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	12/17/2024

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on interview and record review the facility failed to include a resident discharge summary that included a reconciliation of all pre-discharge medications with resident's post-discharge medication (both prescribed and over-the-counter) at discharge for seven of ten residents (R1, R2, R5, R6, R7, R9, and R12). R1 received R2's Mirtazapine (a medication to treat depression) at discharge. Findings include: According to the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revised and issued 8/8/24: -Reconciliation of Medications: A process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. R1's Facesheet indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of multiple fractures of ribs on right side. R1's additional diagnoses included anxiety disorder and need for assistance with personal care. R1 discharged from the facility on 12/6/24. R1's brief interview for mental status (BIMS) dated 11/14/2024 indicated R1 scored thirteen which indicated R1 was cognitively intact. R1's discharge summary and recapitulation assessment dated [DATE] indicated R1 was discharged home on 12/6/24. The form question #5 titled Medication Reconciliation indicated: -At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? Yes - Current reconciled medication list provided to the patient, family and/or caregiver? Yes, sent by paper. Physical medication(s) are to be compared to current medication orders, counted and instructions explained prior to giving medication to resident and or resident representative Ensure that individual receiving medications signs and acknowledges amount. of medications received. (continued on next page)

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

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Were medications sent home with resident and/or representative? Yes -Medication and amount of medication sent with resident and/or responsible party. This area of the summary and recapitulation was left blank and was not identified in the resident medical record. R1's medication administration record (MAR) dated 12/6/24 indicated R1 was not administrated mirtazapine during her admission. R2's Facesheet indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of nontraumatic intracerebral hemorrhage. R2's additional diagnoses included anxiety disorder and need for assistance with personal care. R2 was discharged from the facility on 11/5/24. R2's MAR dated 11/5/24 indicated R2 had an order for mirtazapine three point seven five milligrams (mg) by mouth at bedtime for anxiety. R2's discharge summary and recapitulation assessment dated [DATE] indicated R1 was discharged home on 11/5/24. The form question #5 titled Medication Reconciliation indicated: -At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? Yes - Current reconciled medication list provided to the patient, family and/or caregiver? Yes, sent by paper. Physical medication(s) are to be compared to current medication orders, counted and instructions explained prior to giving medication to resident and or resident representative Ensure that individual receiving medications signs and acknowledges amount. of medications received. -Were medications sent home with resident and/or representative? Yes -Medication and amount of medication sent with resident and/or responsible party. This area of the summary and recapitulation was left blank and was not identified in the resident medical record. R5's Facesheet indicated R5 was admitted to the facility on [DATE] with a primary diagnosis of spinal stenosis of lumbar region without neurogenic claudication. R5 was discharged from the facility on 12/17/24. R5's BIMS assessment dated [DATE] indicated R5 had a score of fifteen, which indicated R5 was cognitively intact. R5's discharge summary and recapitulation assessment dated [DATE] indicated R5 was discharged home on 12/17/24. The form question #5 titled Medication Reconciliation indicated: -At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? Yes - Current reconciled medication list provided to the patient, family and/or caregiver? Yes, sent by paper. Physical medication(s) are to be compared to current medication orders, counted and instructions explained prior to giving medication to resident and or resident representative Ensure that individual receiving medications signs and acknowledges amount. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of medications received. -Were medications sent home with resident and/or representative? Yes -Medication and amount of medication sent with resident and/or responsible party. This area of the summary and recapitulation was left blank and was not identified in the resident medical record. R6's Facesheet indicated R6 was admitted to the facility on [DATE] with a primary diagnosis of polymyalgia rheumatica. R6 was discharged from the facility on 12/17/24. R6's BIMS assessment dated [DATE] indicated R6 scored fifteen, which indicated R6 was cognitively intact. R6's discharge summary and recapitulation assessment dated [DATE] indicated R6 was discharged home on 12/17/24. The form question #5 titled Medication Reconciliation indicated: -At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? Yes - Current reconciled medication list provided to the patient, family and/or caregiver? Yes, sent by paper. Physical medication(s) are to be compared to current medication orders, counted and instructions explained prior to giving medication to resident and or resident representative Ensure that individual receiving medications signs and acknowledges amount. of medications received. -Were medications sent home with resident and/or representative? Yes -Medication and amount of medication sent with resident and/or responsible party. This area of the summary and recapitulation was left blank and was not identified in the resident medical record. R7's Facesheet indicated R7 was admitted to the facility on [DATE] with a primary diagnosis of neoplasm of unspecified behavior or the brain. R7 was discharged from the facility on 12/12/24. R7's BIMS assessment dated [DATE] indicated R7 scored fifteen, which indicated R7 was cognitively intact. R7's discharge summary and recapitulation assessment dated [DATE] indicated R7 was discharged home on 12/12/24. The form question #5 titled Medication Reconciliation indicated: -At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? Yes - Current reconciled medication list provided to the patient, family and/or caregiver? Yes, sent by paper. Physical medication(s) are to be compared to current medication orders, counted and instructions explained prior to giving medication to resident and or resident representative Ensure that individual receiving medications signs and acknowledges amount. of medications received. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Were medications sent home with resident and/or representative? Yes -Medication and amount of medication sent with resident and/or responsible party. This area of the summary and recapitulation was left blank and was not identified in the resident medical record. R9's Facesheet indicated R9 was admitted to the facility on [DATE] with a primary diagnosis of displaced intertrochanteric fracture of right femur. R9 was discharged from the facility on 12/16/24. R9's BIMS assessment dated [DATE] indicated R9 had a score of fifteen, which indicated R9 was cognitively intact. R9's discharge summary and recapitulation assessment dated [DATE] indicated R9 was discharged home on 12/16/24. The form question #5 titled Medication Reconciliation indicated: -At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? Yes - Current reconciled medication list provided to the patient, family and/or caregiver? Yes, sent by paper. Physical medication(s) are to be compared to current medication orders, counted and instructions explained prior to giving medication to resident and or resident representative Ensure that individual receiving medications signs and acknowledges amount. of medications received. -Were medications sent home with resident and/or representative? Yes -Medication and amount of medication sent with resident and/or responsible party. This area of the summary and recapitulation was left blank and was not identified in the resident medical record. R12's Facesheet indicated R12 was admitted to the facility on [DATE] with a primary diagnosis of heart failure. R12 was discharged from the facility on 12/3/24. R12's BIMS assessment dated [DATE] indicated R12 had a score of fifteen, which indicated R12 was cognitively intact. R12's discharge summary and recapitulation assessment dated [DATE] indicated R12 was discharged home on 12/3/24. The form question #5 titled Medication Reconciliation indicated: -At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? Yes - Current reconciled medication list provided to the patient, family and/or caregiver? Yes, sent by paper. Physical medication(s) are to be compared to current medication orders, counted and instructions explained prior to giving medication to resident and or resident representative Ensure that individual receiving medications signs and acknowledges amount. of medications received. -Were medications sent home with resident and/or representative? Yes (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Medication and amount of medication sent with resident and/or responsible party. This area of the summary and recapitulation was left blank and was not identified in the resident medical record. During an interview on 12/17/24 at 8:33 a.m., family member (FM)-A stated R1 was in the facility for approximately three weeks. At the time of discharge, R1 was sent home with R2's Mirtazapine medication. FM-A stated she did not give R1 any of R2's Mirtazapine medication. During an interview on 12/17/24 at 9:47 a.m., registered nurse (RN)-A stated when a resident is discharged from the facility, they will determine what medications the resident can go home with any medications that need to be sent back to the pharmacy. RN-A will go through the locked medication cabinet in the resident's room when she is explaining the medications and the instructions at discharge. During an interview on 12/17/14 at 10:34 a.m., licensed practical nurse (LPN)-A stated during a discharge she will fill out a discharge form that includes a medication list, upcoming appointments, and medication's the resident is taking home in the computer system. LPN-A will put the resident's medications in a bag and then have the resident sign the form. LPN-A stated there was a spot in the discharge form that talks about what medications the resident is going home with but will not fill out that part in the form due to lack of time. At the time of discharge, the discharging nurse will go through the resident's medications to determine which medications can be sent home with the resident or medications that need to be returned to the pharmacy. Medication bubble packs that are opened, any bottled medication, refrigerated medications, or pre-scored tablets in bubble packs need to send home with the resident. Any medication bubble packs that are not used should be returned to the pharmacy. A discharging nurse would check the resident's locked medication cabinet in their room for medications that the resident may have left or medications that need to be sent back to the pharmacy at discharge and again when another resident is being admitted to the room. LPN-A discharged R1 from the facility. LPN-A stated she did not think she sent any medications home with R1 that did not belong to her. During an interview on 12/17/24 at 10:57 a.m., nurse manager (NM)-A stated when a resident is discharging, they will determine what medications the resident can take home with them and what medications need to be sent back to the pharmacy. NM-A will go through medication instructions with the resident. NM-A stated it depends on the nurse who discharges a resident, but the nurse may just grab everything in the resident's locked medication cabinet and put it in a bag without looking at the medications but stated that was not the protocol. The protocol was to go over each medication with the resident. An interview was attempted with R2 on 12/17/24 at 1:11 p.m. but was unsuccessful. An interview was attempted with R1 on 12/17/24 at 1:51 p.m. but was unsuccessful. During an interview on 12/17/24 at 3:04 p.m., the director of nursing (DON) stated when a resident is discharged , the resident would get discharge instructions including therapy recommendations, the most recent set of vitals, the most recent nursing assessments, pain management, pain levels, pain assessment, and activities of daily living (ADL). The resident would also get a signed medication list from the facility provider. (continued on next page)

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