DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 26, 2020

CMS Certification Number (CCN): 245627

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 31, 2020 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 26, 2020

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

RE: CCN: 245627
Cycle Start Date: January 23, 2020

Dear Administrator:

On February 26, 2020, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On March 3, 2020, the Minnesota Department of Health completed a revisit, and on October 1, 2020 and October 14, 2020 the Minnesota Department of Public Safety completed PCRs to verify that your facility had achieved and maintained compliance. Based on our visits, we have determined that your facility has acheived substantial compliance March 31, 2020.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 23, 2020 did not go into effect. (42 CFR 488.417 (b))

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 24GT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 26105

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245627**

2.STATE VENDOR OR MEDICAID NO.
(L2) **513928200**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE BIRCHES AT TRILLIUM WOODS**
(L4) **14585 59TH AVENUE NORTH**
(L5) **PLYMOUTH, MN** (L6) **55446**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/04/2020** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 10/26/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 10/26/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
09/30/2015
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/02/2020
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 24GT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 26105

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245627**
2.STATE VENDOR OR MEDICAID NO.
(L2) **513928200**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE BIRCHES AT TRILLIUM WOODS**
(L4) **14585 59TH AVENUE NORTH**
(L5) **PLYMOUTH, MN** (L6) **55446**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/23/2020** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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13.Total Certified Beds **44** (L17)

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Magdalene Jares, HFE NE II — 02/21/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 02/28/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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09/30/2015
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
February 10, 2020

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

RE: CCN: 245627
Cycle Start Date: January 23, 2020

Dear Administrator:

On January 23, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 23, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 23, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. BUILDING _____ B. WING _____	C 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BIRCHES AT TRILLIUM WOODS	**14585 59TH AVENUE NORTH PLYMOUTH, MN 55446**

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 1/21/20, to 1/23/20, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On January 21, 2020 through January 23, 2020, a standard survey was completed at your facility by the Minnesota Department of Health and the facility was found not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. A complaint investigation was also completed at the time of the standard survey. H5627005C was unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		2/28/20

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

Electronically Signed | 02/19/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. BUILDING _____ B. WING _____	C 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BIRCHES AT TRILLIUM WOODS	14585 59TH AVENUE NORTH PLYMOUTH, MN 55446

(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
F 677	Continued From page 1 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 1 dependent resident (R5) reviewed for activities of daily living (ADLs). Findings include: R5's diagnoses obtained from the care plan report printed on 1/23/20, included dementia, Alzheimer's disease and mild cognitive impairment. R5's quarterly Minimum Data Set (MDS) dated 10/23/19, indicated R5 had severely impaired cognition, and required extensive assistance for ADLs. R5's care plan dated 7/19/19, identified R5 had a functional ADL decline related to dementia. The care plan further indicated that staff were to anticipate her needs and re-approach at another times if behaviors existed. On 1/21/20, at 4:19 p.m. R5 was observed to have several white facial hairs on the chin approximately 1/2 inch long and when asked who assisted her with grooming R5 stated "I don't know." On 1/22/20, at 8:44 a.m. R5 was observed sitting at the dining room table and dressed for the day. R5 observed to still have 1/2 inch white facial hairs on her chin.	F 677	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by The Birches at Trillium Woods of the truth or the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. The Birches at Trillium Woods reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. This statement of deficiencies was taken to The Birches at Trillium Woods Quality Assurance Performance Improvement Committee on February 18, 2020. F677: ADL Care Provided for Dependent Residents How the nursing home will correct the deficiency as it relates to the resident: Resident 5□s (R5) facial hair was removed immediately following breakfast on 1/23/20. R5 did not experience any adverse effects as a result of this practice. All direct care staff working with R5 will be re-educated on the resident summary which indicates to the Nursing Assistants what type of care or assistance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. BUILDING _____ B. WING _____	C 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BIRCHES AT TRILLIUM WOODS	14585 59TH AVENUE NORTH PLYMOUTH, MN 55446

(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
F 677	Continued From page 2 On 1/22/20, at 1:35 p.m. R5 was still observed with the long white facial hairs on the chin. On 1/22/20, at 1:49 p.m. licensed practical nurse (LPN)-C approached R5 and asked her to come with her. time R5 was all dressed and NA-A was standing with R5 by the bathroom sink combing her hair. NA-A looked at R5's face but never offered to remove the facial hairs. On 1/23/20, at 7:45 a.m. NA-A and NA-B acknowledged they had not offered to shave R5 and indicated that they would do it after breakfast. Review of the resident summary sheets dated 1/21/20, indicated NAs are to assist with shaving R5. On 1/23/20, at 8:17 a.m. LPN-B stated "aides are supposed to offer to remove facial hair and if a resident refuses then they were to let the nurse know and to re-approach." On 1/23/20, at 12:53 p.m. R5's family member (FM) explained that this was very important to another family member that R5 have facial hair removed. On 1/23/20, at 3:10 p.m. director of nursing stated "staff should do something about the facial hair."	F 677	is to be provided to each resident. How the nursing home will identify other residents having the potential to be affected by the same practice: No other female residents were found to have any facial hair. All dependent residents whom staff are responsible for facial hair grooming had the potential to be affected. Measures the nursing home will put in place or systemic changes made to ensure the practice will not recur: The Birches will re-educate all direct care staff on appropriate grooming tactics for dependent residents and on the importance of following the resident summaries. Resident Summaries are updated weekly and nurses responsible for updating them will double check to ensure their grooming and personal hygiene needs are documented correctly. All new residents will be screened per our standard of practice for care needs, including personal hygiene and their resident summaries will be created to reflect these needs. How the nursing home plans to monitor its performance to make sure that solutions are sustained: The Administrator or Designee will conduct random visual audits of dependent residents for proper grooming weekly for the next six weeks then on a monthly basis for the next 6 months to ensure compliance. Information from the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 3	F 677	audits will be reviewed monthly at our quality assurance performance improvement meetings. Dates when corrective action will be completed: All education and initial observations will be completed by February 28, 2020. Follow-up audits will be ongoing per the above schedule. The title of the person responsible to ensure correction: Administrator	
F 880 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 services under a contractual arrangement based upon the facility assessment conducted according to	F 880		2/28/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. BUILDING _____ B. WING _____	C 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BIRCHES AT TRILLIUM WOODS	**14585 59TH AVENUE NORTH PLYMOUTH, MN 55446**

(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
F 880	Continued From page 4 §483.70(e) 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	F 880		

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F 880	Continued From page 5 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 and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to follow infection control practices to prevent the spread of infection for 7 of 7 residents (R30, R28, R18, R90, R91, R24, R240) reviewed for medication administration. In addition, failed to properly use gloves and complete hand hygiene during and after catheter cares reviewed for indwelling catheter. Findings included: R30's medication set up and administration was observed on 1/21/20, at 7:03 p.m. by licensed practical nurse (LPN)-D, who brought the laptop into R30's room to administer medications. While setting up R30's medications LPN-D set the laptop on the sink in the bathroom. No barrier was placed, no disinfecting was done to the computer following medication administration. R18's medication set up and administration was observed. LPN-D went into R18's room to complete medication administration, placed laptop on the sink, no barrier placed. Then LPN-D stopped to assist R18 and was observed to set the laptop on the bedside table again with no barrier. During the medication observation no disinfection of the laptop was completed when going from room to room.	F 880	F880: Infection Prevention & Control How the nursing home will correct the deficiency as it relates to the resident: 1. R30, R28, R18, R90, R91, R24 and R240 did not experience adverse effects as a result of the nurses laptops not being disinfected after being set down in their rooms. Nurses will follow disinfecting protocols for all devices, including laptops when they enter all rooms, including those noted at the time of the survey. 2. R28 did not experience any adverse effects as of result of the hand hygiene practice. NA-C and direct caregivers of R28 have been re-educated on required hand hygiene practices as it relates to glove changes and proper catheter care. How the nursing home will identify other residents having the potential to be affected by the same practice: 1. All residents have the potential to be affected by this practice. No residents have been noted to be adversely affected by the lack of disinfecting the nurse s laptop in between each room. 2. Any resident with an indwelling catheter had the potential to be affected by the same practice. R28 was the only	

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F 880	Continued From page 6 On 1/23/20, at 12:54 p.m. registered nurse (RN)-B stated she took the computer into residents room all the time and would set it on the counter by the bathroom sink. RN-B acknowledged never thinking of cleaning it after and between rooms. RN-B further stated except for when a resident was on contact precautions she did not set it anywhere in the room and would hold it. On 1/23/20, at 1:00 p.m. the director of nursing (DON stated because the nurses had to do the medication checks and documentation when in the room administering medications the nurse would put the computer on the bathroom sink. The DON stated after and between the rooms the nurses were supposed to clean the computer with alcohol wipes. The DON further stated he had educated nurses about cleaning the computers between rooms and when a resident was on precautions. Surveyor requested the education presented to the nurses. On 1/23/20, at 3:48 p.m. no further information was provided. R28, on 1/23/20, at 8:25 a.m. nursing assistant (NA)-C was observed to switch the overnight catheter bag to the leg bag for the day. During the observation, NA-C wore gloves and was holding the leg bag as she attempted to disconnect/separate the tubing that extends out of R28's bladder. At the time of the observation, NA-C continued to maneuver the tubing despite one of the fingers on the glove being punctured. After the disconnection and connection to the leg bag, NA-C proceeded to the bathroom, removed gloves, and re-applied another pair without	F 880	resident in the building with an indwelling catheter. Measures the nursing home will put in place or systemic changes made to ensure the practice will not recur: 1. The Birches will implement a new policy requiring that all nurses utilize one of the following options for ensuring proper infection control practices during medication passes as it relates to the laptop with the electronic medical record. 1. Nurses may utilize the computer on wheels (COW) stand when entering resident rooms with their laptops for medication passes in which they keep the laptop on the COW and do not place it on any resident surface. In this instance, the laptop does not need to be sanitized between rooms. Per isolation precaution infection control policies, if the nurse uses a COW in a room under isolation, the entire COW must be disinfected properly before leaving the room. OR 2. Individual sanitizing wipes have been provided to each nurse□s station. Nurses may carry the laptops with them and set them down on resident surfaces if they then sanitize the base of the laptop per the product requirements before they leave each room. 2. Re-education on the Handwashing/Hand Hygiene Policy and Procedure (Policy #4009) will be completed with all nursing team members. This re-education will focus on the process for standard handwashing, re-gloving when there is a tear/puncture	

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F 880	Continued From page 7 washing or cleansing hands. NA-C then approached R28 and assisted R28 to stand up, and used wet wipes to clean around the site where the tubing enters the urethra. NA-C then proceeded to wipe R28's bottom, and with the same gloves, pulled R28's pants up and zipped them. NA-C then went to the bathroom, looked at the night bag with urine remaining and drained it into the toilet, cleaned the bag with soapy water, drained it and hung the bag in the shower. NA-C then removed gloves and washed hands. On 1/23/20, at 8:41 a.m. when asked about hand hygiene during cares and between cares, NA-C stated she completed it before care and after care and in between cares she would change the gloves. On 1/23/20, at 12:22 p.m. during a follow up interview NA-C acknowledged she had a punctured glove as she continued to maneuver the urine tubing when attempting to switch R28 from the night to the day time leg catheter bag. On 1/23/20, at 12:41 p.m. both licensed practical nurse (LPN)-B who was the infection control nurse and the director of nursing (DON) were interviewed together. When asked about hand hygiene both stated all staff were supposed to complete hand washing before going to a residents room, between residents, during cares if they do pericares and then after prior to leaving the room. Both acknowledged if the glove breaks, staff were supposed to remove the glove and wash hands before they proceeded with cares. In addition both stated staff were supposed to use an alcohol wipe to cleanse the connection area for the catheter when switching	F 880	of the original pair, as well as requirements for when in the process of caring for an indwelling catheter gloves need to be changed. How the nursing home plans to monitor its performance to make sure that solutions are sustained: 1. The Administrator or Designee will conduct random visual audits of the nurse□s laptops when in use in resident rooms to ensure that proper infection control practices are being followed. This will occur weekly for the next 6 weeks and then on a monthly basis for the next 6 months to ensure compliance. Information from the audits will be reviewed monthly at our quality assurance performance improvement meetings. 2. The Director of Nursing or Designee will conduct random observations of indwelling catheter care as well as other common resident cares that require glove use to ensure that the Handwashing/Hand Hygiene policy is being followed. These will occur weekly for six weeks and then monthly for the following six months. All findings will be reported to the monthly Quality Assurance and Performance Improvement meetings. Dates when corrective action will be completed: All education and initial observations will be completed by February 28, 2020. Follow-up audits will be ongoing per the above schedule.	

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F 880	Continued From page 8 a night and day leg catheter bag for residents. Policy titled Handwashing/Hand Hygiene dated June 2015 directed staff to complete routine hand hygiene using alcohol-based rub or soap and water before and after handling an invasive device (e.g. urinary catheters), after removing gloves, and after contact with residents intact skin. During observation on 1/22/20, at 7:39 a.m. RN-A was administering medications to four residents R90, R91, R24, and R240. RN-A was observed bring the computer into each room and set it down by the bathroom sink in three of the rooms (R90, R91, R240) and on the bedside table in one of the rooms (R24) without using a barrier prior to setting the computer down. After the observations and between the rooms the computer was not cleaned. During an interview on 1/23/20, at 12:24 p.m. LPN-A said when she administered medications she was supposed to clean the computer in between rooms with wipes. LPN-A also stated she sets the computer by the bathroom sink in each room and on occasion sets it on the shelf by the television.	F 880	The title of the person responsible to ensure correction: Director of Nursing	

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K 000	INITIAL COMMENTS FIRE SAFETY 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on January 22, 2020. At the time of this survey, The Birches at Trillium Woods, 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

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

Electronically Signed | 02/19/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Trillium Woods is a 3-story building with a partial basement built of Type II(111) construction built in 2015. Each floor is divided into 2 smoke compartments by smoke barriers. The basement and first floor are separated from the rest of the campus by a 2 hour fire barrier. The facility is fully sprinklered protected and has a complete fire alarm system with corridor smoke detection, resident rooms and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 41 beds at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 133 SS=F	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that 2 of 3 - two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 8.2.1.3 and 19.1.3.4. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 44 of 44 residents. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 01/22/2020, observations revealed the	K 133	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by The Birches at Trillium Woods of the truth or the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. The Birches at Trillium Woods reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance.	2/26/20

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K 133	Continued From page 3 following deficient conditions: 1. Four 1 1/4 inch holes was found in the 2 hour fire barrier located above the large painting in the 3rd floor Tamarack dining room. 2. A 1 inch hole was found above the ceiling tiles by the large painting that is located in the 2nd floor Maple dining room. This deficient condition was verified by a Maintenance Supervisor.	K 133	This statement of deficiencies was taken to The Birches at Trillium Woods Quality Assurance Performance Improvement Committee on February 18, 2020. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents have been adversely affected by this practice. All penetrations in the smoke barrier were filled with a life-safety code approved product. 2. How the facility will identify other residents who have the potential to be affected by the same deficient practice. All smoke barriers were audited by the plant operation team and found to be free of any additional penetrations. 3. What measures will be put into place or systemic changes made to ensure the deficient practice does not occur again Audits of all two-hour fire rated walls have been added to our Preventative Maintenance system so that they are audited at a minimum twice per year to ensure no further penetrations occur. Furthermore, during this audit, the plant operation team will re-fill any areas that look like they could become compromised. 4. How the facility will monitor to ensure its being corrected and will not recur The Plant Operation Director will monitor the checking of the smoke barriers to the	

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K 133	Continued From page 4	K 133	automated preventative maintenance schedule so that the plant operation team will be prompted bi-annually to complete the audit. A log will be kept with the date and name of the staff member who checked the smoke barriers and this information will be brought to the following Quality Assurance Performance Improvement (QAPI) meeting.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 44 of 44 residents. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 01/22/2020, the following deficient condition	K 346	1. How correction action will be accomplished for those residents found to have been affected by the deficient practice. The Fire Alarm Out of Service Policy has been updated to include current contact information for local and state Fire Marshal authorities. The policy was also updated to state that the fire watch would start when the fire alarm has been down for 4 hours in a 24-hour period per code requirement. 2. How the facility will identify other residents have the potential to be affected	2/14/20

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K 346	Continued From page 5 were during a records review and an interview with a Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy: 1. The fire alarm out of service policy that was provided at the time of the inspection did not have the contact information for the current Deputy State Fire Marshal Division representative. 2. The fire alarm out of service policy that was provided at the time of the inspection stated that the fire watch would start after the fire alarm has been down for 10 hours in a 24 hour time period and not the 4 hours of down time during a 24 hour time period as required by code. This deficient condition was confirmed by a Maintenance Supervisor.	K 346	by the same deficient practice. All residents had the potential to be affected. No residents have been adversely affected by this practice. 3. What measures will be put into place or systemic changes made to ensure the deficient practice does not occur again The Plant Operations Director or Security Supervisor designee shall be responsible for ensuring the policy is updated when we are informed of contact changes by both the local or state Fire Marshall offices. 4. How the facility will monitor to ensure its being corrected and will not recur The Director of Plant Operations or Designee will review all fire safety policy contact information annually when the disaster manual is reviewed to ensure the information is accurate.	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler	K 354		2/14/20

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K 354	Continued From page 6 system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 44 of 44 residents. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 01/22/2020, during a records review and an interview with a Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy that included the contact information for the current Deputy State Fire Marshal Division representative. This deficient condition was confirmed by a Maintenance Supervisor.	K 354	1. How correction action will be accomplished for those residents found to have been affected by the deficient practice. The Sprinkler System Out of Service Policy has been updated to include current contact information for local and state Fire Marshal authorities. 2. How the facility will identify other residents have the potential to be affected by the same deficient practice. All residents had the potential to be affected. No residents have been adversely affected by this practice. 3. What measures will be put into place or systemic changes made to ensure the deficient practice does not occur again The Plant Operations Director or Security Supervisor designee shall be responsible for ensuring the policy is updated when we are informed of contact changes by both the local or state Fire Marshall offices. 4. How the facility will monitor to ensure its being corrected and will not recur The Director of Plant Operations or Designee will review all fire safety policy contact information annually when the disaster manual is reviewed to ensure the information is accurate.	
K 363	Corridor - Doors	K 363		2/26/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. BUILDING **01 - TRILLIUM WOODS** B. WING _____	**01/22/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BIRCHES AT TRILLIUM WOODS	**14585 59TH AVENUE NORTH PLYMOUTH, MN 55446**

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K 363 SS=D	Continued From page 7 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 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,	K 363		

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K 363	Continued From page 8 etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had a corridor door that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition, section 19.3.6.3. This deficient practice could affect 12 of 44 residents location within that smoke compartment. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 01/22/2020, observation revealed that the corridor door for the clean linen room 5450 had a kick down style door hold open device attached to it. It was confirmed at the time of the inspection that this device was being used by laundry personnel to hold the door open while stocking the clean linen in this clean linen room. This deficient condition was confirmed by a Maintenance Supervisor.	K 363	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The kick down attached to door S450 was removed immediately prior to the survey so that staff could not use it to prop open the door when getting the mechanical lifts out. 2. How the facility will identify other residents have the potential to be affected by the same deficient practice. All residents residing on the fourth floor had the potential to be affected. No residents experienced an adverse event as a result of this practice. Plant Operations has conducted a round of the building to identify and remove any remaining kickdowns attached to corridor doors. 3. What measures will be put into place or systemic changes made to ensure the deficient practice does not occur again Maintenance has been educated not to install kick-down attachments to any corridor doors in the Health Center therefore eliminating their use. 4. How the facility will monitor to ensure its being corrected and will not recur The plant operations team will conduct a spot check of three randomly selected storage areas per month for the next three months looking to ensure no	

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K 363	Continued From page 9	K 363	kickdowns or propped doors are located and report their findings at the QAPI meeting. If 100% compliance is found the plant operations team will continue with a quarterly check for the next year, reporting all findings at the QAPI meeting.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 22 of	K 914	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents have been adversely	2/26/20

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K 914	Continued From page 10 44 residents. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 01/22/2020, during a records review and an interview with the facility maintenance supervisor, the facility had not completed the annual electrical outlets that are located in the patient care areas and could only provide 12 of 44 resident room testing documentation at the time of the inspection. This deficient condition was verified by the Regional Maintenance Director.	K 914	affected by this practice. 2. How the facility will identify other residents have the potential to be affected by the same deficient practice. All residents in the Birches had the potential to be affected by this practice; no adverse events occurred. 3. What measures will be put into place or systemic changes made to ensure the deficient practice does not occur again The Plant Operations Director has re-educated the associate responsible. Plant Operations will conduct 4 outlet tests per week and document their results clearly on the electrical outlet log form. This will result in all outlets in the Health Center being tested yearly at a minimum. 4. How the facility will monitor to ensure its being corrected and will not recur The Plant Operations Director or Designee will conduct monthly spot checks of the electrical outlet log to ensure that all audits are conducted timely and documented appropriately.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 10, 2020

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

Re: State Nursing Home Licensing Orders
Event ID: 24GT11

Dear Administrator:

The above facility was surveyed on January 21, 2020 through January 23, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26105	A. BUILDING: _____ B. WING _____	C 01/23/2020

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THE BIRCHES AT TRILLIUM WOODS	14585 59TH AVENUE NORTH PLYMOUTH, MN 55446

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2 000	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 1/21/20, through 1/23/20, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 Along with the recertification survey, a complaint investigation was also completed at the time of the standard survey. The complaint H5627005C was unsubstantiated. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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	2 000		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 1 dependent resident (R5)	2 850	Corrected	2/19/20

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2 850	Continued From page 2 reviewed for activities of daily living (ADLs). Findings include: R5's diagnoses obtained from the care plan report printed on 1/23/20, included dementia, Alzheimer's disease and mild cognitive impairment. R5's quarterly Minimum Data Set (MDS) dated 10/23/19, indicated R5 had severely impaired cognition, and required extensive assistance for ADLs. R5's care plan dated 7/19/19, identified R5 had a functional ADL decline related to dementia. The care plan further indicated that staff were to anticipate her needs and re-approach at another times if behaviors existed. On 1/21/20, at 4:19 p.m. R5 was observed to have several white facial hairs on the chin approximately 1/2 inch long and when asked who assisted her with grooming R5 stated "I don't know." On 1/22/20, at 8:44 a.m. R5 was observed sitting at the dining room table and dressed for the day. R5 observed to still have 1/2 inch white facial hairs on her chin. On 1/22/20, at 1:35 p.m. R5 was still observed with the long white facial hairs on the chin. On 1/22/20, at 1:49 p.m. licensed practical nurse (LPN)-C approached R5 and asked her to come with her. time R5 was all dressed and NA-A was standing with R5 by the bathroom sink combing her hair. NA-A looked at R5's face but never	2 850		

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2 850	Continued From page 3 offered to remove the facial hairs. On 1/23/20, at 7:45 a.m. NA-A and NA-B acknowledged they had not offered to shave R5 and indicated that they would do it after breakfast. Review of the resident summary sheets dated 1/21/20, indicated NAs are to assist with shaving R5. On 1/23/20, at 8:17 a.m. LPN-B stated "aides are supposed to offer to remove facial hair and if a resident refuses then they were to let the nurse know and to re-approach." On 1/23/20, at 12:53 p.m. R5's family member (FM) explained that this was very important to another family member that R5 have facial hair removed. On 1/23/20, at 3:10 p.m. director of nursing stated "staff should do something about the facial hair." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependent on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		

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21385	Continued From page 4	21385		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance 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 policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, and interview, the facility failed to follow infection control practices to prevent the spread of infection for 7 of 7 residents (R30, R28, R18, R90, R91, R24, R240) reviewed for medication administration. In addition, failed to properly use gloves and complete hand hygiene during and after catheter cares reviewed for indwelling catheter. Findings included: R30's medication set up and administration was observed on 1/21/20, at 7:03 p.m. by licensed practical nurse (LPN)-D, who brought the laptop into R30's room to administer medications. While setting up R30's medications LPN-D set the laptop on the sink in the bathroom. No barrier was placed, no disinfecting was done to the computer following medication administration. R18's medication set up and administration was observed. LPN-D went into R18's room to complete medication administration, placed laptop on the sink, no barrier placed. Then LPN-D stopped to assist R18 and was observed to set the laptop on the bedside table again with	21385	Corrected	2/19/20

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21385	Continued From page 5 no barrier. During the medication observation no disinfection of the laptop was completed when going from room to room. On 1/23/20, at 12:54 p.m. registered nurse (RN)-B stated she took the computer into residents room all the time and would set it on the counter by the bathroom sink. RN-B acknowledged never thinking of cleaning it after and between rooms. RN-B further stated except for when a resident was on contact precautions she did not set it anywhere in the room and would hold it. On 1/23/20, at 1:00 p.m. the director of nursing (DON stated because the nurses had to do the medication checks and documentation when in the room administering medications the nurse would put the computer on the bathroom sink. The DON stated after and between the rooms the nurses were supposed to clean the computer with alcohol wipes. The DON further stated he had educated nurses about cleaning the computers between rooms and when a resident was on precautions. Surveyor requested the education presented to the nurses. On 1/23/20, at 3:48 p.m. no further information was provided. R28, on 1/23/20, at 8:25 a.m. nursing assistant (NA)-C was observed to switch the overnight catheter bag to the leg bag for the day. During the observation, NA-C wore gloves and was holding the leg bag as she attempted to disconnect/separate the tubing that extends out of R28's bladder. At the time of the observation, NA-C continued to maneuver the tubing despite one of the fingers on the glove being punctured.	21385		

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21385	Continued From page 6 After the disconnection and connection to the leg bag, NA-C proceeded to the bathroom, removed gloves, and re-applied another pair without washing or cleansing hands. NA-C then approached R28 and assisted R28 to stand up, and used wet wipes to clean around the site where the tubing enters the urethra. NA-C then proceeded to wipe R28's bottom, and with the same gloves, pulled R28's pants up and zipped them. NA-C then went to the bathroom, looked at the night bag with urine remaining and drained it into the toilet, cleaned the bag with soapy water, drained it and hung the bag in the shower. NA-C then removed gloves and washed hands. On 1/23/20, at 8:41 a.m. when asked about hand hygiene during cares and between cares, NA-C stated she completed it before care and after care and in between cares she would change the gloves. On 1/23/20, at 12:22 p.m. during a follow up interview NA-C acknowledged she had a punctured glove as she continued to maneuver the urine tubing when attempting to switch R28 from the night to the day time leg catheter bag. On 1/23/20, at 12:41 p.m. both licensed practical nurse (LPN)-B who was the infection control nurse and the director of nursing (DON) were interviewed together. When asked about hand hygiene both stated all staff were supposed to complete hand washing before going to a residents room, between residents, during cares if they do pericares and then after prior to leaving the room. Both acknowledged if the glove breaks, staff were supposed to remove the glove and wash hands before they proceeded with cares. In addition both stated staff were	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26105	A. BUILDING: _____ B. WING _____	C 01/23/2020

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21385	Continued From page 7 supposed to use an alcohol wipe to cleanse the connection area for the catheter when switching a night and day leg catheter bag for residents. Policy titled Handwashing/Hand Hygiene dated June 2015 directed staff to complete routine hand hygiene using alcohol-based rub or soap and water before and after handling an invasive device (e.g. urinary catheters), after removing gloves, and after contact with residents intact skin. During observation on 1/22/20, at 7:39 a.m. RN-A was administering medications to four residents R90, R91, R24, and R240. RN-A was observed bring the computer into each room and set it down by the bathroom sink in three of the rooms (R90, R91, R240) and on the bedside table in one of the rooms (R24) without using a barrier prior to setting the computer down. After the observations and between the rooms the computer was not cleaned. During an interview on 1/23/20, at 12:24 p.m. LPN-A said when she administered medications she was supposed to clean the computer in between rooms with wipes. LPN-A also stated she sets the computer by the bathroom sink in each room and on occasion sets it on the shelf by the television. SUGGESTED METHOD OF CORRECTION: Staff could be educated on infection control practices during catheter cares, hand hygiene and cleaning equipment when going from room to room. The director of nursing or designee	21385		

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21385	Continued From page 8 could perform random audits to ensure staff are following infection control practices and report the findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21385		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to complete a Tuberculosis (TB) risk assessment according to the current State guidelines for preventing the transmission of	21426	Corrected	2/19/20

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21426	Continued From page 9 Tuberculosis. Findings include: During review of the facility TB three ring binder, with the facility administrator on 1/22/20, at approximately 3:56 p.m., it was revealed the last time the facility risk assessment was completed was 8/13/18. The administrator verified and stated the facility did not need to complete the risk assessment annually for a "Medium risk level" as directed by the State guidelines for health care settings. During a telephone interview with the State TB Controller and Program Manager on 1/23/20, at 11:55 a.m. it was revealed facilities were to continue doing the setting risk assessment annually for medium and high risk facilities and the only thing that had changed was they were no longer expected to do annual TB symptom employee screenings. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing would ensure the TB risk assessment would be completed according to the State guideline recommendations. TIME PERIOD FOR CORRECTION: Ten (10) days.	21426		