly for two months. The audits will be completed by the Director of Nursing or designee with results reported to the QAPI Committee for review and recommendations for further monitoring. The Director of Nursing or designee will be responsible for compliance.	

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F 756	Continued From page 15 forwarded, reviewed and/or acted on by the physician or nurse practitioner prior to 2/15/22. On 2/17/22, at 12:22 p.m. the director of nurse (DON) stated he expected the CP recommendations were acted upon as soon as they are made available but no more than three days after they are made available to the facility. Facility policy, Medication Regimen Review (MRR) dated 3/3/20, instructed the CP's recommendation should be addressed by the attending physician before the CP's next monthly MRR, however, the policy doesn't address how the physician was notified of CP's recommendations.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		3/18/22

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F 758	Continued From page 16 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to re-evaluate the continued use of an as needed (PRN) antipsychotic medication every 14 days as required for 1 of 5 residents (R31) reviewed for unnecessary medication. Findings include: R31's significant change Minimum Data Set (MDS) dated 12/23/21, identified R31 had	F 758	F758- All residents who received a PRN psychotropic medication for 14 days were reviewed to ensure a current order and rationale were in place. The residents on a 14-day psychotropic medication will be monitored weekly in the Unit Manger meeting to ensure current order and rationale are in place to support continued use. Resident R31's pharmacy consult was	

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F 758	Continued From page 17 moderate cognitive impairment. R31 was assessed to have mild depression with no behaviors noted. R31's face sheet printed 2/17/22, identified R31's diagnoses included major depression. R31's Medication Administration Records (MAR) for the months December 2021, January 2022 and February 2022, identified R31 had an order for olanzapine 2.5mg (an antipsychotic) by mouth every six hours as needed for nausea or agitation. The order originated on 12/17/21, there was no end date indicated on the MAR. R31's completed pharmacy Consultation Report with recommendation date 1/4/22, noted R31's medication had been reviewed by the CP and listed, "[R31] has a PRN order for an antipsychotic without a stop date: Olanzapine 2.5mg every 6 hours PRN nausea/agitation (12/17/21). Recommendation: Please discontinue the PRN olanzapine. If to continue, an in person assessment and new order is required every 14 days for PRN ANTIPSYCHOTICS for ALL nursing home residents per CMS (Centers for Medicare and Medicaid Services)" The recorded response from the nurse practitioner, accepting the recommendations as written, was dated 2/15/22. On 2/17/22, at 10:35 a.m. the CP stated the provider needed to review use of PRN antipsychotics every 14 days to ensure appropriate use and to determine if it should be scheduled instead of PRN. On 2/17/22, at 12:22 p.m. the director of nurse (DON) stated he expected the nurse managers to	F 758	addressed by the MD/NP and changes noted on the EMAR. It is policy of the facility to forward all pharmacy consults that require an MD/NP signature for completion to the appropriate MD/NP or provider. The policy and procedure were reviewed and continues to be current. Once we receive the consult form and the recommendation we will refer it to the MD/NP for review to determine if they want to accept or decline the recommendation. Staff were educated that the PRN psychotropic medications are only good for 14 days and we need to obtain an order to continue or discontinue the medication per policy. Auditing will be completed by the Director of Nursing or designee weekly for two months, then twice a month for one month and then monthly for two months. The audits will be completed by the Director of Nursing or designee with results reported to the QAPI Committee for review and recommendations for further monitoring. The Director of Nursing or designee will be responsible for compliance.	

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F 758	Continued From page 18 monitor PRN antipsychotic orders and to ensure the providers are reviewing and addressing continued appropriateness of PRN use every 14 days. A facility policy on PRN antipsychotics was requested but not received.	F 758		
F 880 SS=D	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 §483.70(e) and following accepted national standards; §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	F 880		3/18/22

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F 880	Continued From page 19 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. 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 oxygen	F 880	F880- The water bottle on Resident R39's oxygen concentrator was	

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F 880	Continued From page 20 equipment was maintained in a manner to reduce the risk of bacterial growth and subsequent infection for 1 of 2 residents (R39) observed to use oxygen. In addition, the facility failed to ensure personal cares were provided with clean linens and in a manner to reduce the risk of cross contamination for 1 of 3 residents (R13) observed for activities of daily living (ADLs). Findings include: R39's annual Minimum Data Set (MDS), dated 1/7/22, identified R39 required extensive assistance to complete most ADLs, had asthma, chronic obstructive pulmonary disease (COPD) or another chronic lung diease (e.g., chronic bronchitis), and used oxygen therapy while a resident at the nursing home. Further, R39's Admission Record, printed 2/16/22, identified R39 had COPD, congestive heart failure, and a history of pulmonary embolism. On 2/14/22 at 1:56 p.m., R39 was observed laying in bed while in her room. R39 had an oxygen cannula in place which was connected to a humidifier bottle attached to a liquid oxygen tank present along the wall. The oxygen tubing had a piece of paper tape attached which had black writing present which read, "2/11," however, the humidifier bottle, which had visible water bubbling, had paper tape attached which read, "1-6-22" [over 35 days prior]. R39 stated she used the liquid oxygen and humidifier to help her breath when in bed but did not know who changed the tubing or humidifier, nor how often. During subsequent observations, on 2/15/22 at 5:43 p.m. and 2/16/22 at 9:07 a.m., R39's liquid oxygen machine had the same humidifier bottle,	F 880	exchanged with a new water bottle and appropriately dated. In addition, all residents on oxygen therapy utilizing a oxygen concentrator were checked to ensure that the water bottle was changed weekly and appropriately dated. The policy and procedure were reviewed and remains current. Per policy, staff need to change the oxygen water bottle weekly and put the date of change on the oxygen water bottle. In-service's will be completed by our oxygen provider. The Director of Nursing or designee will audit on all shifts every day for one week, then audit frequency may decrease determined by compliance. The Director of Nursing, the Infection Preventionist, or designee will review the results of audits and monitoring with the QAPI Committee. The Director of Nursing or designee will be responsible for compliance. Directed Plan of Correction for Equipment/Environment: Policy/Procedure/System Changes: Policy and procedures were reviewed per plan of correction per respiratory therapy. The water bottle was replaced and dated for date of change. Continue to monitor for correct exchange of the water bottle on all oxygen concentrators that require the use of a water bottle. Root Cause Analysis: A Root Cause Analysis (RCA) was conducted and determined that staff did not follow policy and procedure when changing water bottles on the oxygen concentrator, resulting in an outdated water bottle. Staff failed to observe oxygen equipment that required changing	

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F 880	Continued From page 21 dated "1-6-22," attached with visible fluid inside. R39's unsigned Order Summary Report printed 2/16/22, identified a physician order for R39;s oxygen use which read, "O2 at 2 L/MIN [liters per minute] by NC [nasal cannula] - DO NOT WEAN," along with a nursing order which read, "CHANGE OXYGEN TUBING AND LABEL IT," with directions to be completed on a weekly basis. However, the report lacked any orders or directions on when or how often to change and/or clean the humidifier bottle used on the oxygen machine. Further, R39's medical record was reviewed and lacked any evidence R39's oxygen humidifier was being tracked or cleaned/changed since 1/6/22 when the bottle was placed into service. When interviewed on 2/16/22, at 9:13 a.m. nursing assistant (NA)-B stated R39 used oxygen from the liquid oxygen tank and humidifier daily, when in bed. NA-B stated there was "an oxygen guy" who came to the nursing home and was responsible to change the tubing and humidifier; however, NA-B stated she was "not sure when he comes in." On 2/16/22 at 10:13 a.m., registered nurse manager (RN)-A stated R39 used oxygen on a continuous basis and mainly used the liquid oxygen while in bed. RN-A stated the floor nurses were responsible to ensure the oxygen tubing and humidifier were changed, not just cleaned, as changing them on a weekly basis was facility' policy to their understanding. RN-A observed R39's humidifier at this time and verified it was dated 1/6/22. RN-A stated he would change it immediately and verified the humidifer should have been changed on a weekly basis after	F 880	of water bottle with the current date per policy and procedure. During the root cause analysis process, nurses stated they dated the oxygen tubing not realizing they also needed to date the water bottle separately. They also did not monitor the water bottles for the correct date when entering a room where an oxygen concentrator was being used. Immediate education was provided to licensed nurses regarding the need to date the water bottle on oxygen concentrators and to monitor the water bottle when in a room where an oxygen concentrator is being utilized to verify the water bottle has the exchange date on it. The orders in the electronic medical record were changed to also include dating the water bottle. Training/Education: Licensed staff were educated on proper policy and procedure and when to change the water bottle on an oxygen concentrator, as well to make sure to put the date on the water bottle that it was exchanged. Licensed staff demonstrated competency to exchange the water bottle and put the exchange date on the water bottle. NAR's and Nurses were also asked to monitor the water bottle when in a room where an oxygen concentrator is being utilized to verify the water bottle has the exchange date on it. Staff training occurred on 3/1/22, 3/2,22, and 3/4/22 to re-educate the nursing staff. Monitoring/Auditing: The Director of Nursing, the Infection Preventionist, or designee will audit on all shifts every day for one week, then audit frequency may	

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F 880	Continued From page 22 1/6/22. RN-A added, "That's the expectation." When interviewed on 2/16/22, at 1:51 p.m. the director of nursing (DON) explained oxygen tubing and humidifiers should be changed, not just cleaned, on a weekly basis as bacteria can begin to grow inside. When discussing R39's unchanged humidifier bottle, the DON voiced, "That is an issue." A provided Northwest Respiratory Services Customer Handbook, dated 2/2020, identified a section labeled, "Infection Control," which directed, "To reduce the risk of infections it is very important to keep the following in mind ... 1. Keep your equipment clean ... [and] ... 4. Change oxygen tubing or supplies on a regular basis." Further, an additional section labeled, "Care of your Cannula/Mask, Tubing, and Humidifier bottle." This included, " ... replace your cannula or mask each week and oxygen extension tubing and humidifier bottle once every month ... The humidifier bottle must be cleaned between fills or once per week ..." R13's face sheet printed 2/16/22, indicated R13's diagnoses included dementia, age-related physical debility, and heart failure. R13's quarterly Minimum Data Set (MDS) dated 12/6/21, indicated R13 required extensive physical assistance with activities of daily living. R13's cognition was severely impaired. On 2/16/22, at 8:23 a.m. nursing assistant (NA)-A was observed using a wet wipe to clean R13's buttocks followed by a wet washcloth. NA-A used the washcloth to clean around R13's anus then placed the washcloth in a sink of water in R13's	F 880	decrease determined by compliance. The Director of Nursing, the Infection Preventionist, or designee will review the results of audits and monitoring with the QAPI Committee. F880- Immediate intervention of retraining the nursing assistant for proper bathing sequencing occurred for Resident R13. The policy and procedure were reviewed and remains current. Staff were re-educated on the Bathing – Partial Policy immediately and during nursing staff meetings on 3/1/22, 3/2/22, and 3/4/22. Education included the order of bathing and obtaining supplies before initiating bathing the resident. The Director of Nursing, the Infection Preventionist, or designee will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. The audits will continue until 100% compliance is met. The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the QAPI Committee. The Director of Nursing or designee will be responsible for compliance. Directed Plan of Correction for Hand Hygiene: Policy/Procedure/System Changes: Policy and procedures were reviewed per plan of correction per bathing policy. The NAR was re-educated on the proper procedure for giving a bed bath to prevent this practice from reoccurring. Root Cause Analysis:	

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F 880	Continued From page 23 bathroom. After assisting R13 with a clean brief and putting on his pants and socks, NA-A returned to the bathroom to get the soiled washcloth used on R13's peri area. NA-A used the soiled washcloth to wash R13's face, including around R13's eyes, nose and mouth. At 8:30 a.m.NA-A confirmed she had used the same soiled washcloth for R13's face after using it on his buttocks and anus. On 2/16/22, at 8:54 a.m. nurse manager (NM)-A stated the order of personal cares included starting with the face and hands. The buttocks and anus should be done last. If cares were started with the buttocks, then a different, clean wash cloth should be used for the face. NM-A stated it was not acceptable to re-use the same washcloth because it increased the risk for infection. On 2/16/22, at 9:16 a.m. director of nursing (DON) stated he expected a partial bath was started with the resident's face and hands, the buttocks and anus were washed last. A washcloth used on the buttocks and anus should not be used on other areas of the body. Doing so placed R13 at increased risk for infections. Facility provided policy and procedure for Bath (Partial) dated 2021, numbered the procedure. Number seven on the list instructed wash face and ears, rinse well and dry carefully. Number 12 on the list instructed wash back, buttocks and genitals.	F 880	A Root Cause Analysis (RCA) regarding improper bathing techniques was conducted and determined that the NAR did not follow facility policy, nor the NAR certification training, in giving a bath to prevent infection. During the root cause analysis process, the NAR was asked what occurred and she stated that she knew better but was very nervous while being observed bathing a resident. She did not follow her NAR training when giving a bath, nor having the proper supplies available prior to beginning the bath. She neglected to inquire where the bathing supplies were kept to bathe the resident which resulted in only utilizing one wash cloth. She stated she did not know where the bathing supplies were kept and when asked why she did not inquire where they were kept, she did not respond. She was immediately instructed in the future to notify her unit manager if she is feeling nervous while being observed providing cares and to ask if she has any questions about where supplies are kept. Training/Education: NA-A was immediately re-educated on the proper procedure for completing a partial bath including the proper sequence of bathing a resident to adhere to appropriate infection control practices. NA-A was also re-educated on making sure they had enough supplies before performing the resident's bath. NAR's were educated on 3/1/22, 3/2,22, and 3/4/22 during nurses' meetings regarding the Partial Bathing policy and having the necessary supplies available before performing a bath. NAR's	

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F 880	Continued From page 24	F 880	demonstrated understanding of the proper completion of a partial bath and infection control practice by completing a test of the bathing procedures. Monitoring/Auditing: The Director of Nursing, the Infection Preventionist, or designee will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. The audits will continue until 100% compliance is met. The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the QAPI Committee.	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/16/2022. At the time of this survey, Anoka Rehabilitation and Living Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/17/2022

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Anoka Rehabilitation & Living Center is a 2-story building with a basement that was built in 2012 and determined to be of Type II(111) construction. The building shares a common wall with an assisted living facility and is separated by a 2-hour fire-rated construction. Each floor containing resident sleeping rooms are divided into smoke compartments. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to	K 000		

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K 000	Continued From page 2 the corridor, and resident rooms that are monitored for automatic fire department notification. The facility has a capacity of 120 beds and had a census of 98 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321		3/18/22

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K 321	Continued From page 3 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous room doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/16/2022 between 10:30 AM and 12:30 PM, it was revealed by observation that 3 Soiled Utility Room doors on the 1st and 2nd floors and one laundry room door would not positively latch into the frame due to the striker plate being stuffed with tissue paper. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 321	K321 The door latches identified in the 2567 were found in good repair and latching properly on 2/17/22. Housekeeping, Laundry, Maintenance, and Nursing Staff began training on 2/17/22. The training included hazardous areas, including general safety, dangers of fire doors not being closed, and hazardous material safety; fire safety and life safety requirements; the dangers of blocking doors; and the consequences of such actions. If there are any similar actions by staff to prevent the doors from latching positively, an investigation will be performed by Human Resources and appropriate action taken. Hazardous areas will be monitored daily for two weeks and then three times per week for two weeks with results reported to the QAPI Committee for review and further recommendations for monitoring. Further system revision, staff education and corrective action will be provided if indicated by audits. The Director of Maintenance and Director of Nursing will be responsible for compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345		3/18/22

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	245205	A. BUILDING **02 - ANOKA CARE & REHAB CENTER** B. WING	**02/16/2022**

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K 345	Continued From page 4 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, sections 14.3.1 and 14.4.5.3.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 02/16/2022 at 9:00 AM, it was revealed by a review of available documentation the semi-annual fire alarm testing documentation was not available at the time of the survey. 2) On 02/16/2022 at 9:00 AM, it was revealed by a review of available documentation the sensitivity testing documentation was not available at the time of the survey. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 345	K345 The facility fire alarm testing including the sensitivity testing was completed on March 15, 2022. Education and training were provided to the Director of Maintenance on fire safety, the importance of fire alarm testing and keeping records current. The applicable vendors were contacted to update our contracts to make sure appropriate testing of the fire alarm system and sensitivity testing are completed as required. The schedule of the semi-annual Fire alarm system testing and the sensitivity testing will be programmed into the TELS preventive maintenance computer system. The TELS system will send electronic reminders to both maintenance and leadership when testing is due. The fire alarm system and sensitivity testing will also be added to the QAPI Committee schedule for ongoing oversight. The Director of Maintenance will be responsible for compliance.	

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K 345	Continued From page 5	K 345	Date of Correction: 3/18/22	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 363		3/18/22

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K 363	Continued From page 6 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5, and CFR 483.90 paragraph (a)(1)(ii). These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 02/16/2022 between 10:30 AM and 12:30 PM, it was revealed by observation that one Clean linen room door on the 1st floor would not positively latch into the frame due to the striker plate being stuffed with tissue paper. 2) On 02/16/2022 between 10:30 AM and 12:30 PM, it was revealed by observation that roller latches were found on corridor closets containing combustible materials in all six units of the facility. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 363	K363 The door latches identified in the 2567 were found in good repair and latching properly on 2/17/22. Housekeeping, Laundry, Maintenance, and Nursing Staff began training on 2/17/22. The training included hazardous areas, including general safety, dangers of fire doors not being closed, and hazardous material safety; fire safety and life safety requirements; the dangers of blocking doors; and the consequences of such actions. If there are any similar actions by staff to prevent the doors from latching positively, an investigation will be performed by Human Resources and appropriate action taken. The roller latches on the corridor closets were removed 2/24/22. Hazardous areas will be monitored daily for two weeks and then three times per week for two weeks with results reported to the QAPI Committee for review and further recommendations for monitoring. Further system revision, staff education and corrective action will be provided if indicated by audits. This will be added to the QAPI Committee schedule for ongoing oversight. The Director of Maintenance Director and	

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K 363	Continued From page 7	K 363	Maintenance staff will be responsible for compliance.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the heating, ventilation, and air conditioning system per NFPA 101 (2012 edition), Life Safety Code, sections 9.2 and 19.5.2.1, and NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 5.4.8.1 and 5.4.8.2, and NFPA 80 Standard for Fire Doors and Other Opening Protective's (2010 Edition), sections 19.4.1.1, 19.4.9, 19.4.10 and 19.5.5 and NFPA 105 Standard for Smoke Door Assemblies and Other Opening Protective's (2010 Edition), sections 6.5.2, 6.5.11, 6.5.12 and 6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/16/2022 at 09:00 AM, it was revealed by a review of available documentation the facility had	K 521	K521 Education and training were provided to the Director of Maintenance on the requirements for the frequency of testing of the smoke and fire dampers. The applicable vendors were contacted to update our contracts to make sure appropriate smoke and fire damper testing is completed as required. The updated contract with the vendor was approved and signed on March 15, 2022, and the testing of the smoke and fire dampers is scheduled for March 28, 2022. The Schedule of the smoke and fire damper testing will be programmed into the TELS preventive maintenance computer system for testing. The TELS system will send electronic reminders to both maintenance and leadership when testing is due. The smoke and fire damper	3/18/22

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K 521	Continued From page 8 exceeded the required four-year testing of the smoke and fire dampers. An interview with Environmental Services Director verified this deficient finding at the time of discovery.	K 521	testing will also be added to the QAPI Committee schedule for ongoing oversight. The Director of Maintenance Director and Maintenance staff will be responsible for compliance. Date of Correction: 3/18/22	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/16/2022 at 09:30 AM, it was revealed by a review of available documentation the day shift drill for the 3rd quarter of 2021 was completed in	K 712	F712 Fire drill testing will be conducted as required on all three shifts. The fire drills will be conducted separately between the skilled nursing facility and the assisted living building. A fire drill was performed in the skilled nursing facility on 2/23/22. Education and training were provided to the Director of Maintenance on the	3/18/22

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K 712	Continued From page 9 the Assisted Living and not in the Nursing Home. An interview with the Administrator and Environmental Service Director verified this deficient finding at the time of discovery.	K 712	process for fire drill testing in the skilled nursing facility and assisted living building separately. The required fire drills will be added to the QAPI Committee schedule for ongoing oversight. The Director of Maintenance Director will be responsible for compliance.	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to limit flammable decorations per NFPA 101 (2012 edition), Life Safety Code, section 19.7.5.6. This deficient finding could have an isolated impact on the residents within the facility.	K 753	K753 The resident room identified in the 2567 will be cleaned with the overflow of books removed to prevent a fire hazard. It will be explained to the resident the reasons why this needs to occur. Social Services,	3/18/22

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K 753	Continued From page 10 Findings include: On 02/16/2022 at 11:45 AM, it was revealed by observation that room 2127B had 75-80 percent of the wall surface covered with pictures and other items. An interview with the Administrator and Environmental Service Director verified this deficient finding at the time of discovery.	K 753	Nursing, Life Enrichment, Maintenance, and Housekeeping staff will be trained on the importance of maintaining resident rooms in a safe manner to reduce fire hazards and combustible decoration requirements. Five resident rooms will be audited to monitor for the amount of wall surface covered with pictures and other items weekly for four weeks; then five resident rooms will be audited twice a month with results reported to the QAPI Committee for review and further recommendations for monitoring. Further system revision, staff education and corrective action will be provided if indicated by audits. The Director of Maintenance Director will be responsible for compliance.	