Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 16, 2025

Administrator
Birchwood Health Care Center
604 1st Street NE
Forest Lake, MN 55025

RE: CCN: 245200
Cycle Start Date: April 10, 2025

Dear Administrator:

On June 11, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered
April 23, 2025

Administrator
Birchwood Health Care Center
604 1st Street Ne
Forest Lake, MN 55025

RE: CCN: 245200
Cycle Start Date: April 10, 2025

Dear Administrator:

On April 10, 2025, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 July 10, 2025 (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 October 10, 2025 (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)

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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
	245200	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH CARE CENTER	604 1ST STREET NE FOREST LAKE, MN 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
E 000	Initial Comments On 4/7/25 to 4/10/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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.	E 000		
F 000	INITIAL COMMENTS On 4/7/25 through 4/10/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H52002448C (MN111444). Deficient practice was identified related to incidental finding 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	F 000		

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

Electronically Signed | 05/02/2025

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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F 000	Continued From page 1 validate substantial compliance with the regulations has been attained.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for 2 of 2 residents (R48, R75) reviewed for call lights. Findings include: R48's quarterly Minimum Data Set (MDS) dated 3/18/25, indicated R78 had severe cognitive impairment and diagnoses of dementia. R48's care plan revised 7/2/24, indicated R48 had limited mobility related to weakness and dementia. R48 was dependent on 1-2 staff for bed mobility and required a soft touch call light in reach. An observation on 4/7/25 at 1:26 p.m., R48 was sitting up in their broda wheelchair next to the bed. The wheelchair was slightly reclined and R48 was sleeping with their arms bent laying on their torso. The chair was next to their bed. R48's soft touch call light was laying flat in the middle of the bed.	F 558	Resident R48 and R75 currently reside in center. R48 and R75 care plans have been updated to reflect the call light be in reach. R48 and R75 were placed within reach of resident. The facility has determined that all residents have the potential to be affected. To prevent recurrence, education will be completed with all staff addressing the policies and procedures, regulations and facility expectations of staff to assure the accessibility of call lights in resident rooms at all times. Director of Nursing/designee will complete 6 call light observation audits weekly x 4 weeks, then 4 call light audits weekly x 3 weeks, and then 2 call light audits weekly x 2 weeks to ensure plan of care is being followed. This plan of correction will be monitored at	5/27/25

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F 558	Continued From page 2 An observation on 4/8/25 at 9:37 a.m., R48 was sitting in their broda wheelchair next to their bed. R48's arms were bent and laying on their torso. R48's soft touch call light was laying flat on the bed. An observation on 4/8/25 at 1:31 p.m., R78 was laying in bed sleeping. R48's soft touch call light appeared to be placed under R78. At 1:41p.m., Nursing assistant (NA)-C pulled back R48's blanket and determined R48's call light was under the blanket and laying on the side next to R48. R48's arms and hands were lying on their stomach. When interviewed on 4/8/25 at 1:31 p.m., NA-C stated a soft touch call light was used when residents were not able to push a button. NA-C stated R48 has not used the call light regularly, but has used it a few times and further stated even if not used regularly, still needed to be in reach to allow the opportunity. NA-C further stated R48 had some contractions and needed the call light to be on them near her hands to use. R75's admission Minimum Data Set (MDS) dated indicated R75 had severe cognitive impairment and diagnoses of dementia and heart failure. R75's care plan revised 2/22/25, indicated R75 had limited physical mobility and required partial to moderate assistance of one staff member to transfer for chair/bed mobility. R75's care plan lacked indication R75 was not able to use the call light or preferred not to use the call light.	F 558	the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Completion Date: 5/27/25	

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F 558	Continued From page 3 An observation on 4/8/25 at 12:29 p.m., R75 was seated in his chair with his lunch tray in front of him. R75 stated they may need to use the bathroom and requested help. Writer asked R75 to place call light on and R75 stated "I don't know where it is". While looking around. R75 had a call light looped over a bedside table drawer that was behind him and out of reach. Another call light was wrapped around the grab bar and hanging down towards the floor. Writer left room and alerted registered nurse (RN)-A R75 needed assistance. RN-A went into R75's room to help and verified R75's call light was hanging on the grab bar and not in reach. When interviewed on 4/9/25 at 10:37 a.m., NA-B stated R75's call light needed to be in reach, however, doesn't want to use it and gets up on his own at times. NA-B further stated R75's family wants him to be more active and not in bed. When interviewed on 4/9/25 at 11:26 a.m., RN-A stated R75 was confused at times and would get up on their own. RN-B wasn't sure if R75 didn't want to use the call light and stated all residents should have the call light in place, even if they didn't choose to use it and we encourage residents to ask for help. When interviewed on 4/9/25 at 12:30, the Director of Nursing (DON) expected staff to ensure call lights were in reach with all residents. This was important to help residents communicate their needs. DON further stated there were many residents who did not touch their call lights and it was a gray area if needing to be in reach if never used.	F 558		

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F 558	Continued From page 4 A facility policy for call light use was requested however the facility does not have one.	F 558		
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 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 feeding assistance and routine personal hygiene cares i.e., nail care, facial hair removal, was provided for 2 of 4 residents (R23, R28) reviewed for activities of daily living (ADLs) and whom were dependent on staff for such cares. Findings include: R23 R23's Optional State Assessment (OSA) dated 2/19/25, indicated severe cognitive impairment, rejected cares one to three days, required extensive assist with toilet use and limited assistance with transfers. R23's annual Minimal Data Set (MDS) dated 2/19/25, indicated severe cognitive impairment, rejected cares one to three days, required substantial maximal assistance with toileting hygiene, showering and bathing, and personal hygiene including shaving. Further, R23 had the following diagnoses: heart failure, Alzheimer's disease, and muscle weakness.	F 677	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Residents R23 and R28 are currently residing in the center and have had care plan revisions made to their ADL needs and preferences. R23 was shaved and provided nail care on Tuesday April 8th. R28 plan of care was reviewed for assistance with dining and updated per needs. The facility has determined that all residents have the potential to be affected. Education with all staff to be completed to	5/27/25

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F 677	Continued From page 5 R23's care plan dated 11/26/24, indicated R23 had an ADL self-care performance deficit due to Alzheimer's disease and required substantial maximal assist of one for shaving at regular time or when R23 was most willing. R23's care plans were reviewed and lacked information R23 required nail care. R23's nursing assistant (NA) care sheets indicated R23 had a bath on Sunday p.m., shift and required stand by assistance with shaving as needed. The care sheet lacked information R23 required nail care. R23's physician's orders indicated the following order: 9/22/24, Complete body audit assessment in the electronic medical record. R23's Behaviors task form 30-day lookback 3/12/25, thru 4/10/25, indicated R23 did not reject cares. R23's Bathing 30-day lookback from 3/16/25, thru 4/6/25, indicated R23 did not reject cares. R23's Bathing Shower, Bath and Skin Condition task form 30-day lookback from 4/10/25, indicated "No Data Found". R23's Body Audit form dated 3/16/25, indicated R23 received a shower, and allowed his fingernails to be trimmed and were clean and trim. R23's Body Audit form dated 3/23/25, indicated R23 received a shower, fingernails were clean	F 677	ensure that the care plan is followed for ADL needs for residents including grooming and assistance with dining. Director of Nursing/designee will complete 4 audits weekly x 4 weeks, then 3 audits weekly x 3 weeks, and 2 audits weekly until substantial compliance is achieved or as otherwise determined by the Risk Management/Quality Assurance committee. Date of correction 5/27/25	

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F 677	Continued From page 6 and trim and did not need to be trimmed. R23's Body Audit form dated 3/30/25, indicated R23 received a shower, fingernails were clean and trim, and did not need to be trimmed. R23's Body Audit form dated 4/6/25, indicated R23 received a shower, fingernails were clean and trim, and did not need to be trimmed. R23's progress notes were reviewed from 3/16/25, to 4/8/25, and lacked information R23 refused shaving or nail care. R23's progress note created 4/8/25 at 3:51 p.m., and effective 4/8/25 at 3:48 p.m., indicated licensed practical nurse (LPN)-A assisted R23 to shave facial hair and trimmed, filed, and cleaned under R23's fingernails and R23 stated he was refreshed and felt like a brand new man. R23's aide tasks lacked information for documentation of completion of shaving. During observation on 4/7/25 at 3:22 p.m., R23 had gray sweatpants and a black t-shirt with crusty yellow particles on the upper pants and R23 had facial hair that was approximately ¼ inch long. R23's fingernails had brown debris located under the nails. During observation on 4/8/25 at 11:16 a.m., R23 was in the dining room participating in a balloon activity. R23 had brown checkered pajama type pants on and a gray t shirt. During observation on 4/8/25 at 11:27 a.m., R23's fingernails were still long with debris under the nails and R23 was still unshaven.	F 677		

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F 677	Continued From page 7 During observation on 4/8/25 at 2:25 p.m., R23 was still unshaven and had long nails with debris under them. During interview and observation on 4/8/25 at 2:26 p.m., licensed practical nurse (LPN)-A stated the evening nurse started at 2:00 p.m., and the day nursing assistants and nurses left at 2:30 p.m. At 2:27 p.m., R23 started to bring himself to the bathroom and LPN-A assisted R23 into the bathroom. During interview and observation on 4/8/25 at 2:31 p.m., nursing assistant (NA)-A stated they had care sheets to know what cares a resident required. NA-A stated if a resident refused cares she would reapproach and would document refusals and let the nurse know and stated the nurse would document refusals as well. NA-A stated shaving was completed after showers and as needed and stated she completed nail cares and trimming in the evenings. NA-A verified R23 had facial hair and stated they hadn't shaved R23 in a while and verified R23 had long nails adding, it did not look like R23 was shaved on 4/6/25, and nails did not look like they had been trimmed either and stated it had been a couple weeks since shaving and nail care had been provided. Further, NA-A stated R23 did not refuse cares and stated R23 loved to get washed up and R23 states, "Oh yay" and won't typically refuse. During interview and observation on 4/8/25 at 2:42 p.m., LPN-A stated the aides knew what cares a resident required based on the care sheets. LPN-A stated if a resident refused cares, aides reapproach and document refusals in point of care and the nurses documented refusals in a	F 677		

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F 677	Continued From page 8 behavior note or in a progress note. LPN-A stated residents were shaved as needed and encouraged on shower days and nail cares was completed on shower days and also as needed and if a resident had diabetes was referred to podiatry due to thicker nails and would be documented in a body audit form. LPN-A verified care sheets provided on 4/7/25, were current and verified R23's bath day was on Sunday evenings and verified R23 did not refuse nail care or shaving and expected staff complete nail care and shaving on bath days and as needed when nails were long and dirty and when facial hair was getting long. At 2:53 p.m., LPN-A verified R23 had long nails with debris under the nails and was unshaven. LPN-A stated if R23 was provided a razor he could possibly shave himself, but nurses should trim R23's nails because R23 had diabetes. LPN-A stated it did not look like nail care was completed on 4/6/25, and stated it was important for skin and with dirt sitting under the nails and trying to avoid skin tears and R23 would need supervision to make sure R23 could thoroughly shave. During observation on 4/9/25 at 7:09 a.m., R23 was in the dining room and nails were trim and clean and was clean shaven. During interview on 4/9/25 at 9:57 a.m., the director of nursing (DON) stated she expected staff try nail care and shaving on shower days and added R23's care plan indicated as willing. The DON verified R23's tasks lacked documentation R23 refused and viewed the progress notes which also lacked documentation R23 refused cares and stated nails should be cleaned on shower day and as needed and added they washed hands with Sani wipes and	F 677		

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F 677	Continued From page 9	F 677		

R23 used the restroom often so his nail care should be done on a daily basis adding it was important how residents felt in general and for personal hygiene.

R28

R28's Optional State Assessment (OSA) dated 2/25/25, indicated R28 rejected care 1 to 3 days, required extensive assist with bed mobility, and toileting, and required set up support for eating, and was totally dependent on staff for transfers.

R28's quarterly Minimum Data Set (MDS) dated 2/25/25, indicated severe cognitive impairment, required set up assistance with eating, was dependent on staff for transfers, had non-Alzheimer's dementia, cancer, malnutrition, depression, Alzheimer's disease, gastroesophageal reflux disease (GERD), and generalized muscle weakness. Additionally, R28 was on hospice care.

R28's physician orders dated 12/23/24, indicated R28 "Needs to be up in chair and in dining room for meals".

R28's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated April 2025 and printed 4/9/25 at 10:53 a.m., indicated nine times a "9" was documented under the order R23 needed to be in in the chair and in the dining room for meals. A "9" was documented in the 7:30 a.m., time slot on 4/1/25, 4/2/25, 4/4/25, 4/6/25, 4/7/25, 4/8/25, and 4/9/25. A "9" was documented in the 11:00 a.m., time slot on 4/2/25 and a "9" was documented in the 4:00 p.m., time slot on 4/5/25. A chart code in the MAR and TAR identified a "9" indicated

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F 677	Continued From page 10 "Other/See Progress Notes". R28's progress notes were reviewed from 4/1/25 to 4/9/25, and R28's orders administration progress note dated 4/2/25 at 12:04 p.m., indicated R28 refused to be up in the chair for meals. No other refusals to be up in the chair were documented. R28's care plan dated 6/21/24, indicated R28 had depression and interventions included encouraging dining in the dining room to improve socialization. R28's care plan dated 9/25/24, indicated R28 had limited physical mobility and required a Broda wheelchair. R28's care plan dated 12/22/24, indicated R28 required set up and clean up assistance from one staff to eat. Additionally, R28 had a terminal prognosis requiring hospice involvement due to dementia. R28's care plan dated 1/13/25, indicated R28 had severe cognitive impairment and interventions included to cue and supervise as needed. R28's care plan dated 4/8/25, indicated R28 had GERD (gastroesophageal reflux disease) and interventions included to observe document and report to the medical practitioner as needed signs and symptoms of GERD: belching, coughing, choking when lying down. R28's care plan was reviewed and lacked information R28 was required to be up in the chair for meals.	F 677		

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F 677	Continued From page 11	F 677		

R28's care sheet undated, indicated R28 was on hospice, required assist of one for dressing, grooming, and bathing, was incontinent, was on a regular diet, required set up assist with meals and lacked information R28 was to be up in the dining room for meals.

R28's Amount Eaten/Eating question 2 Task form indicated R28 needed to be up in the chair and in the dining room for meals. Additionally, R28 required supervision, oversight, encouragement, and cueing on 4/9/25.

R28's Amount Eaten/Eating question 3 Task form indicated R28 generally required setup help and on 4/9/25, required one-person physical assist.

R28's Amount Eaten/Eating question 4 Task form indicated R28 needed to be up in the chair and in the dining room for meals. Additionally, R28 did not refuse.

R28's Behaviors task form from 3/12/25, printed on 4/10/25, indicated R28 did not have any behaviors of refusals.

A form, Dining Hours, indicated the facilities mealtime schedule was as follows: Breakfast 7:30 a.m., to 8:30 a.m., lunch 11:30 a.m., to 12:30 p.m., and supper was from 4:30 p.m., to 5:30 p.m.

R28's meal ticket dated 4/9/25, indicated R28 was on a regular diet and instructions included to setup and cut up meat into bite sized pieces and included 8 ounces of milk, 4 ounces of juice, 1 serving of choice of cereal, 1 hard cooked egg, 1 muffin, and 6 ounces of milk.

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F 677	Continued From page 12	F 677		

During observation on 4/8/25 at 12:08 p.m., R28 was in the dining room and was assisting herself with her meal.

During continuous observation on 4/9/25 from 7:59 a.m., to 9:28 a.m., dietary aide (DA)-A brought breakfast to R28 in her room. DA-A did not uncover the meal tray or take the lids off the juice and milk. R28's meal ticket indicated setup and cut up meat into bite sized pieces. R28 was in bed and sleeping. At 8:11 a.m., staff entered the room to assist R28's roommate. At 8:16 a.m., R28's head of the bed was observed to be elevated approximately 45 degrees. At 8:26 a.m., no staff came in to assist R28 with her breakfast. At 8:29 a.m., R28's eyes were closed, and her head was tilted towards the window. At 8:30 a.m., a staff person entered the room to assist R28's roommate. R28's meal was still covered with the lids on. At 8:33 a.m., R28's breakfast was still covered and R28's eyes were closed. At 8:35 a.m., nursing assistant (NA)-D went to the closet and R28's roommate told NA-D to get out and NA-D turned the light off and did not come to assist R28. At 8:42 a.m., an unknown staff person entered the room checked on R28 and stated R28 was snoozing and did not try to assist with setting up breakfast and did not try to offer food and left the room. At 8:43 a.m., NA-D entered the room and tried to wake R28 and told R28 her breakfast was in front of her. NA-D did not offer to get R28 up. NA-D took the cover off the plate and R28 had oatmeal and a muffin and assisted to take off the liquid covers. NA-D gave R28 a bite of oatmeal and R28 stated it was yummy. NA-D asked R28 if she wanted her head of the bed elevated but did not elevate the bed more and left the room. NA-D did not cut up the egg. At 8:47 a.m., R28 put a spoon in the

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F 677	Continued From page 13 oatmeal and then closed her eyes and her spoon dropped into her bowl of oatmeal and did not attempt to further feed herself. NA-D returned to R28's room at 9:00 a.m., and asked if R28 had finished eating and began feeding R28. NA-D took a spoon and a fork and cut up the egg and gave R28 a bite of eggs. NA-D stated R28 ate breakfast in bed and went out for lunch because R28 had pain in her legs and further stated someone should always be with R28 because R28 may choke and stated R28 did not need help to eat and ate well when fully awake and further stated if residents refused cares they reapproached residents and added she never approaches R28 because R28 eats and sleeps at the same time and was wasting her time reapproaching R28. At 9:13 a.m., R28 closed eyes, but reopened them when NA-D assisted with feeding and readily accepted breakfast. At 9:18 a.m., R28 pointed to her oatmeal for a bite and required assistance with eating the entire time. By 9:21 a.m., R28 ate approximately 50% and drank most of her milk and half of her orange juice. At 9:28 a.m., R28 stated she was all done and NA-D stated R28 ate 80% of her meal. During interview on 4/9/25 at 9:33 a.m., licensed practical nurse (LPN)-A stated R28 had to get up in order to encourage her to eat and stated R28 does refuse in the mornings and will sometimes help herself eat in bed but was more likely to eat when sitting up in the chair and expected staff to offer to get R28 up. LPN-A stated if R28 doesn't eat in the dining room, dietary staff deliver meals to the room and added R28 didn't need help but lacked motivation in bed and did not need physical help to eat and further stated if R28 was not eating it was not acceptable for a meal to be left for 40 plus minutes and the dietary aides	F 677		

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F 677	Continued From page 14 should remove covers and place drinks close to residents and alert them their food was there and if unable to alert the resident, should place the tray back on the cart and update nursing. LPN-A verified R28 had an order to be up in the dining room for meals, but did not know why R28 had to be in the dining room. During interview on 4/9/25 at 9:42 a.m., the director of nursing (DON) reviewed R28's order that R28 had to be up in the chair and stated she recalled stuff happening with R28. The DON stated she had conversations with a family member and R28 needed to come out to meals because she was not eating as much in bed and added if R28 declined staff should reapproach and added it was the dietary department's responsibility to help with setting up trays and stated she completed education R28 needed to be upright and to follow the meal ticket. LPN-A stated R28 could eat on her own after meal set up but that was with items within reach and the covers off. The DON stated that was why R28 ate in the dining room because she ate better and thrived on stimulation. Further, the DON stated R28 needed encouragement and expected staff to offer to get up and verified the care sheet lacked information to get R28 up and stated it would be helpful to the aides to have the information on the care sheet. During observation on 4/10/25 at 8:23 a.m., R28 was in bed and her meal appeared untouched. R28 had biscuits and gravy that had not been cut up and a bowl that looked like malt o meal cereal. At 8:25 a.m., NA-D came in the room and asked R28 if it was time to get up and R28 dipped her knife in the bowl and took a bite of the cereal with her knife. At 8:27 a.m., NA-D told R28 she	F 677		

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F 677	Continued From page 15 wanted to help her to eat, and readily accepted help and NA-D gave R28 a bite of biscuits and gravy and R28 stated it was cold. NA-D asked if she could reheat the plate and R28 started speaking nonsensically and NA-D gave R28 another bite of the biscuits and R28 furrowed her eyebrows and stated it was cold and NA-D gave R28 another bite of biscuits and R28 started speaking nonsensically. NA-D did not know how long R28's meal had been in the room because she was assisting another resident and added the kitchen delivered the meals and does not inform staff working and further stated R28 had a disability, and somebody needed to assist R28 to eat. A policy on ADLs was requested, however the interim executive director sent an email on 4/10/25 at 10:44 a.m., they did not have a policy related to aide or staff responsibilities regarding assistance with nails, shaving, or meal assistance.	F 677		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757		5/27/25

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F 757	Continued From page 16 use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure an antibiotic ointment was still necessary for 1 of 1 residents (R75) reviewed for antibiotic use. Findings include: R75's admission Minimum Data Set (MDS) dated indicated R75 had severe cognitive impairment and diagnoses of dementia and heart failure. R75's provider order dated 3/1/25, indicated R75 required bacitracin external ointment 500 units/gram (antibiotic ointment) applied to foreskin topically every day and evening for 7 days and then daily for foreskin care. The order lacked an end date. R75's Treatment Administration Record (TAR) dated 3/1/2025-4/8/2025 indicated R75 had received the bacitracin ointment as ordered. R75's interdisciplinary team (IDT) progress note dated 3/1/25 at 8:08 a.m., R75 had a small amount of blood in brief. R75 stated their foreskin gets stuck at times and they pulled on it to get it back up. The provider was notified and an order for bacitracin twice daily for 7 days and	F 757	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Resident R75 is currently residing in the facility. The medication in review has been discontinued by the physician. The facility has determined that all residents receiving the prescribed drug have the potential to be affected. There are no residents receiving this medication actively. A review of all medication orders and indications for use, was completed on 4/24/2025. All licensed nursing staff will be in serviced regarding Unnecessary Drugs. Education will be provided that antibiotics	

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F 757	Continued From page 17 then daily was received. R75's electronic medical record (EMR) lacked indication monitoring of R75's foreskin occurred between 3/15/25- 4/9/25, to ensure R75's bacitracin was still needed. The facilities 3/2025- 4/2025 antibiotic tracker and skin tracking log was requested and was not received. However, an email communication dated 4/10/25, verified R75 was not listed on the antibiotic and skin tracking log. When interviewed on 4/9/25 at 11:28 a.m., registered nurse (RN)-A stated residents who were on antibiotics would have their vital signs monitored and any assessments related to why they were on antibiotics. RN-A further stated there was no specific order or note template used. RN-A verified R75's order for bacitracin had no end date. RN-A was not aware of any infection or skin concerns with the foreskin and did not know why R75 required the bacitracin daily. When interviewed on 4/10/25 at 10:37 a.m., the clinical pharmacist stated all antibiotics were reviewed during monthly medication reviews, including topical antibiotics. The CP verified R75's order for bacitracin had no end date. CP stated the facility monitored the conditions for any topical antibiotics and would discontinue the antibiotic when it was no longer needed. When interviewed on 4/10/25 at 11:28 a.m., the Director of Nursing (DON) who was also the Infection Preventionist verified there was no end date for R75's topical antibiotic and believed since it was recently changed to an as needed	F 757	warrant an indication of infection. Director of Nursing/designee will audit all topical antibiotic medications weekly for 4 weeks, then monthly x 1. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Completion Date: 5/27/25	

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F 757	Continued From page 18 medication on 4/9/25, it was monitored. The DON needed to follow up with the provider and determine what the order was and should be. A follow up interview on 4/10/25 at 11:35 a.m., the DON verified R75 was not on the facilities antibiotic tracker as bacitracin did not require a 72-hour time out. DON stated any topical antibiotics required actual monitoring of their condition that required the topical ointment and this was tracked separately. When the skin condition resolved, the antibiotic should be discontinued. The DON verified R75 was not tracked on their skin tracker and verified the bath audits since 3/14/25 did not mention any concerns with R75's foreskin. The DON further acknowledged R75's skin condition was not being tracked or monitored and R75 was potentially receiving the Bacitracin unnecessarily. A facility policy titled Antibiotic Stewardship revised 6/2021, directed staff to ensure optimal antibiotic therapy included the recommended duration of the therapy. Furthermore the policy directed all providers to follow the 5 D's of basic antimicrobial stewardship practices which include duration of use.	F 757		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance;	F 803		5/27/25

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F 803	Continued From page 19 §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure preferences for drinks and food choices was followed for 2 of 2 residents (R38, R75) reviewed for food choices. Findings include: R38's admission Minimum Data Set (MDS) dated 2/22/25 indicated R38 was cognitively intact with diagnoses of diabetes. R38's care plan revised 2/22/25, indicated R38 had a potential nutritional problem related to acute gallbladder infection. Interventions included review food preferences with resident and family. R38's meal ticket dated 4/8/25, indicated R38 wanted milk.	F 803	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Residents R38 and R75 preferences for food and drink have been transcribed on meal order tickets. New preferences were assessed for R38 & R75 and shown to be reflected on meal tickets.	

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F 803	Continued From page 20 R38's meal ticket dated 4/9/25 was requested however was not received. An interview on 4/7/25 at 1:09 p.m., R38 stated staff give items someone with diabetes shouldn't have. R38 stated they always get juice with breakfast and has told them she prefers milk, tea or coffee. The juice causes blood sugar to elevate. R38 further stated she had talked to the registered dietician (RD) but still gets the wrong items. An observation on 4/8/25 at 8:11 a.m., R38 was sitting up for breakfast. R38 had oatmeal. On the tray was a glass of apple juice. Review of R38's meal ticket indicated milk should have been served. An interview on 4/9/24 at 8:25 a.m., R38 was sitting up at bedside for breakfast. R38 had a muffin, a hard-boiled egg and no coffee on their breakfast tray. R38 was upset and stated I talked to the RD yesterday and I was supposed to get fried eggs, toast, and coffee. This was not what I wanted and not what I requested. R38's breakfast meal ticket stated muffin and hard-boiled egg. R75's admission MDS dated indicated R75 had severe cognitive impairment and diagnoses of dementia and heart failure. R75's care plan revised 2/24/25, indicated R75 had a nutritional problem related to heart failure and weakness. Interventions included for meals to be served as ordered and to review preferences with resident/family.	F 803	All residents have the potential to be affected. All residents were interviewed to obtain food preferences. Preferences were then transcribed to meal tickets. Education provided to all staff on understanding the importance of accurately honoring resident food and drink preferences, meal tray, and ticket accuracy. Dietician and/or designee to audit 4 resident meal tickets for preferences & accuracy a week for 3 weeks, 2x a week for 2 weeks. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Completion Date: 5/27/25	

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	245200	A. BUILDING _____ B. WING _____	C 04/10/2025

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F 803	Continued From page 21	F 803		

R75's meal ticket dated 4/8/25, indicated R75 wanted decaf coffee at all meals.
An observation on 4/8/25 at 8:15 a.m., R75 was sitting on their bed with the bedside table in front of them eating breakfast. R75's meal ticket indicated "Decaf coffee at all meals". R75's breakfast tray did not contain coffee. R75 stated "I guess I didn't get any".

An observation on 4/8/25 at 12:29 p.m., R75's lunch was delivered. R75 was seated up in their wheelchair. R75's meal ticket indicated "decaf coffee at all meals". Registered nurse (RN)-A verified R75's lunch did not have coffee and R75 stated "I like coffee".

An interview on 4/9/25 at 8:30 a.m., the registered dietician (RD) stated when residents were admitted and at least quarterly, residents were assessed for food and drink preferences. RD stated I discussed food preferences yesterday and R38's breakfast ticket was updated to fried eggs, toast and coffee. RD verified R38's ticket did not have the correct items listed for breakfast and further stated they were not sure how an old ticket was provided. RD expected residents to get the items matched on their meal ticket.

When interviewed on 4/9/25 at 8:36 a.m. dietary aide (DA) stated meal tickets were printed each day around 11:00 a.m. for the next day. DA further stated if RD made any changes after that time, either the RD would need to print a new ticket or communicate to the dietary staff what the change was.

When interviewed on 4/10/25 at 11:20 a.m., the Administrator expected the RD to meet with

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F 803	Continued From page 22 residents upon admission and as needed to review meal preferences. Furthermore, resident meal preferences should be on the meal tickets and served as written. A facility policy for food choices was requested however was not received.	F 803		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure an antibiotic was monitored, tracked and had an end date for 1 of 1 residents (R75) who was prescribed a topical antibiotic. Findings include: R75's admission Minimum Data Set (MDS) dated indicated R75 had severe cognitive impairment and diagnoses of dementia and heart failure. R75's interdisciplinary team (IDT) progress note dated 3/1/25 at 8:08 a.m., R75 had a small amount of blood in brief. R75 stated their foreskin gets stuck at times and they pulled on it to get it back up. The provider was notified and an order for bacitracin twice daily for 7 days and	F 881	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Resident R75 still resides in the facility. The antibiotic topical has been reviewed and discontinued per orders.	5/27/25

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F 881	Continued From page 23 then daily was received. R75's provider order dated 3/1/25, indicated R75 required bacitracin external ointment 500 units/gram (antibiotic ointment) applied to foreskin topically every day and evening for 7 days and then daily for foreskin care. The order lacked an end date. R75's Treatment Administration Record (TAR) dated 3/1/2025-4/8/2025 indicated R75 had received the bacitracin ointment as ordered. R75's electronic medical record (EMR) lacked indication monitoring of R75's foreskin occurred between 3/15/25- 4/9/25, to ensure R75's bacitracin was still needed. The facilities 3/2025- 4/2025 antibiotic tracker and skin tracking log was requested and was not received. However, an email communication dated 4/10/25, verified R75 was not listed on the antibiotic and skin tracking log. When interviewed on 4/9/25 at 11:28 a.m., registered nurse (RN)-A stated residents who were on antibiotics would have their vital signs monitored and any assessments related to why they were on antibiotics. RN-A further stated there was no specific order or note template used. RN-A verified R75's order for bacitracin had no end date. RN-A was not aware of any infection or skin concerns with the foreskin and did not know why R75 required the bacitracin daily. When interviewed on 4/10/25 at 10:37 a.m., the clinical pharmacist stated all antibiotics were	F 881	All residents receiving antibiotic topical medication have the potential to be affected. All residents with antibiotic medications were reviewed to ensure that antibiotic usage is tracked, monitored and with appropriate stop dates. Education provided to Infection Preventionist for appropriate tracking, usage and monitoring of antibiotic medications. Director of Nursing/designee to audit all antibiotic usage weekly for 4 weeks, then monthly x 1, to ensure that tracking, monitoring and appropriate stop dates are in place. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Completion Date: 5/27/25	

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F 881	Continued From page 24 reviewed during monthly medication reviews, including topical antibiotics. The CP verified R75's order for bacitracin had no end date. CP stated the facility monitored the conditions for any topical antibiotics and would discontinue the antibiotic when it was no longer needed. The CP further stated if R75 was noted to be on it for a second monthly review, they would then notify the facility to determine if it was still required. When interviewed on 4/10/25 at 11:28 a.m., the Director of Nursing (DON) who was also the Infection Preventionist verified there was no end date for R75's topical antibiotic and believed since it was recently changed to an as needed medication on 4/9/25, it was monitored. The DON needed to follow up with the provider and determine what the order was and should be. A follow up interview on 4/10/25 at 11:35 a.m., the DON verified R75 was not on the facilities antibiotic tracker as bacitracin did not require a 72-hour time out. DON stated any topical antibiotics required actual monitoring of their condition that required the topical ointment and this was tracked separately. When the skin condition resolved, the antibiotic should be discontinued. The DON verified R75 was not tracked on their skin tracker and verified the bath audits since 3/14/25 did not mention any concerns with R75's foreskin. The DON further acknowledged R75's skin condition was not being tracked or monitored to ensure appropriate use and necessity of the bacitracin. A facility policy titled Antibiotic Stewardship revised 6/2021, directed all providers to follow the 5 D's of basic antimicrobial stewardship practices which include duration of use. Furthermore, the	F 881		

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F 881	Continued From page 25 policy directed staff to assess residents for the appropriateness of the antibiotic use and duration.	F 881		

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K 000	INITIAL COMMENTS Initial Comments Section FIRE SAFETY An annual Life Safety Code survey was conducted on 04/10/2025, 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/02/2025

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. 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.	K 000		

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K 000	Continued From page 2 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 100 beds and had a census of 75 at the time of the survey.	K 000		
K 222 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: 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	K 222		5/27/25

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K 222	Continued From page 3 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 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the delayed egress system per NFPA 101 (2012 edition), Life Safety Code	K 222	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	

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K 222	Continued From page 4 sections 19.2.1 and 7.2.1.6.1.1 (4). These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 04/10/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the exit door in the fireside room had a delayed egress system installed and did not have a sign saying "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 30 SECONDS" on it. An interview with the Administrator and the Director of Environmental Services verified these deficient findings at the time of discovery.	K 222	as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.) Corrective Action Taken A permanent sign was placed on the Fireside Room exit door stating: “PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 30 SECONDS.” 2.) Plan to Ensure Deficiency Does Not Recur Education was provided to the Environmental Services Director regarding signage requirements for egress doors. All facility egress doors were audited to ensure proper signage. 3.) Plan to Monitor Future Performance The Environmental Services Director and/or designee will audit all facility egress doors for proper signage once a month for three months to ensure ongoing compliance. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. 4.) Person Responsible Environmental Services Director and/or designee.	

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K 222	Continued From page 5	K 222	5.) Date of Compliance 5/27/25	
K 291 SS=D	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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 04/10/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the emergency light located in the laundry room was non-operational. An interview with the Administrator and the Environmental Services Director verified this deficient finding at the time of discovery.	K 291	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.) Corrective Action Taken In accordance with guidance from the fire marshal, the emergency light was removed from the laundry room, as it was determined to be unnecessary. 2.) Plan to Ensure Deficiency Does Not Recur Education was provided to the Environmental Services Director regarding emergency lighting requirements to ensure ongoing	5/27/25

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K 291	Continued From page 6	K 291	compliance. All emergency lighting was audited to ensure proper functioning 3.) Plan to Monitor Future Performance The Environmental Services Director and/or designee will audit the completion of emergency lighting testing utilizing the TELS system once a month for three consecutive months. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. 4.) Person Responsible Environmental Services Director and/or designee. 5.) Date of Compliance 5/27/25	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K 324		5/27/25

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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
K 324	Continued From page 7 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain commercial cooking equipment per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3, NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 10.2.6, and NFPA 17A (2009 edition), Wet Chemical Extinguishing Systems, section 4.3.1.5. This deficient finding could have a isolated impact on residents within the facility. Findings include: On 04/10/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the baffle filters within the kitchen hood was dislodged allowing grease into the duct work. An interview with the Administrator and The Environmental Services Director verified this deficient finding at the time of discovery.	K 324	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.) Corrective Action Taken Baffle filters were replaced to ensure a proper fit within the kitchen hood, preventing grease from entering the ductwork. 2.) Plan to Ensure Deficiency Does Not Recur Education was provided to Environmental Services Director regarding standard ventilation control and fire protection	

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	245200	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/10/2025**

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K 324	Continued From page 8	K 324	requirements for commercial cooking operations, including wet chemical systems. 3.) Plan to Monitor Future Performance The Environmental Services Director and/or designee will audit the proper fitting of baffle filters once a week for 3 months to ensure ongoing compliance. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. 4.) Person Responsible Environmental Services Director and/or designee. 5.) Date of Compliance 5/27/25	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission	K 341		5/27/25

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K 341	Continued From page 9 paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install smoke detectors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm Code, section 17.7.4.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 04/10/2025 between 9:00 AM and 12:00 PM, it was revealed by observation a smoke detector on the first floor near room 153 was within 36" of the HVAC supply, which is close enough for airflow to prevent operation. An interview with the Administrator and the Director of Environmental Services verified these deficient findings at the time of discovery.	K 341	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.) Corrective Action Taken Smoke detector was moved at greater than 36 inches away from HVAC supply. 2.) Plan to Ensure Deficiency Does Not Reoccur Education was provided to the Environmental Services Director regarding appropriate placement of smoke detectors near air intake systems. 3.) Plans to Monitor Future Performance The Environmental Services Director and/or designee will audit smoke detector placement 2x a month for 3 months.	

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K 341	Continued From page 10	K 341	Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. 4.) Who is Responsible Environmental Services Director and/or designee. 5.) Date Certain 5/27/25	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353		5/27/25

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K 353	Continued From page 11 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 04/10/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that there were wires resting on the sprinkler pipe above the ceiling near the first-floor dining room. 2. On 04/10/2025 between 9:00 AM and 12:00 PM, it was revealed by observation on the second floor near the elevator there was paint covering a portion of the sprinkler head. 3. On 04/10/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that there are missing ceiling tiles in the kitchen room. An interview with the Administrator and the Director of Environmental Services and verified this deficient finding at the time of discovery.	K 353	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.) Corrective Action Taken Ceiling wires were relocated to avoid interference with sprinkler piping. The identified sprinkler head was serviced on the second floor, and ceiling tiles were installed in the identified kitchen area. 2.) Plan to Ensure Deficiency Does Not Reoccur Education was provided to the Environmental Services Director regarding sprinkler system maintenance and testing. Including but not limited to interference, debris, and ceiling coverage. 3.) Plans to Monitor Future Performance The Environmental Services Director and/or designee will audit sprinkler system	

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K 353	Continued From page 12	K 353	to ensure freedom from interference, debris, and proper ceiling coverage. Occurring twice monthly for 3 months. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. 4.) Who is Responsible Environmental Services Director and/or designee. 5.) Date Certain 5/27/25	
K 363 SS=D	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 complying with 7.2.1.9 are permissible if provided	K 363		5/27/25

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K 363	Continued From page 13 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: 1. On 04/10/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the door to room 142 would not positively latch. 2. On 04/10/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the emergency exit door near the chapel would not positively latch.	K 363	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.) Corrective Action Taken The strike plate on the door frame of room 142 was adjusted to allow the door	

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K 363	Continued From page 14 An interview with the Administrator and the Environmental Services Director verified this deficient finding at the time of discovery.	K 363	to latch properly. The exit door near chapel door latching mechanism was serviced to allow for proper latching to occur. 2.) Plan to Ensure Deficiency Does Not Reoccur Education was provided to the Environmental Services Director regarding proper door latching requirements. 3.) Plans to Monitor Future Performance Environmental Services Director and/or designee will audit proper door latching 2x a month for 3 months to ensure positively latching doors. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. 4.) Who is Responsible Environmental Services Director and/or designee. 5.) Date Certain 5/27/25	