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	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anoka Rehabilitation and Living Center	3000 4th Avenue Anoka, MN 55303

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43080 Based on observation, interview and document review, the facility failed to ensure assessed and/or care-planned interventions for pressure ulcer care were implemented for 1 of 3 residents (R3) reviewed for heel pressure ulcers, who were at risk for additional, and/or worsened, pressure ulcers. Findings include: R3's significant change Minimum Data Set (MDS), dated [DATE], indicated R3 was cognitively intact, and he required substantial/maximal assistance with mobility. R3's diagnoses included Parkinson's Disease, diabetes, coronary artery disease, and age-related physical debility. The MDS identified R3 was at risk for pressure ulcers with an identified stage 3 pressure ulcer and an unstageable pressure ulcer with suspected deep tissue injury in evolution. R3 was provided pressure ulcer care. An Incident-Post Incident Review form, dated 3/19/24, identified the medical provider noticed a left heel ulcer that was open that day. Root cause of the ulcer appear[ed] to be a pressure sore. An Incident - IDT (interdisciplinary team) Initial Post Investigation Review, dated 3/20/24, indicated the left heel ulcer was a pressure injury. An Incident-Post Incident Review form, dated 3/21/24, indicated a right heel blister was identified that day. A root cause was documented as .continus [sec] placing the heel on the foot rest. R3's care plan, reviewed 4/19/24, identified R3 had a potential for skin breakdown due to impaired mobility and indicated he had a stage 3 pressure injury to his left heel, a deep tissue injury to his right heel, and a diabetic wound on his right calf. The goal was to show no complications in skin integrity. An intervention, initiated on 3/21/24, directed heel protecting boots to be applied when he was in bed and in the wheelchair to protect his feet and heels. An Incident - IDT Initial Post Investigation Review, dated 3/22/24, identified the root cause of the right heel blister was Pressure to heels from foot pedals on wheelchair. R3's Braden Scare for Predicting Pressure Sore Risk, dated 3/22/24, identified a score of 16 (at risk) related to slightly limited sensory perception, occasionally moist skin, chairfast activity status, slightly limited mobility, and a potential problem with friction and shearing. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Incident-Post Incident Review form, dated 3/25/24, indicated a blister on R3's left heel. The form identified, after review, R3 stayed up in his wheelchair all day as he disliked the recliner chair and thus his feet rested on the foot pedals all day. R3's April 2024 Treatment Administration Record (TAR), identified on 3/25/24, a treatment order was initiated for R3 to have heel managers on while up and while in bed. The frequency of documented completion was once during the day, evening, and night shifts. An Incident - IDT Initial Post Investigation Review, dated 3/26/24, identified R3's right heel PI (pressure injury) required the following interventions: heel manager (boot), supplements to promote wound healing, and a vascular consult as it was suspected R3 had vascular problems that contributed to his lower extremity wounds. An Incident - IDT Initial Post Investigation Review, dated 3/28/24, identified an intervention to only use foot pedals for transport and to wear protective boots while up in the wheelchair or in bed as R3 applied most pressure to heels while sitting in wheelchair. The root cause was related to Pressure. R3's comprehensive care plan, reviewed 4/19/24, lacked a directed intervention to keep R3's feet off the foot pedals unless he was being transported. R3's April 2024 TAR, identified on 4/10/24, the 3/25/24 order was discontinued, and a new order was initiated that directed R4 to have heel protecting boots on while up and while in bed, and that his feet were not to be resting on the foot pedals unless he was being transported. The frequency of documented completion was once during the day, evening, and night shifts. Two Wound Evaluations, each dated 4/19/24, at 10:01 a.m., identified that morning the stage 3 pressure ulcer on R3's left lateral heel and the deep tissue pressure injury on his right heel were assessed. R3's TAR Administration Details report, dated 4/19/24, identified LPN-A signed off R3's boot and foot pedal task at 11:13 a.m. as completed. On 4/19/24, at 12:10 p.m., R3 was observed seated in his wheelchair at a dining room table. He wore blue gripper type socks and his feet rested on the wheelchair pedals. No protective boots were observed on R3's feet. During an interview on 4/19/24, at 12:12 p.m., R3's nurse, licensed practical nurse (LPN)-A, identified R3 had a wound on his right calf and his left heel. She did not think he had an ulcer on his right heel. Initially, LPN-A was unsure of R3's ulcer treatments and/or interventions other than for a daily dressing and a twice a week treatment. Upon review of the TAR, she identified he was to have a boot on his left heel when he was up in the wheelchair and when in bed. She stated, He should have it on .it is in the orders. Immediately after, LPN-A went to the dining room and identified R3 did not have boots on his feet. She asked, Do you want me to put it on? She was directed to do whatever the facility expected her to do. She stated she would have someone bring it. She expected she would have seen it on to protect the foot; however, she explained when staff toileted R3 the boot was removed but she expected staff reapplied it when finished. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/19/24, at 12:17 p.m., LPN-A approached R3 with the heel boots and applied them. Once on, she placed his boot covered feet back onto the wheelchair pedals. When interviewed on 4/19/24, at 12:20 p.m., NA-A stated this was the first time she worked with R3 and was unsure about any alterations in his skin integrity; however, she assumed he had concerns as he wore heel boots when she got him up that morning. Despite this assumption, when she assisted him with morning cares, she took the boots off and placed the blue grippy socks on and did not replace the boots. She identified she got him up for lunch and did not put the boots on as he still had on the grippy socks. She was unaware of R3's care planned preventative skin/pressure ulcer interventions as she did not review resident care plans, or Kardexes (NA care plan) despite a response she was expected to follow the care plan/Kardex for resident safety and the prevention of pressure ulcers. She explained she just followed the resident group sheets she carried with her. In addition, she did not ask staff about any additional interventions for R3 that morning. NA-A's group sheet was reviewed and lacked an intervention for the boots. R3's Kardex was reviewed after NA-A opened it and she identified the Kardex directed the boots. She stated, I did not know he was supposed to have the boots on in his wheelchair. During interview on 4/19/24, at 12:37 p.m., with the clinical assistant LPN-B, she stated NAs were updated about resident skin statuses during the daily huddles. She expected the care plan to be followed, especially as the group sheets lacked enough room to add all the interventions to it. The nurse was responsible to ensure skin/pressure ulcer interventions were implemented as setup, thus the reason why such interventions were placed on the TAR. She provided examples of boots and off-loading (repositioning). LPN-B stated one of R3's pressure ulcer interventions included boots on when he was up in his wheelchair to assist with pressure reduction. If staff failed to follow this, We are going to cause more injury to what is going on with his heels .it is going to get worse. LPN-B declined knowledge R3 ever declined the boots. On 4/19/24, a copy of the aide group sheet was requested; however, was not provided that date. During an observation and interview on 4/19/24, at 1:02 p.m., with R3 and his family member (FM)-A, R3 sat in his wheelchair with his boot covered feet on the wheelchair pedals. R3 stated he had sores on both his heels and his ankle. The heel sores were identified about a month or so ago and he was unsure of the cause. He identified all of them were healing. He explained the NAs placed the boots on a couple times a day and he wore them to bed. He stated he did not always wear the boots when up. FM-A stated she saw them on most of the time but confirmed there were extended periods of time when they were not on when he was up. FM-A felt R3 did not have the boots on that morning prior to them being placed when he ate lunch. Both denied they removed the boots prior to lunch. FM-A stated R3 disliked the recliner and thus he spent most of his day seated in his wheelchair just like he is now. He and FM-A stated he was up in the wheelchair since he got up that morning and had not laid down. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 4/19/24, at 2:36 p.m., the director of nursing (DON), stated NAs were updated on pressure ulcers during their huddles and thus those residents with pressure ulcers were not specifically identified on the group sheets. In addition, not all interventions were placed on the group sheet as the group sheets only reflected tidbits and highlights from the care plan. He expected staff to follow what was on the group sheets and what was identified on the Kardex/care plan. In addition, if an intervention was identified on the TAR, it was the nurse's responsibility to ensure the setup/ordered intervention was followed. The DON explained the importance of ensuring R3's boots were on centered around pressure injury prevention. He was aware of the 12:10 p.m. observation and responded, It is disappointing and expected LPN-A would have ensured the boots were on, especially as R3 was prone to skin breakdown. On 4/22/24, at 9:21 a.m., 1:23 p.m., and 3:08 p.m., R3 was observed seated in his wheelchair with blue gripper socks and protective boots; however, feet rested on the wheelchair pedals. A Prevention and Treatment of Pressure Ulcers/Pressure Injury policy, dated 11/22/22, identified the facility implemented preventative measures and provided appropriate treatment modalities for wounds according to professional standards of care.