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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: E5F6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00853

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245200**

2.STATE VENDOR OR MEDICAID NO.
(L2) **250053000**

3. NAME AND ADDRESS OF FACILITY
(L3) **BIRCHWOOD HEALTH CARE CENTER**
(L4) **604 - 1ST STREET NE**
(L5) **FOREST LAKE, MN** (L6) **55025**

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) **05/01/2007**

6. DATE OF SURVEY **05/15/2015** (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)
09/30

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

12.Total Facility Beds **110** (L18)

13.Total Certified Beds **110** (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
	110			
(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 :
Gloria Derfus, Unit Supervisor 05/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 05/29/2015 (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
12/01/1974
(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.
03001
(L31)

30. REMARKS
Posted 06/09/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/11/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245200
May 29, 2015

Mr. Brian Pattock, Administrator
Birchwood Health Care Center
604 - First Street Northeast
Forest Lake, Minnesota 55025

Dear Mr. Pattock:

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 May 12, 2015 the above facility is certified for or recommended for:

110 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 110 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 29, 2015

Mr. Brian Pattock, Administrator
Birchwood Health Care Center
604 - First Street Northeast
Forest Lake, Minnesota 55025

RE: Project Number S5200025

Dear Mr. Pattock:

On April 17, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 2, 2015 that included an investigation of complaint number H5200034. This survey found the most serious deficiencies 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) whereby corrections were required.

On May 15, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction, on April 1, 2015 the Minnesota Department of Public Safety completed a PCR, and on May 26, 2015 the Minnesota Department of Health, Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 2, 2015 and a partial extended survey completed April 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 2, 2015, effective May 12, 2015 and therefore remedies outlined in our letter to you dated April 17, 2015, will not be imposed.

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.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245200	A. Building B. Wing	5/15/2015

Name of Facility	Street Address, City, State, Zip Code
BIRCHWOOD HEALTH CARE CENTER	604 - 1ST STREET NE FOREST LAKE, MN 55025

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **05/12/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **05/12/2015**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **05/12/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/12/2015**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **05/12/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/KJ	05/29/2015	18623	5/15/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/2/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245200	A. Building: 01 - MAIN BUILDING 01 B. Wing	5/28/2015

Name of Facility	Street Address, City, State, Zip Code
BIRCHWOOD HEALTH CARE CENTER	604 - 1ST STREET NE FOREST LAKE, MN 55025

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	04/22/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	05/29/2015	12424	05/28/2015
CMS RO				

Followup to Survey Completed on: 4/1/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E5F6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00853

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245200**
2.STATE VENDOR OR MEDICAID NO.
(L2) **250053000**

3. NAME AND ADDRESS OF FACILITY
(L3) **BIRCHWOOD HEALTH CARE CENTER**
(L4) **604 - 1ST STREET NE**
(L5) **FOREST LAKE, MN** (L6) **55025**

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) **05/01/2007**

6. DATE OF SURVEY **04/02/2015** (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)
09/30

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

12.Total Facility Beds **110** (L18)

13.Total Certified Beds **110** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: **X**
* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(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 :
Becky Wong, HFE NE II 04/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/08/2015 (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)

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
12/01/1974
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 17, 2015

Mr. Brian Pattock, Administrator
Birchwood Health Care Center
604 - 1st Street NE
Forest Lake, Minnesota 55025

RE: Project Number S5200025

Dear Mr. Pattock:

On April 2, 2015, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 12, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved

in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 2, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 2, 2015 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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 _____	04/02/2015

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
F 000	INITIAL COMMENTS 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		5/12/15

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

Electronically Signed | 04/29/2015

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.

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 _____	04/02/2015

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
F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to report an allegation of abuse to the Minnesota Department of Health (MDH), and failed to protect the resident during the investigation for 1 of 1 resident (R74) reviewed for abuse. Findings include: Facility failed to protect resident (R74) during investigation of abuse and to report it to the MDH. On 3/30/15, at 3:57 p.m. during a stage one interview, when asked if staff, a resident or anyone else had abused you, R74 stated "This happened last spring, perhaps May. When she was on West station, the nurse pulled her left arm when trying to get her up from chair. Resident stated she was sedated and her arm had been hurting worse since then. That nurse was on West station; her name was (identified nurse by name) registered nurse (RN)-B. She did report it	F 225	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. With respect to the identified resident (#74), the incident has been reported and investigation submitted via the MDH on-line reporting system. 2. The previous 3 months Feedback Forms have been reviewed for any allegations of potential abuse and reported. Reports were reviewed and re-investigated as indicated.	

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F 225	Continued From page 2 to head nurse in this department, RN-A. "R74 was told by RN-A it was investigated but not told anything further. The facility's quality improvement input form dated 6/4/14 revealed R74 stated "I don't feel safe with her here RN-B. I'm afraid of her and what she could do." Care plan dated 4/28/14, indicated R74 considered vulnerable adult related to recent falls, congestive heart failure (CHF), arthritis, able to make needs known with goal of no episodes of maltreatment or abuse and interventions to investigate suspicions of abuse and report as necessary, offer cues and reminders, remove physically from potentially harmful situations while reassuring mentally, resident screening for vulnerable adult (VA) at admission and quarterly/significant changes, staff education in VA, staff, resident, and family education abuse prevention. The care plan also indicated R74's mood/behavior related to anxiety and depression, long psych history per nurse practitioner (NP), takes psychotropic medications, can have multiple complaints, goal to have improved mood state as evidenced being happier, calmer appearance, with interventions to administer meds as ordered, assist to identify strengths, behavioral health consult as needed, encourage activities, encourage/assist independence, observe mood patterns and document. R74's quarterly Minimum Data Set (MDS) dated 1/1/15, indicated R74 had intact cognition, and required limited assistance with dressing and personal hygiene. The MDS included diagnoses of cerebrovascular accident (CVA), non-Alzheimer's dementia, anxiety disorder and depression.	F 225	3. All leadership will receive education regarding Birchwood Care Center□s Vulnerable Adult Policy, including: a. Definitions of types of abuse and neglect. b. The facility□s internal reporting procedures. c. Individual□s responsibilities for internal reporting per the Vulnerable Adult Policy. d. The facility□s external reporting procedure. e. Procedure to assure safety of the resident during an investigation 4. The Administrator, and/or designee will audit two resident Feedback Forms each week for one month and then one Feedback form each week for two months to assure proper identification, investigation, resident safety, notification and documentation is completed. 5. The data collected will be presented to the QA committee by the Executive Director or designee. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies.	

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F 225	Continued From page 3 A review of RN-B's timesheet revealed that RN-B was not suspended from work during review of the alleged abuse allegation. Review of RN-B's timesheets revealed RN-B worked on 6/5/14, and 6/6/14, while the investigation was still ongoing. On 4/1/15, at 12:44 p.m. interview was completed with facility's executive director (ED) and director of nursing (DON). DON was asked why incident that occurred with R74 the end of April or beginning of May was not reported until 6/4/14. DON stated it was reported 6/4/14 to RN-D. When asked if it was reported to the State, DON stated it was not. DON was asked if the RN had been suspended during the investigation. The DON stated she believed RN was not on the schedule and was not suspended because she was not working. DON indicated there probably was documentation in the employee file, and if not, she would provide the schedule. The DON stated at that time two staff were to be present to provide cares. On 4/2/15, at 1:22 p.m. when asked had RN-B provided cares for R74 since incident, DON stated RN-B had never done cares since, cares were changed to have two people in the room and the other night nurse was covering for RN-B. RN-B does not work on the West unit. At time of the incident told RN-B to not go back in R74's room, had other West nurse cover. R74 had since moved and changed to Long Term Care unit. The facility's Vulnerable Adult Abuse/Neglect Prevention Policy and Procedure dated 12/30/13, indicated: "The Administrator, Director of Nursing or their designee shall notify the MN Department of Health via the On-Line Reporting System....	F 225		

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F 225	Continued From page 4 The individual identified as suspected for abuse/neglect will be removed from the situation. If the individual is an employee, they will be suspended pending the completion and outcome of the investigation."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to implement their abuse policy, did not report allegation of abuse to the state agency, and failed to protect the resident until the investigation for allegation of abuse was completed for 1 of 1 residents (R74) reviewed. In addition, the facility failed to obtain reference checks prior to hire for 2 of 5 employees (E-1, E-5). Findings include: Facility failed to protect resident (R74) during investigation of abuse and to report it to the MDH. The facility's Vulnerable Adult Abuse/Neglect Prevention Policy and Procedure dated 12/30/13, indicated: "The Administrator, Director of Nursing or their designee shall notify the MN Department of Health via the On-Line Reporting System.... The individual identified as suspected for	F 226	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. With respect to the identified resident (#74), the incident has been reported and investigation submitted via the MDH on-line reporting system. 2. The previous 3 months Feedback Forms have been reviewed for any allegations of potential abuse and reported. Reports were reviewed and re-investigated as indicated.	5/12/15

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F 226	Continued From page 5 abuse/neglect will be removed from the situation. If the individual is an employee, they will be suspended pending the completion and outcome of the investigation." On 3/30/15, at 3:57 p.m. during a stage one interview, when asked if staff, a resident or anyone else had abused you, R74 stated "This happened last spring, perhaps May. When she was on West station, the nurse pulled her left arm when trying to get her up from chair. Resident stated she was sedated and her arm had been hurting worse since then. That nurse was on West station; her name was (identified nurse by name) registered nurse (RN)-B. She did report it to head nurse in this department, RN-A. "R74 was told by RN-A it was investigated but not told anything further. The facility's quality improvement input form dated 6/4/14 revealed R74 stated "I don't feel safe with her here RN-B. I'm afraid of her and what she could do." Care plan dated 4/28/14, indicated R74 considered vulnerable adult related to recent falls, congestive heart failure (CHF), arthritis, able to make needs known with goal of no episodes of maltreatment or abuse and interventions to investigate suspicions of abuse and report as necessary, offer cues and reminders, remove physically from potentially harmful situations while reassuring mentally, resident screening for vulnerable adult (VA) at admission and quarterly/significant changes, staff education in VA, staff, resident, and family education abuse prevention. The care plan also indicated R74's mood/behavior related to anxiety and depression, long psych history per nurse practitioner (NP), takes psychotropic medications, can have multiple complaints, goal to have improved mood	F 226	3. All leadership will receive education regarding Birchwood Care Center□s Vulnerable Adult Policy, including: a. Definitions of types of abuse and neglect. b. The facility□s internal reporting procedures. c. Individual□s responsibilities for internal reporting per the Vulnerable Adult Policy. d. The facility□s external reporting procedure. e. Procedure to assure safety of the resident during an investigation 4. The Administrator, and/or designee will audit two resident Feedback Forms each week for one month and then one Feedback form each week for two months to assure proper identification, investigation, resident safety, notification and documentation is completed. 5. The data collected will be presented to the QA committee by the Executive Director or designee. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies.	

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F 226	Continued From page 6	F 226		

state as evidenced being happier, calmer appearance, with interventions to administer meds as ordered, assist to identify strengths, behavioral health consult as needed, encourage activities, encourage/assist independence, observe mood patterns and document.

R74's quarterly Minimum Data Set (MDS) dated 1/1/15, indicated R74 had intact cognition, and required limited assistance with dressing and personal hygiene. The MDS included diagnoses of cerebrovascular accident (CVA), non-Alzheimer's dementia, anxiety disorder and depression.

A review of RN-B's timesheet revealed that RN-B was not suspended from work during review of the alleged abuse allegation. Review of RN-B's timesheets revealed RN-B worked on 6/5/14, and 6/6/14, while the investigation was still ongoing.

On 4/1/15, at 12:44 p.m. interview was completed with facility's executive director (ED) and director of nursing (DON). DON was asked why incident that occurred with R74 the end of April or beginning of May was not reported until 6/4/14. DON stated it was reported 6/4/14 to RN-D. When asked if it was reported to the State, DON stated it was not. DON was asked if the RN had been suspended during the investigation. The DON stated she believed RN was not on the schedule and was not suspended because she was not working. DON indicated there probably was documentation in the employee file, and if not, she would provide the schedule. The DON stated at that time two staff were to be present to provide cares.

On 4/2/15, at 1:22 p.m. when asked had RN-B

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F 226	Continued From page 7 provided cares for R74 since incident, DON stated RN-B had never done cares since, cares were changed to have two people in the room and the other night nurse was covering for RN-B. RN-B does not work on the West unit. At time of the incident told RN-B to not go back in R74's room, had other West nurse cover. R74 had since moved and changed to Long Term Care unit. Reference checks: The facility's Vulnerable Adult Abuse/Neglect Prevention Policy and Procedure dated 12/30/13, indicated: ..."Submitting the Report: Internal Reporting Procedure 1. During the shift that the alleged abuse/neglect or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their Supervisor, after securing the resident's safety. Following the review of the situation, the Supervisor will immediately report to the Administrator and the Director of Nursing. 2. Upon report to a Supervisor of the suspected abuse, the employee in question will be interviewed, re-assigned duties, placed under the direct supervision of a licensed nurse, assigned to non-resident related tasks or suspended pending investigation. This is for the protection of the resident. 3. The Supervisor, Director of Nursing or Administrator will immediately institute an internal investigation of the reported allegation or incident. 4. The Administrator or Director of Nursing shall determine if the incident/allegation meets the criteria for "Reportable Incident". All incidents deemed reportable under MN statute are called to CEP. All incidents deemed reportable are submitted to MDH via the on-line Reporting System immediately (as soon as possible). External Reporting Procedure 1. The	F 226		

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F 226	Continued From page 8	F 226		

Administrator, Director of Nursing or their designee shall notify the MN Department of Health via the On-Line Reporting System. 2. The Administrator or Director of Nursing or their designee shall notify or fax the Common Entry Point to relay the report. Protection 1. The individual identified as suspected for abuse/neglect will be removed from the situation. If the individual is an employee, they will be suspended pending the completion and outcome of the investigation."

E1 certified nursing assistant (CNA), was hired 2/25/15, and the employee file lacked evidence of references checks. E1 had provided names of two other references, two CNAs and one veterinary hospital, and paperwork indicated the human resources (HR) representative had left one voicemail (VM) for each of the two CNA's, but had not attempted to contact any former employers. Telephone reference check form indicated: name of applicant E1, reference was contacted with notation on right side of page indicating left VM, with no additional information on the page. Reference was a "CNA/PTC". Telephone reference check form indicated: name of applicant E1, reference was contacted with notation on right side of page indicating left message (LM), with no additional information on the page. Upon review of E1's employee reference page, there were noted references of CNA, Animal Hospital, and CNA/PCA.

E5's was hired on 3/18/15, it was noted facility did not verify dates of employment with prior employer. Telephone reference check form indicated: name of applicant E5, person contacted was supervisor, prior company employer's name, and notation on right side of

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F 226	Continued From page 9 page indicated L/M 3/11/15, with no additional information on page, dates of hire were not verified by alleged former employer. On 4/1/15, at 2:30 p.m. when asked human resources manager-D stated had left message for E1's reference but could not force reference to call back. If employee had a background check, she felt that ensured more security. Reference checks were confidential to the employee, she did not want to call the employee back to say her reference did not answer the phone, it was too much information. She would get company and date information from the application, but keep it blank until she talked to the reference and then would fill in that information. She further stated some companies now do electronic checks where an employer lists dates and position only. When asked about E5's reference checks stated she left a message but never got a return response.	F 226		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating	F 322		5/12/15

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F 322	Continued From page 10 skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure services to prevent possible complications with the use of a gastrostomy tube for 1 of 1 resident (R123) who received medications through a gastric tube. Findings include: During observation of medication administration on 3/31/15, at 3:54 p.m. registered nurse (RN)-E was observed to prepare R123's medications as follows: Namenda (used for memory improvement) 5 milligrams (mg), Coumadin (blood thinner) 3.5 mg, multilex (vitamin supplement) 1 tablet, metoprolol (blood pressure medication) 25 mg, Tylenol (a mild analgesic) 1000 mg. RN-E crushed all the medications together, put the crushed medications in a small plastic cup with 60 milliliters (mls) of water, mixed the medications with the 60 ml water then administered the medications through the gastrostomy tube (g-tube). RN-E stated there was a doctor's order for "OK" to crush, mix and give R123's medications through the g-tube. R123's electronic Admission Record (AR) printed on 3/5/15, indicated R123 was admitted to facility on 5/20/13, with diagnoses including dysphagia (difficulty swallowing) due to cerebrovascular disease and esophageal reflux. The AR also	F 322	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. With respect to resident #123, the physician was notified of the standard or care for administering medications internally to be administered one at a time followed by water flushes. The physician order has been changed to allow for single medications administered via the gastric tube for administration followed by water flushes. 2. All residents who are receiving their medications via gastric tubes have been reviewed for single medication administration followed by water flushes to comply with the standard of practice. Orders have been changed when indicated. 3. All licensed staff will receive re-education regarding the standard of	

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F 322	Continued From page 11 indicated R123 had a g-tube in place. R123's care plan dated 11/23/13, indicated R123 required tube feeding related to swallowing problem. The care plan further indicated R123 was at risk for dislodgement of feeding tube related to (r/t) cognitive deficits. The written goals included R123 to remain free of side effects and complications r/t use of feeding tube. On 4/2/15, at 8:45 a.m. licensed practical nurse (LPN)-F stated when residents come to facility and they have medications to be administered through the g-tube, nurses would call the doctor or nurse practitioner (NP) to get an order for crushing and giving all the medications together, then staff would do as ordered. LPN-F stated ever since she had worked at the facility, the practice was to crush all medications together and give through the g-tube. During interview on 4/2/15, at 12:13 p.m., the consultant pharmacist (CP) stated that preparing medications separately and giving through the g-tube with flushes in between each medication is the "conventional way" that would be preferred, but its main purpose was to "save the g-tube from possible problems such as clogging." On 4/2/15, at 3:41 p.m. the director of nursing (DON) stated she expected staff to follow best practice guidelines related to medications administration through the g-tube, to include preparing medications separately and flushing in between each medication. The facility's Merwin LTC Pharmacy policy on Enteral Tube Medication Administration Procedure dated 4/20/12, directed staff to	F 322	practice for the administration of medications via enteral tube by 05/12/2015. 4. The Director of Nursing and/or designee will audit one medication pass via enteral tube each week for three months to assure standards of practice for medication administration are followed. 5. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies.	

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 _____	04/02/2015

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
F 322	Continued From page 12 "Administer each medication separately, flushing the tube with 5 cc of water after dose." In addition, the facility's Practice Guideline and Procedure: Enteral Tube Guidelines for Administering Fluids and Medications Through a G/J-Tube dated 3/12/14, provided that medications should be prepared separately and should not be mixed together. The procedure further outlined the medication administration as follows: "Instill 30cc [milliliter] of water, then the first medication, 15cc water, then second medication, 15cc water, third medication, etc. ..."	F 322		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431		5/12/15

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 _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 13 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure an expired insulin was not stored for use in 1 of 6 medication carts; did not ensure 4 of 6 medication carts were free from outdated creams and shampoo, and the facility did not ensure unlabeled medications were not stored in 2 of 6 medication carts. Findings include: West Unit Team 1 Medication Cart: On 4/2/15, at 2:15 p.m. the West Unit Team 1 medication cart was inspected with licensed practical nurse (LPN)-C, where a vial of Levemir insulin was found with an expiration date of 3/31/15. LPN-C verified the insulin bottle was the only supply available in the medication cart for R10. LPN-C checked the medication administration record and found that the expired Levemir insulin was still given on 4/1/15. LPN-C stated the expired Levemir insulin should have been discarded and not kept in the medication cart. In addition, the West Unit Team 1 medication cart also contained a jar of unlabeled nystatin	F 431	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. With respect to the identified medication; it was removed from medication storage and disposed of properly. 2. All medication storage areas have been inspected for proper compliance with handling, storage and dating of opened medications. All medications not in compliance have been disposed of according to facility protocol. 3. Processes have been developed for periodic inspection of the medication storage areas for cleanliness, proper storage and disposal. All licensed staff	

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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
F 431	Continued From page 14 triamcinolone acetonide cream which expired on 3/15; a container of Ammonium lactate for R112 had expiration label date that was unreadable. LPN-C stated the nystatin cream would have been used to any resident as it had no label, and since it was also expired, it should have been discarded. East Unit Team 3 Medication Cart: On 4/2/15, at 1:07 p.m. a bottle of milk of magnesia (laxative) for R3 which was expired on 12/14, was stored in the East Unit Tea 3 medication cart. LPN-B stated all nurses were expected to clean medication carts at the end of every shift, to include making sure that medications stored were not expired. East Unit Team 2 Medication Cart: On 4/2/15, at 1:15 p.m. a full container of Extra Protective Cream with expiration date of 11/2014 and an unlabeled bottle of Dandruff shampoo which expired in 2007 was stored in the East unit medication cart. East Unit Team 1 Medication Cart: On 4/2/15, at 1:20 p.m. a half full bottle of facility stock of Senna S (laxative) which expired in 3/15 remained in store for use at the East unit medication cart. During interview with on 4/2/15, at 3:41 p.m., the director of nursing (DON) stated her expectations that expired medications should not be stored in any of the facility's medication carts. The Medication Storage in the Facility (MFS) policy dated 4/20/12, provided that "outdated, contaminated or deteriorated" medications are immediately removed from stock. The MFS policy	F 431	and trained medication aids will receive education regarding medication expiration and storage guidelines by 05/12/2015. 4. The Director of Nursing and/or designee will audit three medication storage areas each week for one month and then two medication storage areas each week for two months to assure proper storage, dating and disposal of expired medications. 5. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 15 also provided that "medication storage areas should be kept clean."	F 431		
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to stop charging residents (R23, R143) for demand bills while decision was pending. In addition, the facility failed to submit an appeal request for 1 of 3 residents (R108) who appealed liability notice. Findings include: R23's family received a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) on 9/12/14, which indicated the last day of Medicare A covered services was 9/16/14. The SNFABN indicated R23's family requested to have the decision appealed to the Medicare A Contractor (MAC). R143's family received a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) on 11/10/14, which indicated the last day of Medicare A covered services was 11/13/14. The SNFABN indicated R143's family requested to have the decision appealed to the Medicare A contractor	F 492	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. With respect to resident #23 and #143, bills were reissued for the period in question while determinations made. In addition, an appeal was made on behalf of resident #108. Billing was stopped while a determination was made. 2. All residents who have requested an appeal have been reviewed to assure billing is on hold during an appeal. 3. A log will be maintained by the business office for all demand bills and will be	5/12/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH CARE CENTER	604 - 1ST STREET NE FOREST LAKE, MN 55025

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F 492	Continued From page 16 (MAC). R108's family received a Notice of Medicare Non-Coverage on 2/20/15, which indicated the last day of covered services was 2/23/15. The Notice of Medicare Non-Coverage indicated R108 requested to have the decision appealed to the American Association for Retired Persons (AARP). There was no indication the facility had submitted the appeal to AARP. On 4/2/15, at 2:00 p.m. Business Office Manager (Other-E) stated that the facility had not stopped "sending out statements" when demand bills or appeal had been requested, and the facility had received payment for R108's bill while they were in the appeal process.	F 492	referenced each month prior to billing to assure billing is on hold while determinations are made. 4. The Administrator and/or designee will audit Medicare Denials for 3 months to assure residents are not billed during periods while determinations are made. . 5. The data collected will be presented to the QA committee by the Administrator. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH CARE CENTER	**604 - 1ST STREET NE** **FOREST LAKE, MN 55025**

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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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Birchwood Health Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/27/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH CARE CENTER	**604 - 1ST STREET NE** **FOREST LAKE, MN 55025**

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K 000	Continued From page 1 Angela.Kappenman@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. Birchwood Health Care Center is a 2-story building with 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. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. 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 licensed capacity of 110 beds and had a census of 96 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		5/12/15

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	245200	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH CARE CENTER	**604 - 1ST STREET NE** **FOREST LAKE, MN 55025**

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K 029 SS=D	Continued From page 2 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 Findings include: On facility tour between 09:00 AM and 01:00 PM on 04/01/2015, it was observed that penetrations in the corridor wall around conduit and wires where the fire stopping has been removed or fallen out in the following areas: 1) Lower level Storage Room 017. 2) Lower level Storage Room 020. 3) Lower level General Storage Room 005. This deficiency was verified by the facility Environmental Service Director (SD) at the time of discovery.	K 029	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. On 4/22/2015, the Maintenance Director applied fire caulking and/or fire tape to the identified penetrations in the lower level storage rooms where the fire stopping had fallen out. To the lower level storage rooms to prevent penetration of the smoke barrier. 2. The Maintenance Director will do a facility walk through inspection monthly to identify any gaps or penetrations around	

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	245200	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/01/2015**

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K 029	Continued From page 3	K 029	conduit and wires. 3. All maintenance staff will be educated on the procedure and report for the walk through and the areas for inspection. 4. The Maintenance Director and/or designee will audit the Inspection report monthly for three months to assure completion of any identified areas needing repair. 5. The data collected will be presented to the QA committee by the Maintenance Director and/or designee. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies.	

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 17, 2015

Mr. Brian Pattock, Administrator
Birchwood Health Care Center
604 - 1st Street NE
Forest Lake, Minnesota 55025

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5200025

Dear Mr. Pattock:

The above facility was surveyed on March 30, 2015 through April 2, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 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. 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 after the statement, "This Rule 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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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 contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	04/02/2015

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) COMPLETE DATE
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 March 30, 2015 through April 2, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	04/02/2015

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2 000	Continued From page 1 federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and	2 930		5/12/15

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	00853	A. BUILDING: _____ B. WING _____	04/02/2015

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2 930	Continued From page 2 nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure services to prevent possible complications with the use of a gastrostomy tube for 1 of 1 resident (R123) who received medications through a gastric tube. Findings include: During observation of medication administration on 3/31/15, at 3:54 p.m. registered nurse (RN)-E was observed to prepare R123's medications as follows: Namenda (used for memory improvement) 5 milligrams (mg), Coumadin (blood thinner) 3.5 mg, multilex (vitamin supplement) 1 tablet, metoprolol (blood pressure medication) 25 mg, Tylenol (a mild analgesic) 1000 mg. RN-E crushed all the medications together, put the crushed medications in a small plastic cup with 60 milliliters (mls) of water, mixed the medications with the 60 ml water then administered the medications through the gastrostomy tube (g-tube). RN-E stated there was a doctor's order for "OK" to crush, mix and give R123's medications through the g-tube. R123's electronic Admission Record (AR) printed on 3/5/15, indicated R123 was admitted to facility on 5/20/13, with diagnoses including dysphagia (difficulty swallowing) due to cerebrovascular disease and esophageal reflux. The AR also indicated R123 had a g-tube in place.	2 930	5/12/2015	

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	00853	A. BUILDING: _____ B. WING _____	04/02/2015

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2 930	Continued From page 3 R123's care plan dated 11/23/13, indicated R123 required tube feeding related to swallowing problem. The care plan further indicated R123 was at risk for dislodgement of feeding tube related to (r/t) cognitive deficits. The written goals included R123 to remain free of side effects and complications r/t use feeding tube. On 4/2/15, at 8:45 a.m. licensed practical nurse (LPN)-F stated when residents come to facility and they have medications to be administered through the g-tube, nurses would call the doctor or nurse practitioner (NP) to get an order for crushing and giving all the medications together, then staff would do as ordered. LPN-F stated ever since she had worked at the facility, the practice was to crush all medications together and give through the g-tube. During interview on 4/2/15, at 12:13 p.m., the consultant pharmacist (CP) stated that preparing medications separately and giving through the g-tube with flushes in between each medication is the "conventional way" that would be preferred, but its main purpose was to "save the g-tube from possible problems such as clogging." On 4/2/15, at 3:41 p.m. the director of nursing (DON) stated she expected staff to follow best practice guidelines related to medications administration through the g-tube, to include preparing medications separately and flushing in between each medication. The facility's Merwin LTC Pharmacy policy on Enteral Tube Medication Administration Procedure dated 4/20/12, directed staff to "Administer each medication separately, flushing the tube with 5 cc of water after dose." In addition, the facility's Practice Guideline and	2 930		

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2 930	Continued From page 4 Procedure: Enteral Tube Guidelines for Administering Fluids and Medications Through a G/J-Tube dated 3/12/14, provided that medications should be prepared separately and should not be mixed together. The procedure further outlined the medication administration as follows: "Instill 30cc [milliliter] of water, then the first medication, 15cc water, then second medication, 15cc water, third medication, etc. ..." SUGGESTED METHOD OF CORRECTION: The DON can inservice all staff responsible for tube feedings medication administration to use accepted current practices. Also to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
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.	21426		5/12/15

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21426	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement a Tuberculin (TB) screening and prevention program for 4 of 5 residents (R95, R27, R8, R76) reviewed for TB prevention. The TB screening questionnaire should be used to determine the residents known history of TB, risk of acquiring TB, or adverse reactions to TB testing in the past. The screening is necessary to determine which TB testing should be completed for each individual resident. If appropriate the resident would then receive 1st step TST, which was measured 48 hours later to determine millimeters (mm) of induration (a hardness under the skin, the reaction), and then interpreted as either a positive or negative response to the TST. A 0 mm of induration would be interpreted as a negative TST. A 2nd step TST would be administered Findings include: R95 R95 was admitted to the facility on 1/31/15 for hospice care with admission diagnoses of encephalopathy, anxiety, ill defined cerebrovascular disease with palliative care. The Minimum Data Set (MDS) dated 2/6/15 indicated R95 has severe cognitive impairment and required extensive assist of two staff and mechanical lift for transfer and toileting.	21426	5/12/2015	

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21426	Continued From page 6 R95 received step 1 of the tuberculin skin test (TST) on 1/31/15, but was not screened to determine the appropriate test for TB until 2/3/15, three days after the 1st step dose was administered. R27 R27 was admitted to the facility on 12/23/14, with admission diagnoses of ill defined cerebrovascular disease, hemiplegia of the dominate side, rehabilitation needs. The MDS dated 3/18/15, indicated R27 had severe cognitive impairment and required extensive assist of two staff for transfer and toileting. R27 received step 1 of the tuberculin skin test (TST) on 12/23/14, but was not screened to determine the appropriate test for TB until 12/24/14, one day after the 1st step dose was administered. R8 R8 was admitted to the facility on 1/31/15, with admission diagnoses of multiple myeloma (cancer) and palliative care, and chronic kidney disease. The MDS dated 3/16/15, indicated R8 was cognitively intact, and required extensive assist of one staff for transfer and toileting. R8 received step 1 of the tuberculin skin test (TST) on 1/31/15, but was not screened to determine the appropriate test for TB until 2/2/15, two days after the 1st step dose was administered. In addition the chart lacked the required documentation of mm of induration for step 1 and step 2 of the TST test, and instead only recorded the interpretation of the test. R76 R76 was admitted to the facility 1/30/15, with	21426		

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21426	Continued From page 7 admission diagnoses of paranoid state, dementia and weakness; with a history of malignant neoplasm of larynx and lip (throat and lip cancer). The MDS dated 3/5/15, indicated mild cognitive impairment, and required extensive weight bearing assistance of one staff for transfer and toileting. R76 received step 1 of the tuberculin skin test (TST) on 1/30/15, but was not screened to determine the appropriate test for TB until 2/2/15, three days after the 1st step dose was administered. In addition the chart lacked the required documentation of mm of induration for step 1 and step 2 of the TST test, and instead only recorded the interpretation of the test. On 4/2/15, at 3:15 p.m. registered nurse (RN)-C will look for the missing documentation of TB screening, and will review the medication administration record to see if mm of induration were recorded there, but not transcribed into Point Click Care (PCC) electronic health record. -at 4:13 RN-C verified that the PCC charting did not always indicate mm of induration measured and interpretation (i.e. negative) as required, and that TB screening was not always competed prior to step 1 of the tuberculin skin test (TST), which should be completed to indicate if TST testing was needed, or chest x-ray should be done, or if the resident had an adverse reaction to TST testing in the past. The facility Tuberculosis Infection Control Plan Policy and Procedure indicated... Screening and Records - Resident a. Residents must receive baseline TB testing within 3 months prior to or 72 hours after admission. This TB screening will consist of 3 components:	21426		

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21426	Continued From page 8 i. Assessing for current symptoms of active TB disease, AND ii. Assessing the resident's risk factors for TB, AND iii. Testing for the presence of TB infection by administering either a two-step TST or a single TB blood test. SUGGESTED METHOD OF CORRECTION: The administrator could review and revise policies and procedures to ensure the Minnesota Department of Health Tuberculosis Prevention and Control Guidelines were followed. The administrator could complete and periodically review a tuberculosis risk assessment. The administrator could educate staff and monitor compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure an expired insulin was not stored for use in 1 of 6 medication carts; did not ensure 4 of 6 medication carts were free from outdated creams and shampoo, and the facility did not ensure unlabeled medications were not stored in 2 of 6 medication carts.	21610	5/12/2015	5/12/15

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21610	Continued From page 9 Findings include: West Unit Team 1 Medication Cart: On 4/2/15, at 2:15 p.m. the West Unit Team 1 medication cart was inspected with licensed practical nurse (LPN)-C, where a vial of Levemir insulin was found with an expiration date of 3/31/15. LPN-C verified the insulin bottle was the only supply available in the medication cart for R10. LPN-C checked the medication administration record and found that the expired Levemir insulin was still given on 4/1/15. LPN-C stated the expired Levemir insulin should have been discarded and not kept in the medication cart. In addition, the West Unit Team 1 medication cart also contained a jar of unlabeled Nystatin Triamcinolone acetonide cream which expired on 3/15; a container of Ammonium lactate for R112 had expiration label date that was unreadable. LPN-C stated the Nystatin cream would have been used to any resident as it had no label, and since it was also expired, it should have been discarded. East Unit Team 3 Medication Cart: On 4/2/15, at 1:07 p.m. a bottle of milk of magnesia (laxative) for R3 which was expired on 12/14, was stored in the East Unit Tea 3 medication cart. LPN-B stated all nurses were expected to clean medication carts at the end of every shift, to include making sure that medications stored were not expired. East Unit Team 2 Medication Cart: On 4/2/15, at 1:15 p.m. a full container of Extra Protective Cream with expiration date of 11/2014 and an unlabeled bottle of Dandruff shampoo	21610		

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21610	Continued From page 10 which expired in 2007 was stored in the East unit medication cart. East Unit Team 1 Medication Cart: On 4/2/15, at 1:20 p.m. a half full bottle of facility stock of Senna S (laxative) which expired in 3/15 remained in store for use at the East unit medication cart. During interview with on 4/2/15, at 3:41 p.m., the director of nursing (DON) stated her expectations that expired medications should not be stored in any of the facility's medication carts. The Medication Storage in the Facility (MFS) policy dated 4/20/12, provided that "outdated, contaminated or deteriorated" medications are immediately removed from stock. The MFS policy also provided that "medication storage areas should be kept clean." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to medication storage, for compliance with requirements. Pertinent employees could be re-educated on these policies. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being reviewed by the facility's Quality Assessment & Assurance committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21610		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults	21980		5/12/15

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21980	Continued From page 11 Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision	21980		

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21980	Continued From page 12 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, facility failed to implement their abuse policy, did not report allegation of abuse to the state agency, and failed to protect the resident until the investigation for allegation of abuse was completed for 1 of 1 residents (R74) reviewed. In addition, the facility failed to obtain reference checks prior to hire for 2 of 5 employees (E-1, E-5). Findings include: Facility failed to protect resident (R74) during investigation of abuse and to report it to the MDH. The facility's Vulnerable Adult Abuse/Neglect Prevention Policy and Procedure dated 12/30/13, indicated: "The Administrator, Director of Nursing or their designee shall notify the MN Department of Health via the On-Line Reporting System.... The individual identified as suspected for abuse/neglect will be removed from the situation. If the individual is an employee, they will be suspended pending the completion and outcome of the investigation." On 3/30/15, at 3:57 p.m. during a stage one interview, when asked if staff, a resident or	21980	5/12/2015	

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21980	Continued From page 13 anyone else had abused you, R74 stated "This happened last spring, perhaps May. When she was on West station, the nurse pulled her left arm when trying to get her up from chair. Resident stated she was sedated and her arm had been hurting worse since then. That nurse was on West station; her name was (identified nurse by name) registered nurse (RN)-B. She did report it to head nurse in this department, RN-A. "R74 was told by RN-A it was investigated but not told anything further. The facility's quality improvement input form dated 6/4/14 revealed R74 stated "I don't feel safe with her here RN-B. I'm afraid of her and what she could do." Care plan dated 4/28/14, indicated R74 considered vulnerable adult related to recent falls, congestive heart failure (CHF), arthritis, able to make needs known with goal of no episodes of maltreatment or abuse and interventions to investigate suspicions of abuse and report as necessary, offer cues and reminders, remove physically from potentially harmful situations while reassuring mentally, resident screening for vulnerable adult (VA) at admission and quarterly/significant changes, staff education in VA, staff, resident, and family education abuse prevention. The care plan also indicated R74's mood/behavior related to anxiety and depression, long psych history per nurse practitioner (NP), takes psychotropic medications, can have multiple complaints, goal to have improved mood state as evidenced being happier, calmer appearance, with interventions to administer meds as ordered, assist to identify strengths, behavioral health consult as needed, encourage activities, encourage/assist independence, observe mood patterns and document. R74's quarterly Minimum Data Set (MDS) dated	21980		

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21980	Continued From page 14 1/1/15, indicated R74 had intact cognition, and required limited assistance with dressing and personal hygiene. The MDS included diagnoses of cerebrovascular accident (CVA), non-Alzheimer's dementia, anxiety disorder and depression. A review of RN-B's timesheet revealed that RN-B was not suspended from work during review of the alleged abuse allegation. Review of RN-B's timesheets revealed RN-B worked on 6/5/14, and 6/6/14, while the investigation was still ongoing. On 4/1/15, at 12:44 p.m. interview was completed with facility's executive director (ED) and director of nursing (DON). DON was asked why incident that occurred with R74 the end of April or beginning of May was not reported until 6/4/14. DON stated it was reported 6/4/14 to RN-D. When asked if it was reported to the State, DON stated it was not. DON was asked if the RN had been suspended during the investigation. The DON stated she believed RN was not on the schedule and was not suspended because she was not working. DON indicated there probably was documentation in the employee file, and if not, she would provide the schedule. The DON stated at that time two staff were to be present to provide cares. On 4/2/15, at 1:22 p.m. when asked had RN-B provided cares for R74 since incident, DON stated RN-B had never done cares since, cares were changed to have two people in the room and the other night nurse was covering for RN-B. RN-B does not work on the West unit. At time of the incident told RN-B to not go back in R74's room, had other West nurse cover. R74 had since moved and changed to Long Term Care unit.	21980		

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21980	Continued From page 15 Reference checks: The facility's Vulnerable Adult Abuse/Neglect Prevention Policy and Procedure dated 12/30/13, indicated: ..."Submitting the Report: Internal Reporting Procedure 1. During the shift that the alleged abuse/neglect or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their Supervisor, after securing the resident's safety. Following the review of the situation, the Supervisor will immediately report to the Administrator and the Director of Nursing. 2. Upon report to a Supervisor of the suspected abuse, the employee in question will be interviewed, re-assigned duties, placed under the direct supervision of a licensed nurse, assigned to non-resident related tasks or suspended pending investigation. This is for the protection of the resident. 3. The Supervisor, Director of Nursing or Administrator will immediately institute an internal investigation of the reported allegation or incident. 4. The Administrator or Director of Nursing shall determine if the incident/allegation meets the criteria for "Reportable Incident". All incidents deemed reportable under MN statute are called to CEP. All incidents deemed reportable are submitted to MDH via the on-line Reporting System immediately (as soon as possible). External Reporting Procedure 1. The Administrator, Director of Nursing or their designee shall notify the MN Department of Health via the On-Line Reporting System. 2. The Administrator or Director of Nursing or their designee shall notify or fax the Common Entry Point to relay the report. Protection 1. The individual identified as suspected for abuse/neglect will be removed from the situation. If the individual is an employee, they will be suspended pending the completion and outcome	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	04/02/2015

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21980	Continued From page 16 of the investigation." E1 certified nursing assistant (CNA), was hired 2/25/15, and the employee file lacked evidence of references checks. E1 had provided names of two other references, two CNAs and one veterinary hospital, and paperwork indicated the human resources (HR) representative had left one voicemail (VM) for each of the two CNA's, but had not attempted to contact any former employers. Telephone reference check form indicated: name of applicant E1, reference was contacted with notation on right side of page indicating left VM, with no additional information on the page. Reference was a "CNA/PTC". Telephone reference check form indicated: name of applicant E1, reference was contacted with notation on right side of page indicating left message (LM), with no additional information on the page. Upon review of E1's employee reference page, there were noted references of CNA, Animal Hospital, and CNA/PCA. E5's was hired on 3/18/15, it was noted facility did not verify dates of employment with prior employer. Telephone reference check form indicated: name of applicant E5, person contacted was supervisor, prior company employer's name, and notation on right side of page indicated L/M 3/11/15, with no additional information on page, dates of hire were not verified by alleged former employer. On 4/1/15, at 2:30 p.m. when asked human resources manager-D stated had left message for E1's reference but could not force reference to call back. If employee had a background check, she felt that ensured more security. Reference checks were confidential to the employee, she did not want to call the employee back to say her	21980		

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21980	Continued From page 17 reference did not answer the phone, it was too much information. She would get company and date information from the application, but keep it blank until she talked to the reference and then would fill in that information. She further stated some companies now do electronic checks where an employer lists dates and position only. When asked about E5's reference checks stated she left a message but never got a return response. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to immediately reporting suspected abuse to the designated state agency/common entry point. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21980		