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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HCL6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00168

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E166**
2.STATE VENDOR OR MEDICAID NO.
(L2) **458995500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BIRCHWOOD CARE HOME**
(L4) **715 WEST 31ST STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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) **01/01/2004**
6. DATE OF SURVEY **04/23/2014** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **10** (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 **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
X 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
X 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: * Code: A , 4 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		60		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Supervisor 06/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 07/07/2014 (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
03/31/1974
(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.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/02/2014
(L33)

DETERMINATION APPROVAL

CCN: 24E166
Documentation supporting the facility's request for a continuing waiver involving tag F 0354 was previously forwarded. The waiver request is approved. Refer to the CMS 2567.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: July 24, 2014

CMS Certification Number (CCN): 24-E166

Mr. Randal Hagemeyer, Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, Minnesota 55408

Dear Mr. Hagemeyer:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective May 30, 2014 the above facility is certified for:

60 - Nursing Facility II Beds

Your facility's Medicaid approved area consists of all 60 nursing facility beds.

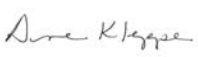
Your request for waiver of has been approved based on the submitted documentation. If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicaid Program.

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 Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,



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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: July 24, 2014

Mr. Randal Hagemeyer, Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, Minnesta 55408

RE: Project Number

Dear Mr. Hagemeyer:

On May 12, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 23, 2014. 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 June 18, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 5, 2014 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 April 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 23, 2014, effective May 30, 2014 and therefore remedies outlined in our letter to you dated May 12, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiencycited under tag 0354 at the time of the April 23, 2014 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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,

Anne Kleppe

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E166	A. Building B. Wing	6/18/2014

Name of Facility	Street Address, City, State, Zip Code
BIRCHWOOD CARE HOME	715 WEST 31ST STREET MINNEAPOLIS, MN 55408

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 F0356 Reg. # 483.30(e) LSC	05/20/2014	ID Prefix F0425 Reg. # 483.60(a),(b) LSC	05/20/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	05/20/2014
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 State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 4/23/2014		**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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E166	A. Building B. Wing **01 - MAIN BUILDING 01**	6/5/2014

Name of Facility	Street Address, City, State, Zip Code
BIRCHWOOD CARE HOME	715 WEST 31ST STREET MINNEAPOLIS, MN 55408

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 Reg. # **NFPA 101** LSC K0020	Correction Completed **05/16/2014**	ID Prefix Reg. # **NFPA 101** LSC K0072	Correction Completed **05/30/2014**	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 06/18/2014	**Signature of Surveyor:** 28120	**Date:** 06/05/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 4/22/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Hand Delivered on June 18, 2014

June 18, 2014

Mr. Randal Hagemeyer, Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, MN 55408

Re: Project # SE166023

Dear Mr. Hagemeyer:

On June 18, 2014, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 23, 2014.

State licensing orders issued pursuant to the last survey completed on April 23, 2014 and found corrected at the time of this June 18, 2014, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on April 23, 2014, found not corrected at the time of this June 18, 2014 revisit and subject to penalty assessment are as follows:

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 with any questions related to this letter.

Sincerely,

Anne Kleppe

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HCL6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00168

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E166**
2.STATE VENDOR OR MEDICAID NO.
(L2) **458995500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BIRCHWOOD CARE HOME**
(L4) **715 WEST 31ST STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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) **01/01/2004**

6. DATE OF SURVEY **04/23/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (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 **60** (L18)

13.Total Certified Beds (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
X 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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B, 4*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		60		
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Robyn Woolley, HFE Nursing Evaluator II 05/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/29/2014 (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
03/31/1974
(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.
(L31)

30. REMARKS
Health Waiver F354 emailed CMS 06/02/2014

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-E166

At the time of the standard survey completed 03/23/14, the facility was not in substantial compliance and the most serious deficiencies were found 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 are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

The facility has requested a waiver for health survey Tag 0354.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: May 12, 2014

Mr. Randal Hagemeyer, Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, Minnesota 55408

RE: Project Number SE166023

Dear Mr. Hagemeyer:

On April 23, 2014, 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.

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:

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

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

<u>Remedies</u> - 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:

Susanne Reuss, Supervisor
Metro A Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
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 June 2, 2014, 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 June 2, 2014 the following remedy will be imposed:

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

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.

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 23, 2014 (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 23, 2014 (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
Division of Compliance Monitoring
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 electronic 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) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
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
	24E166	A. BUILDING _____ B. WING _____	04/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	715 WEST 31ST STREET MINNEAPOLIS, MN 55408

(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 354 SS=D	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide the services of a registered nurse for 8 consecutive hours, 7 days a week. This had the potential to affect all 57	F 354	See attachment for letter re: RN waiver.	

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

Electronically Signed | 05/27/2014

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

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F 354	Continued From page 1 residents in the facility. Findings include: Review of the facility working schedules, received on 4/21/14 and 4/22/14, indicated there was not a registered nurse (RN) on duty for 13 of the last 70 days. Interview with the director of nursing (DON), on 4/23/14 at 11:00 a.m., indicated a RN was hired and then quit. The DON indicated they are trying to hire another RN for the evening and night shift. The DON indicated the facility did not have a waiver for the nursing requirement.	F 354		
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,	F 356		5/30/14

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F 356	Continued From page 2 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, interview, and document review, the facility failed to ensure the required daily staffing information included the total number of hours worked by each category of nursing staff. This had the potential to affect all 57 residents residing in the facility. Findings include: During tour on 4/21/14 at 2:00 p.m., the Staff Posting was observed on the wall by the medication room window. The facility name, date, census, and the actual number of licensed and unlicensed staff were identified for each shift. The posting dated 4/21/14, included for the Day shift: 8-4:30 shift - 1 RN (registered nurse), 7 -3:30 shift - 1 LPN (licensed practical nurse), 6:45 - 2:30 1 TMA (trained medication aide) and 6:15 -1:00 - 1 NAR (nursing assistant registered). For the evening shift: 3 -11:30 - 1 LPN, 3 -9:30 - 1 TMA, and 3 - 10:30 - 1 NAR. For the night shift: 11 - 7:30 1 LPN. The total number of hours of the licensed and unlicensed staff were not included on the posting. Review of the staffing posting from 4/21/14 to 4/23/14 revealed the total number of hours worked had not been included in the posting.	F 356	Policy and procedure and form that is posted daily was updated 5/12/14 to include all items including number of hours worked. Copy of policy attached, form available upon request. Implementation date expected to be 5/22/14 after forms are updated and laminated. Staff training has been completed as of 5/12/14. Staff Development Coordinator makes a copy of the Nurse staffing information on a daily basis, will be responsible for monitoring for compliance. Director of Nursing will do random audits to assure compliance/ completion according to policy.	

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F 356	Continued From page 3 During interview with the director of nursing, on 4/23/14 at 11:30 a.m., she verified the form did not have the total hours worked by the staff.	F 356		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to ensure prescription medications were accurately dispensed for 2 of 2 residents (R25, R48) receiving insulin via a Novolog insulin pen. Findings include:	F 425	Policy and procedure was reviewed with all nursing staff. All nursing staff have reviewed and been re educated on priming of 2 units of insulin pen prior to any administration. All residents who receive insulin have been re educated on priming with 2 units prior to administration. A sign has been posted in the treatment	5/23/14

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F 425	Continued From page 4 Review of R25's physician orders indicated an order for Novolog 70/30 insulin administer 6 units sub q (subcutaneous) with evening meal . One of R 25's diagnoses was diabetes. During observation of medication administration on April 21, 2014 at 5:00 p.m., licensed practical nurse (LPN)-A was observed to administer R25's Novolog insulin via a Novolog Flex Pen (a disposable dial-a-dose insulin pen). LPN-A was observed to attach the needle to the Flex Pen, dial to 6 units, and as LPN-A was to administer the insulin to R25, R25 asked the surveyor to step out of the room. LPN-A indicated she wiped R25's abdomen and administered the 6 units of insulin. Review of R48's physician orders indicated an order for Novolog insulin give 6 units at supper time-diagnosis diabetes mellitus. During observation of medication administration on April 21, 2014 at 5:05 p.m., R48 entered the medication room and after informing LPN-A that his/her blood sugar was 170, LPN-A was observed to attach a needle to the Flex Pen, and dial the Flex Pen to 6 units. R48 then indicated wanting the insulin in the "belly, to the right." LPN-A wiped the area with alcohol and then administered the 6 units. After administering R48's insulin , LPN-A was interviewed regarding "priming" (also called giving an airshot) the Flex Pen after the needle was attached. LPN-A indicated she did not prime the Flex Pen before administering the insulin for R25 or R48. Interview with the director of nursing (DON) on 4/21/14 at 5:20 p.m. revealed staff should prime the Flex Pen with 2 units of insulin prior to administering.	F 425	area as a reminder to staff and residents who self administer with supervision. Training completed by 5/21/14. Director of Nursing and Staff Development Coordinator will do audits every week x 4 weeks to assure compliance, thereafter random audits will be done to assure compliance.	

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F 425	Continued From page 5 Interview with the DON on 4/23/14 at 11:30 a.m. indicated LPN-A only works part time and was nervous because the surveyor was present. On 4/23/14 at 11:30 a.m., the policy on administering insulin via Novolog Pen was requested and received. Review of the pharmacy policy titled Medication Administration, Subcutaneous Insulin, dated 09/10 indicated the following: 9.b. prepare syringe/pen and safety needle. (see pen example). On page 3 of 6 the following directions were provided: Line up the needle with the pen, and keep it straight as you attach it. If the needle is not kept straight while you attach it, it can damage the rubber seal and cause leakage, or break the needle. Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate does by: . ensuring that the pen and needle work properly. . removing air bubbles. A. Select the dose of units by turning the dosage selector (picture shows a pen with a dose of 2 units) Check that the dose window show "0" following the safely test. C. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. D. Hold the pen with the needle pointing upwards. E. Tap the insulin reservoir so that any air	F 425		

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F 425	Continued From page 6 bubbles rise up towards the needle. F. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before the insulin is seen. . If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them. . If still no insulin come out, the needle be be blocked. Change the needle and try again. . If no insulin comes out after changing the needle, the pen may be damaged. Do not use this pen.	F 425		
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.	F 431		5/9/14

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F 431	Continued From page 7 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to ensure inhalers were labeled with the date opened, for 3 of 7 residents (R13, R30, R49) whose inhalers were observed during the medication storage tour. Findings include: On 4/21/14, at 5:00 p.m. during medication storage tour with trained medication aide (TMA)-A, the following was observed: an open Advair Diskus (inhaler for the treatment of asthma) stored in the medication cart was undated for R30, an open Advair Diskus undated for R13, and an open undated Proventil inhaler for R49. During interview with the director of nursing on 4/21/14 at 5:30 p.m., she indicated all inhalers should have a sticker indicating date opened. Review of the facility's undated Medication Expiration Dating Policy and Procedure directed the following:	F 431	Med cart audit was completed on 4/22/14 to be sure all drugs are properly dated. Policy and procedure reviewed with all nursing staff and training done with each staff member to ensure adherence. A med cart audit will be completed by Staff Development Coordinator weekly x next 4 weeks to assure compliance. Birchwood has recently changed pharmacies and the new pharmacy will be doing monthly med room and med cart audits to assure compliance. Staff Development Coordinator will do random audits in between pharmacy audits for next 6 months to assure compliance. Policy and procedure attached.	

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F 431	Continued From page 8 POLICY It is the policy of Birchwood Care Home for staff to date medications with limited expiration times when opening them. This includes but is not limited to: eye drops, eye ointments, insulin, multidose inhalers ...and certain liquid medications according to pharmacy consultant guidelines. PURPOSE To ensure that medications are utilized according to manufacturer guidelines and accepted practice. PROCEDURE 1. When medication is delivered from the pharmacy, the staff checking in the medication will affix a "date opened" label to each medication from the above list . 2. Staff will date the exempted medication when opening them for their first use. 3. Staff giving these exempted medications will check the label for date opened and that it has not expired. 4. Staff will reorder the above listed medications before the expiration date.	F 431		

Birchwood
Care Home
715 West 31st. Street Minneapolis, Minnesota 55408
Phone 612.823.7286 Fax 612.823.0518

May 15, 2014

Ms Anne Kleppe, Enforcement Specialist
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Dear Ms. Reuss:

Birchwood Care Home respectfully requests a waiver of Federal Requirement 483.30(b), Registered Nurse for eight (8) consecutive hours a day, 7 days per week.

While we continue to strive to always meet this requirement, when our R.N. staff stakes vacations, requests days off or calls in sick we are not always able to replace those R.N. staff with another.

Birchwood Care Home continues to employ an R.N. Director of Nursing, who is on call 24 hours per day, has 24 hour licensed nurse coverage and also has a contract with a Medical Director who is on call 24 hours per day.

I feel that a waiver of the R.N. requirement will not endanger the health or safety of the residents at Birchwood Care home.

Thank you for your consideration of this request.

Sincerely,

Randal L. Hagemeyer
Administrator

BIRCHWOOD CARE HOME
Minneapolis, Minnesota 55408

MEDICATION EXPIRATION DATING POLICY AND PROCEDURE

POLICY

It is the policy of Birchwood Care Home for staff to date medications with limited expiration times when opening them. This includes but is not limited to: eye drops, eye ointment, insulin, multidose inhalers, multi-dose vials, nitroglycerin and certain liquid medications according to pharmacy consultant guidelines.

PURPOSE

To ensure that medications are utilized according to manufacturer guidelines and accepted practice.

PROCEDURE

1. **When medication is delivered from the pharmacy, the staff checking in the medication will affix a "date opened" label to each medication from the above list.**

2. **Staff will date the exempted medication when opening them for their first use.**

3. **Staff giving these exempted medications will check the label for date opened and that it has not expired.**

4. **Staff will reorder the above listed medications before the expiration date.**

BIRCHWOOD CARE HOME
Minneapolis, Minnesota 55408

POSTING OF NURSE STAFFING INFORMATION

POLICY

The facility will post the total number and actual hours worked by all nursing staff.

PROCEDURE

1. Each night shift, the night nurse will check the census and employee schedule and enter the current census, number of employees scheduled in the nursing department and the total number of hours for each category.

2. A copy of the hours will be placed in the Staff Development Coordinators mailbox to be retained x 24 months per regulation.

3. If there are changes in staffing due to a call in and the shift did not get replaced, the Director of Nursing will be responsible to change the number of hours or to delegate to the charge nurse to change the number of hours on the staffing report.

4. The Staff Development Coordinator will verify the correct information when she places the forms in the binder.

715 West 31st. Street
Minneapolis, Minnesota 55408

Birchwood
Care Home

STAFFING DATE: _____
CURRENT CENSUS: _____

SHIFT	RN	LPN	TMA	NAR
DAY	____ 8-4:30A (8.0) HRS Worked____ ____7-3:30P (8.0) HRS Worked____	_____7A-3:30P (8.0) HRS Worked____	____ 6:45A-2:30P (7.75) HRS Worked_____	_____6:15A-2:00P (7.75) HRS Worked_____
EVENING	____3-11:00P (8.0) HRS Worked____	____3-11:30P (8.0) HRS Worked_____	_____3-9:45P (6.25) HRS Worked_____	____3-10:30P (7.0) HRS Worked_____
NIGHT	___ 11P-7:30A (8.0) HRS Worked_____	___11P-7:30A (8.0) HRS Worked_____		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: May 12, 2014

Mr. Randal Hagemeyer, Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, Minnesota 55408

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SE166023

Dear Mr. Hagemeyer:

The above facility survey was completed on April 23, 2014 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 Boarding Care 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 is 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.

When all orders are corrected, the order form should be acknowledged electronically and submitted to this office at 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 me.

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.

Feel free to contact me with any questions related to this electronic notice.

Sincerely,

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

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	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/22/2014**

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BIRCHWOOD CARE HOME	**715 WEST 31ST STREET** **MINNEAPOLIS, MN 55408**

(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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Birchwood Care Home was found to be 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: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/22/2014

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
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/22/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	**715 WEST 31ST STREET** **MINNEAPOLIS, MN 55408**

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K 000	Continued From page 1 Marian.Whitney@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 Care Home is a 3-story building with a partial basement. The building was constructed at 2 different times. The original 3 story building was constructed in 1966 and was determined to be of Type II(222) construction. In 2000, a 1 story addition was constructed to the East that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 59 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation	K 020		5/16/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 020	Continued From page 2 shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain vertical openings as required by LSC(00) Section 19.3.1.1. This deficient practice could affect all residents. Findings include: On facility tour between 9:15 AM and 10:30 AM on 04/22/2014, observation revealed the that first floor stair door near the nurses station has a damaged hinge and does not fully close. This deficient practice was verified by the maintenance director at the time of the inspection.	K 020	Hinge was fixed on 4/23/14 and door is operating properly. Maintenance does an audit of all fire doors for proper latching on a monthly basis. This is supervised by Director of Environmental Services.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 072	Planter box was moved from second floor	5/30/14

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K 072	Continued From page 3 has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of patients in an emergency situation. Findings include: On facility tour between 9:15 AM and 10:30 AM on 04/22/2014, observation revealed that: 1. There is a large planter box in the second floor corridor, 2. There are benches located in the third floor corridor that are not secured to the floor in accordance with CMS Categorical Waivers. These deficient practices were verified by the maintenance director at the time of the inspection.	K 072	corridor on 4/23/14. Benches will be secured by 5/30/14.	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HCL6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00168

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E166**
2.STATE VENDOR OR MEDICAID NO.
(L2) **458995500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BIRCHWOOD CARE HOME**
(L4) **715 WEST 31ST STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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) **01/01/2004**

6. DATE OF SURVEY **04/23/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (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 **60** (L18)

13.Total Certified Beds (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
X 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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B, 4*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		60		
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Robyn Woolley, HFE Nursing Evaluator II 05/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/29/2014 (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
03/31/1974
(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.
(L31)

30. REMARKS
Health Waiver F354 emailed CMS 06/02/2014

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-E166

At the time of the standard survey completed 03/23/14, the facility was not in substantial compliance and the most serious deficiencies were found 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 are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

The facility has requested a waiver for health survey Tag 0354.

Birchwood
Care Home
715 West 31st. Street Minneapolis, Minnesota 55408
Phone 612.823.7286 Fax 612.823.0518

May 15, 2014

Ms Anne Kleppe, Enforcement Specialist
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Dear Ms. Reuss:

Birchwood Care Home respectfully requests a waiver of Federal Requirement 483.30(b), Registered Nurse for eight (8) consecutive hours a day, 7 days per week.

While we continue to strive to always meet this requirement, when our R.N. staff stakes vacations, requests days off or calls in sick we are not always able to replace those R.N. staff with another.

Birchwood Care Home continues to employ an R.N. Director of Nursing, who is on call 24 hours per day, has 24 hour licensed nurse coverage and also has a contract with a Medical Director who is on call 24 hours per day.

I feel that a waiver of the R.N. requirement will not endanger the health or safety of the residents at Birchwood Care home.

Thank you for your consideration of this request.

Sincerely,

Randal L. Hagemeyer
Administrator

BIRCHWOOD CARE HOME
Minneapolis, Minnesota 55408

MEDICATION EXPIRATION DATING POLICY AND PROCEDURE

POLICY

It is the policy of Birchwood Care Home for staff to date medications with limited expiration times when opening them. This includes but is not limited to: eye drops, eye ointment, insulin, multidose inhalers, multi-dose vials, nitroglycerin and certain liquid medications according to pharmacy consultant guidelines.

PURPOSE

To ensure that medications are utilized according to manufacturer guidelines and accepted practice.

PROCEDURE

1. **When medication is delivered from the pharmacy, the staff checking in the medication will affix a "date opened" label to each medication from the above list.**

2. **Staff will date the exempted medication when opening them for their first use.**

3. **Staff giving these exempted medications will check the label for date opened and that it has not expired.**

4. **Staff will reorder the above listed medications before the expiration date.**

BIRCHWOOD CARE HOME
Minneapolis, Minnesota 55408

POSTING OF NURSE STAFFING INFORMATION

POLICY

The facility will post the total number and actual hours worked by all nursing staff.

PROCEDURE

1. Each night shift, the night nurse will check the census and employee schedule and enter the current census, number of employees scheduled in the nursing department and the total number of hours for each category.

2. A copy of the hours will be placed in the Staff Development Coordinators mailbox to be retained x 24 months per regulation.

3. If there are changes in staffing due to a call in and the shift did not get replaced, the Director of Nursing will be responsible to change the number of hours or to delegate to the charge nurse to change the number of hours on the staffing report.

4. The Staff Development Coordinator will verify the correct information when she places the forms in the binder.

715 West 31st. Street
Minneapolis, Minnesota 55408

Birchwood
Care Home

STAFFING DATE: _____
CURRENT CENSUS: _____

SHIFT	RN	LPN	TMA	NAR
DAY	____ 8-4:30A (8.0) HRS Worked____ ____7-3:30P (8.0) HRS Worked____	_____7A-3:30P (8.0) HRS Worked____	____ 6:45A-2:30P (7.75) HRS Worked_____	_____6:15A-2:00P (7.75) HRS Worked_____
EVENING	____3-11:00P (8.0) HRS Worked____	____3-11:30P (8.0) HRS Worked_____	_____3-9:45P (6.25) HRS Worked_____	____3-10:30P (7.0) HRS Worked_____
NIGHT	___ 11P-7:30A (8.0) HRS Worked_____	___11P-7:30A (8.0) HRS Worked_____		

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	24E166	A. BUILDING _____ B. WING _____	04/23/2014

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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 354 SS=D	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide the services of a registered nurse for 8 consecutive hours, 7 days a week. This had the potential to affect all 57	F 354	See attachment for letter re: RN waiver.	5/20/14

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

Electronically Signed | 05/27/2014

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 354	Continued From page 1 residents in the facility. Findings include: Review of the facility working schedules, received on 4/21/14 and 4/22/14, indicated there was not a registered nurse (RN) on duty for 13 of the last 70 days. Interview with the director of nursing (DON), on 4/23/14 at 11:00 a.m., indicated a RN was hired and then quit. The DON indicated they are trying to hire another RN for the evening and night shift. The DON indicated the facility did not have a waiver for the nursing requirement.	F 354		
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,	F 356		5/30/14

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F 356	Continued From page 2 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, interview, and document review, the facility failed to ensure the required daily staffing information included the total number of hours worked by each category of nursing staff. This had the potential to affect all 57 residents residing in the facility. Findings include: During tour on 4/21/14 at 2:00 p.m., the Staff Posting was observed on the wall by the medication room window. The facility name, date, census, and the actual number of licensed and unlicensed staff were identified for each shift. The posting dated 4/21/14, included for the Day shift: 8-4:30 shift - 1 RN (registered nurse), 7 -3:30 shift - 1 LPN (licensed practical nurse), 6:45 - 2:30 1 TMA (trained medication aide) and 6:15 -1:00 - 1 NAR (nursing assistant registered). For the evening shift: 3 -11:30 - 1 LPN, 3 -9:30 - 1 TMA, and 3 - 10:30 - 1 NAR. For the night shift: 11 - 7:30 1 LPN. The total number of hours of the licensed and unlicensed staff were not included on the posting. Review of the staffing posting from 4/21/14 to 4/23/14 revealed the total number of hours worked had not been included in the posting.	F 356	Policy and procedure and form that is posted daily was updated 5/12/14 to include all items including number of hours worked. Copy of policy attached, form available upon request. Implementation date expected to be 5/22/14 after forms are updated and laminated. Staff training has been completed as of 5/12/14. Staff Development Coordinator makes a copy of the Nurse staffing information on a daily basis, will be responsible for monitoring for compliance. Director of Nursing will do random audits to assure compliance/ completion according to policy.	

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F 356	Continued From page 3 During interview with the director of nursing, on 4/23/14 at 11:30 a.m., she verified the form did not have the total hours worked by the staff.	F 356		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to ensure prescription medications were accurately dispensed for 2 of 2 residents (R25, R48) receiving insulin via a Novolog insulin pen. Findings include:	F 425	Policy and procedure was reviewed with all nursing staff. All nursing staff have reviewed and been re educated on priming of 2 units of insulin pen prior to any administration. All residents who receive insulin have been re educated on priming with 2 units prior to administration. A sign has been posted in the treatment	5/23/14

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F 425	Continued From page 4 Review of R25's physician orders indicated an order for Novolog 70/30 insulin administer 6 units sub q (subcutaneous) with evening meal . One of R 25's diagnoses was diabetes. During observation of medication administration on April 21, 2014 at 5:00 p.m., licensed practical nurse (LPN)-A was observed to administer R25's Novolog insulin via a Novolog Flex Pen (a disposable dial-a-dose insulin pen). LPN-A was observed to attach the needle to the Flex Pen, dial to 6 units, and as LPN-A was to administer the insulin to R25, R25 asked the surveyor to step out of the room. LPN-A indicated she wiped R25's abdomen and administered the 6 units of insulin. Review of R48's physician orders indicated an order for Novolog insulin give 6 units at supper time-diagnosis diabetes mellitus. During observation of medication administration on April 21, 2014 at 5:05 p.m., R48 entered the medication room and after informing LPN-A that his/her blood sugar was 170, LPN-A was observed to attach a needle to the Flex Pen, and dial the Flex Pen to 6 units. R48 then indicated wanting the insulin in the "belly, to the right." LPN-A wiped the area with alcohol and then administered the 6 units. After administering R48's insulin , LPN-A was interviewed regarding "priming" (also called giving an airshot) the Flex Pen after the needle was attached. LPN-A indicated she did not prime the Flex Pen before administering the insulin for R25 or R48. Interview with the director of nursing (DON) on 4/21/14 at 5:20 p.m. revealed staff should prime the Flex Pen with 2 units of insulin prior to administering.	F 425	area as a reminder to staff and residents who self administer with supervision. Training completed by 5/21/14. Director of Nursing and Staff Development Coordinator will do audits every week x 4 weeks to assure compliance, thereafter random audits will be done to assure compliance.	

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 CARE HOME	715 WEST 31ST STREET MINNEAPOLIS, MN 55408

(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 425	Continued From page 5 Interview with the DON on 4/23/14 at 11:30 a.m. indicated LPN-A only works part time and was nervous because the surveyor was present. On 4/23/14 at 11:30 a.m., the policy on administering insulin via Novolog Pen was requested and received. Review of the pharmacy policy titled Medication Administration, Subcutaneous Insulin, dated 09/10 indicated the following: 9.b. prepare syringe/pen and safety needle. (see pen example). On page 3 of 6 the following directions were provided: Line up the needle with the pen, and keep it straight as you attach it. If the needle is not kept straight while you attach it, it can damage the rubber seal and cause leakage, or break the needle. Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate does by: . ensuring that the pen and needle work properly. . removing air bubbles. A. Select the dose of units by turning the dosage selector (picture shows a pen with a dose of 2 units) Check that the dose window show "0" following the safely test. C. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. D. Hold the pen with the needle pointing upwards. E. Tap the insulin reservoir so that any air	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING _____ B. WING _____	04/23/2014

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F 425	Continued From page 6 bubbles rise up towards the needle. F. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before the insulin is seen. . If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them. . If still no insulin come out, the needle be be blocked. Change the needle and try again. . If no insulin comes out after changing the needle, the pen may be damaged. Do not use this pen.	F 425		
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.	F 431		5/9/14

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 431	Continued From page 7 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to ensure inhalers were labeled with the date opened, for 3 of 7 residents (R13, R30, R49) whose inhalers were observed during the medication storage tour. Findings include: On 4/21/14, at 5:00 p.m. during medication storage tour with trained medication aide (TMA)-A, the following was observed: an open Advair Diskus (inhaler for the treatment of asthma) stored in the medication cart was undated for R30, an open Advair Diskus undated for R13, and an open undated Proventil inhaler for R49. During interview with the director of nursing on 4/21/14 at 5:30 p.m., she indicated all inhalers should have a sticker indicating date opened. Review of the facility's undated Medication Expiration Dating Policy and Procedure directed the following:	F 431	Med cart audit was completed on 4/22/14 to be sure all drugs are properly dated. Policy and procedure reviewed with all nursing staff and training done with each staff member to ensure adherence. A med cart audit will be completed by Staff Development Coordinator weekly x next 4 weeks to assure compliance. Birchwood has recently changed pharmacies and the new pharmacy will be doing monthly med room and med cart audits to assure compliance. Staff Development Coordinator will do random audits in between pharmacy audits for next 6 months to assure compliance. Policy and procedure attached.	

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F 431	Continued From page 8 POLICY It is the policy of Birchwood Care Home for staff to date medications with limited expiration times when opening them. This includes but is not limited to: eye drops, eye ointments, insulin, multidose inhalers ...and certain liquid medications according to pharmacy consultant guidelines. PURPOSE To ensure that medications are utilized according to manufacturer guidelines and accepted practice. PROCEDURE 1. When medication is delivered from the pharmacy, the staff checking in the medication will affix a "date opened" label to each medication from the above list . 2. Staff will date the exempted medication when opening them for their first use. 3. Staff giving these exempted medications will check the label for date opened and that it has not expired. 4. Staff will reorder the above listed medications before the expiration date.	F 431		