

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245205	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER Anoka Rehabilitation and Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844</p> <p>Based on observation, interview and document review, the facility failed to maintain proper holding food temperatures for 18 of 19 residents observed to receive the noon meal on the Reflections unit. Further, the facility failed to maintain the ice machine in a sanitary manner to prevent potential food-borne illness for 39 residents who currently received ice from the ice machine in the Transitional care unit and Cardiac care unit area, and 36 residents who currently received ice from the ice machine in the Riverbend and cornerstone unit area.</p> <p>Findings include:</p> <p>FOOD TEMPERATURE</p> <p>During an interview on 1/21/25 at 1:20 p.m., family member (FM)-A stated several times when she was at the facility visiting R1, the food was cold and R1 refused to eat the food. FM-A further stated she began bringing food in for R1 to ensure R1 had food to eat.</p> <p>During a continuous observation on 1/21/25 at 11:49 a.m., dietary aide(DA)-A entered the Reflections unit with a covered cart of food trays in a heated cart from the second floor kitchen. DA-A plugged in the cart and left the unit. Nursing staff began removing the trays with food from the cart and placed a cover on each tray as they passed them out to each resident in the dining room. At 12:42 p.m., staff removed two of the remaining trays from the food cart and delivered them to the residents rooms. At 12:46 p.m., as the last tray was being delivered in the dining room DA-A checked the temperature of a test tray that had been stored in the food cart since the beginning of food service and the temperatures were as follows:</p> <p>Spaghetti noodles were 102 degrees F.</p> <p>Hamburger meat sauce was 114 degrees F.</p> <p>Peas and carrots were 115 degrees F.</p> <p>During an interview on 1/21/25 at 12:55 p.m., DA-A stated it was his first day of work and he was unsure of what the holding temperatures for hot food were expected to be. DA-A stated he would need to find out what the proper holding temperatures for hot food were to ensure in the future the hot food remained within the proper temperatures so residents do not become ill.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/21/25 at 1:05 p.m., dietary manager (DM) stated her expectation was that holding temps for hot food would have been between 135 and 165 degrees F. DM stated it was important to maintain holding temperatures, to prevent foodborne illness and to ensure quality of food for the residents.</p> <p>49620</p> <p>ICE MACHINE</p> <p>R7's annual Minimum Data Set (MDS), dated [DATE], identified R7 had intact cognition with diagnoses of hypertension (high blood pressure) and arthritis. R7 was independent with eating after setup help from staff.</p> <p>During an observation on 1/21/25 at 11:42 a.m., the ice machine located in the dining area of the Riverbend and Cornerstone unit had a white flaky substance approximately one-half an inch to three-quarters of an inch in height on both the inside and outside rim of the ice spout and water spout. The tray of the ice machine had a white flaky substance covering the entire removable tray with noticeable dripping of water from the ice spout about every one to two seconds into the tray.</p> <p>During an observation on 1/21/25 at 2:10 p.m., the ice machine located in the dining area of the Transitional care unit and Cardiac care unit had a white flaky substance approximately one-half an inch to three-quarters of an inch in height on both the inside and outside rim of the ice spout and water spout. The tray of the ice machine had a white flaky substance covering the entire removable tray with noticeable dripping of water from the ice spout about every one to two seconds into the tray.</p> <p>During an interview on 1/21/25 at 3:42 p.m., R7 stated the ice and water tasted terrible. R7 further stated he had to discard seven glasses of water before being able to get water that tasted alright from the ice machine. R7 stated he reported the terrible ice and water taste to licensed practical nurse (LPN)-A on many occasions and the ice machine continued to be dirty with water and ice that tasted terrible.</p> <p>During an interview on 1/22/25 at 10:04 a.m., LPN-A verified a resident had asked for the ice and water machine to be cleaned. LPN-A stated maintenance was notified and LPN-A did not follow up with maintenance about the ice machine after that.</p> <p>During an interview on 1/22/25 at 9:14 a.m., dietary manager (DM) verified a white substance on the outside and inside of the ice and water machine spouts and identified it was calcium buildup. DM verified the white substance on the ice machine in the dining area of the Riverbend and cornerstone unit and the ice machine in the dining area of the transitional care unit and cardiac care unit. DM stated the calcium buildup could break off of the spouts and get in the ice and or water and residents could become ill. DM further stated, maintenance staff cleaned the machine and was unsure when the ice machines had been cleaned last. DM stated maintenance staff was out ill and unavailable. DM confirmed cleaning logs for the ice machines were not available.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A facility policy titled Food Temperatures dated 2021, identified all hot food must be cooked to appropriate internal temperatures, held, and served a temperature of at least 135 degrees F. Identified hot foods may not fall below 135 degrees F. after cooking unless it is an item which was to be rapidly cooled to 41 degrees F. Further identified temperatures should have been taken periodically to assure hot foods stayed above 135 degrees F.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for for 2 of 2 residents (R8, R9) observed for COVID-19 transmission based precautions (TBP) and for 1 of 2 residents (R10) observed for enhanced barrier precautions (EBP), (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). This deficient practice had the potential to affect all 112 residents who resided in the facility.</p> <p>Findings Include:</p> <p>Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions (EBP) included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.</p> <p>Review of CDC guidance dated 6/24/24, Infection Control Guidance SARS-COV-2 indicated health care professionals (HCP) who entered the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).</p> <p>Review of CDC guidance dated 5/16/23, How to Use Your N95 Respirator indicated N95 respirators must form a seal to the face to work properly. This was especially important for people at increased risk for severe disease.</p> <p>R8's admission Minimum Data Set (MDS) dated [DATE], identified R8 had moderately impaired cognition with diagnoses of hypertension (high blood pressure), heart failure, diabetes, and dementia. Identified R8 required extensive assistance of two staff with bed mobility, transfers, toileting and was independent with setup help for eating.</p> <p>R9's admission MDS dated [DATE], identified R9 had intact cognition with diagnoses of heart failure, hypertension, and end stage renal disease (ESRD). Identified R9 required limited assistance of two staff with bed mobility, transfers, toileting and was independent with setup help for eating.</p> <p>R10's admission MDS still in progress dated 1/26/25, identified R10 had intact cognition with diagnoses of hypertension, diabetes, chronic kidney disease, obesity, chronic obstructive pulmonary disease (COPD). The MDS lacked completion of R10's requirements of staff assistance for activities of daily living (ADL's).</p> <p>R8's covid test dated 1/20/25, identified positive COVID-19.</p> <p>R9's covid test dated 1/20/25, identified positive COVID-19.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A facility policy titled Infection Control and Manual for Transmission Based Precautions dated 2023, identified PPE use to Prevent Spread of Multidrug-resistant Organisms (MDROs) identified examples of high-contact resident care activities requiring gown and glove use for EBP included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.</p> <p>A facility policy titled Red, Yellow, [NAME] Personal Protective Equipment, Resident Placement and Signage Supplemental Guidelines for Use related to COVID-19 revised 6/26/23, identified a positive COVID-19 (Red) guidelines included; N95 mask would be worn prior to entry of a COVID-19 resident room and removed and discarded when leaving the specific isolation unit/area or if soiled or damaged. If unable to obtain a new N95 every shift due to supply shortage, rotate at least every 72 hours and replace after 5 uses or if soiled or damaged. A face shield or goggles would be worn prior to entry of a COVID-19 resident room and would be cleaned and disinfected (or changed) if visibly soiled, including splashes and sprays or difficult to see through. A gown would be worn prior to entry of a COVID-19 resident room and changed when soiled. Gloves would be worn prior to entry of a COVID-19 resident room and would be changed per standard precautions guidelines</p>		