

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 07/18/2024
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013</p> <p>Based on observation, interview and document review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 5 of 5 residents (R3, R14, R74, R36, and R95), reviewed and observed for self-administration of medications.</p> <p>Findings include:</p> <p>R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 was cognitively intact, and required assistance/supervision with activities of daily living (ADL's).</p> <p>The self-administration of medications assessment completed on [DATE], indicated R3 did not wish to self-administer medications or to keep them bedside.</p> <p>During observation and interview on [DATE] at 4:13 p.m., a bottle of prescription fluticasone propionate (nasal spray) was sitting on over-bed table. A tube of prescription arthritis pain relieving cream was sitting on stand in front of television. R3 stated he used the nasal spray whenever he needed due to his nose being dry all the time. R3 also stated he applied the pain-relieving cream to his knees, hands, feet and ribs all the time to help with his pain.</p> <p>R14's quarterly MDS dated [DATE], identified R14 had intact cognition and was independent with all ADL's.</p> <p>The self-administration of medications assessment completed [DATE], indicated R14 did not wish to self-administer medications or to keep them bedside.</p> <p>During observation and interview on [DATE] at 5:19 p.m., three different bottles of eye drops were sitting on stand in front of R14's television. R14 stated he used the eye drops several times a day or as much as he needed them for his dry and burning eyes.</p> <p>R74's admission MDS dated [DATE], identified R74 had moderate cognitive impairment and required partial to moderate assistance with all ADL's.</p> <p>The self-administration of medications assessment completed on [DATE], indicated R74 did not wish to self-administer nebulizer's even after setup.</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
-----------------------------------------------------------------------	-------	-----------

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 07/18/2024
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During observation and interview on [DATE] at 12:33 p.m., R74 was sitting on the side of his bed, was holding nebulizer pipe in his mouth, nebulizer treatment running with clear solution noted in the nebulizer cup, no staff present in room. R74 stated staff set up nebulizer, handed it to him, turned the machine on and left the room while it is running. R74 stated that staff will come back later to shut the nebulizer machine off.</p> <p>During interview on [DATE] at 12:16 p.m., licensed nursing staff (LPN)-B stated there were no residents on this unit that were able to self-administer medications. LPN-B stated if a resident wished to self-administer medications, an assessment needed to be completed and an order needed to be obtained from the physician before resident would be allowed to self-administer medications. LPN-B confirmed that R3 did not have an order to self-administer medications and confirmed that R3 had pain relieving cream and nasal spray present in room. LPN-B confirmed that R14 did not have an order to self-administer medications and confirmed that R14 had three bottles of eye drops present in R14's room. LPN-B confirmed that R74 did not have an order to self-administer medications and confirmed staff set up solution in R74's nebulizer machine, turned the machine on, left the room and came back later to shut the machine off.</p> <p>During interview on [DATE] at 12:27 p.m., registered nurse case manager (RN)-A stated there were no residents that had a self-administration of medications order currently. RN-A stated that if a resident stated they wanted to self-administer medications, an assessment would need to be completed to ensure that resident was capable of safely self-administering medications. If assessment determined resident was capable, then an order would be obtained from the provider for the resident to be able to self-administer medications. RN-A confirmed that staff set up solution in R74's nebulizer machine, turned the machine on, left the room and came back later to shut the machine off. RN-A confirmed that R3, R14 and R74 did not have an order for self-administration of medications. RN-A stated it was important to complete the assessment to ensure that the resident was competent and able to self-administer medications safely and correctly.</p> <p>R36's significant change Minimum Data Sheet (MDS) dated [DATE], identified her cognition was intact. R36's did not have upper extremity impairment.</p> <p>R36's self-administration of medications data collection assessment dated [DATE], indicated resident did not wish to self-administer medications or keep them at the bedside.</p> <p>During observation on [DATE] at 1:45 p.m., R36 had Voltaren arthritis topical gel (a topical cream for pain relief) and simethicone anti-gas chewable tabs on her bedside tray table.</p> <p>During interview on [DATE] at 5:00 p.m., R36 stated she kept her Voltaren arthritis topical gel (a topical cream for pain relief) and simethicone anti-gas chewable tabs in her room. R36 stated she took simethicone 125 mg tabs three times a day and would have staff assist with application of Voltaren gel twice a day. R36 stated staff have talked with her about the simethicone anti-gas chewable tabs prior and were aware she had the in her room.</p> <p>During interview with [DATE] at 1:03 p.m., registered nurse (RN)-A confirmed R36 did not have an order for self-administration of medications. RN-A stated the facility was aware R36's family brings in simethicone tabs from home and staff would look for medications every time they came in the room. RN-A confirmed resident had simethicone anti-gas chewable tabs and Voltaren cream in her room.</p> <p>(continued on next page)</p>		

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 07/18/2024
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R95's admission Minimum Data Set (MDS) dated [DATE], identified R95 was cognitively intact and had diagnoses which included a fracture around the internal prosthetic right hip joint, and right hip pain. The MDS also indicated R95 received scheduled and as needed medication for pain and non-medication interventions for occasional mild pain.</p> <p>R95's order summary report dated [DATE], included the following current orders: Oxycodone HCL oral tab 5 milligrams (MG). Take 0.5 tabs by mouth every four hours as needed for pain. The order start date was [DATE]. Acetaminophen 500 mg. Take two tablets three times daily. The order start date was [DATE].</p> <p>R95's care plan dated [DATE], identified R95 was a readmission at risk for falls, pain, and safety. The care plan included interventions including administer medication per MD order for pain management. The care plan lacked direction regarding R95 self-administration of medication or storage of medications at bedside.</p> <p>R95's Self Administration of Medication form dated [DATE], indicated R95 did not want to administer medications per self or keep at his bedside.</p> <p>During observation and interview on [DATE], at 10:53 a.m., an unidentified nursing assistant was seated in R95's room directly behind a bedside table as R95 exited the bathroom. A bottle of Tylenol 8 Hour Arthritis Pain sat on R95's bedside table. R95 reported he took the medication himself and received scheduled doses from facility staff.</p> <p>During observation on [DATE], at 5:03 p.m., the bottle of Tylenol remained on R95's bedside table. A pharmacy dispensing label was not affixed to the bottle.</p> <p>During interview on [DATE], at 5:05 p.m., licensed practical nurse (LPN)-B stated it was rare residents in the facility self-administered their medications and he was not aware of any resident who did so. For a resident to self-administer their medications and keep it at their bedside there would need to be an order and the nursing staff would have to ask the resident when the medication was taken so it could be documented in their medical record. Further, LPN-B stated if staff observed a resident to have medication at their bedside, nursing staff would have to have a discussion with the resident about it and review the facility policy on self-administration with the resident. At this time, LPN-B was brought to R95's room where the bottle of Tylenol remained on the bedside table. LPN-B asked R95 how often he took the medication, to which R95 replied he did not take it often. LPN-B then removed the bottle of Tylenol from R95's bedside table and placed it in the locked medication cabinet above the sink in R95's room. LPN-B confirmed R95 did not have an order to keep the medication at the bedside, nor an order for self-administration.</p> <p>(continued on next page)</p>		

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 07/18/2024
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on [DATE], at 10:01 a.m., registered nurse (RN)-G stated a resident would have to be assessed for appropriateness of self-administration of medications and a provider order would need to be obtained. The assessment would be required to identify the medication, indication and dosage and if the resident was cognitively able to be safe to self-administer. The provider and nursing would need to ensure the resident was safe to keep the medication at the bedside and self-administer. RN-G stated she expected staff to immediately notify nursing staff if it was identified a resident had medications at the bedside, ask the resident where it came from, and identify if there was an active order for the medication. Nursing staff would need to check for residents' allergies, if the medication was expired, if the medication belonged to the resident, and how it got there. This would be important information so the resident labs could be monitored. The medication could potentially interact with the residents' other medications, so it was a safety issue. RN-G stated although R95's record included a self-administration assessment from a previous admission, he did not have a current assessment completed for this admission and there was no order for R95 to self-administer his Tylenol.</p> <p>During interview on [DATE], at 10:39 a.m., assistant director of nursing (ADON) stated the facility required an assessment from a nurse and the resident would need to be able to demonstrate they were safe to administer medication by themselves. They would also need to have a written provider order. The order should specify what medication the resident wanted to administer and if they wanted to keep the medication at the bedside to self-administer. ADON confirmed R95 did not have a current assessment or order for self-administration of medications. He expected that if staff observed, medications at a resident's bedside, they would clarify if there was an order for the medication and a completed assessment. This was important for resident safety to prevent medication errors and to prevent overdose of a medication. It was also important for accurate documentation.</p> <p>The facility Self-Administration of Medications policy, dated [DATE], indicated the facility will act in accordance with the right of the resident to self-administer their medications if the interdisciplinary team has assessed and evaluated that the resident is able to physically and cognitively, safely administer the prescribed medication.</p> <ol style="list-style-type: none"> 1. The resident will be informed of their right to self-administer medications upon admission. 2. If the resident wished to self-administer their medications, at the time of admission or anytime during their stay at the facility, the Interdisciplinary Team will initiate a Self-Administration of medication assessment to determine if the resident is capable and clinically appropriate, base on the resident's cognition, physical ability, functionality, and status of health conditions(s). 3. A physician order will be obtained by the nurse prior to proceeding with self-administration. <p>49035</p> <p>49654</p>		

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 07/18/2024
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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49657</p> <p>Based on document review and interviews, the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN-CMS-10055) was provided to 1 of 3 residents (R86) reviewed for beneficiary notification.</p> <p>Findings include:</p> <p>R86's part A discharge minimum data set (MDS) dated [DATE], indicated R86 was admitted to the facility on [DATE] and their Medicare part A coverage ended on 5/23/24.</p> <p>R86's progress notes dated 5/21/24, indicated R86 received a Medicare-A Non-Coverage (CMS-10123) form. The form indicated R86's current covered services would end on 5/23/24. Although R86 remained in the facility, R86's medical record lacked evidence R86 received the SNFABN-CMS-10055 form as required.</p> <p>On 7/18/24 at 1:20 p.m., registered nurse (RN)-C and RN-D confirmed no SNFABN-CMS-10055 form was provided, and it should have been.</p> <p>On 7/18/24 at 3:37 p.m., the administrator stated their expectation was the SNFABN-CMS-10055 form should have been provided to R86, and it was important to provide the SNFABN-CMS-10055 form to ensure the residents were aware of the date on which their services ended, and their right to appeal the process.</p> <p>The SNF ABN (Advanced Beneficiary) Notice Policy and Procedure revised on 9/2022, indicated the SNF ABD (Advanced Beneficiary Notice (CMS 10055) is issued before providing care or services that do not meet Medicare coverage criteria.</p>

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 07/18/2024
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47638</p> <p>Based on interview, and document review the facility failed to ensure a written notification of transfer was sent to the office of the Ombudsman for long term care for 2 of 2 residents (R106, R107) with the potential to affect all residents transferred to the hospital.</p> <p>Findings include:</p> <p>R106's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition with medical diagnoses of displaced bimalleolar fracture of right lower leg, subsequent encounter for closed fracture with routine healing, anemia, hypertension, gastroesophageal reflux (GERD), chronic kidney disease stage 3, diabetes mellitus, hyperlipidemia, depression, insomnia, chronic pain, muscle weakness, and history of falls.</p> <p>R106's progress note dated 5/26/24, indicated resident went to the emergency room (ER) for evaluation of new concerns. It was also noted that a bed hold was signed and sent with R106 to the hospital, and her family was notified of the transfer. Resident returned to the facility and discharged to home from the facility 5/29/24.</p> <p>R106's medical record lacked evidence a written notification of transfer was sent to the ombudsman for long term care.</p> <p>R107's admission MDS dated [DATE], identified moderately impaired cognition with medical diagnoses of unilateral primary osteoarthritis, left knee, hypertension, hyperlipidemia, arthritis, anemia, atrial fibrillation (Afib), insomnia, personal history of peptic ulcer disease, presence of prosthetic heart valve, presence of right artificial knee joint, muscle weakness, difficulty walking.</p> <p>R107's progress note dated 4/6/24, indicated resident went to the ER due to new concerns. It was also noted that a bed hold policy was sent with the resident and was declined by family. R107 returned to the facility 4/9/24 and discharged home 4/16/24.</p> <p>R107's medical record lacked evidence a written notification of transfer was sent to the ombudsman for long term care.</p> <p>Facility provide document, referred to as, Monthly Notice to MN Office of Ombudsman for Long-Term Care for Emergency Acute Care Transfers and Discharges. The fax cover sheet lists May as the time frame. R106 was not listed on the report provided.</p> <p>(continued on next page)</p>

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 07/18/2024
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 7/17/24 at 4:59 p.m., Licensed Social Worker (LSW)-A stated the previous employee responsible for this data transmission kept the faxes in a folder and she was not able to locate the fax or report for the month of April that was requested to confirm R107's notification to the ombudsman was sent. LSW was able to provide the transmitted data for the remaining months of 2024. LSW confirmed no fax confirmation pages were retained. LSW verified that R106 was not listed on the report for May, which was the time that she was sent to the hospital. LSW stated she was aware that if the report is not generated correctly the information is not accurate, and she has been training staff on the correct way to pull the information. LSW also stated she had trained former employee to save the information to a shared drive and update there as well to ensure accuracy and information availability.</p> <p>Email received on 7/18/24 at 12:09 p.m. from the Ombudsman confirming no notification was received for either resident for either hospital transfer.</p> <p>The facility policy, titled Facility Initiated Notice of Intent to Discharge, section 5 Notice of Voluntary Resident/Patient Transfer or Discharge indicated in an emergent situation notice to the LTC Ombudsman must be sent as soon as practicable, including in the form of a list of residents on a monthly basis.</p>		

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 07/18/2024
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013</p> <p>Based on interview and document review, the facility failed to complete care conferences for 5 of 7 residents (R14, R16, R24, R29 and R69) reviewed for care planning.</p> <p>Findings include:</p> <p>R14's quarterly Minimum Data Set (MDS) dated [DATE], identified R14 had intact cognition.</p> <p>During interview on 7/15/24 at 5:37 p.m., R14 stated he could not remember having quarterly care conferences with the facility.</p> <p>R14 had MDS submissions completed on 12/3/23, 2/2/24 and 5/20/24. The medical record failed to include documentation of care conferences.</p> <p>R16's quarterly MDS dated [DATE], identified R16 had severe cognitive impairment.</p> <p>During interview on 7/15/24 at 2:14 p.m., family member (FM)-A stated care conferences are held every 6 months or so and does not recall the last care conference with the facility.</p> <p>R16 had MDS submissions completed on 11/17/23, 1/23/24, 4/16/24 and 7/9/24. The medical record failed to include documentation of care conferences.</p> <p>R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 was cognitively intact.</p> <p>During interview on 7/15/24 at 12:04 p.m., resident stated he could not remember having quarterly care conferences with the facility.</p> <p>R24 had MDS submissions completed on 2/29/24 and 5/23/24. The medial record failed to include documentation of care conferences.</p> <p>R29's quarterly MDS dated [DATE], identified R29 had intact cognition.</p> <p>During interview on 7/15/24 at 4:57 p.m., R29 stated he could not remember having quarterly care conferences with the facility.</p> <p>R29 had MDS submissions completed on 12/27/23, 3/20/24, 4/19/24 and 7/12/24. The medical record failed to include documentation of care conferences.</p> <p>R69's quarterly MDS dated [DATE], identified R69 had intact cognition.</p> <p>During interview on 7/16/24 at 9:01 a.m., R69 stated he could not remember having quarterly care conferences with the facility.</p> <p>(continued on next page)</p>		

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 07/18/2024
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R69 had MDS submissions completed on 10/14/23, 12/31/23, 3/25/24 and 6/18/24. The medial record failed to include documentation of care conferences.</p> <p>During interview on 7/17/24 at 3:03 p.m., licensed social worker (LSW)-A stated care conferences should be held quarterly or with any changes and be held within two weeks of completion of the MDS. LSW-A stated documentation of the care conference should have been placed in a progress note. LSW-A confirmed the last care conference for:</p> <ul style="list-style-type: none"> -R14 was on 9/14/23 and he should have had three additional care conferences. -R16 was on 10/18/23 and she should have had four additional care conferences. -R24 was completed 9/21/23 and he should have had 2 additional quarterly care conferences. -R29 was on 10/11/23 and that he should have had three additional care conferences. <p>Further, LSW-A confirmed that R69 has not had a care conference and he should have had 4 additional care conferences. LSW-A stated regular care conferences are important because it is a resident right and for collaboration of care. LSW-A stated even if the family and resident did not want to attend, the care conference should still be completed.</p> <p>The facility Care Conference policy, dated 10/23, indicated it is the facility policy to hold Care conferences for each resident at least quarterly or more often as needed. Residents/resident representatives will be involved with the development of their plan of care to promote autonomy and dignity. The care conference will take place no more than 7 days after the MDS is completed.</p> <p>49035</p>

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 07/18/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013</p> <p>Based on interview, and document review the facility failed to complete neurological assessments following falls for 1 of 1 resident (R85) who had unwitnessed falls.</p> <p>Findings include:</p> <p>R85's significant change Minimum Data Set (MDS) dated [DATE], identified R85 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R85's diagnoses included progressive neurological condition, hypertension, BPH, renal failure, diabetes mellitus, non-Alzheimer's dementia, Parkinson's disease, depression, and repeated falls.</p> <p>R85's post incident review, dated 6/2/24, identified an unwitnessed fall. R85 was found lying on floor in his room. Record indicated that neurological assessment was initiated but was not completed.</p> <p>R85's post incident review, dated 6/6/24, identified an unwitnessed fall. R85 was found lying on floor in his room. Record indicated that neurological assessment was initiated but was not completed.</p> <p>R85's post incident review, dated 6/8/24, identified an unwitnessed fall. R85 was found lying on floor in his room. Record indicated that neurological assessment was initiated but was not completed.</p> <p>R85's post incident review, dated 6/11/24, identified an unwitnessed fall. R85 was found lying on floor in his room. Record indicated that neurological assessment was initiated but was not completed.</p> <p>R85's post incident review, dated 6/19/24, identified an unwitnessed fall. R85 was found lying on floor in his room. Record indicated that neurological assessment was initiated but was not completed.</p> <p>R85's post incident review, dated 6/22/24, identified an unwitnessed fall. R85 was found lying on floor in his room. Record indicated that neurological assessment was initiated but was not completed.</p> <p>R85's post incident review, dated 7/5/24, identified an unwitnessed fall. R85 was found lying on floor in his room. Record indicated that neurological assessment was initiated but was not completed.</p> <p>R85's post incident review, dated 7/8/24, identified an unwitnessed fall. R85 was found lying on floor in his room. Record indicated that neurological assessment was initiated but was not completed.</p> <p>R85's post incident review, dated 7/10/24, identified an unwitnessed fall. R85 was found lying on floor in his room. Record indicated that neurological assessment was initiated but was not completed.</p> <p>(continued on next page)</p>		

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 07/18/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R85's post incident review, dated 7/11/24, identified an unwitnessed fall. R85 was found lying on floor in his room. Record indicated that neurological assessment was initiated but was not completed.</p> <p>During interview on 7/18/24 at 9:45 a.m., licensed practical nurse manager (LPN)-A stated when a resident fell staff notified the nurse. The nurse obtained vitals and assessed the resident for injury. LPN-A stated if fall was unwitnessed staff would initiate neurological assessments as follows:</p> <ul style="list-style-type: none"> -every fifteen minutes times two, -every one-hour times two, -every two hours times two, -every four hours times two, -every shift on days two and three. <p>LPN-A stated the neurological assessments should be completed at all times, even if a resident was sleeping, as it would be important to monitor throughout the day and night in case the resident had a head injury. LPN-A stated the nurses completed the neurological assessments and notified the provider of any abnormal readings. LPN-A stated if a time got missed, staff continued with the current flow sheet. LPN-A confirmed that the neurological assessments on 6/2/24, 6/6/23, 6/8/23, 6/11/24, 6/19/24, 6/22/23, 7/5/24, 7/8/24, 7/10/24 and 7/11/24 were not thoroughly completed with assessment times on flow sheet missing documentation.</p> <p>During an interview on 7/18/24 at 10:51 a.m., assistant director of nursing (ADON) stated when a resident fell the nurse completed a risk management assessment that consisted of the details of the fall and implement any immediate interventions to prevent future falls. ADON stated if fall was unwitnessed or if there was suspected head injury, neurological assessment would be initiated and completed as follows:</p> <ul style="list-style-type: none"> -every fifteen minutes times two, -every one-hour times two, -every two hours times two, -every four hours times two, -every shift on days two and three. <p>ADON stated if a neurological assessment time was missed, staff continued on the current flow sheet and the nurse manager followed up with staff to see why assessment was missed. ADON stated staff monitored the resident throughout the day and night. ADON confirmed the neurological assessments on 6/2/24, 6/6/23, 6/8/23, 6/11/24, 6/19/24, 6/22/23, 7/5/24, 7/8/24, 7/10/24 and 7/11/24 were not thoroughly completed with assessment times on flow sheet missing documentation which was very concerning. ADON stated neurological assessment were important to rule out any neurological damage.</p> <p>(continued on next page)</p>		

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 07/18/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility Neurological Assessment policy was requested but was not received.</p>

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 07/18/2024
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013</p> <p>Based on interview and document review the facility failed to ensure coordination of dialysis care for 1 of 1 resident (R14) who required dialysis (treatment to filter blood when kidneys are no longer able).</p> <p>Findings include:</p> <p>R14's quarterly Minimum Data Set (MDS) dated [DATE], identified R14 had intact cognition and independent with all activities of daily living (ADL)'s. R14's diagnoses included end stage renal disease, heart failure, hypertension, depression, dependent on renal dialysis, tremors, and personal history of traumatic brain injury.</p> <p>R25's provider order printed 7/18/24, indicated R14 left for dialysis treatments every Monday, Wednesday, and Friday.</p> <p>On 07/15/24 at 5:19 p.m., R14 stated the facility had never sent any paperwork with him when he went to dialysis appointments.</p> <p>On 07/18/24 at 9:41 a.m., licensed practical nurse (LPN)-A stated when a resident went to dialysis, a communication sheet was usually sent with them which included a weight and vital signs. LPN-A further stated the paperwork was kept in a book located at the desk. LPN-A verified there were no dialysis communication sheets for R14, and LPN-A had never sent any paperwork with R14 to dialysis appointments.</p> <p>On 7/18/24 at 1:35 a.m., health unit coordinator (HUC)-A stated residents who received dialysis were sent with communication sheets. After their appointment, the communication sheet and dialysis run sheet were returned and placed in the resident's binder. HUC-A further stated R14 refused to take or bring back any communication sheets as dialysis was his baby and R14 does everything regarding dialysis. HUC-A confirmed there has been no communication between facility and dialysis center in the past 5 years. HUC-A stated if there was a new order the dialysis center called the facility.</p> <p>A long-term care facility and outpatient dialysis services coordination agreement directed both parties shall ensure there was documented evidence of collaboration of care and communication between the long-term care facility and dialysis facility. Furthermore, the contract directed the care facility to keep a copy of the resident's short term and long-term dialysis care plan.</p> <p>A facility Hemo Dialysis policy, dated 8/2021, indicated the facility is to assure that each resident receives care and services for provisions of hemodialysis consistent with professional standards of practice - including ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility, and includes the comprehensive person-centered care plan, and the residents' goals and preferences, and ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.</p> <p>Dialysis binder specific to resident to be kept at assigned Nurses Station and sent with resident to each hemodialysis appointment. Dialysis Binder to include but is not limited to the following:</p> <p>(continued on next page)</p>		

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 07/18/2024
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Face Sheet</p> <p>b. Facility contact information</p> <p>c. Current Medication List including supplements</p> <p>d. Recent lab work</p> <p>e. Dialysis Communication Form</p> <p>The following items should be sent with resident to hemodialysis appointment:</p> <p>c. Dialysis Binder with information (see above)</p> <p>g. Other Communication to include, but not limited to:</p> <p>i. Medication administration (new medications initiated, administered, held or discontinued) by the nursing home or dialysis facility.</p> <p>ii. Physician treatment orders, labs and vital signs</p> <p>iii. Advance Directives and code status</p> <p>iv. Nutrition/fluid management including weights, resident compliance with food and fluid restrictions.</p> <p>v. Dialysis treatment completed and resident response, including declines in functional status, falls, anxiety, depression, confusion and or behavioral symptoms that interfere with treatments.</p> <p>vi. Dialysis adverse reactions/complications and or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site catheter.</p> <p>vii. Changes or decline in condition unrelated to dialysis.</p> <p>viii. The occurrence or risk of falls and any concerns related to transportation to and from the dialysis facility.</p>

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 07/18/2024
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 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>49657</p> <p>Based on document review and interviews the facility failed to ensure the required staffing information was posted daily. This had the potential to affect all 112 residents residing in the facility and their visitors who may wish to view the information.</p> <p>Findings include:</p> <p>During the review of the staff posting documentation from 6/3/24 through 7/18/24 the facility failed to provide evidence of staff postings for the following dates: 6/8/24, 6/9/24, 6/15/24, 6/16/24, 6/22/24, 6/23/24, 6/29/24, 6/30/24, 7/4/24 through 7/7/24, 7/13/24 and 7/14/24.</p> <p>On 7/18/24 at 1:11 p.m., the staffing manager (O)-D confirmed they had not been doing the staff posting on the weekends.</p> <p>On 7/18/24 at 3:37 p.m., the administrator stated they were unaware it had not been completed, and their expectation was it would be completed daily to ensure the information was available for residents or visitors who may like to see it.</p> <p>The Staffing Hours Posting Policy last revised 01/2015, indicated the facility will post daily at the beginning of each shift the facility-specific shift schedule for the 24-hour period.</p>

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 07/18/2024
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013</p> <p>Based on interview and document review, the facility failed to assure the use of PRN (as needed) psychotropic medications (a drug which affects mood/behavior) were limited to 14 days, or had a physician specified, time limited order for 2 of 2 residents (R74 and R85) reviewed for Hospice.</p> <p>Findings include:</p> <p>R74's admission Minimum Data Set (MDS) dated [DATE], identified R74 had moderate cognitive impairment and required partial to moderate assistance with all activities of daily living (ADL)'s. R74's diagnoses heart failure, hypertension, GERD, anxiety disorder, depression, asthma/COPD, and encounter for palliative care.</p> <p>R74's electronic health record (EHR) identified R74 had an order for Lorazepam 0.5 mg PRN every four hours as needed for anxiety. The care plan indicated the facility worked with resident, hospice, and staff to meet resident needs.</p> <p>R74's medication administration record (MAR) indicated lorazepam 0.5 mg every four hours as needed. This order was initiated on 6/14/24 and was open-ended. The documentation reflected use of this medication four times in the month of July.</p> <p>R85's significant change MDS dated [DATE], identified R85 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R85's diagnoses included progressive neurological condition, hypertension, BPH, renal failure, diabetes mellitus, non-Alzheimer's dementia, Parkinson's disease, depression, and repeated falls.</p> <p>R85's electronic health record (EHR) identified R85 had an order for Lorazepam 0.5 mg PRN every four hours as needed for unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. The care plan indicated the facility worked with resident, hospice, and staff to meet resident needs.</p> <p>R85's medication administration record (MAR) indicated lorazepam 0.5 mg every four hours as needed. This order was initiated on 6/21/24 and was open-ended. The documentation reflected use of this medication two times in the month of July.</p> <p>During interview on 7/18/24 at 9:23 a.m., registered nurse case manager (RN)-A stated for psychotropic medications, monitoring needed to be completed for behaviors. RN-A stated she was not aware any reassessment was required for PRN Lorazepam. RN-A confirmed R74's lorazepam was ordered on 6/14/24 and had no end date. RN-A confirmed R85's lorazepam was ordered on 6/21/24 and had no end date.</p> <p>During interview on 7/18/24 at 9:38 a.m., licensed practical nurse case manager (LPN)-A stated PRN Lorazepam required reassessment every 14 days. LPN-A stated it was important to reassess to see if medication was still needed and if it was effective and that the resident was not having any adverse side effects from medications.</p> <p>(continued on next page)</p>		

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 07/18/2024
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 7/18/24 at 10:48 a.m., assistant director of nursing (ADON) confirmed the lack of stop date for the PRN Lorazepam for R74 and R85. The ADON stated PRN psychotropic medications required a stop date of 14 days. ADON stated the provider needed to re-evaluate medication after 14 days and write a new order with rationale and end date if the medication was to be continued. ADON stated it was important to re-evaluated to see if the medication was effective and the resident did not receive any unnecessary medications.</p> <p>During interview on 7/18/24 at 1:38 p.m., consultant pharmacist (CP) stated Lorazepam required re-evaluation every 14 days. Provider was expected to document rationale and specify duration of medication. CP stated it was important to re-evaluate medication to make sure the resident was benefiting from it and to ensure the resident was not having any adverse effects from the medication.</p> <p>The facility Psychoactive Medication Use policy, reviewed 8/14/2023, indicated a resident will not receive unnecessary medications including psychoactive medications, unless non-pharmacological interventions have failed to sufficiently modify a resident's target behavioral, mood, or sleep disturbance. Residents prescribed psychoactive medications will receive adequate monitoring and will have gradual dose reductions attempted, unless clinically contraindicated. For PRN psychotropic medication orders, they must be reevaluated after 14 days, Add to TAR order for MD to re-evaluate after 14 days.</p>		

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 07/18/2024
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 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654</p> <p>Based on interview and record review, the facility failed to assist in obtaining routine dental services for 1 of 1 resident (R56) reviewed for dental services.</p> <p>Findings include:</p> <p>R56's quarterly Minimum Data Set (MDS) dated [DATE], identified R56 was cognitively intact and could make her needs known. The admission MDS dated [DATE], indicated R56 required supervisor and verbal cues to complete oral care. R56 did not display any type of dental concerns.</p> <p>During interview on 7/15/24 at approximately 12:00 p.m., R56 stated they would be interested in seeing a dentist and could not recall facility staff offering a dental appointment since admission. R56 could not recall their last dental appointment.</p> <p>During follow up interview on 7/17/24 at 1:35 p.m., R56 stated their teeth did not hurt but would like to see a dentist.</p> <p>R56's care plan dated, 11/15/23, directed the staff to assist R56 with oral cares. The plan directed R56 to brush teeth, gums, end of tongue; observe for mouth pain, ulcers, sensitivity, loose teeth, tooth decay, or improper fitting dentures; schedule dental exams as ordered, per facility policy, and/or as needed.</p> <p>R56's medical record lacked an oral assessment, or a referral for a dental evaluation.</p> <p>During interview on 7/18/24 at 7:33 a.m., licensed practical nurse (LPN)-A stated the facility had an in-house dental provider and LPN-A was usually the person who coordinated dental referrals for the long-term care residents. In order for a resident to be seen by the dental provider, the resident or family would sign a consent to share information with the dental provider. They would then be added to the list of residents to be seen on their next visit. LPN-A confirmed R56's record lacked a dental consent and had not expressed their wishes to be seen by the dentist. LPN-A stated they would contact R56's family for a dental visit consent.</p> <p>During follow up interview on 7/18/24, at 8:09 a.m. LPN-A stated R56 had signed the dental consent and R56's family had been contacted.</p> <p>During interview on 7/17/24 at 10:01 a.m., the assistant director of nursing (ADON) stated if the resident wanted to see the dentist they had two options; they could use the in-house dentist who visited the facility every couple of months, or they could choose to find their own dentist and the facility would arrange transportation and assist with setting up any appointments. ADON confirmed R56 had not received a dental referral or examination since admission.</p> <p>(continued on next page)</p>		

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 07/18/2024
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 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Dental Care policy dated 10/2019, directed the facility to meet the dental needs of the residents, to ensure quality of life, proper nutrition, dignity, and psychosocial well-being. Resident's dentition was be assessed upon admission and appropriate referrals were to be completed. Upon admission, the resident was to be provided information on dentist of choice or was to be given information on dentists available. Referrals were be made to the dentist as needed, per physician order and approval of resident/responsible party. Health unit coordinator or designee were make the residents appointment with the provider of choice.</p>

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 07/18/2024
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 - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49654</p> <p>Based on observation, interview, and document review the facility failed to ensure food was properly stored, labeled, dated, and failed to maintain a clean and sanitary kitchen to reduce and/or prevent the risk of food borne illness this practice had the potential to affect all 112 residents, staff and guests who consumed foods from the facility kitchen.</p> <p>Findings include:</p> <p>During initial kitchen tour on 7/15/24 at 11:26 a.m., with certified dietary manager (CDM) the following concerns were observed:</p> <ul style="list-style-type: none"> - Three dietary staff were observed without hairnets as they placed plastic wrap over plates of cooked food. - A reach in refrigerator to the immediate left of the stove top contained the following items of concern: <ol style="list-style-type: none"> 1) An unsealed bag of shredded cabbage dated 7/8/24. 2) Two open unsealed undated bags of bagels of bagels. 3) A small metal dish containing an undated, unidentified liquid, partially covered with plastic wrap. 4) An undated plate containing 2 baked biscuits loosely covered with plastic wrap. - The metal shelving units across from the stove had unidentified dried food particles next to clean dishes. - A floor drain under the ovens was covered with a grate like barrier which contained bread ties, tinfoil, dirt, hair, discarded food items, and other debris. The floor of the drain was also damp with unknown liquid. - The walk-in cooler had the following concerns: <ol style="list-style-type: none"> 1) An undated opened quart of heavy cream. 2) An undated pumpkin pie with one piece removed and a fork in the tin. 3) An undated, uncovered container of sliced tomatoes. (approximately 6 cups of tomatoes) 4) A loosely wrapped package of pulled pork was observed on top of a box of roasted turkey breast. Liquid from the pork was observed to drip onto the turkey, the refrigerator shelf and the floor. <p>(continued on next page)</p>		

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 07/18/2024
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 - Many</p>	<p>5) A box of gluten free meatballs dated 6/14/24 (one month prior to survey).</p> <p>6) One half of a fruit pie dated 6/10/24. (This pie was located directly below the dripping pork.)</p> <p>7) An open bag of precooked baby red mashed potatoes was observed with potatoes oozing out of the top of the bag next to the fruit pie.</p> <p>8) A red/brown liquid was pooled on the refrigerator floor next to the meatal shelving wheels. The CDM stated she did not know what the liquid and the walk in cooler had not been cleaned in weeks.</p> <p>- The walk-in freezer had the following concerns:</p> <p>1) A sign on next the top shelf indicated Top shelf do no stack anything on these shelves. The top shelf contained: An uncovered, undated paper tray of cooked corn bread with the edges covered in frost, two plate of uncovered, undated chocolate pie,</p> <p>an undated, unsealed plastic bag of barbeque ribs along with 25 assorted boxes and loose food items.</p> <p>2) An undated open bag containing four unidentified meat patties.</p> <p>3) An open bag of ham dated 1/11/24.</p> <p>4) A loosely covered undated 4 inch x 4 inch x six inch deep metal pan contained an unknown pureed substance which was covered with white crystals. The CDM was unable to identify the pureed substance.</p> <p>5) An undated open bag of raw chicken was on top of an open bag of breaded cooked chicken.</p> <p>6) An open undated bag of strudel bread was located below the chicken.</p> <p>7) A loosely covered blueberry pie dated 3/1/24, was noted to have thick white frost around the edges of the crusts.</p> <p>8) A open undated bag of diced green peppers were found on the floor under the metal shelves.</p> <p>During interview on 7/15/24 at 1:10 p.m., the CDM confirmed the kitchen was in poor condition. The CMS stated they worked as the cook, manager and dietary aide. CDM stated with multiple roles, routine items were missed. The facility had recently changed policies regarding the food storage and preparation, therefore she was unsure of the current policies. They did not have a set cleaning scheduled to ensure all areas of the kitchen were maintained in an orderly fashion. The CDM confirmed they were responsible to direct the kitchen staff, ensure all aspects of food sanitation and preparation were completed in a manner to minimize food bore pathogens. A copy of the kitchen cleaning schedule was requested but not provided.</p> <p>During follow up visit to the kitchen on 7/16/24 at 12:36 p.m., the following concerns were identified:</p> <p>(continued on next page)</p>

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 07/18/2024
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 - Many</p>	<p>- Cook-A was observed browning meat without a hairnet.</p> <p>- The aforementioned dried food on the metal shelving across from the stove remained next to the clean dishes.</p> <p>- The aforementioned floor drain below the ovens was unchanged.</p> <p>- The walk in cooler additional area of concern:</p> <ol style="list-style-type: none"> 1) An undated, open container of Mrs. Jerry's chicken salad. 2) An undated, open bag of fresh mixed vegetables. 3) Undated, open take-out food containers with unidentified food were noted on the top shelf. 4) The aforementioned brown liquid remained on the floor of the cooler. 5) A three inch by six inch by six in deep steam table pan was observed with three open undated packages of pureed beef. 6) A loosely covered six inch by six inch by six inch steam table pan dated 6/15/24, indicated the contents were chili. There was a layer of green/black/white fuzzy like substance on top of the chili. <p>-Walk in freezer additional areas of concern:</p> <ol style="list-style-type: none"> 1)An open, undated bag of frozen tater triangles. 2) An open, undated bag of frozen seasoned French fries. 3) An open undated bag of sliced zucchini. <p>During observation and interview on 7/16/24 at 3:35 p.m., the administrator, CDM and other facility staff were observed to remove items from the walk-in cooler and walk-in freezer and placing items in garbage cans. The administrator stated he could not find any record or cleaning log for the kitchen but indicated the staff were in the process of a full deep cleaning of the kitchen and removing any undated open food items.</p> <p>(continued on next page)</p>		

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 07/18/2024
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 - Many</p>	<p>During interview on 7/17/24 at 2:26 p.m., administrator stated the CDM duties included overseeing all areas of the dietary department. This would include ensuring food was stored and prepared appropriately, all areas and equipment were to be maintained in a clean/sanitary condition. The facility currently utilized a private companies' policies and procedures for the kitchen which had been tailored to the facilities unique needs and expected the facility dietary staff to be compliant with all State and federal regulations. The CDM was to be knowledgeable with all food related health codes and was to delegate task to the appropriate dietary staff. In addition, the CDM was also to the dietary department quality officer. The administrator confirmed the kitchen had many areas of concern which they were unaware of. The administrator's expectation was the CDM would maintain regular cleaning schedules for all areas in the kitchen, follow sanitary regulations as they pertained to the dietary department. This practice was to ensure the residents of the facility were only served properly stored and prepared food that would minimize any potential food borne illnesses.</p> <p>The Food Storage policy dated 3/22, indicated sufficient food storage would be provided to keep food safe, wholesome, appetizing and stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. The policy further stated:</p> <ul style="list-style-type: none"> - All refrigerator units were to be kept clean and in good working condition. - Cooked foods were to be stored above raw foods to prevent contamination. - Raw animal food was to be separated from each other and stored on lower shelves (below cooked foods or raw fruits and vegetables) and in drip proof containers. -All foods were to be covered, labeled, and dated and routinely monitored to assure that foods (including leftovers) were to be consumed by their safe use by dates, or frozen (where applicable), or discarded. -Refrigerated foods should be stored upon delivery and careful rotation procedures should be followed. -All freezer units were to be kept clean and in good working condition. -Frozen foods were to be maintained at a temperatures to keep the food frozen solid. -Meat, fish, and poultry were to be stored on lower shelves, while fruits, vegetables, juices, and breads should be stored on upper shelves. <p>The Cleaning and Sanitation of Dining and Food Service Areas policy dated 5/11, directed the food and nutrition services staff to maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule.</p> <p>A copy of the written cleaning schedule was requested but not provided.</p>		

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 07/18/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 49657</p> <p>Based on observation, interview and document review the facility failed to ensure enhanced barrier precautions were used for 1 of 3 residents (36) reviewed for infection control.</p> <p>Findings include:</p> <p>R36's significant change Minimum Data Sheet (MDS) dated [DATE], identified her cognition was intact. R36's required partial assistance with dressing her upper body, substantial assistance with dressing her lower body and was dependent with transfers.</p> <p>R36's diagnosis list dated 7/18/24 listed the following diagnoses: surgical amputation, diabetes, osteomyelitis (infection of the bone), methicillin resistant staphylococcus aureus infection (MRSA-type of bacteria that is highly resistant to antibiotics), a colostomy (opening in the abdomen to expel feces) and chronic ulcers (skin breakdown).</p> <p>R36's care plan dated 5/14/24, indicated R36 has a diagnosis of multi-drug resistant organism (MDRO) and met the criteria for enhanced barrier precautions. Care plan interventions included to don gown and gloves during high contact resident care activities including dressing, transfers, and providing hygiene.</p> <p>On 7/16/24 at 10:02 a.m., nursing assistant (NA)-B was observed entering R36's room without donning a gown. Signage on the door of R36's room indicated enhanced barrier precautions. A clear rubber three drawer cart was placed outside of R36's door and held yellow gowns. NA-B was observed providing morning hygiene cares to the resident without [NAME] precautions.</p> <p>On 7/16/24 at 10:02 a.m., NA-B confirmed she assisted R36 with emptying her colostomy bag, providing personal hygiene cares, getting dressed, putting on compression socks, making her bed and transferring. NA-B confirmed she wore gloves but not a gown. NA-B stated the sign for enhanced barrier precautions means the resident was contagious, but she would only have to wear a gown if the resident had an active infection such as COVID.</p> <p>On 7/17/24 at 1:07 p.m., registered nurse (RN)-F was in F36's room completing a medication pass, they realized they had forgotten something and removed their gloves completed hand hygiene, however, did not remove the gown and proceeded to leave the room and go out in the hall and enter the medication storage room. Writer interjected, and RN-F stated they had forgotten to remove the gown, and stated they should have removed both gloves and gown prior to exiting the room and put on new ones upon entering the room again to prevent the spread of infection.</p> <p>On 7/17/24 at 5:08 p.m., the assistant director of nursing (O)-B stated they expected staff, in a resident room with enhanced barrier precautions, to remove both gloves and gowns prior to exiting the room to prevent the spread of contagious infections.</p> <p>(continued on next page)</p>

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 07/18/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/18/34 at 09:57 a.m., the infection preventionist RN-E stated the expected staff, in a resident room with enhanced barrier, precautions to remove both gloves and gown prior to exiting the room to prevent the spread of infection.</p> <p>The facility policy Infection Prevention and Control Manual Personal Protective Equipment (PPE) dated 2020, indicated personal protective equipment will be removed before leaving the work area and placed in an appropriately designated area or container.</p>

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 07/18/2024
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 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49657</p> <p>Based on interview and document review the facility failed to ensure 4 of 5 residents (R24, R56, R80, and R102) were offered, educated and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC), who were reviewed for immunizations.</p> <p>Findings include:</p> <p>A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old.</p> <p>R24' s annual Minimum Data Set (MDS) dated [DATE], indicated R24 was 79, moderately cognitively impaired and had the following diagnoses: atrial fibrillation (top two chambers of the heartbeat erratically), congested heart failure (CHF), high blood pressure (HTN), diabetes (DM), and peripheral vascular disease (PVD) (inability of the body to return blood effectively from the extremities).</p> <p>R24's immunization record dated 7/18/24, indicated they received a PPSV23 on 7/23/2010 and a PCV13 on 5/23/16. The record lacked evidence of shared clinical decision making with the physician for a PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence R24 or representative was offered, educated on or received a PCV20.</p> <p>R56's quarterly MDS dated [DATE], indicated R56 was [AGE] years old, cognitively intact and had the following diagnoses: coronary heart disease (CAD) (hardening of the arteries of the heart), CHF, HTN, and chronic renal insufficiency (CRI) (poor kidney function).</p> <p>R56's immunization record dated 7/18/24, indicated they received a PPSV23 on 11/24/2012 and a PCV13 on 7/12/18. The record lacked evidence of shared clinical decision making with the physician for a PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R56 or representative was offered, educated on or received a PCV20.</p> <p>R80's quarterly MDS dated [DATE], indicated R80 was [AGE] years old, severely cognitively impaired and had the following diagnoses: HTN, Alzheimer's disease, and dementia.</p> <p>R80's immunization record dated 7/18/24, indicated they received a PPSV23 on 12/1/1998 and a PCV13 on 10/06/15. The record lacked evidence of shared clinical decision making with the physician for a PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence R80 or representative was offered, educated on or received a PCV20.</p> <p>R102's admission MDS dated [DATE], indicated R102 was [AGE] years old, cognitively intact and had the following diagnoses: HTN, orthostatic hypotension (blood pressure drops when they stand), and DM.</p> <p>(continued on next page)</p>		

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 07/18/2024
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 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R102's immunization record, dated 7/18/24, indicated they received a PPSV23 on 10/31/2008 and a PCV13 on 9/1/16. The record lacked evidence of shared clinical decision making with the physician for a PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence R102 or representative was offered, educated on or received a PCV20.</p> <p>On 7/18/24 at 9:57 a.m., the infection preventionist and registered nurse (RN)-E, stated they thought the residents were up to date and did not need PCV20. They also stated when they call and offer the corona virus vaccinations they would ask if the resident would like PCV20. However, the medical records for R24, R56, R80, and R102 all lacked any evidence of what was discussed, when the calls took place, education provided and whether consent was obtained or declined for PCV20 per the CDC recommendations for pneumococcal vaccinations.</p> <p>On 7/18/24 at 5:08 p.m., the assistant director of nursing (O)-B stated their expectation was upon admission the resident vaccination record was to be reviewed, when appropriate the vaccinations should be offered and educated on and the nurses will administer them to prevent the spread of communicable diseases.</p> <p>The facility policy Pneumococcal Vaccine Program dated 5/17/23, indicated for adults [AGE] years or older who have received PCV13 at any age and PPSC23 at or after age [AGE] years, CDC recommends shared clinical decision-making on whether to administer PCV20. If the vaccine provider and patient decide PCV20 is appropriate, the dose of PCV20 should be administered at least 5 years after the last pneumococcal vaccine.</p>