DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 7, 2022

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

RE: CCN: 245205
Cycle Start Date: September 26, 2022

Dear Administrator:

On November 1, 2022, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered

November 7, 2022

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

Re: Reinspection Results
Event ID: 9MG812

Dear Administrator:

On November 1, 2022 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 September 26, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Electronically delivered
October 11, 2022

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

RE: CCN: 245205
Cycle Start Date: September 26, 2022

Dear Administrator:

On September 26, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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 December 26, 2022 (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 March 26, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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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 09/26/2022

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
F 000	INITIAL COMMENTS On 9/23/22 - 9/26/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H52054762C (MN00087020), with a deficiency cited at F689. The following complaint was found to be UNSUBSTANTIATED: H52054793C (MN00087004). As a result of the investigation a deficiency was cited at F573. 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/21/22

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

Electronically Signed | 10/20/2022

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 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify fall risk, and failed to implement and care plan individualized pre and post-fall interventions for 1 of 1 residents (R1) with a high fall risk who was observed by multiple staff members to be self-transferring and self-ambulating prior to a fall within the facility. Findings include: R1's hospital Discharge Summary, dated 9/19/22, identified R1 underwent insertion of a right ventriculoperitoneal (VP) shunt (medical device that relieves pressure on the brain caused by fluid accumulation) on 9/6/22, in response to normal pressure hydrocephalus (fluid build-up in brain cavities). R1 exhibited "poor mobility (shuffling, using sara-steady) in which he was "impulsive, forgetful (although fully oriented and conversant, which hides his deficits). Favor these are baseline cognitive deficits aggravated by sleep loss, pain, environment change, and narcotic (pain medication). On 9/19/22, R1 was discharged to the facility for continued rehabilitation and medical management. In addition, an unlabeled hospital report, printed 9/19/22 by the facility staff, indicated R1 was a high fall risk, displayed memory loss dating back to 3/31/21, and had a history of falling. A Nursing Data Collection - Admission/Readmission Day 1 form, dated 9/19/22, identified a category for Fall Risk. The section indicated R1 was free of fall history with a	F 689	F-689 It is the policy of the facility to begin with the forty-eight hour with the day one assessment which entails the fall care plan. There was one resident alleged to be affected in the deficient practice related to a fall on the day following the admission. Resident R1 was noted by the nurse to have an unsteady gait while ambulating to the nursing station. The nurse assisted resident back to his room. Resident fell on day two of admission, 9/20/22 at 1610. He stated he hit his head and neuros checks were started immediately per facility policy. He was noted to develop a condition change and was sent to Mercy Hospital ER for evaluation. Resident R1 discharged from the facility on 5/20/22. Licensed nursing staff were immediately educated on the importance of including risk for falls, goals and fall interventions in the care plan. Nurses were also educated on the same in nurses meetings held on 10/5/22 and 10/6/22. Nurses were also educated on the importance of completing the day one admission assessment with a list of problems, goals and interventions which initiates the 48-hour care plan. In addition, nurses were educated that when a nurse sees a medical/physical issue that it needs to be addressed on the residents' care plan. We conducted a 100% audit of	

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F 689	Continued From page 2 focus on falls to assist R1 to remain free of falls and/or receive no injury due to falling. The intervention selected was for staff to anticipate and meet R1's needs. No other available intervention options were checked. This section directed staff to "Complete Fall Risk Data Collection." A review of R1's medical record lacked evidence of a Fall Risk Data Collection form. Review of R1's progress notes revealed: -On 9/20/22, entered at 11:50 a.m. R1 ambulated independently to the nurses station. R1 indicated he had a headache and requested medication. R1 was observed to be "very unsteady on his feet" and was assisted back to his room. -On 9/20/22, entered at 10:43 p.m. R1 was found on the floor in his room around 3:40 p.m. that shift. R1 confirmed to the nurse he hit his head when he fell attempting to ambulate to the bathroom. Approximately an hour later, the nurse was called to R1's room where she observed R1 with his eyes open but he was unable to talk. 911 was called and he was transferred to the hospital at 5:40 p.m. Review of R1's therapy evaluations revealed: -R1's physical therapy (PT) evaluation dated 9/20/22, identified a goal for R1 was to decrease risk of falling. Further review of R1's evaluation indicated R1 had one fall in the past year. R1's strength and coordination were impaired. He presented with a festinating (short, shuffling that begins slowly but increases in rapidity) with additional fall risk predictors of reduced reactive	F 689	our charts of residents having fall risks and found no other residents with the potential to be affected by the alleged deficient practice. The Director of Nursing or designee using an audit tool will do an audit of the day one assessment that it is complete and that the problems, goals, and interventions are carried on to the 48-hour care plan. This will be done daily for one week on all new admissions to the facility. Then the audit will be done 3 times per week for 3 weeks and then weekly for 3 weeks and then as needed to maintain compliance. The results of the audit will be brought to QAPI meeting for further follow up if needed. The Director of Nursing is responsible for compliance.	

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F 689	Continued From page 3 and proactive balance. -R1's occupational therapy (OT) evaluation dated 9/20/22, identified R1 required contact guard - minimal physical assist with activities of daily living due to fall risks and decreased safety awareness with the need for a four wheeled-walker. R1 presented with increased weakness and fatigue in which R1 reported he fell at home and resulted in his recent hospitalization. In addition, the evaluation identified R1 displayed impairments such as: impairment in attention follow through, planning, and problem solving, self-modification, self-monitoring, use of coping strategies and use of environmental modification strategies which resulted in limitations in general tasks and demands, mobility and self-care. Review of R1's Nursing Skilled Services Data Collection form dated 9/20/22, at 1:16 p.m. identified he was oriented to person, place and time; however, he was forgetful. R1 ambulated with a walker with stand by assist and identified R1 as unsteady and had shuffled gait. Further review of form indicated R1 required staff assistance with transferring, dressing, and toileting. R1's SLUMS (Saint Louis University Mental Status) Examination dated 9/20/22, indicated R1 scored a 24 out of 30 points which indicated R1 displayed a mild neurocognitive disorder. A Post Incident Review, dated 9/20/22, identified R1's fall information and provided an area for "immediate interventions" to be put into place to "prevent this from happening again or at least on your shift again:" this section remained blank. A section for root cause analysis identified "Self	F 689		

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F 689	Continued From page 4 transfer/Overestimates or forgets limits." A section for information obtained from staff interview identified R1 failed to use his call light despite it being within his reach. Within the review, a MORSE FALL Scale was completed with a score of 85 which indicated R1 was at a high risk for falls and directed staff, based on this score, to implement high risk fall prevention interventions. R1's Care Plan, printed 9/23/22, identified on 9/19/22, R1 was at risk for falls with a goal he would remain free of falls or receive no injury due to falling. One intervention directed staff to anticipate and meet R1's needs. Further review of R1's care plan, lacked fall risk etiology(s) or history of fall(s) prior to or during stay, as well as R1's cognitive impairments with episodes of not using his call light for required assistance, staff witnessed self-transfers and self-ambulation, unsteady gait, impaired balance, weakness, etc. In addition, R1's care plan lacked individualized care plan interventions to help mitigate the risk of falls based on his high fall risk. When interviewed on 9/23/22, at 3:39 p.m. nurse supervisor (NS)-A stated fall risk was initially determined on admission and then the MORSE Fall Scale (a rapid and simple method that determined a residents likelihood for falls) was to be completed the second day after admission during the night shift. NS-A confirmed R1's medical record lacked a MORSE and explained R1 discharged back to the hospital before it was due to be completed. He acknowledged he was unsure as to the reason the facility's practice did not complete the MORSE on the day of admission. NS-A stated R1 was not a fall risk, due to an event where "one time [R1] walked all	F 689		

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F 689	Continued From page 5 the way to the nurses station;" however, he was unaware of how R1 walked during that incident. He indicated if a resident had a fall history on admission, the care plan would have required additional fall risk information and interventions; however, being the initial Nursing Data Collection indicated there was no prior fall history, R1's care plan interventions were appropriate until after the MORSE could be completed. NS-A stated the nurse "was going to stay close by and do the neuros at 15 minutes apart" after R1's fall which was an appropriate intervention. He stated he was unaware of any other interventions put into place to help mitigate R1's fall risk. During interview on 9/23/22, at 4:57 p.m. the director of nursing (DON) stated R1 ambulated to the bathroom independently when he fell. He explained R1 "was up ad lib as tolerated;" however, he was without knowledge of R1's medical status. The DON was updated on R1's documented independent walking to the nurses station and his very unsteady gait and he reviewed R1's fall care plan. He indicated R1's observed independent mobility placed R1 at a higher fall risk, especially with his unsteady gait and being new to the facility. The DON confirmed R1's care plan lacked identified fall risk factors and associated individualized interventions, or was revised, prior to and after R1's fall. He confirmed he expected R1's care plan to identify his fall risk factors and individualized interventions and he would have expected R1 to be reevaluated and education provided for call light use to help ensure R1's safety by lowering his risk for falls and subsequent injuries. When interviewed on 9/26/22, at 11:27 a.m. licensed practical nurse (LPN)-B stated R1 had	F 689		

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F 689	Continued From page 6 walked independently to the nurses station from his room "right away in the morning" prior to his therapy evaluation. She indicated R1's room was at the farthest end of the unit's hallway. She stated she updated the nursing assistant that morning after her observation of R1 to "keep an eye on him;" however, she denied she updated therapy or R1's plan of care to reflect his observed self ambulation and unsteady gait or interventions to decrease his risk of falls. During interview on 9/26/22, at 11:35 a.m. nursing assistant (NA)-A stated R1 was observed to have an unsteady or shuffled gait and would self transfer or ambulate independently without utilizing the call light for staff assistance, and thus she considered R1 a fall risk. NA-A stated she was unsure if she discussed R1's gait or self-mobility habits with any other staff. When interviewed on 9/26/22, at 12:08 p.m. physical therapist (PT)-A stated typically after a resident therapy evaluation is completed, the only information that was communicated to nursing would be the assistance level the resident required, not the residents fall risk. She acknowledged she was unaware R1 self-transferred and/or ambulated independently. She identified R1 was at risk for falls related to his festinating gait, increased and easily fatigued with mobility, and cognitive impairments in which he required cues for safety and thus he required assistance of one staff for mobility, especially when he made turns around rooms as at those times his gait instability increased. When PT-A was updated about R1's self-transfers/ambulation, she stated such resident information would help assist her in therapy treatment session and evaluation	F 689		

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F 689	Continued From page 7 decisions. During interview on 9/26/22, at 2:59 p.m. LPN-A stated R1 was at risk for falls prior to his fall and more at risk after and "it was not safe for him to walk by himself." She confirmed she was the nurse who followed-up in response to R1's fall. She confirmed R1's care plan was not revised following the fall. She explained she does not do anything with the care plan and if changes are required she alerted the nurse manager. In addition, she explained fall interventions were expected to be implemented when staff completed the risk management form and then management would update the care plan after they reviewed the incident information. LPN-A confirmed R1's risk management form lacked fall interventions. She identified R1's post-fall intervention was the routine neuro checks she started. She denied implementing any other interventions to help mitigate R1's fall risk after his fall. A facility policy titled Falls, undated, indicated the policy's purpose was to direct staff to evaluate the extent of injury and to prevent complications after a fall. The policy lacked direction related to fall risk care plan intervention evaluation and/or implementation.	F 689		

Electronically delivered
October 11, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 9MG811

Dear Administrator:

The above facility was surveyed on September 23, 2022 through September 26, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTEI	3000 4TH AVENUE ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/23/22 - 9/26/22 a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52054762C (MN00087020), with licensing orders issued at 0830. The following complaint was found to be UNSUBSTANTIATED: H52054793C (MN00087004). As a result of the investigation an order was cited at 1860. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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2 000	Continued From page 2 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify fall risk, and failed to implement and care plan individualized pre and post-fall interventions for 1 of 1 residents (R1) with a high fall risk who was observed by multiple staff members to be self-transferring and self-ambulating prior to a fall within the facility.	2 830	Corrected	10/21/22

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2 830	Continued From page 3 Findings include: R1's hospital Discharge Summary, dated 9/19/22, identified R1 underwent insertion of a right ventriculoperitoneal (VP) shunt (medical device that relieves pressure on the brain caused by fluid accumulation) on 9/6/22, in response to normal pressure hydrocephalus (fluid build-up in brain cavities). R1 exhibited "poor mobility (shuffling, using sara-steady) in which he was "impulsive, forgetful (although fully oriented and conversant, which hides his deficits). Favor these are baseline cognitive deficits aggravated by sleep loss, pain, environment change, and narcotic (pain medication). On 9/19/22, R1 was discharged to the facility for continued rehabilitation and medical management. In addition, an unlabeled hospital report, printed 9/19/22 by the facility staff, indicated R1 was a high fall risk, displayed memory loss dating back to 3/31/21, and had a history of falling. A Nursing Data Collection - Admission/Readmission Day 1 form, dated 9/19/22, identified a category for Fall Risk. The section indicated R1 was free of fall history with a focus on falls to assist R1 to remain free of falls and/or receive no injury due to falling. The intervention selected was for staff to anticipate and meet R1's needs. No other available intervention options were checked. This section directed staff to "Complete Fall Risk Data Collection." A review of R1's medical record lacked evidence of a Fall Risk Data Collection form. Review of R1's progress notes revealed: -On 9/20/22, entered at 11:50 a.m. R1 ambulated	2 830		

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2 830	Continued From page 4 independently to the nurses station. R1 indicated he had a headache and requested medication. R1 was observed to be "very unsteady on his feet" and was assisted back to his room. -On 9/20/22, entered at 10:43 p.m. R1 was found on the floor in his room around 3:40 p.m. that shift. R1 confirmed to the nurse he hit his head when he fell attempting to ambulate to the bathroom. Approximately an hour later, the nurse was called to R1's room where she observed R1 with his eyes open but he was unable to talk. 911 was called and he was transferred to the hospital at 5:40 p.m. Review of R1's therapy evaluations revealed: -R1's physical therapy (PT) evaluation dated 9/20/22, identified a goal for R1 was to decrease risk of falling. Further review of R1's evaluation indicated R1 had one fall in the past year. R1's strength and coordination were impaired. He presented with a festinating (short, shuffling that begins slowly but increases in rapidity) with additional fall risk predictors of reduced reactive and proactive balance. -R1's occupational therapy (OT) evaluation dated 9/20/22, identified R1 required contact guard - minimal physical assist with activities of daily living due to fall risks and decreased safety awareness with the need for a four wheeled-walker. R1 presented with increased weakness and fatigue in which R1 reported he fell at home and resulted in his recent hospitalization. In addition, the evaluation identified R1 displayed impairments such as: impairment in attention follow through, planning, and problem solving, self-modification, self-monitoring, use of coping strategies and use of environmental modification	2 830		

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2 830	Continued From page 5 strategies which resulted in limitations in general tasks and demands, mobility and self-care. Review of R1's Nursing Skilled Services Data Collection form dated 9/20/22, at 1:16 p.m. identified he was oriented to person, place and time; however, he was forgetful. R1 ambulated with a walker with stand by assist and identified R1 as unsteady and had shuffled gait. Further review of form indicated R1 required staff assistance with transferring, dressing, and toileting. R1's SLUMS (Saint Louis University Mental Status) Examination dated 9/20/22, indicated R1 scored a 24 out of 30 points which indicated R1 displayed a mild neurocognitive disorder. A Post Incident Review, dated 9/20/22, identified R1's fall information and provided an area for "immediate interventions" to be put into place to "prevent this from happening again or at least on your shift again:" this section remained blank. A section for root cause analysis identified "Self transfer/Overestimates or forgets limits." A section for information obtained from staff interview identified R1 failed to use his call light despite it being within his reach. Within the review, a MORSE FALL Scale was completed with a score of 85 which indicated R1 was at a high risk for falls and directed staff, based on this score, to implement high risk fall prevention interventions. R1's Care Plan, printed 9/23/22, identified on 9/19/22, R1 was at risk for falls with a goal he would remain free of falls or receive no injury due to falling. One intervention directed staff to anticipate and meet R1's needs. Further review of R1's care plan, lacked fall risk etiology(s) or	2 830		

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2 830	Continued From page 6 history of fall(s) prior to or during stay, as well as R1's cognitive impairments with episodes of not using his call light for required assistance, staff witnessed self-transfers and self-ambulation, unsteady gait, impaired balance, weakness, etc. In addition, R1's care plan lacked individualized care plan interventions to help mitigate the risk of falls based on his high fall risk. When interviewed on 9/23/22, at 3:39 p.m. nurse supervisor (NS)-A stated fall risk was initially determined on admission and then the MORSE Fall Scale (a rapid and simple method that determined a residents likelihood for falls) was to be completed the second day after admission during the night shift. NS-A confirmed R1's medical record lacked a MORSE and explained R1 discharged back to the hospital before it was due to be completed. He acknowledged he was unsure as to the reason the facility's practice did not complete the MORSE on the day of admission. NS-A stated R1 was not a fall risk, due to an event where "one time [R1] walked all the way to the nurses station;" however, he was unaware of how R1 walked during that incident. He indicated if a resident had a fall history on admission, the care plan would have required additional fall risk information and interventions; however, being the initial Nursing Data Collection indicated there was no prior fall history, R1's care plan interventions were appropriate until after the MORSE could be completed. NS-A stated the nurse "was going to stay close by and do the neuros at 15 minutes apart" after R1's fall which was an appropriate intervention. He stated he was unaware of any other interventions put into place to help mitigate R1's fall risk. During interview on 9/23/22, at 4:57 p.m. the director of nursing (DON) stated R1 ambulated to	2 830		

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2 830	Continued From page 7 the bathroom independently when he fell. He explained R1 "was up ad lib as tolerated;" however, he was without knowledge of R1's medical status. The DON was updated on R1's documented independent walking to the nurses station and his very unsteady gait and he reviewed R1's fall care plan. He indicated R1's observed independent mobility placed R1 at a higher fall risk, especially with his unsteady gait and being new to the facility. The DON confirmed R1's care plan lacked identified fall risk factors and associated individualized interventions, or was revised, prior to and after R1's fall. He confirmed he expected R1's care plan to identify his fall risk factors and individualized interventions and he would have expected R1 to be reevaluated and education provided for call light use to help ensure R1's safety by lowering his risk for falls and subsequent injuries. When interviewed on 9/26/22, at 11:27 a.m. licensed practical nurse (LPN)-B stated R1 had walked independently to the nurses station from his room "right away in the morning" prior to his therapy evaluation. She indicated R1's room was at the farthest end of the unit's hallway. She stated she updated the nursing assistant that morning after her observation of R1 to "keep an eye on him;" however, she denied she updated therapy or R1's plan of care to reflect his observed self ambulation and unsteady gait or interventions to decrease his risk of falls. During interview on 9/26/22, at 11:35 a.m. nursing assistant (NA)-A stated R1 was observed to have an unsteady or shuffled gait and would self transfer or ambulate independently without utilizing the call light for staff assistance, and thus she considered R1 a fall risk. NA-A stated she was unsure if she discussed R1's gait or	2 830		

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2 830	Continued From page 8 self-mobility habits with any other staff. When interviewed on 9/26/22, at 12:08 p.m. physical therapist (PT)-A stated typically after a resident therapy evaluation is completed, the only information that was communicated to nursing would be the assistance level the resident required, not the residents fall risk. She acknowledged she was unaware R1 self-transferred and/or ambulated independently. She identified R1 was at risk for falls related to his festinating gait, increased and easily fatigued with mobility, and cognitive impairments in which he required cues for safety and thus he required assistance of one staff for mobility, especially when he made turns around rooms as at those times his gait instability increased. When PT-A was updated about R1's self-transfers/ambulation, she stated such resident information would help assist her in therapy treatment session and evaluation decisions. During interview on 9/26/22, at 2:59 p.m. LPN-A stated R1 was at risk for falls prior to his fall and more at risk after and "it was not safe for him to walk by himself." She confirmed she was the nurse who followed-up in response to R1's fall. She confirmed R1's care plan was not revised following the fall. She explained she does not do anything with the care plan and if changes are required she alerted the nurse manager. In addition, she explained fall interventions were expected to be implemented when staff completed the risk management form and then management would update the care plan after they reviewed the incident information. LPN-A confirmed R1's risk management form lacked fall interventions. She identified R1's post-fall intervention was the routine neuro checks she	2 830		

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2 830	Continued From page 9 started. She denied implementing any other interventions to help mitigate R1's fall risk after his fall. A facility policy titled Falls, undated, indicated the policy's purpose was to direct staff to evaluate the extent of injury and to prevent complications after a fall. The policy lacked direction related to fall risk care plan intervention evaluation and/or implementation. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written	21860		10/21/22

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21860	Continued From page 10 information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 residents (R1) received a copy of their medical record, within 2 working days upon request excluding weekends and holidays. Findings include: An Authorization to Disclose Protected Health Information (ROI) form was completed on 9/21/22, by R1's family member (FM)-A identified FM-A requested R1's medical records from 9/19/22 - 9/21/22, along with the facility's fall policy. When interviewed on 9/23/22, at 1:35 p.m. FM-A stated R1 was admitted to the hospital and placed on a ventilator on 9/20/22. Further, FM-A stated she provided the facility with a copy of R1's healthcare directive which identified her as a healthcare power of attorney, and she completed the ROI form on 9/21/22. FM-A stated on 9/22/22, she received an email from the facility indicating the requested health information was unable to be provided. An email, sent to FM-A and FM-B, on 9/22/22,	21860	Corrected	

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21860	Continued From page 11 identified social worker (SW)-A's response to FM-A's medical record request: "As per my director of nursing (DON) and the rest of my administrative staff, as this is now involving higher-ups in my agency, I have been instructed to inform you that I am sorry, we cannot comply with your request at this time. There are privacy rules that we are required to follow and we are researching how we should respond. Once we are able to move forward, my team will reach out with information." During interview on 9/23/22, at 2:35 p.m. SW-A stated an ROI form was required to be completed to start the process for providing medical records when requested. She explained any of the specifically checked medical record items requested on the form would be provided. SW-A identified FM-A was not provided with the information per her request as, "We had to wait for legal to be involved as it was an atypical situation," as FM-A requested facility policies in addition to R1's medical records. When interviewed on 9/23/22, at 3:13 p.m. the health information manager (HIM) stated she was aware of FM-A's ROI request but the DON instructed HIM to postpone sending the information as the "legal department" needed to review the request. HIM indicated since FM-A had requested policies and head neurological checks which were "considered legal" and thus were "under investigation." She indicated she was unsure as to the reason FM-A was not provided with the medical record components of FM-A's request. In addition, HIM confirmed she was unsure when the requested health information would be provided to FM-A. During interview on 9/23/22, at 4:57 p.m. the	21860		

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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) COMPLETE DATE
21860	Continued From page 12 DON stated FM-A's ROI request was postponed as the facility's legal team was reviewing the request and the information which would be provided to FM-A. The DON indicated he was unsure as to when FM-A would be provided R1's medical records as he had not received a follow-up response from the legal team to release FM-A's medical records. Review of facility policy, titled Notice of Privacy Practices dated 3/13/19, identified a resident was provided the right to inspect and copy their health information which usually included health and billing records. The policy directed a written request was required if a resident wanted to inspect and copy their health information, in which the facility would "generally act on your written request within 30 days of receipt. Where appropriate, we may provide you with a summary of your health information, rather than access to, and copies of, it. We may deny your request to inspect and copy your health information. In certain very limited circumstances, our denial will be unreviewable." The policy lacked the resident's right to review all their personal and medical records, upon oral and/or written request within 24 hours of the request or the right to obtain a copy of their records upon request and two working days advance notice to the facility, excluding weekends and holidays. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies for resident/representative access to resident records. All staff could be educated as necessary to the importance of complaince with resident record requests. The administrator or designee, could perform record request audits to ensure staff are providing requested records timely and according to regulation. The	21860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00893	A. BUILDING: _____ B. WING _____	09/26/2022

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21860	Continued From page 13 administrator or designee could take that information to QAPI to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: (21) days.	21860		