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	11/13/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to identify, treat, monitor, and manage 1 of 3 residents (R1) reviewed for pain to the extent possible in accordance with R1's care plan, goals, and preferences. R1 stated pain and was observed having pain. R1 had available morphine sulfate every two hours as needed (PRN), which was not administered to him for his breakthrough pain. Findings include: Upon observation and interview on 11/12/25 at 9:54 a.m. R1 laying in his bed wearing a hospital gown. On his wall was a sign indicating for staff to be gentle and go slow with R1. R1 stated the care was bumpy, R1 referred to himself as an old, skinny man with soft skin. He stated it hurt every time he was moved. R1 stated he took Tylenol, a narcotic, and a steroid. R1 was not aware that he could ask for pain medication when he was having pain. Why didn't they tell me that? Upon observation on 11/12/25 at 10:58 a.m. nursing assistant (NA)-A entered R1's room to start his morning cares. NA-A emptied R1's catheter bag, brought in the mechanical lift and waited for another NA to assist with cares. NA-B entered the room, and the aides proceeded to dress R1's upper body. The staff worked slowly, gently and explained what they were doing with R1. Upon lifting R1's left arm to put on his shirt R1 winced in pain, flailing his right arm out as if he were going to strike the staff. The staff proceeded to change R1's incontinent brief, NA-A cleansed his catheter insertion area with a wet wipe. R1 had a thick layer of barrier cream on his penis and testicles. R1 was screaming out to NA-A to be gentle because his private areas were sensitive, and stated NA-A should understand as he was a man as well. R1 was then turned to his right side so staff could clean his backside. R1 screamed ouch and to hurry while being turned. Registered nurse (RN-A) entered the room as staff was wiping the thick barrier cream between R1's buttock folds and scrotum. R1 screamed to stop as he was in pain. The staff stopped momentarily and explained to R1 that they needed to get the old cream off before applying the fresh barrier cream. NA-B got a wet washcloth and NA-A continued to clean R1. A fresh incontinent pad and pants were placed on R1. R1 was transferred to his wheelchair using the mechanical lift. R1 made facial grimaces and winched in pain during the lift. R1 stated that was the process every single day. Upon observation and interview on 11/13/25 at 9:10 a.m. NA-A and NA-C brought R1's breakfast tray into his room. The aides boosted R1 up in his bed using the lift sheet. R1 winced in pain shouting my back, my back. R1 was placed with the head of his back up so he could eat his breakfast. R1 stated his pain was in his back and his buttock. He rated the pain a 5 on a scale from 1 to 10, 10 being the worst pain. Upon observation on 11/13/25 at 10:21 a.m. NA-A and NA-C entered R1's room to start his morning cares. The staff explained to R1 what they would be doing and R1 agreed. Upon putting R1's shirt over his head R1 screamed damn that hurt. Staff slowly and gently cleaned R1's penis and scrotum R1 was silent but made facial grimaces and jolted his body in a tight position when they touched him. R1 was rolled on his right side for staff to clean his back side. R1 screamed you are beating up my legs. R1's pants were put on and R1 was lifted in the mechanical lift sling. R1 was flailing his arms out to hit NA-C. NA-C handed R1 a bed pillow to hug during the lift and telling R1 to relax. The staff got R1 seated in his wheelchair. NA-C removed the sling from under R1 and R1 stated my pain is a 10 now. R1's care plan dated 3/12/22 indicated R1 had pain related to rheumatoid arthritis (chronic inflammatory disorder), polymyalgia rhematica (muscle pain and inflammation around the shoulder and hips), and chronic pain. R1's goal was to remain comfortable. His interventions were:-Administer pain medication per physician order for breakthrough pain-Medications as ordered-Monitor for probable cause of pain. Notify nursing-Monitor opioid side effects: sedation, hypoxia (the body not receiving enough oxygen), urinary retention, pruritis (itching)-Monitor pain characteristics: quality, severity, location, onset, duration, precipitating or relieving factors. R1's annual Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 12 indicating R1 was cognitively impaired. R1's did not have any behavior symptoms. R1 required maximum assistance with toileting, upper body dressing, and rolling side-to-side in bed. He was dependent upon staff for lower body dressing and transferring from chair-to-bed and bed-to-chair. R1's pertinent diagnoses were cerebrovascular disease (stroke), monoplegia of the upper limb affecting nondominant side (paralysis), age-related physical debility, chronic pain, lower back pain and weakness. R1's physician orders dated 10/30/25 indicated to give morphine sulfate, 2.5 milligrams (mg) sublingually (under the tongue) every two hours as needed (PRN) for pain solutab (dissolvable tablet). R1's medication administration sheet (MAR) dated October 2025 indicated R1 was administered scheduled morphine sulfate oral solution 0.125 milliliters (ml) twice a day at 8:00 a.m.