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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: GGXW
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 **07/12/2016** (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
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* 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 :
Gayle Lantto, Unit Supervisor 07/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 07/22/2016 (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 07/29/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **07/07/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245200
July 22, 2016

Ms. Amanda Gentilli, Administrator
Birchwood Health Care Center
604 First Street Northeast
Forest Lake, MN 55025

Dear Ms. Gentilli:

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 June 17, 2016 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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6214
July 22, 2016

Ms. Amanda Gentilli, Administrator
Birchwood Health Care Center
604 First Street Northeast
Forest Lake, MN 55025

RE: Project Number S5200026 & F5200024

Dear Ms. Gentilli:

On June 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 26, 2016 . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 12, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 18, 2016 the Minnesota Department of Public Safety 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 May 26, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 17, 2016 . Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 26, 2016, effective July 17, 2016 and therefore remedies outlined in our letter to you dated June 7, 2016, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245200	A. Building B. Wing	7/12/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0167 Reg. # 483.10(g)(1) LSC	Correction Completed 07/05/2016	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 07/05/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 07/05/2016
ID Prefix F0492 Reg. # 483.75(b) LSC	Correction Completed 07/05/2016	ID Prefix F0505 Reg. # 483.75(j)(2)(ii) LSC	Correction Completed 07/05/2016	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 STATE AGENCY ☐	REVIEWED BY (INITIALS) GL/KJ	DATE 07/22/2016	SIGNATURE OF SURVEYOR 15507	DATE 07/12/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/26/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245200	A. Building 01 - MAIN BUILDING 01 B. Wing	7/18/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 07/17/2016	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
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 07/22/2016	SIGNATURE OF SURVEYOR 15507	DATE 07/18/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH L&C 3201 **PLEASE DATE**

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Ms. Amanda Gentilli, Administrator
Birchwood Health Care Center
604 First Street NE
Forest Lake, MN 55025

9590 9403 0900 5223 2343 84

2. Article Number *(Transfer from service label)*

7015 0640 0003 5695 6214

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Megan Hayes. ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* Megan Hayes

C. Date of Delivery 1/27

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

S5200026 + F5200024 L+C

3. Service Type
- ☒ Adult Signature
- ☐ Adult Signature Restricted Delivery
- ☒ Certified Mail®
- ☐ Certified Mail Restricted Delivery
- ☐ Collect on Delivery
- ☐ Collect on Delivery Restricted Delivery
- Mail
- Mail Restricted Delivery
- ☐ Priority Mail Express®
- ☐ Registered Mail™
- ☐ Registered Mail Restricted Delivery
- ☐ Return Receipt for Merchandise
- ☐ Signature Confirmation™
- ☐ Signature Confirmation Restricted Delivery

PS Form 3811, July 2015 PSN 7530-02-000-9053 **PLEASE RETURN IN 5 DAYS** Receipt

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

ID: GGXW
Facility ID: 00853

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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 **07/12/2016** (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	
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FISCAL YEAR ENDING DATE: (L35)
09/30

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

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:
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__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

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

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

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 :
Gayle Lantto, Unit Supervisor 07/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 07/22/2016 (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
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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
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25. LTC EXTENSION DATE:
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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
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OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted 07/29/2016

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/07/2016
(L33)

DETERMINATION APPROVAL

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

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ID: GGXW

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

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Gayle Lantto, Unit Supervisor — 06/22/2016 (L19)

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Kate JohnsTon, Program Specialist — 07/01/2016 (L20)

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DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1050

June 7, 2016

Ms. Amanda Gentilli, Administrator
Birchwood Health Care Center
604 - 1st Street NE
Forest Lake, MN 55025

RE: Project Number S5200026

Dear Ms. Gentilli:

On May 26, 2016, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the May 26, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5200035 that was found to be unsubstantiated.

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;
>
> 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:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Gayle.Lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 215-9697

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 July 5, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 5, 2016 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 August 26, 2016 (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 November 26, 2016 (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 a PoC 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

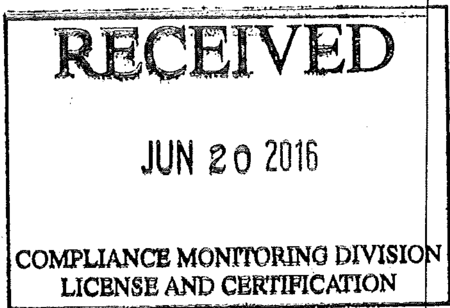
Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. BUILDING ____ B. WING ____	C 05/26/2016

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. 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 recertification survey was conducted and complaint investigation was also completed at the time of the standard survey. An investigation of complaint H#5200035 was completed and found not to be substantiated.	F 000	 RECEIVED JUN 20 2016 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most recent survey results were readily accessible to	F 167 POC accepted [illegible] 6/22/16	F167 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:	7.5.16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Executive Director
(X6) DATE: 6.16.16

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 _____	C 05/26/2016

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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 167	Continued From page 1 residents, families and visitors. This had the potential to affect the 87 residents currently in the facility interested in reviewing the results, and/or any interested families or visitors. Findings include: During the initial tour on 5/23/16, from 1:45 p.m. to 2:05 p.m. and the most recent survey results could not be found, nor was a posted notice observed to identify the location/availability of the survey results. When interviewed on 5/25/16, at 2:28 p.m. R60 stated she was unaware of where the most recent survey results were kept. When interviewed on 5/26/16, at 9:55 a.m. the activity director stated that the most recent survey results were kept in the front lobby in a black binder. On 5/26/16, at 10:00 a.m. the most current survey results were located in a black binder in a desk drawer in the front lobby. However, there was no sign posted indicating the location/availability of the survey results. When interviewed on 5/26/16, at 10:03 a.m. the administrator stated that the survey results should be visible on top of a table in the front lobby and wasn't sure who had placed them in the desk drawer. The administrator also verified the facility had not posted any notice identifying where the survey findings were located. A policy was requested related to survey results being available and the facility was unable to provide one.	F 167	1. With respect to posting survey results; the document was located on 5/26/2016 and replaced to its standard location in the lobby so it was accessible for resident or family members to review without having to request the document. 2. Unable to determine who removed the survey results from its standard location. Sign posted along with survey results to identify the location of the most recent survey results and to return the document when completed . 3. The guideline for posting survey results has been reviewed and includes current regulatory language. All staff will be educated regarding the need to keep the survey results posted in a location that is accessible to all residents and families. 4. The Executive Director and/or designee will audit the survey results being posted to assure it remains available for residents and family to examine without having to ask. 5. The data collected will be presented to the QA committee by the Executive 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure that the number of licensed and unlicensed nursing staff for each shift was displayed in a location that	F 356	F356 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 posting facility hours; the actual hours worked were completed and posted on 5/24/2016 prior to survey exit. 2. The Staffing Coordinator received education regarding the requirement for posting the Nursing Hours in a timely manner. 3. The guideline for Posting Nursing Hours has been reviewed and revised for implementation. 4. The Executive Director and/or designee will audit the posting for accuracy and timelines each week for three months to assure compliance. 5. The data collected will be presented to the QA committee by the Executive 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.	7.5.16

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

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F 356	Continued From page 3	F 356		

could be visualized by the public on a daily basis. This had the potential to affect all 87 residents residing in the facility and their families or visitors.

Findings include:

During initial tour observations on 5/23/16 at 1:50 p.m., the facility's nursing staff posting was observed to be posted on the wall at the reception desk. The posting was dated as 5/24/16.

During a random observation on 5/24/16 at 4:12 p.m., the facility's nursing staff posting was dated 5/25/16.

During an interview on 5/24/16, at 4:12 p.m. the facility's receptionist verified the currently posted staff hours were not for the current day. The receptionist also verified the postings for 5/26 and 5/27 had already been prepared and were in place behind the 5/25/16 information. The receptionist stated she was unaware of who was responsible to ensure the staff postings were current and accurate.

The facility's Practice Guidelines and Procedure Nursing Hours Posting protocol revised 2015, included:

The facility will post the Nurse Staffing Hours on a daily basis in a format which includes;
1. The facility name
2. Current date
3. Total number and actual hours worked by the following categories of nursing personnel;
   a. Registered Nurses
   b. Licensed Practical Nurses
   c. Certified Nursing Assistants"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 4	F 441		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 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 regards to the identified employee: education has been provided regarding handwashing.. 2. Infection control reports were reviewed and no trends were identified for any particular group assignment. Staff will be observed for proper hand washing technique to prevent the transmission of pathogens and possible infection. 3. All nursing staff will receive education for proper technique regarding hand washing procedure. Education will be completed by July 5th, 2016. 4. The Director of Nursing and/or designee will audit two staff each week for one month and then one employee/week for two months to assure proper hand washing,	7.5.16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene was completed after glove use for 1 of 4 residents (R6) observed during cares. Findings include: On 5/25/16, at 9:03 a.m. nursing assistant (NA)-A was observed completing perineal cares for R6 following a bowel movement. NA-A wore gloves and used toilet paper to wipe R6's bottom. NA-A needed wipes so NA-B, who was running the standing lift lowered R6 back to a seated position on the toilet. NA-A removed her gloves and did not perform hand hygiene. NA-B handed NA-A the perineal wipes. NA-A grabbed a clean set of gloves and placed them on her hands. NA-B raised R6 to a standing position with the lift. NA-A finished perineal cares with her gloved hands, removed the gloves and did not perform hand hygiene. NA-A then pulled up R6's incontinent brief and pants up. R6 was placed in her wheelchair. NA-A placed the wheelchair pedals on R6's wheelchair then proceeded to look for R6's comb. NA-A looked in the cupboard above the closet and could not find a comb, then proceeded to the bedside stand, opened the drawer and removed a comb. NA-A combed R6's hair. NA-A pushed R6 in the wheelchair to the dining room. NA-A then went to the sink and washed her hands with soap and water. When interviewed on 5/25/16, at 9:22 a.m. NA-B verified she had not performed hand hygiene after removing her gloves or anytime while in R6's	F 441	5. The data collected will be presented to the QAPI Committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Meeting. At this time the 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 441	Continued From page 6 room. NA-B stated she should have washed her hands or used hand sanitizer after removing her gloves. When interviewed on 5/26/16, at 10:22 a.m. registered nurse (RN)-A stated that standard precautions were taught at the time of hire and annually. RN-A stated standard precautions included hand hygiene and glove use expectations. RN-A stated that gloves needed to be used when coming in contact with any resident body fluids and that after removal of the gloves hand hygiene was to be completed. The facility's Handwashing policy dated 11/14, indicated staff were to complete hand hygiene helping someone with toilet use, and that hand hygiene needed to be completed after removing gloves.	F 441		
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, the facility failed to suspend billing for services for 4 of 4 residents (R13, R31, R115, and R119) reviewed who requested demand bill review. Finding include:	F 492	F492 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:	7·5·16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 492	Continued From page 7 R13 received a notice of Medicare non-coverage on 2/4/16, which indicated the last day of Medicare A covered service was 2/9/16. On 2/4/16, R13's family member requested a demand bill, whereby the decision would be appealed to the quality improvement organization (QIO). However, the facility billed R13's family for services on 2/17/16 and had not submitted the appeal to the QIO until 5/24/16. R31 received a notice of Medicare non-coverage on 1/6/16, which indicated the last day of Medicare A covered service was 1/9/16. On 1/6/16, R31 requested a demand bill in order to have the decision appealed to the QIO. However, the facility billed R31 for services on 1/22/16 and had not submitted the appeal to the QIO until 5/24/16. R115 received a notice of Medicare non-coverage on 12/4/15, which indicated the last day of Medicare A covered service was 12/9/15. On 12/4/15, R115's family member requested a demand bill to have the decision appealed to the QIO. However, the facility billed R115's insurance on 2/29/16, 3/31/16 and 4/30/16. The facility did not submit the appeal to the QIO until 5/24/16. R119 received a notice of Medicare non-coverage on 12/21/15, which indicated the last day of Medicare A covered service was 12/28/15. On 12/22/15, R119's family member requested a demand bill to have the decision appealed to the QIO. However, the facility billed R119's family on 1/4/16, 2/23/16, 3/24/16, and 5/23/16. The facility did not submit the appeal to the QIO until 5/24/16. During an interview with the business office	F 492	1. With respect to R13, R31, R115 and #119, bills were re-issued for the period in question while determinations made. 2. All residents who requested an appeal in the past month have been reviewed to assure billing was on hold during the appeal process and bills reissued if indicated. 3. A log will be maintained by the business office for all demand bills and will be referenced each month prior to billing to assure billing is on hold while determinations are made. 4. The Executive Director 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 QAPI committee by the Executive Director and/or designee. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/re-commendation regarding any necessary follow-up studies.	7.5.16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 492	Continued From page 8 manager (BOM) at 8:45 a.m. on 5/26/16, the BOM acknowledged doing the appeal process incorrectly. The BOM stated the demand bill appeals had first been put in for processing 5/24/16. The BOM verified the resident's should not have been billed during this time. The facility's undated policy, Practice Guidelines and Procedure, Medicare Demand Submission, indicated the facility could not bill any other payer sources until the final decision had been made by Medicare.	F 492		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly notify the physician of abnormal lab results for 1 of 1 resident (R144) who had been recently admitted from the hospital. Findings include: R144 was admitted to the facility on 5/20/16 for therapy after a recent hospitalization. R144's hospital notes, dated 5/7/16, listed acute encephalopathy (brain damage or dysfunction), acute alcohol withdrawal, and acute on chronic respiratory failure as diagnoses related to the hospitalization. An internal medicine note, dated 5/19/16, listed R144 as having an AKI (acute kidney injury) during the hospitalization too.	F 505	F505 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::	7·5·16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. BUILDING ______ B. WING ______	C 05/26/2016

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 505	Continued From page 9 R144's discharge "After Visit Summary," dated 5/20/16, directed staff to obtain labs "at least once over the weekend (or if not possible over the weekend, then on Monday, 5/23/16)." It further specified labs to be drawn to include: potassium, magnesium, and creatinine (blood test to determine kidney function), in order to check R144's electrolytes and renal (kidney) function. Lastly, the summary directed staff that "further [lab] checks will be dependent on results of the potassium, magnesium, and creatinine." A lab report, dated 5/21/16, reported an abnormally low potassium and an abnormally high creatinine. A record review was completed for R144 which showed no evidence R144's physician had been notified of the abnormal results. On 5/25/16, at 8:36 a.m., registered nurse (RN)-B stated if the physician had been notified, the lab sheet would be signed and dated by the nurse. RN-B verified the lab sheet dated 5/21/16 had not been signed and dated. RN-B also stated the nurse practitioner was rounding the following day 5/26/16; however, she went on to say the physician should have been updated right away regarding the lab results and that abnormal labs should be reported quicker than waiting for the nurse practitioner to round. During a follow-up interview that day, at 9:21 a.m., RN-B stated she had just notified R144's physician of the abnormal labs and that the physician had given new orders for K-Dur (a potassium supplement) daily and to re-check R144's labs for a diagnosis of renal insufficiency (poor kidney function) and hypokalemia (low	F 505	1. With respect to R144; lab results were called into the primary physician on date of receipt, however notification had not been documented. The licensed person responsible for the omission has received education regarding the facility procedure for documentation. 2. All resident records have been reviewed for laboratory results in the past 30 days, to assure physician notification. MD has been updated if indicated with follow-up staff education. The nurse responsible for notification has received education. 3. All nursing staff will receive re-education for Change in Condition Guidelines and notification of providers. All education will be completed by July 5th , 2016. 4. The Director of Nursing and/or designee will audit 24 hour report to conduct change in condition audits to assure notifications have been completed. Audits to be conducted on 2 residents/week for one month and then one resident per week for two months. 5. The data collected will be presented to the QAPI committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly quality meeting. At this time the 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 ______	C 05/26/2016

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 505	Continued From page 10 potassium level). RN-B confirmed that at the time she received the new orders, she signed and dated the lab sheet. On 5/26/16, at 1:40 p.m., the director of nursing (DON) stated as a standard of practice, labs should be either faxed or called to the physician or nurse practitioner. R144's temporary care plan, dated 5/21/16, instructed staff with the following intervention "medications, labs, follow-up appointments per MD order." The facility's policy dated 10/11, Change of Condition, directed "non-immediate and routine notifications are to be made same day during normal business hours or the next day when after hours."	F 505		

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

F5200024

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FORM APPROVED
OMB NO. 0938-0391

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	05/25/2016

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
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, and By email to: Marian.Whitney@state.mn.us and	K 000	APPROVED By Tom Linhoff at 8:37 am, Jun 21, 2016 RECEIVED JUN 20 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	6-17-16

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	05/25/2016

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
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 88 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

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	**05/25/2016**

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 018 SS=F	Continued From page 2 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 4 sets corridor doors and one resident room door according to NFPA 101 LSC (00) section 19.3.6.3.1 & 19.3.6.3.1 and S&C-06-08. This deficient practice could affect the safety of all 88 residents and an undetermined amount of staff and visitors, if smoke or fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 9:00 am to 12:30 pm on 05-25-2016 observations and staff interview revealed the following. 1. Resident room door 212 does not fit tightly in the frame 2. The doors on the four clean linen storage	K 018	K018 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 room door 212 not fitting tightly in the frame, a Siliconseal Fire and Smoke Adhesive Gasketing has been installed and is forming a proper seal between the door and the doorframe. With respect to the four clean linen storage doors, Emerald Builders has been retained and a bid has been received to complete the project.	7-6-16

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	245200	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 018	Continued From page 3 rooms, three located on the first floor and one located on the second floor, are equipped with roller latches. This deficient condition was verified by the Facility Adminstrator and the Maintenance Supervisor.	K 018	2. The date of completion for resident room door 212 was 6/16/2016. The date of completion for the four linen closet doors is 7/17/2016. 3. The Director of Environmental Services, Steve Daniels, will monitor for potential future conditions.	