



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 1, 2026

Administrator
BIRCHWOOD HEALTH CARE CENTER
604 1ST STREET NE
FOREST LAKE, MN 55025

RE: CCN: 245200

Cycle Start Date: May 6, 2026

Dear Administrator:

On May 19, 2026, we informed you that we may impose enforcement remedies.

On June 12, 2026, the Minnesota Department(s) of Health and Public Safety completed a revisit/survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety.

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On June 1, 2026, the situation of immediate jeopardy to potential health and safety cited at F684 Quality of Care was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 16, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 16, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 16, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, BIRCHWOOD HEALTH CARE CENTER is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 12, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 6, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file

electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies. A copy of the Department's informal dispute resolution policies is posted on the MDH

Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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Administrator

BIRCHWOOD HEALTH CARE CENTER

604 1ST STREET NE

FOREST LAKE, MN 55025

Re: State Nursing Home Licensing Orders

Event ID: 231C4C-H1

Dear Administrator:

The above facility survey was completed on June 12, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

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Administrator

BIRCHWOOD HEALTH CARE CENTER

604 1ST STREET NE

FOREST LAKE, MN 55025

Re: State Nursing Home Licensing Orders

Event ID: 231C4C-H1

Dear Administrator:

The above facility survey was completed on June 12, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245200		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/12/2026	
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 604 1ST STREET NE , FOREST LAKE, Minnesota, 55025			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E0000	Initial Comments On 6/8/26 to 6/12/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			07/28/2026
F0000	INITIAL COMMENTS On 6/8/26 to 6/12/26, a standard recertification survey S5200042-0 was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52002725C (iQIES2795234), H52002726C (iQIES2696696), H52002727C (iQIES2582169), H52002728C (iQIES2563319), H52002729C (iQIESmn00114243). NO deficiencies were cited. This survey resulted in an immediate jeopardy (IJ) at F684 when the facility failed to verify and obtain on admission a resident's need for bipap (bilevel positive airway pressure machine which delivers pressurized air through a mask over the nose or mouth to provide improvement in breathing) equipment and failed to notify the provider after prescribed breathing interventions were ineffective for 1 of 1 resident (R90) reviewed for hospitalization. This resulted in an Immediate Jeopardy situation when R90 continued to have respiratory decompensation leading to the need for transfer to the emergency room, intubation, and admission to the intensive care unit. The IJ began on 6/4/26, when R90 was hospitalized, intubated, and admitted to the intensive care unit. Administration was notified of the IJ on 6/11/26, at			F0000			07/28/2026

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 reverse for further 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245200		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/12/2026	
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F0000	Continued from page 1 3:40 p.m. The IJ was removed on 6/11/26 at 8:38 p.m., however non-compliance remained at a lower scope and severity, level 2, isolated scope, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The above findings constituted substandard quality of care, and an extended survey was conducted on 6/12/26. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000			07/28/2026
F0684 SS = SQC-J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to verify and obtain on admission a resident's need for bipap (bilevel positive airway pressure machine which delivers pressurized air through a mask over the nose or mouth to provide improvement in breathing) equipment and failed to notify the provider after prescribed breathing interventions were ineffective for 1 of 1 resident (R90) reviewed for hospitalization. This resulted in an Immediate Jeopardy situation when R90 continued to have respiratory decompensation leading to the need for transfer to the emergency room, intubation, and admission to the intensive care unit. The IJ began on 6/4/26, when R90 was hospitalized, intubated, and admitted to the intensive care unit.			F0684	IMMEDIATE JEOPARDY REMOVAL PLAN Facility: Birchwood Health Care Center CMS Certification Number (CCN): 24-5200 Survey Date: June 11, 2026 F-Tag: F684 - Quality of Care Date Immediate Jeopardy Identified: June 11, 2026 IMMEDIATE ACTIONS TAKEN TO REMOVE THE IMMEDIATE JEOPARDY The facility immediately implemented corrective actions to protect all residents from potential harm related to unmet respiratory needs, failure to obtain necessary respiratory equipment, inadequate assessment of changes in condition, and failure to notify providers when interventions are ineffective.		06/11/2026

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F0684 SS = SQC-J	Continued from page 2 Administration was notified of the IJ on 6/11/26, at 3:40 p.m. The IJ was removed on 6/11/26 at 8:38 p.m., however non-compliance remained at a lower scope and severity, level 2, isolated scope, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R90's Admission Record dated 6/12/26, identified R90 was admitted on 6/2/26 and had diagnoses of chronic obstructive pulmonary disease (COPD, a condition where lung tissue is damaged), acute and chronic respiratory failure with hypercapnia (too much carbon dioxide in the bloodstream) and hypoxia (not enough oxygen in the bloodstream), malignant neoplasm (cancer) of bronchus or lung, pulmonary hypertension, dependence on supplemental oxygen, and heart failure. R90's care plan dated 6/3/26 identified a focus statement for altered respiratory status with difficulty breathing and shortness of breath (SOB) and included interventions to observe, document, and report any signs or symptoms of SOB, provide oxygen as ordered, observe and record pulse oximeter (SpO2) readings, and report abnormalities to provider. R90's provider orders dated 6/3/26 identified: Facility standing orders without exception. Standing orders identified to initiate and titrate supplemental oxygen from one to four liters per minute (LPM) via nasal cannula for dyspnea, hypoxia (oxygen saturation less than 90% or less than 88% for COPD) or acute angina to keep oxygen saturations (a measurement of blood oxygen gases quantified in a percentage) less than 90%; immediately update provider with nursing assessment. May wean supplemental oxygen per nursing judgment to maintain oxygen saturation greater than 90%; monitor SaO2 three times per day for three days after oxygen is discontinued, including once during night-time sleep. Budesonide inhalation suspension 0.5 MG/2M, inhale 2 milliliters (mL) by inhalation in the morning. Formoterol fumarate inhalation nebulization solution 20 MCG/2ML, inhale 2 mL via nebulizer two times per day. Sodium chloride inhalation nebulization solution 3%, inhale 4 mL via nebulizer two times per day.			F0684	Continued from page 2 Resident-Specific Corrective Actions 1. Resident R90 was transferred to the hospital for evaluation and treatment on 6/3/26. Immediate Facility-Wide Corrective Actions 1. A100% audit of all current residents with the following diagnosis was completed, and treatments were completed on 6/11/26 Oxygen therapy; COPD; Chronic respiratory failure; BiPAP, CPAP, and Trilogy Sleep Apnea Recent hospital admissions within the last 30 days 2. The audit verified: Physician orders are present and complete. Required respiratory equipment is available and functioning. 0 Oxygen parameters are clearly documented. BIRCHWOOD SENIOR LIVING Inspiring vibrant living www.BirchwoodSeniorLiving.com a &		06/11/2026

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F0684 SS = SQC-J	Continued from page 3 Ipratropium-albuterol inhalation solution 3MG/3ML, inhale 3 mL orally as needed (PRN) four times per day for wheezing or SOB. Use second after albuterol inhaler. Ventolin (albuterol) inhalation aerosol solution 108 micrograms per actuation (MCG/ACT), give two puffs by inhalation as needed for wheezing or SOB. Use first prior to ipratropium-albuterol. Continuous oxygen at 1 LPM via nasal cannula or mask to keep SaO2 greater than 90%. Ensure tubing patency and proper flow rate. Obtain and record SaO2 every shift. R90's progress notes identified the following: 6/3/26 at 2:37 a.m., a respiratory status note: A respiratory evaluation was performed 06/03/2026 for R90. Resident currently sleeps in recliner. Resident currently sleeps with HOB elevated when lying in bed. Resident has needed rest breaks d/t shortness of breath with ADLs (activities of daily living) and/or Mobility. Resident uses oxygen. Lung sounds with wheezes. Respirations were shallow. Dry, non-productive cough present. 6/3/26 at 4:15 p.m., a social services note: Met with resident's wife regarding her concern that the resident did not have a bipap in the facility. The wife expressed concerned with his breathing. SS reviewed resident's orders and hospital notes. SS followed up with the wife informing her that there were no orders for a bipap, just oxygen. SS informed that that the nursing team will work with the doctor here to see if a bipap can be ordered. SS directed the nurses to monitor the resident's breathing. 6/4/26 at 2:15 a.m., progress note: R90 having a difficult time breathing, SpO2 mid-80's on 3 LPM oxygen. Lung sounds diminished on left with crackles and wheezes on right. PRN albuterol inhaler utilized with little effect. Nebulizer then utilized. SpO2 remaining in upper 80's. Oxygen turned up to 4 LPM and head of bed (HOB) at 65 degrees to maintain SpO2 above 90% at this time. SpO2 92% upon completion of interventions. R4 remains uncomfortable and SOB. 6/4/26 2:20 a.m., a medication administration note: Ipratropium-Albuterol Inhalation Solution 3 MG/3ML, 3 ml inhale orally as needed for wheezing or SOB. Use 2nd after Albuterol inhaler. PRN Administration was: Ineffective R90's SpO2 88-89% on 3 LPM. Turned oxygen up to 4 LPM at this time.			F0684	Continued from page 3 IMMEDIATE JEOPARDY REMOVAL PLAN Respiratory care plans are current. 3. Arespiratory equipment verification process was implemented on 6/11/26, requiring the admissions team to confirm the need for respiratory equipment before admitting, and the nurse to verify the need for respiratory equipment and to ensure the following was in place upon discharge: Physician orders; Equipment availability; Vendor coordination has been completed and delivery scheduled. STAFF EDUCATION All licensed nursing staff in the building on 6/11/26, including RNs and LPNs, received 1:1 education. RNs/LPNs employed but not in the building were called and educated by clinical leadership staff, and licensed staff not working or contacted via phone will receive education before starting their shift. All agency staff will be educated via the facility agency education onboarding before the start of their shift on the following information: Admission and Readmission Process e Review of hospital discharge summaries. e Verification of physician orders.		06/11/2026

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F0684 SS = SQC-J	Continued from page 4 6/4/26 at 2:58 a.m., vital signs: oxygen saturation 85%, blood pressure 164/89, pulse 78, respirations 24 6/4/26 at 3:10 a.m., a medication administration note: Ventolin inhalation aerosol solution 108 MCG/ACT, 2 puffs every 4 hours as needed for wheezing or SOB. Use first prior to duoneb. PRN administration was ineffective R90's SpO2 remains in upper 80s. 6/4/26 at 3:46 a.m., an oxygen administration note: R90 cannot tolerate one LPM, patient on four LPMs oxygen at this time to maintain saturations above 90%. 6/4/26 at 8:13 a.m., greeted resident for morning and R90 was sitting on the edge of bed. Nurse asked if resident was alright, resident shook head, indicating "no." Checked SpO2, and was 80 percent. Got resident sitting up in bed and checked other vitals. Respirations were 50 (typical rate 12 to 20). Provided both scheduled nebulizer treatments, but no improvement. Called 911, after emergency medical system (EMS) arrived, R90 became nonresponsive to all stimuli. EMS transported R90 to the emergency department. R90's discharge summary dated 6/2/26, identified during cardiology course of care dated 5/16 to 5/19/26, R90 had become increasingly somnolent (sleepy) and tachypneic (fast breathing) when bipap had not been worn consistently overnight. During the pulmonary course of care dated 5/26/26 to 6/1/26, R90 was seen by sleep medicine for a bipap prescription with settings of inspiratory positive airway pressure (IPAP) of 22, expiratory positive airway pressure (EPAP) of 10, and a backup rate of 16. A sleep medicine follow-up visit was arranged in three to six months. Referrals were sent for a skilled nursing facility which accepted 6/1. A discharge medication list included line items for disposable medical equipment (DME) oxygen with the message to see Order Report for details. R90's electronic medical record (EMR) included an ExuCare Summary Report (an AI-powered platform designed to analyze full admission packets) for R90, identified the hospital referral source was the same hospital as the discharge summary and included equipment and assistive devices to include nighttime bipap with settings documented in hospital discharge. During an interview on 6/11/26 at 8:27 a.m., licensed practical nurse (LPN)-B, who identified as			F0684	Continued from page 4 e Identification of required respiratory equipment before admission acceptance. e Escalation procedures when equipment is unavailable. A review of the admissions summary report that includes the equipment and assistive devices and the residents' respiratory care needs was incorporated into the standardized admission/readmission checklist. If respiratory equipment is identified and not ordered, the nurse will clarify with the physician: e Respiratory diagnoses; e Respiratory equipment orders/needs; e Follow-up specialty appointments; IMMEDIATE JEOPARDY REMOVAL PLAN Change in Condition Assessment Recognition of respiratory distress. Signs and symptoms of Elevated CO2. Monitoring oxygen saturation levels. Escalation of care requirements. Provider Notification e Expectations for timely physician notification.		06/11/2026

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F0684 SS = SQC-J	Continued from page 5 the clinical coordinator for R90, stated she would have expected the provider to be updated or call 911 if interventions were not helping him improve. The risk of not doing so was respiratory failure and up to death. Raising the oxygen flow on someone with COPD could be detrimental to the patient and would expect nursing staff to have that knowledge. During an interview on 6/11/26 at 9:06 a.m. social services staff (SS)-A stated R90's wife had come to her on 6/3 asking why R90 didn't have a bipap. At the hospital she was told a bipap was important for his care. SS-A stated she talked to the administrator at that point, and he reached out to the admissions team, and it was found there were no orders for R90 to have bipap here, just oxygen. SS-A stated she then talked with R90's wife and explained they would try get orders for a bipap. SS-A didn't know if the provider was notified, but she did tell nursing staff to keep an eye on his breathing and let them know of his wife's concern. During an interview on 6/11/26 at 10:44 a.m., LPN-C, who identified as a long-term care clinical coordinator, stated their process was to have an outside admissions team receive the referral, the history and physical, discharge orders and any other pertinent orders and then accept or deny the referral. Before the residents came to the facility, they received finalized admit orders, looked into equipment needs, any oxygen or bipap needs, and they confirmed Northwest Respiratory has received the orders. LPN-C further stated they also review the ExuCare report that summarizes the care and equipment used in the hospital course and what the resident may need for care and equipment here. LPN-C pulled up R90's report in the EMR and a bipap was identified on the report. During an interview on 6/11/25 at 10:59, registered nurse (RN)-B stated he worked the morning shift of 6/4/26 and noted R90 to be in respiratory distress, he initiated help from an LPN, so that he could stay with the resident while the LPN called 911 and started to get the paperwork ready. During an interview on 6/11/26 at 11:29 a.m., customer service lead (CS)-D at Northwest Respiratory stated they had received orders for oxygen for R90 on 6/1/26, but they hadn't received an order for a bipap until yesterday when he was discharged from the hospital to a different facility. During an interview on 6/11/26 at 11:35 a.m., RN-A identified as the nurse caring for R90 on the night of 6/3 to 6/4/26, stated she hadn't updated another			F0684	Continued from page 5 e Notification when standing orders or interventions are ineffective. e Documentation requirements. Chain-of-command process. Oxygen and Respiratory Management Use of oxygen within ordered parameters. Risks associated with inappropriate oxygen administration in residents with elevated CO2. Management of residents requiring BiPAP and CPAP. Clinical Escalation Process was Educated Immediate clinical assessment for respiratory changes. Provider notification when interventions are ineffective. DON/Designee notification for significant changes in condition. Documentation of all notifications and resulting orders. The nursing and the admissions team were educated 6/11/26 on the expectations for ensuring verifying respiratory equipment prior to admission and ensuring the following is in place upon admission: Physician orders;		06/11/2026

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F0684 SS = SQC-J	Continued from page 6 RN, DON, or provider that R90 continued to decompensate after provided interventions. During an interview on 6/11/26 at 12:23 p.m., the director of nursing (DON) stated when oxygen needs required increasing oxygen, or if the initial treatments were not helping, then the staff should notify the provider. During an interview on 6/11/26 at 12:37 p.m., corporate admissions coordinator (AC)-E stated there wasn't anything that indicated R90 needed a bipap but did remember the facility administrator asking her if R90 was supposed to have a bipap, and she had told them it didn't flag on the discharge note from the provider. AC-E stated she sent the paperwork to the respiratory company to get a machine delivered after talking with the facility. During an interview on 6/11/26 at 12:42 p.m., LPN-A stated she remembered working the morning of 6/4/26 and helping RN-B with R90. LPN-A stated that she and RN-B both felt that R90 needed to be sent in when they assessed the resident on the morning of 6/4/26. R90's hospital record dated 6/4/26 at 9:32 a.m., identified patient was obtunded and in respiratory failure on arrival requiring intubation to protect airway. Provider noted they suspected patient developed increasing carbon dioxide retention since discharging as he does not have home bipap machine that was recommended. During an interview on 6/11/26 at 1:40 p.m., the medical director stated he would have expected the nurse to call a provider if the patient didn't look good and interventions were not successful. This patient really needed a BIPAP to "wash out" the carbon dioxide, all the oxygen wouldn't help. With sooner intervention, he may have avoided intubation. The facility needs more education for nursing staff about when to call the provider. The immediate jeopardy was removed on 6/11/26 at 8:38 p.m., when it was determined the facility had completed the following: -Identified any residents that had unmet respiratory needs -Implemented education to licensed nursing staff regarding the admission process, assessments, and how to utilize oxygen administration orders in conjunction with oxygen standing orders			F0684	Continued from page 6 Equipment availability; Vendor coordination has been completed, and the delivery is scheduled. POLICY REVIEW AND REVISION On 6/11/26, the facility reviewed the following policies: 1. Admission and Readmission Process IMMEDIATE JEOPARDY REMOVAL PLAN 2. Respiratory Equipment Verification 3. Change in Condition Notification 4. Oxygen Administration The revised policies clarify staff responsibilities, escalation requirements, and documentation expectations. SYSTEMIC CHANGES The facility implemented the following systemic changes: A review of the admissions summary report that includes the equipment and assistive devices and the residents' respiratory care needs was incorporated into the standardized admission/readmission checklist. If respiratory equipment is identified and not ordered, the nurse will clarify with the physician:		06/11/2026

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F0684 SS = SQC-J	Continued from page 7 -Implemented education on when to notify the provider and other nursing staff when a resident is experiencing a change of condition -Reviewed and revised necessary policies pertaining to admission process and assessments, oxygen or equipment needs, provider notification, management of COPD for residents with hypercapnia Policies regarding oxygen use and respiratory equipment needs, and the admission process were requested but not received.			F0684	Continued from page 7 Respiratory diagnoses; Respiratory equipment orders/needs; Shift-to-Shift Communication Residents with respiratory changes/concerns are identified during clinical report to ensure ongoing monitoring and continuity of care. AUDIT/MONITORING PLAN Respiratory Equipment Verification All new admissions and readmissions will be audited for dx, orders, and respiratory equipment upon admission for 4 weeks, and if compliant, reduce to 2 random audits per wk. for 4 weeks. Results of all audits will be brought to QAPI for review and recommendations. Responsible Party: Director of Nursing or Designee Change in Condition / Provider Notification All residents experiencing respiratory changes will have charts audited for: assessments completed by clinical staff, timely provider notification, orders implemented (if provided), IMMEDIATE JEOPARDY REMOVAL PLAN and documentation completed daily for 4 weeks, and if compliant, reduce to 2 random audits per wk. for 4 weeks. Results of all audits will be brought to QAPI for review and recommendations.		06/11/2026

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F0684 SS = SQC-J				F0684	Continued from page 8 Responsible Party: Director of Nursing or Clinical Manager QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) QAPI oversight will continue until sustained compliance is demonstrated. ALLEGATION OF COMPLIANCE The facility alleges compliance and removal of Immediate Jeopardy on 6/11/26 at 8:36pm. The facility has implemented immediate corrective actions to ensure resident safety, prevent recurrence, and maintain Agoing compliance with F684 Quality of Care Page 6 [OCR could not extract text from this page.]		06/11/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing			F0880	Deficiency: The facility failed to ensure residents on transmission-based precautions were prevented from participating in communal dining, creating the potential for transmission of infectious organisms to other residents. 1. Corrective action for the resident(s) found affected The residents identified have been offered hand washing/sanitizing wipes when in the dining room. 2. Identification of other residents with the potential to be affected All residents who eat in the dining room have the potential to be affected. All residents are offered hand washing/sanitizing when in the dining room. 3. Measures/system changes to prevent recurrence		07/28/2026

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F0880 SS = E	Continued from page 9 services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP			F0880	Continued from page 9 All staff educated on the need to offer the wipes to the residents in the dining room for added infection prevention. The following interventions have been implemented: Dietary staff and nursing staff received education regarding transmission-based precautions, offering resident sanitizing wipe/hand washing/antibacterial, preventing the spread of infection and encouragement of good hand hygiene to promote infection control practices. The Infection Preventionist will verify dining appropriateness during routine infection prevention rounds. The facility's Infection Prevention and Control Committee reviewed this event and incorporated monitoring into the Quality Assurance and Performance Improvement (QAPI) program. 4. Monitoring to ensure ongoing compliance The Infection Preventionist, Director of Nursing, or designee will conduct audits as follows: 3 audits per week for 4 weeks of residents who dine in communal spaces to verify appropriate hand washing/sanitizing have been offered at meals. Weekly audits for an additional 4 weeks thereafter. Any identified concerns will be corrected immediately through coaching and education. Audit results will be reviewed at the monthly QAPI Committee meeting. Additional interventions or continued monitoring will be implemented if compliance falls below 100%.		07/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245200		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/12/2026	
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F0880 SS = E	Continued from page 10 and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure residents were given an opportunity to wash their hands prior to eating. This had the potential to affect any resident who chose to eat in the main dining room. Findings include: During an observation on 6/8/26 at 12:06 p.m., dining was in progress in the main dining room. Tables had hand wipes on the tables. Staff were not observed to offer residents an opportunity to clean their hands as they were brought in and seated at the tables. During an observation on 6/9/26 at 4:13 p.m., in the main dining room staff were bringing residents to the tables, staff were not observed offering any residents hand wipes to clean their hands. There were hand wipes on each table. During an observation on 6/9/26 at 4:25 p.m., in the main dining room staff were bringing residents into the dining room, staff were not observed offering hand wipes to residents as they brought them in. During an observation on 6/9/26 at 4:40 p.m., another resident was brought into the dining room and placed at a table, they were not offered a hand wipe to clean their hands. During an observation on 6/11/26 at 7:17 a.m., a resident was brought into the dining room and situated at the table she was not offered an opportunity for handwashing, she was however offered something to drink. During an observation on 6/11/26 at 7:19 a.m., R24 was brought into the main floor dining room and was assisted to her table, she was not offered an opportunity to wash her hands but was brought some juice. During an observation on 6/11/26 at 7:22 a.m., R47 was brought into the dining room and seated by R12, he was not offered an opportunity to wash his hands but was brought some juice. During an observation on 6/11/26 at 7:26 a.m., R69 and R51 were seated at a table in the dining room coloring and looking at magazines at the table where they eat.			F0880			07/28/2026

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F0880 SS = E	Continued from page 11 During an observation on 6/11/26 at 7:26 a.m., R12 was observed getting juice on his own. During an observation on 6/11/26 at 7:31 a.m., R69 was brought her breakfast, no handwashing was offered. R51 had not been offered handwashing and she was eating toast with her hands. During an observation on 6/11/26 at 7:44 a.m., R13 was brought into the dining room, they were not offered hand washing but they were offered a beverage. During an observation on 6/11/26 at 7:45 a.m., R24 was observed eating peanut butter toast with her hands. During an observation on 6/11/26 at 7:51 a.m., R16 was brought to a table, no offer was made for handwashing. During an observation on 6/11/26 at 7:51 a.m., R13 entered and did not perform handwashing but helped herself to items from the counter. During an observation on 6/11/26 at 7:57 a.m., R34 was brought into the dining room, she was given a clothing protector but not offered handwashing. During an interview on 6/11/26 at 10:23 a.m., nursing assistant (NA)-F stated it was the nursing assistants' job to make sure residents received assistance to wash their hands prior to eating. During an interview on 6/11/26 at 10:25 a.m., NA-E stated they should be offering residents a chance to use the hand wipes before meals. During an interview on 6/11/26 at 10:31 a.m., registered nurse (RN)-F stated all staff should be helping residents with hand washing before meals. RN-F stated it was important to do this to prevent the spread of germs. During an interview on 6/1/26 at 10:43 a.m., the director of nursing (DON) stated when the NAs brought residents into the dining room they should be offering them the hand wipes to clean their hands. The DON stated this would be important to prevent the spread of germs. The DON further qualified any staff who brought a resident to the dining room should be offering handwashing. Hand Hygiene dated 8/2025, identified proper hand washing should be used to protect the spread of			F0880			07/28/2026

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F0880 SS = E	Continued from page 12 infection. The policy did not address hand hygiene related to residents and meals.			F0880			07/28/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure a resident's call			F0550	F550 – Plan of Correction Deficiency: The facility failed to ensure a resident's call light was answered timely, resulting in a bladder incontinence episode, thereby failing to promote the resident's dignity and right to timely assistance. 1. Corrective action for the resident found affected Resident (R53) was assessed following the identified incident. The resident was given a urinal to help promote continence. The resident's toileting schedule, continence needs, and call light response expectations were reviewed by the interdisciplinary team. The resident's care plan was reviewed and updated as appropriate to reflect individualized toileting needs and interventions. 2. Identification of other residents with the potential to be affected An audit of residents requiring toileting assistance, frequent incontinence care, or identified as high risk for bladder or bowel accidents was completed by the Director of Nursing or designee. The audit included review of: Care plans for toileting assistance and needs of the resident. Staff awareness of individualized toileting needs on admission and throughout stay in facility. Any concerns identified during the audit were corrected immediately. 3. Measures/system changes to prevent recurrence The facility reviewed expectations regarding resident rights, dignity, and timely response to resident call lights. The following interventions have been implemented:		07/28/2026

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F0550 SS = D	Continued from page 13 light was answered timely to prevent a bladder accident for 1 of 1 resident (R53) reviewed for bowel and bladder. Findings include: R53 was admitted on 6/8/26, his admission Minimum Data Set (MDS) was in progress. R53's Face Sheet dated 6/11/26, identified R53 had diagnoses which included post-polio syndrome (a progressive neurological condition that causes new or worsening muscle weakness, fatigue, and pain decades after an initial polio infection), benign prostatic hyperplasia without lower urinary tract symptoms (non-cancerous enlargement of the prostate gland that commonly occurs as men age, obstructing urine flow and causing bothersome lower urinary tract symptoms like frequent urination, weak flow, and the inability to fully empty the bladder). R53's care plan dated 6/9/26, identified R53 was at risk for falls, interventions included to have his call light accessible and within reach. R53's care plan identified incontinence and interventions included to have urinal available. R53's admission note dated 6/8/26, identified R53 was oriented to time, place, and person. His speech was clear and he was able to make himself understood and usually understood others. In addition, R53 was identified as continent of bladder. On 6/8/26 at 2:32 p.m., someone was heard shouting and saying, "quickly I need the urinal". The call light was on for R53's room. On 6/8/26 at 2:32 p.m., therapy staff were observed outside of R53's room, no actions were taken for R53 by therapy staff. On 6/8/26 at 2:34 p.m., the call light banner was scrolling and flashing for R53's room. On 6/8/26 at 2:41 p.m., R53's call light remained on, a staff member walked past R53's room but no actions were taken. On 6/8/26 at 2:42 p.m., a staff member from activities found a nursing staff and informed them R53's call light was on. The staff member knocked and went into R53's room and shut the door. On 6/8/26 at 2:49 p.m., nursing assistant (NA)- B left R53's room and returned with a urinal for R53.			F0550	Continued from page 13 Licensed nurses and nursing assistants were re-educated on: Resident Rights (F550) Prompt response to call lights Preserving resident dignity Timely toileting assistance Escalating requests when assistance is delayed Managers reinforced expectations that call lights are answered promptly regardless of assignment. Shift leaders will monitor unanswered call lights throughout each shift and assist staff when necessary. Residents identified as requiring frequent toileting assistance will have individualized interventions reflected in their care plans. Expectations regarding call light response have been reviewed during staff meetings and daily clinical huddles. 4. Monitoring to ensure ongoing compliance The Director of Nursing, Nurse Managers, or designee will complete random audits of call light response and toileting assistance as follows: Four audits per week for four weeks Two audits per week for an additional eight weeks Audits will evaluate:		07/28/2026

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F0550 SS = D	Continued from page 14 During an interview on 6/8/26 at 2:51 p.m., R53 stated his call light had been on "for a h*** of a long time", he stated he'd had an accident waiting for someone to answer his call light. R53 stated after the call light had been on for 20 minutes he started calling out loud for help. He said he had been in the facility for about an hour. R53 stated he was not given a urinal when he was admitted and stated he'd had to use drinking cups to urinate in. He stated his clothes had gotten wet and also the floor got wet. He pointed to two bags on the floor as "evidence" of the accident and the long wait for help. On 6/8/26 at 3:10 p.m., R53 wanted the administrator to come to the room, R53 told the administrator his chair was not working and pointed out the two bags on the floor, the drinking cups were visible in the bag. The administrator stated he was aware that R53's motorized wheelchair was not working when he arrived, and he then took a picture of the control screen. During an interview on 6/8/26 at 3:27 p.m., NA-C stated when she entered R53's room he had urinated in the drinking cups, she stated there was also urine on the floor, the overbed table, and the bed. She stated she cleaned it all up and "sanitized" the table. NA-C stated R53 would not allow her to remove the bags with the linen and the garbage. During an interview on 6/10/26 at 2:41 p.m., NA-D stated when a new admission arrived it was nursing's job to ensure they had supplies which for some residents would include a urinal. During an interview on 6/10/26 at 3:42 p.m., the unit coordinator (UC)- F stated she had heard later that when R53 arrived his motorized wheelchair was not working. UC-F stated the hospital had not communicated anything about his wheelchair not working. During an interview on 6/11/26 at 8:29 a.m., the social service director (SS)-A stated they found out the day he arrived that his motorized wheelchair wasn't working but had heard registered nurse (RN)-E and the administrator had figured out how to fix it (it had been in a manual mode setting). During an interview on 6/11/26 at 9:15 a.m., the administrator verified when R53 arrived his motorized wheelchair was not working properly, and it took three staff to get the motorized wheelchair out of the van. He stated RN-E figured out the problem and corrected it. The administrator			F0550	Continued from page 14 Timeliness of call light response Timely toileting assistance Staff adherence to resident care plans Preservation of resident dignity during care Any identified concerns will be addressed immediately through coaching, education, and corrective action as appropriate. Audit results will be reviewed monthly through the facility's Quality Assurance and Performance Improvement (QAPI) Committee. Additional monitoring or interventions will be implemented if compliance falls below 100%.		07/28/2026

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F0550 SS = D	Continued from page 15 volunteered R53's call light had been on 14 minutes before it was answered. During an interview on 6/11/26 at 10:26 a.m., NA-E stated part of getting a new resident settled would include asking a male resident if they needed a urinal. During an interview on 6/11/26 at 10:41 a.m., the director of nursing (DON) stated it would be important to ensure a resident was provided with items they needed upon admission, including a urinal for male resident to prevent accidents and to promote dignity. Call Lights Accessibility and Timely Response Policy dated 4/2025, identified the purpose of the call light was to allow residents to call for assistance. The policy included the call light would be relayed directly to a staff member. The policy also included "All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified."			F0550			07/28/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy			F0628	F0628 — Notice of Bed-Hold Policy Before/Upon Transfer 1. Corrective action for the resident(s) found affected R90 did not return to the facility following hospitalization; therefore, the resident-specific corrective action could not be completed. 2. Identification of other residents with the potential to be affected Residents who experience hospitalization, therapeutic leave, transfer, or discharge events requiring bed-hold notification have the potential to be affected by the alleged deficient practice. The Director of Social Services or designee has completed audits of all recent hospitalization/transfer records and bed-hold notification documentation for the last 30 days as of July 28, 2026 to ensure no other residents were affected. 3. Measures/system changes to prevent recurrence The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: Social services re-educated all licensed nurses on		07/28/2026

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F0628 SS = D	Continued from page 16 of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.			F0628	Continued from page 16 the requirement to provide bed-hold notice before or upon transfer/hospitalization, including documentation expectations and escalation when the resident or representative cannot be reached. The Director of Social service or designee will review each transfer/hospitalization at the daily clinical start up meeting for bed-hold compliance and will correct any missed documentation or incomplete notice prior to the end of the shift. 4. Monitoring to ensure ongoing compliance Birchwood Health Care Center will monitor performance to ensure sustained compliance. The Director of Social Services or designee will audit 100% of hospitalizations/transfers for bed-hold notice completion and documentation, 3 audits per week for 4 weeks. Weekly audits for an additional 4 weeks thereafter. Any identified concerns will be corrected immediately through coaching and education. Audit results will be reviewed at the monthly QAPI Committee meeting. Additional interventions or continued monitoring will be implemented if compliance falls below 100%. Birchwood Health Care Center will be in substantial compliance by July 28, 2026.		07/28/2026

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F0628 SS = D	Continued from page 17 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written			F0628			07/28/2026

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F0628 SS = D	Continued from page 18 notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent			F0628			07/28/2026

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F0628 SS = D	Continued from page 19 of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to meet the requirements for a bed hold notification for 1 of 2 residents (R90) reviewed for hospitalization. Findings include: R90's Admission Record dated 6/12/26, identified R90 was admitted on 6/2/26 and had diagnoses of chronic obstructive pulmonary disease (COPD, a condition where lung tissue is damaged), acute and chronic respiratory failure with hypercapnia (too much carbon dioxide in the bloodstream) and hypoxia (not enough oxygen in the bloodstream), malignant neoplasm (cancer) of bronchus or lung, pulmonary hypertension, dependence on supplemental oxygen, and heart failure. R90's electronic medical record (EMR) didn't contain evidence of a bed hold offered to R90 or his spouse when he was transferred to the hospital. During an interview on 6/11/26 at 8:27 a.m., licensed practical nurse (LPN)-A stated the usual process for bed hold was when they go out ask if they want to hold the bed and provide them with bed hold policy at the time of their need to transfer or if the resident was unable to say, they will call the family. LPN-A stated she saw social work had put in a note this morning, stating bed hold policy was sent with resident to the hospital on 6/4. LPN-A's expectation would be the resident or family were asked if they wanted to hold the bed and that it is documented at that time, which was important because there could be a private pay responsibility and the hospital needs to know if they have a bed hold. During an interview on 6/11/26 at 9:06 a.m. social services person (SS)-A stated when a resident was sent out, they were sent with a copy of the bed hold and transfer form and then she would follow up with the family and find out if they want to hold the bed. SS-A stated she attempted to call R90's wife on 6/9, who then called SS-A back on 6/10 stating they didn't wish to hold the bed. SS-A further stated she usually would want to make that call the next day or once they knew if the resident had been admitted,			F0628			07/28/2026

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F0628 SS = D	Continued from page 20 unfortunately time got away from her on this one. A bed hold policy was requested but not received.		F0628			07/28/2026	
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff was properly educated on how to monitor a dialysis access site for 1 of 1 resident (R1) reviewed for dialysis. Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/26/26, indicated R1 was cognitively intact, with diagnoses that included end stage renal disease (ESRD), and required dialysis. R1's care plan dated 6/9/26, indicated R1 required hemodialysis with potential for (arteriovenous) AV fistula malfunction. Instructions included to check for a thrill/bruit at the AV fistula/graft left arm access site every shift and as needed. R1's orders dated 6/11/26, indicated hemodialysis three times weekly, and instructed: Monitor hemodialysis vascular access AV fistula on left arm for signs and symptoms of infection every shift. Dialysis -Thrill/Bruit: Check Thrill (palpate) & Bruit (listen with stethoscope) every shift. Dialysis Post Run: Obtain full vital signs (VS) post dialysis run every evening shift every Tuesday, Thursday, Saturday. During an observation on 6/9/26 at 3:12 p.m., R1 returned from dialysis and licensed practical nurse (LPN)-D checked R1's vitals and AV fistula site. LPN-D looked at the AV fistula dressing and placed a gloved hand at the site. LPN-D did not use a stethoscope to auscultate the AV fistula site.		F0698	F698 – Plan of Correction Deficiency: The facility failed to ensure staff were appropriately educated regarding assessment and monitoring of a resident's dialysis access site in accordance with professional standards of practice. 1. Corrective action for the resident found affected Resident (R1) was immediately assessed by the licensed nurse. The resident's dialysis access site was evaluated for the presence of a palpable thrill, audible bruit, signs of infection, bleeding, swelling, redness, pain, or other abnormalities. No adverse outcome was identified. The resident's care plan and dialysis orders were reviewed and updated as appropriate to ensure dialysis access monitoring requirements were clearly identified. Licensed nursing staff caring for the resident received immediate education regarding proper assessment and monitoring of dialysis access sites, including documentation expectations and notification parameters. 2. Identification of other residents with the potential to be affected An audit of all residents currently receiving dialysis services was completed by the Director of Nursing or designee. There are no other residents receiving dialysis services in facility at this time. 3. Measures/system changes to prevent recurrence The facility reviewed its policy regarding the care and monitoring of residents receiving dialysis. The following system changes have been implemented: All licensed nurses received education regarding: Assessment of AV fistulas, AV grafts, and dialysis		07/28/2026	

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F0698 SS = D	Continued from page 21 During an interview on 6/9/26 at 3:38 p.m., LPN-D stated they did not know what a thrill or bruit was but indicated it was related to the AV fistula. They stated they thought the thrill and bruit should be checked when a resident returned from dialysis, but they needed to look it up. During an interview on 6/9/26 at 3:41 p.m., LPN-D returned and stated the thrill was what they felt at the AV fistula when they rested their hand on the site, and the bruit was a sound to listen for at the site. LPN-D confirmed they had not listened for the bruit and stated they would grab their stethoscope to listen now. During an interview on 6/11/26 at 8:37 a.m., director of nursing (DON) stated that when a resident returns from dialysis, nurses were to obtain vitals, check port site for bleeding, thrill and bruit, and monitor for lethargy. They stated they expected nurses to know how to check for a thrill and a bruit and stated it was important to auscultate for a bruit to ensure patency of the AV fistula. If it were not patent, they would have concern for a possible blood clot. Dialysis Care Plan and Treatment Sheet guideline instructed staff to monitor for complications following dialysis and monitor the shunt site by checking for the bruit and thrill.			F0698	Continued from page 21 catheters Verification of palpable thrill and audible bruit for AV access Recognition of complications including bleeding, infection, clotting, swelling, pain, redness, absence of thrill/bruit, and changes in circulation Required documentation When to notify the physician and dialysis provider A standardized dialysis order has been implemented to promote consistent documentation. The Director of Nursing and Infection Preventionist reviewed the facility's dialysis policy to ensure consistency with current standards of practice. 4. Monitoring to ensure ongoing compliance The Director of Nursing or designee will complete audits of all residents receiving dialysis as follows: Weekly for four (4) weeks Bi-weekly for an additional eight (6) weeks The audits will verify: Dialysis access assessment completed each shift as ordered Presence and documentation of thrill/bruit when applicable Documentation of abnormal findings Appropriate physician and dialysis provider notification when indicated		07/28/2026

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F0698 SS = D				F0698	Continued from page 22		07/28/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure that assessments and orders were in place for self-administration of medication and bedside storage for 1 of 1 resident (R40) who was reviewed for safe self-administration and storage of medications. Findings include: R40's quarterly Minimum Data Set (MDS) dated 6/17/26, indicated R40 was cognitively intact with diagnoses of diabetes, chronic kidney			F0761	F761 – Plan of Correction Deficiency: The facility failed to ensure physician assessments and physician orders were obtained prior to implementing bedside medication storage and self-administration of medications for one resident, in accordance with facility policy and federal regulations. 1. Corrective action for the resident found affected Resident (R40) has been discharged from the facility. 2. Identification of other residents with the potential to be affected The Director of Nursing or designee completed an audit of all residents currently approved for: Self-administration of medications Bedside medication storage The audit verified the presence of: Physician orders Comprehensive nursing assessment Safe storage of medications Updated care plans Ongoing monitoring documentation		07/28/2026

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F0761 SS = D	Continued from page 23 disease, and peripheral vascular disease. R40's care plan last reviewed 3/22/26, included Focus area Med Self Administration dated 9/30/25, which indicated R40 was able to keep at besides, and self-administer Voltaren gel. The associated intervention section instructed: (9/30/25) facility to administer medications as resident is not safe to independently administer medications at this time. R40's Order Summary Report, Active Orders as of 6/11/26, included okay to have over the counter medications for nerve pain in room. The order summary lacked administration parameter orders and/or orders to keep at bedside for the following medication/supplements: Amala super fruit extract, aged garlic extract, Alphacure, total pain relief supplement, Lymphavive, vision supplement, triple complex magnesium, coq10 complex, Antartic krill oil, and Moringa. A medication assessment completed on 7/17/25, indicated R40 was safe to keep at bedside and self-administer the medication Nerve Renew Supplement two times a day. The chart lacked evidence of completion of subsequent self-administration assessments for oral medication administration. During an interview on 6/8/26 at 12:40 p.m., it was noted R40's bedside table in their room had multiple over the counter medication bottles on it. During an observation on 6/9/26 at 4:29 p.m., multiple over the counter bottles of medications remained on R40's bedside table in their room. During an interview on 6/10/26 at 2:50 p.m., R40 stated they had ordered the bottles of medication from advertisements they had seen. R40 confirmed the following medication/supplement bottles were located on their room bedside table: Amala super fruit extract, aged garlic extract, Alphacure, total pain relief supplement, Lymphavive, vision supplement, triple complex magnesium, coq10 complex, Antartic krill oil, and Moringa. R40 confirmed they had been keeping the bottles on their bedside table. R40 did not think that any of the nursing staff had taken a list of the bottles for the doctor or the pharmacist to review. R40 did not think they had been tested on taking the pills either. During an observation on 6/11/26 at 7:27 a.m., R40 was in bed with eyes closed. Multiple over the counter medication bottles remained on R40's bedside table.			F0761	Continued from page 23 Any deficiencies identified during the audit were corrected immediately. 3. Measures/system changes to prevent recurrence The facility reviewed and revised its Self-Administration of Medications Policy to ensure compliance with CMS regulations. The following system changes have been implemented: A standardized Self-Administration Assessment Tool has been must be completed before any resident is approved for self-administration. Residents may not self-administer medications or maintain bedside medications until: A comprehensive nursing assessment is completed. Physician orders are obtained. Safe storage has been verified. The resident demonstrates competency. The care plan has been updated. Licensed nurses received education regarding: CMS requirements for self-administration Required physician orders Documentation expectations Safe medication storage requirements Ongoing monitoring responsibilities		07/28/2026

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F0761 SS = D	Continued from page 24 During an interview on 6/11/26 at 9:08 a.m., the bottles of over-the-counter medication were present on R40's bedside table. During an interview on 6/11/26 at 10:22 a.m., the director of nursing stated (DON) if a resident would like to self-administer medications or supplements, nursing would do an assessment to see if they could safely do so. If safe, an order from the doctor for the resident to be able to self-administer the medications would be requested. Most medications kept at bedside should have an order and a completed assessment to ensure the medication(s) could be safely kept at bedside. When staff become aware a resident has medications at bedside, they should notify the nurse so the nurse can make sure the resident has orders and an assessment in place for the medications. If nothing is in place the nurse should initiate the process. The facility policy Medication Self Administration Safety Screen and /or Self Administration dated 9/2023, included evaluation and approval of self-administration will be based on the medication self-administration safety screen which is to be completed prior to a resident self-administering medication. A physician order will be obtained with indication of which medications the resident may self-administer with or without staff supervision. Repeat self-administration safety assessments will be completed at minimum quarterly and with medication changes, changes in function/condition that might impact ability to self-administer.			F0761	Continued from page 24 Admission and quarterly assessment processes were updated to include review of residents approved for self-administration. 4. Monitoring to ensure ongoing compliance The Director of Nursing/ designee will complete audits of residents approved for self-administration as follows: Weekly for four (4) weeks Monthly for two (2) months Audits will verify: Physician orders are present. Nursing assessments are completed. Resident competency documentation is current. Care plans accurately reflect self-administration. Medications are safely stored. Ongoing monitoring is documented. Any identified concerns will be corrected immediately through education, coaching, and additional assessment as appropriate. Audit results will be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Additional monitoring or corrective action will be implemented if compliance falls below 100%.		07/28/2026
F0582 SS = B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must--			F0582	F0582 – Resident Notification 1. Corrective action for the resident(s) found affected The alleged deficient practice was corrected for the resident(s) identified during the survey. The resident		07/28/2026

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F0582 SS = B	Continued from page 25 (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.			F0582	Continued from page 25 record was reviewed, the required notification was completed, and documentation was updated as appropriate. 2. Identification of other residents with the potential to be affected Residents requiring notification under F582 have the potential to be affected by the alleged deficient practice. The Social Services Director or designee completed a review of resident records requiring notification within the previous 30 days to verify compliance. Any identified concerns were corrected immediately. 3. Measures/System changes to prevent recurrence Social Services staff were re-educated on the facility policy for required resident and representative notifications. The Medicare Beneficiary Notice Requirements Checklist for Skilled Nursing Facilities was updated to include the CMS 10055 form versus the CMS-R-131. The Social Services Director or designee will verify required notifications during routine record review. 4. Monitoring to ensure ongoing compliance The Social Services Director or designee will audit 5 resident records per week for 4 weeks, then 5 resident records monthly for 2 months to verify notification requirements have been completed and documented. Any identified deficiencies will be corrected immediately through staff education and coaching. Audit results will be reviewed at the monthly QAPI meeting, and additional monitoring will be implemented if compliance falls below 100%. The facility will be in substantial compliance by: 7/28/26		07/28/2026

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F0582 SS = B	Continued from page 26 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to provide residents the Skilled Nursing Facility Advance Beneficiary notice of Non-coverage (SNF ABN) CMS-10055 when Medicare part A services were being discontinued and the resident stayed in the facility. This affected 4 of 4 (R1, R5, R8, R11) residents reviewed for beneficiary notices. Findings include: R1's Notice of Medicare Non-Coverage (CMS-10123) dated 4/21/26, indicated R1's last covered day of Medicare A would be 4/23/26. R1's electronic medical record (EMR) lacked indication the SNF ABN was provided. R1's Census list and progress notes indicated R1 remained at the facility after 4/21/26 (Medicare Part A discharge date). R5's CMS-10123 dated 3/12/26, indicated R5's last covered day of Medicare A would be 3/13/26. R5's electronic medical record (EMR) lacked indication the SNF ABN was provided. R5's Census list and progress notes indicated R5 remained at the facility after 3/12/26 (Medicare Part A discharge date). R8's CMS-10123 dated 2/2/26, indicated R8's last covered day of Medicare A would be 2/5/26. R8's electronic medical record (EMR) lacked indication the SNF ABN was provided. R8's Census list and progress notes indicated R8 remained at the facility after 2/5/26 (Medicare Part A discharge date). R11's CMS-10123 dated 5/14/26, indicated R11's last covered day of Medicare A would be 5/23/26. R11's electronic medical record (EMR) lacked indication the SNF ABN was provided. R11's Census list and progress notes indicated R11 remained at the facility after 5/23/26 (Medicare Part A discharge date). During an interview on 6/9/26 at 5:21 p.m., the licensed social worker (LSW) stated she was not aware the SNF ABN needed to be given to residents. The facility had been using form CMS-R-131 (the ABN form for home health and hospices) instead. The LSW reviewed all medical records and confirmed R1, R5, R8, and R11 remained in the			F0582			07/28/2026

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F0582 SS = B	Continued from page 27 facility after discharge from Medicare-A. During an interview on 6/9/26 at 5:34 p.m., the administrator stated the facility had been told by corporate staff to use CMS-R-131 when all residents were discharged from Medicare-A and stayed in the facility. Facility policy Advanced Beneficiary Notices dated 4/1/26, indicated residents would receive form CMS-10055 when residents were discharged from Medicare-A services. Form CMS-R-131 would be utilized for residents under Medicare-B services.			F0582			07/28/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/8/26 to 6/12/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H52002725C (iQIES2795234), H52002726C			20000			07/28/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/12/2026	
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20000	Continued from page 1 (iQIES2696696), H52002727C (iQIES2582169), H52002728C (iQIES2563319), H52002729C (iQIESmn00114243) . NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		20000			07/28/2026	
21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the		21385	F880 – Plan of Correction Deficiency: The facility failed to ensure residents on transmission-based precautions were prevented from participating in communal dining, creating the potential for transmission of infectious organisms to		07/28/2026	

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21385	Continued from page 2 policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure residents were given an opportunity to wash their hands prior to eating. This had the potential to affect any resident who chose to eat in the main dining room. Findings include: During an observation on 6/8/26 at 12:06 p.m., dining was in progress in the main dining room. Tables had hand wipes on the tables. Staff were not observed to offer residents an opportunity to clean their hands as they were brought in and seated at the tables. During an observation on 6/9/26 at 4:13 p.m., in the main dining room staff were bringing residents to the tables, staff were not observed offering any residents hand wipes to clean their hands. There were hand wipes on each table. During an observation on 6/9/26 at 4:25 p.m., in the main dining room staff were bringing residents into the dining room, staff were not observed offering hand wipes to residents as they brought them in. During an observation on 6/9/26 at 4:40 p.m., another resident was brought into the dining room and placed at a table, they were not offered a hand wipe to clean their hands. During an observation on 6/11/26 at 7:17 a.m., a resident was brought into the dining room and situated at the table she was not offered an opportunity for handwashing, she was however offered something to drink. During an observation on 6/11/26 at 7:19 a.m., R24 was brought into the main floor dining room and was assisted to her table, she was not offered an opportunity to wash her hands but was brought some juice. During an observation on 6/11/26 at 7:22 a.m., R47 was brought into the dining room and seated by R12, he was not offered an opportunity to wash his hands but was brought some juice. During an observation on 6/11/26 at 7:26 a.m., R69 and R51 were seated at a table in the dining room			21385	Continued from page 2 other residents. 1. Corrective action for the resident(s) found affected The residents identified have been offered hand washing/sanitizing wipes when in the dining room. 2. Identification of other residents with the potential to be affected All residents who eat in the dining room have the potential to be affected. All residents are offered hand washing/sanitizing when in the dining room. 3. Measures/system changes to prevent recurrence All staff educated on the need to offer the wipes to the residents in the dining room for added infection prevention. The following interventions have been implemented: Dietary staff and nursing staff received education regarding transmission-based precautions, offering resident sanitizing wipe/hand washing/antibacterial, preventing the spread of infection and encouragement of good hand hygiene to promote infection control practices. The Infection Preventionist will verify dining appropriateness during routine infection prevention rounds. The facility's Infection Prevention and Control Committee reviewed this event and incorporated monitoring into the Quality Assurance and Performance Improvement (QAPI) program. 4. Monitoring to ensure ongoing compliance The Infection Preventionist, Director of Nursing, or designee will conduct audits as follows: 3 audits per week for 4 weeks of all residents who dine in communal spaces to verify appropriate hand washing/sanitizing have been offered at meals. Weekly audits for an additional 4 weeks thereafter.		07/28/2026

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21385	Continued from page 3 coloring and looking at magazines at the table where they eat. During an observation on 6/11/26 at 7:26 a.m., R12 was observed getting juice on his own. During an observation on 6/11/26 at 7:31 a.m., R69 was brought her breakfast, no handwashing was offered. R51 had not been offered handwashing and she was eating toast with her hands. During an observation on 6/11/26 at 7:44 a.m., R13 was brought into the dining room, they were not offered hand washing but they were offered a beverage. During an observation on 6/11/26 at 7:45 a.m., R24 was observed eating peanut butter toast with her hands. During an observation on 6/11/26 at 7:51 a.m., R16 was brought to a table, no offer was made for handwashing. During an observation on 6/11/26 at 7:51 a.m., R13 entered and did not perform handwashing but helped herself to items from the counter. During an observation on 6/11/26 at 7:57 a.m., R34 was brought into the dining room, she was given a clothing protector but not offered handwashing. During an interview on 6/11/26 at 10:23 a.m., nursing assistant (NA)-F stated it was the nursing assistants' job to make sure residents received assistance to wash their hands prior to eating. During an interview on 6/11/26 at 10:25 a.m., NA-E stated they should be offering residents a chance to use the hand wipes before meals. During an interview on 6/11/26 at 10:31 a.m., registered nurse (RN)-F stated all staff should be helping residents with hand washing before meals. RN-F stated it was important to do this to prevent the spread of germs. During an interview on 6/1/26 at 10:43 a.m., the director of nursing (DON) stated when the NAs brought residents into the dining room they should be offering them the hand wipes to clean their hands. The DON stated this would be important to prevent the spread of germs. The DON further qualified any staff who brought a resident to the dining room should be offering handwashing.			21385	Continued from page 3 Any identified concerns will be corrected immediately through coaching and education. Audit results will be reviewed at the monthly QAPI Committee meeting. Additional interventions or continued monitoring will be implemented if compliance falls below 100%.		07/28/2026

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21385	Continued from page 4 Hand Hygiene dated 8/2025, identified proper hand washing should be used to protect the spread of infection. The policy did not address hand hygiene related to residents and meals. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should re-educate nursing staff to appropriately implement correct hand hygiene when assisting residents in the dining room. The DON or designee could review and revise dining policies to ensure appropriateness. The DON or designee should perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.		21385			07/28/2026	
21610	Medicine Cabinet and Preparation Area;Storage CFR(s): MN Rule 4658.1340 Subp. 1 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure that assessments and orders were in place for self-administration of medication and bedside storage for 1 of 1 resident (R40) who was reviewed for safe self-administration and storage of medications. Findings include: R40's quarterly Minimum Data Set (MDS) dated 6/17/26, indicated R40 was cognitively intact with diagnoses of diabetes, chronic kidney disease, and peripheral vascular disease. R40's care plan last reviewed 3/22/26, included Focus area Med Self Administration dated 9/30/25, which indicated R40 was able to keep at besides, and self-administer Voltaren gel. The associated intervention section instructed: (9/30/25) facility to administer medications as resident is not safe to independently administer medications at this time. R40's Order Summary Report, Active Orders as of 6/11/26, included okay to have over the counter medications for nerve pain in room. The order summary lacked administration parameter orders		21610	Deficiency: The facility failed to ensure physician assessments and physician orders were obtained prior to implementing bedside medication storage and self-administration of medications for one resident, in accordance with facility policy and federal regulations. 1. Corrective action for the resident found affected Resident (R40) has been discharged from the facility. 2. Identification of other residents with the potential to be affected The Director of Nursing or designee completed an audit of all residents currently approved for: Self-administration of medications Bedside medication storage The audit verified the presence of: Physician orders Comprehensive nursing assessment Safe storage of medications		07/28/2026	

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21610	Continued from page 5 and/or orders to keep at bedside for the following medication/supplements: Amala super fruit extract, aged garlic extract, Alphacure, total pain relief supplement, Lymphavive, vision supplement, triple complex magnesium, coq10 complex, Antartic krill oil, and Moringa. A medication assessment completed on 7/17/25, indicated R40 was safe to keep at bedside and self-administer the medication Nerve Renew Supplement two times a day. The chart lacked evidence of completion of subsequent self-administration assessments for oral medication administration. During an interview on 6/8/26 at 12:40 p.m., it was noted R40's bedside table in their room had multiple over the counter medication bottles on it. During an observation on 6/9/26 at 4:29 p.m., multiple over the counter bottles of medications remained on R40's bedside table in their room. During an interview on 6/10/26 at 2:50 p.m., R40 stated they had ordered the bottles of medication from advertisements they had seen. R40 confirmed the following medication/supplement bottles were located on their room bedside table: Amala super fruit extract, aged garlic extract, Alphacure, total pain relief supplement, Lymphavive, vision supplement, triple complex magnesium, coq10 complex, Antartic krill oil, and Moringa. R40 confirmed they had been keeping the bottles on their bedside table. R40 did not think that any of the nursing staff had taken a list of the bottles for the doctor or the pharmacist to review. R40 did not think they had been tested on taking the pills either. During an observation on 6/11/26 at 7:27 a.m., R40 was in bed with eyes closed. Multiple over the counter medication bottles remained on R40's bedside table. During an interview on 6/11/26 at 9:08 a.m., the bottles of over-the-counter medication were present on R40's bedside table. During an interview on 6/11/26 at 10:22 a.m., the director of nursing stated (DON) if a resident would like to self-administer medications or supplements, nursing would do an assessment to see if they could safely do so. If safe, an order from the doctor for the resident to be able to self-administer the medications would be requested. Most medications kept at bedside should have an order and a completed assessment to ensure the medication(s)			21610	Continued from page 5 Updated care plans Ongoing monitoring documentation Any deficiencies identified during the audit were corrected immediately. 3. Measures/system changes to prevent recurrence The facility reviewed and revised its Self-Administration of Medications Policy to ensure compliance with CMS regulations. The following system changes have been implemented: A standardized Self-Administration Assessment Tool has been must be completed before any resident is approved for self-administration. Residents may not self-administer medications or maintain bedside medications until: A comprehensive nursing assessment is completed. Physician orders are obtained. Safe storage has been verified. The resident demonstrates competency. The care plan has been updated. Licensed nurses received education regarding: CMS requirements for self-administration Required physician orders Documentation expectations		07/28/2026

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21610	Continued from page 6 could be safely kept at bedside. When staff become aware a resident has medications at bedside, they should notify the nurse so the nurse can make sure the resident has orders and an assessment in place for the medications. If nothing is in place the nurse should initiate the process. The facility policy Medication Self Administration Safety Screen and /or Self Administration dated 9/2023, included evaluation and approval of self-administration will be based on the medication self-administration safety screen which is to be completed prior to a resident self-administering medication. A physician order will be obtained with indication of which medications the resident may self-administer with or without staff supervision. Repeat self-administration safety assessments will be completed at minimum quarterly and with medication changes, changes in function/condition that might impact ability to self-administer. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for self-administration and proper labeling and storage of medications and or/ storage of medications in. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21610	Continued from page 6 Safe medication storage requirements Ongoing monitoring responsibilities Admission and quarterly assessment processes were updated to include review of residents approved for self-administration. 4. Monitoring to ensure ongoing compliance The Director of Nursing/ designee will complete audits of residents approved for self-administration as follows: Weekly for four (4) weeks Monthly for two (2) months Audits will verify: Physician orders are present. Nursing assessments are completed. Resident competency documentation is current. Care plans accurately reflect self-administration. Medications are safely stored. Ongoing monitoring is documented. Any identified concerns will be corrected immediately through education, coaching, and additional assessment as appropriate. Audit results will be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Additional monitoring or corrective action will be implemented if compliance falls below 100%.		07/28/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on June 9, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Birchwood Health Care Center, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			07/07/2026

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 reverse for further 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.

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Building Info: Birchwood Health Care Center is a 2-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1971, an addition was constructed to the south side of the building that was determined to be of Type II(111)construction. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a capacity of 73 beds and had a census of 65 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			07/07/2026

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K0222 SS = F Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed			K0222	K0222 Egress doors What was done to correct the deficiency- Exit door was lubricated, door closer replaced, and latch adjusted to make door function as it was intended. Measures taken to ensure deficient practice will not reoccur- All exit doors will be tested and exercised monthly for function. How the facility will monitor future performance to ensure solution is sustained- maintenance staff will document testing of doors in the TELS preventive maintenance application. Who is responsible for the corrective actions and monitoring of compliance- The maintenance Director is responsible for completion and monitoring of this corrective action. When was this deficient practice completed- This deficient practice was completed on 6-9-2026		06/10/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0222 SS = F Bldg. 01	Continued from page 3 in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed maintain emergency exits in accordance with NFPA 101, 2012 Edition, 7.2.1.4.5. This deficient finding could have an widespread impact on the residents within the facility. Findings Include: On 6/9/2026, at 12:30 PM, observations and staff interview revealed that the emergency exit door leading from the dining room to the stairwell/exit to the outside would not freely open and took greater than 15 lbs. or pressure to open. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0222			06/10/2026
K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency lighting in accordance with NFPA 101, 2012 Edition, 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings Include:			K0291	K0291Emergency Lighting What was done to correct the deficiency- Maintenance staff have been verbally educated to code requirements and the importance of completion and documentation of inspection of the emergency lighting system. Measures taken to ensure deficient practice will not reoccur- Maintenance Director will monitor completion of inspections on the TELS preventive maintenance application to prevent this deficient practice from reoccurring. How the facility will monitor future performance to ensure solution is sustained- Use of the TELS preventive maintenance application will indicate the completion each month.		07/28/2026

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K0291 SS = F Bldg. 01	Continued from page 4 On 6/9/2026, at 11:30 AM, observations and staff interview revealed that the emergency lighting had not been tested in the months of April, May, June or July of 2025. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0291	Continued from page 4 Who is responsible for the corrective actions and monitoring of compliance- The Director of Maintenance is responsible for the completion of this inspection. When was this deficient practice completed- This is an ongoing completion from month to month starting immediately.		07/28/2026
K0521 SS = F Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2 and NFPA 105 (2010 edition). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 6/9/2026, at 11:25 AM, it was revealed by a review of available documentation that the facility could not provide a current fire damper inspection report. The last inspection had been completed in April of 2022. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0521	K0521 HVAC-Damper Testing What was done to correct the deficiency- To correct the deficiency a damper inspection was scheduled to be completed. Measures taken to ensure deficient practice will not reoccur- Communication with TELS was made to ensure it is part of the preventive maintenance program to trigger the next inspection in 4 years. In addition, a note will be made on the report upon completion to indicate when it is due in 4 years. How the facility will monitor future performance to ensure solution is sustained- The frequency of inspection requirement was entered into the TELS preventive maintenance application to indicate the need to be completed prior to the expiration of the current test. Who is responsible for the corrective actions and monitoring of compliance- The Maintenance Director is responsible for scheduling the completion of this testing. When was this deficient practice completed- This testing will take place on July 9th and 10th 2026.		07/11/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall			K0918	K0918- Essential Electric Systems Fuel Testing After discussion with the State Deputy Fire Marshal Inspector, it was determined to have been completed and the documentation to show completion was provided. The information required is located on the report completed by Ziegler Cat dated 3-30-26 and can be found near the bottom in the Level 31 PM section 1.1 Fuel sample completed.		06/10/2026

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NAME OF PROVIDER OR SUPPLIER BIRCHWOOD HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 604 1ST STREET NE , FOREST LAKE, Minnesota, 55025			
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K0918 SS = F Bldg. 01	Continued from page 5 be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, and NFPA 110 (2010 edition) section 8.3.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 6/9/2026, at 11:40 AM, it was revealed by a review of available documentation, the facility did not have documentation on the annual fuel testing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0918			06/10/2026
K0311 SS = D Bldg. 01	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING			K0311	K0311 Vertical Openings – Encloser What was done to correct the deficiency- 3M product Fire Barrier Moldable Putty Stix MP+ was pressed into the five penetrations in the ceiling of the basement storage fire sprinkler riser room.		06/19/2026

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K0311 SS = D Bldg. 01	Continued from page 6 Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to seal the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1). This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 6/9/2026, at 12:05 PM, observations and staff interview revealed that there were 5 penetrations through the floor of the Basement Storage/Sprinkler Riser Room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0311	Continued from page 6 Measures taken to ensure deficient practice will not reoccur- Quarterly penetration inspections will be carried out to ensure this deficient practice will not reoccur. How the facility will monitor future performance to ensure solution is sustained- TELS preventive maintenance application is in place to ensure this solution is sustained. Who is responsible for the corrective actions and monitoring of compliance- Director of Maintenance is responsible to ensure the completion of this inspection. When was this deficient practice completed- June 19th 2026		06/19/2026
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors			K0363	K0363 Corridor Doors What was done to correct the deficiency- The latch to the double doors leading into the chapel were adjusted to allow the doors to latch properly each time the opened and closed. Measures taken to ensure deficient practice will not reoccur- All corridor doors will be tested monthly to ensure proper door functioning of latching mechanisms. How the facility will monitor future performance to ensure solution is sustained- TELS preventive maintenance application will be used to monitor the testing of corridor doors. Who is responsible for the corrective actions and		06/10/2026

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K0363 SS = D Bldg. 01	Continued from page 7 complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.7.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 6/9/2026, at 12:20 PM, it was revealed by observation that the doors to the Chapel failed to latch when tested An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.			K0363	Continued from page 7 monitoring of compliance- The Maintenance Director is responsible for the monitoring and completion of the testing of corridor doors. When was this deficient practice completed- Door latches were adjusted immediately upon exit of annual life safety inspection on June 9th, 2026.		06/10/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 18, 2026

Administrator
BIRCHWOOD HEALTH CARE CENTER
604 1ST STREET NE
FOREST LAKE, MN 55025

RE: CCN: 245200

Cycle Start Date: May 6, 2026

Dear Administrator:

On July 1, 2026, we notified you a remedy was imposed. On August 4, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 30, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 16, 2026, be discontinued as of July 30, 2026. (42 CFR 488.417 (b))

In our letter of July 1, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from **June 12, 2026**. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 18, 2026

Administrator
BIRCHWOOD HEALTH CARE CENTER
604 1ST STREET NE
FOREST LAKE, MN 55025

Re: Reinspection Results
Event ID: 231C4C-H2

Dear Administrator:

On August 4, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 6, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us