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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LYS5

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/01/2007**

6. DATE OF SURVEY **04/20/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Tim Rhonemus, HFE NE II 03/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 10/02/2017 (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 10/12/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/28/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245200 October 2, 2017

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 April 1, 2017 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
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 2, 2017

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

RE: Project Number S5200027

Dear Ms. Gentilli:

On March 13, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 18, 2017. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil Money Penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on February 24, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 20, 2017, the Minnesota Department of Health, and on April 10, 2017 the Minnesota Department of Public Safety completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 24, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 1, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 24, 2017, as of April 1, 2017.

As a result of the revisit findings, the Department discontinued the Category 1 remedy of state monitoring effective April 1, 2017.

On August 4, 2017 we informed you that your Informal Dispute Resolution (IDR) of the deficiency cited at F314 resulted in changes to the deficiency, including a reduction in the scope and severity level from G to D.

In our letter of March 13, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years

from February 24, 2017 due to imposition of a Civil Money Penalty (CMP). The Centers for Medicare and Medicaid Services did not impose the CMP and the IDR resulted in a reduction of the scope and severity level of F314 from a G to a D. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245200		4/20/2017

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 F0314 Reg. # 483.25(b)(1) LSC	Correction Completed 04/01/2017	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TA/KJ	DATE 04/28/2017	SIGNATURE OF SURVEYOR 20794	DATE 04/20/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/24/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245200		4/20/2017

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 F0314 Reg. # 483.25(b)(1) LSC	Correction Completed 04/01/2017	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TA/KJ	DATE 04/28/2017	SIGNATURE OF SURVEYOR 20794	DATE 04/20/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/24/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 2, 2017

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

Re: Reinspection Results - Project Number S5200027

Dear Ms. Gentilli:

On April 20, 2017 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 February 24, 2017 with orders received by you on March 14, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00853 Y1	A. Building B. Wing Y2	4/20/2017 Y3

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	Correction Completed 04/01/2017	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TA/KJ	DATE 04/28/2017	SIGNATURE OF SURVEYOR 20794	DATE 04/20/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/24/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: LYS512

STATE FORM: REVISIT REPORT (11/06)

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered
August 4, 2017

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

Subject: Birchwood Health Care Center - IDR
CCN: # 245200
Project # S5200027

Dear Ms. Gentilli:

This is in response to your letter of March 16, 2017, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency at tag F314 issued pursuant to the survey event LYS511, completed on February 24, 2017.

The information presented with your letter, the CMS 2567 dated February 24, 2017 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F314 S/S G 42 CFR § 483.25(b)(1) Skin Integrity: Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

Summary of the facility's reason for IDR of this tag: The facility disputed the findings at F314 based on their assertion that staff assessed, evaluated, monitored, care planned and provided care to meet the resident's needs while maintaining standards of practice in the care and treatment of the wound. Documents provided during the face to face, indicate the resident was diagnosed with a Kennedy Terminal Ulcer and thus was unavoidable, and that due the resident's medical condition, the resident's body was shutting down and the wound was not expected to heal.

Summary of facts: The resident was assessed and interventions were implemented upon admission to minimize skin breakdown including: (1) Pamacea Clinical mattress which provides pressure redistribution with a heel slope that redirects pressure to the calves (mattress has a capacity for 450 lbs.); (2) moisture barrier products were applied to protect the resident's skin from excess moisture;

and (3) incontinence products utilized absorb and wick away moisture. Care plan i**nterventions** related to pressure ulcer prevention included on the care plan dated 5/22/15 with revision 12/20/16 included: (1) repositioning; (2) routine skin checks; (3) pressure redistribution mattress and cushion; (4) diabetic management-glucose checks and insulin; (5) application of moisture barrier; (6) toileting plan; (7) Lachydrin lotion to bilateral lower extremities at bedtime; (8) lie down every afternoon; (9) care of skin fold due to weight; (10) use of compression garments; and (11) staff to use sit to stand lift for transfer to reduce potential friction and shear.

Summary of findings: Following review of the CMS 2567, information submitted by the facility, a face to face conference with facility staff, review of MDH surveyor documentation, and discussion with licensing and certification staff, it was determined the facility had conducted multiple assessments of the unavoidable pressure ulcer prior to and following the development of the wound. The facility had identified interventions to utilize, including use of an AirPro Elite Alternating Air Flotation Therapy overlay device. Although the device had been added to the resident's bed, the facility failed to ensure the device was functioning properly and inflated in a manner to meet the resident's need for a period of several hours.

Although the provider had conducted regular inspection and provision of wound care, a deficient practice exists due to their failure to ensure the AirPro overlay was functional. However, the resident's medical co-morbidities made the pressure ulcer development unavoidable. The findings will be modified to remove reference to failure to assess. The deficiency remains valid at a reduced scope and severity of (S/S) D.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Kathryn Serie

Kathryn M. Serie, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 507-476-4233 Fax: 507-537-7194

cc: Office of Ombudsman for Long-Term Care
Pamela Kersson, Assistant Program Manager
Kathy Lucas, St. Cloud B Unit Supervisor
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 _____	02/24/2017

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 "Revised 2567 as a result of an Informal Dispute Resolution." The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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.	F 000		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 314	The preparation of the following plan of	4/1/17

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

Electronically Signed | 03/22/2017

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 _____	02/24/2017

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 314	Continued From page 1 review, the facility failed to implement interventions to promote healing of an unavoidable pressure ulcer, for 1 of 1 resident (R12) reviewed who had an unavoidable pressure ulcer. Findings include: R12's annual Minimum Data Set (MDS) dated 12/15/16, indicated R12 had moderate cognitive impairment and required extensive assistance for bed mobility and transfers. The MDS further identified R12 as frequently incontinent of bladder and occasionally incontinent of bowel and identified diagnoses including: dementia, anemia, diabetes and renal insufficiency. The MDS also identified R12 as at risk to develop pressure ulcers and indicated R12 did not have current pressure ulcers. Interventions identified on the MDS included a pressure reducing device in the bed and chair, and application of ointments or medications to areas other than the feet. R12's pressure ulcer Care Area Assessment (CAA) dated 12/19/16, indicated R12 had a potential for pressure ulcer development related to cognitive deficits, mobility limitations, poor nutrition, incontinence, diabetes and renal failure. The CAA identified a need for a special mattress or seat cushion to reduce or relieve pressure, and identified a care plan was to be developed to minimize risks. R12's care plan dated 12/30/16, indicated R12 had the potential for pressure ulcer development and included a goal: to have intact skin, free of redness, blisters or discoloration by/through the review date of 1/4/17. Interventions included: encourage reposition/position changes during	F 314	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 #12: a Comprehensive Skin and Positioning Evaluation was completed on 2/23/17. On 3/3/17 due to continued decline in condition, R12 was enrolled in hospice. She was seen by certified wound specialist on 3/8/17 and diagnosed with a Kennedy Terminal Ulcer to her buttock wound. R12 expired 3/13/17. 2) All residents with high risk Braden Assessments have had a new Comprehensive Skin and Positioning Evaluation completed with revisions to the resident plan of care as indicated. 3) All nursing staff will be re-educated on the Pressure Ulcer Guidelines by 4/1/17; Weekly Wound Rounds are conducted ongoing for review of wound assessment and treatment progress 4) The Director of Nursing and/or designee will audit two residents each week for one month and one resident each week for the following two months regarding wound care and assessment 5) The data collected will be presented at QAPI by the Director of Nursing. Data will be reviewed/discussed at the monthly	

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 _____	02/24/2017

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 314	Continued From page 2 customer service rounds, observe/document/report to medical practitioner changes in skin status, and a pressure relieving support surface in bed and chair. R12's Nursing Assistant Care Plan dated 2/15/17, indicated to reposition R12 every two to three hours, as R12 was frequently incontinent, and to assist to the bathroom every two to three hours and per request. The Nursing Assistant Care Plan also included to encourage R12 to lay down after lunch and that R12 preferred to go to bed by 8:30 p.m. R12's progress noted were reviewed and indicated the following: On 1/26/17, at 9:30 p.m. a blister was discovered on the resident's left buttock during evening cares. The blister measured 1.4 centimeters (cm) x 1 cm. Aloe Vesta lotion was applied and the resident was repositioned. On 1/29/17, at 10:02 p.m. the blister on the left buttock opened up and was covered with a bandage. The bandage became soiled so the area was cleaned and the bandage replaced. The blister area was noticeably larger with a painful red area around it and measured 5.1 cm x 5.1 cm. The resident was given morphine for pain and repositioned off the sore area. On 2/10/17, at 12:40 p.m. the registered dietician provided education on the need for increased calories and protein to promote healing. The resident had agreed to increase protein intake with larger portions at meals, and to try 30 cubic centimeters (cc) of Prostat (a protein supplement)	F 314	Quality Assurance meeting. At this time, the committee will make the decision/recommendation 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 _____	02/24/2017

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 314	Continued From page 3	F 314		

twice a day.

On 2/22/17, at 9:00 p.m. a blister like area was found on R12's left heel approximately 2 cm x 3 cm, about quarter sized. Floating feet on pillows off mattress and monitoring every shift. Updated nurse practitioner (NP) and the nurse manager via voicemail and updated the resident's daughter.

On 2/23/17, at 2:51 a.m., the notes indicated the resident continued with a purple blister to the left heel, with dark pink mushy skin next to the blister, heels floated in bed.

R12's Wound Assessment Detail Reports dated 2/1, 2/8, 2/16, and 2/23/17 identified the progress of the wound on the resident's buttock. A note dated 2/23/17 at 9:43 a.m. indicated a facility acquired left heel unstageable pressure ulcer which measured 2.6 cm x 2.0 cm with intact skin.

During observation on 2/22/17, at 3:09 p.m. R12's bed was observed, while resident was not in bed, an Air Pro mattress overlay was noted to be on R12's bed. The pump was running however, the overlay was not inflated.

During continuous observation on 2/23/17, from 6:59 a.m. to 7:38 a.m. R12 was observed in bed on her left side with a body pillow behind her back that was half on the bed and half hanging off the bed. During this period of observation R12 tried several times to reposition herself by reaching up to her grab bar and attempting to move herself but was unable. No staff members entered R12's room during this time. Although the pump was running, R12's mattress overlay remained under inflated.

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 _____	02/24/2017

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 314	Continued From page 4 During observation on 2/23/17, at 7:52 a.m. nursing assistants (NA)-A and NA-B knocked and entered R12's room and told R12 that they were there to reposition her. NA-A and NA-B repositioned R12 to her right side and put a body pillow behind her and elevated her heels off the mattress with pillows. NA-A stated to R12 that they would be back after a bit to get her ready for the day. The state surveyor intervened and asked about the air mattress overlay. NA-A then felt the air mattress and verified it was not inflated and stated she would let the nurse know. NA-A stated R12 is repositioned and toileted at least every two hours unless she refused. NA-A left the room and returned at 8:07 a.m. and stated to R12 that she needed to get ready and get out of bed as her air mattress needed to be checked. The dressing to R12's left buttock was observed to be intact at the time, with some drainage observed on the dressing. During interview on 2/23/17, at 8:49 a.m. RN-A stated ideally observation of the air mattress overlay should be made prior to staff placing the resident on the bed. RN-A confirmed the air overlay was flat (under inflated) and said she would have maintenance look at it right away. RN-A further stated she had placed the air mattress overlay on R12's mattress on 2/22/17, and could not recall if it was inflated or not. During a follow up interview on 2/23/17, at 11:26 a.m. RN-A stated that R12 had received an order for OT to evaluate and treat R12 on 2/1/17, and that OT had started on 2/2/17. RN-A stated the overlay mattress had been placed on R12's bed on 2/22/17, because she had realized she had forgotten to implement and place the mattress	F 314		

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 _____	02/24/2017

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 314	Continued From page 5	F 314		

earlier. RN-A further stated that she did not test the air overly to see if it was functioning. RN-A stated otherwise the mattress on R12's bed is the standard mattress every resident has. RN-A added that nursing assistants observe the skin daily and that a licensed nurse observes the skin weekly and documents irregularities. Anything that is abnormal, and any interventions initiated, are communicated through report verbally and on the communication report.

During interview on 2/23/17, at 1:07 p.m. the NP stated she had never seen R12's wound. The NP stated she only observed wounds if the nursing team asked her specifically to assess it. The NP stated that the nurses had suggested new treatments to the wound and orders for an OT assessment and that she had agreed and signed off on the orders. The NP confirmed that due to the location of the wound, she would suspect it was pressure related. The NP further added that R12 had been declining and had multiple co-morbidities.

During interview on 2/23/17, at 1:24 p.m. the occupational therapist (OT)-A stated R12 had been referred to OT for positioning and toileting. OT-A stated that during the assessment it had been noted that a blue foam backrest in R12's wheelchair was creating pressure, so she had assessed R12 for a tilt and space wheelchair. OT-A stated on 2/16/17, a recommendation had been made to reposition R12 every two hours at night. OT-A stated she had not assessed R12's mattress at this time and stated it had been reported that R12 had developed a heel ulcer and would be looking into interventions for that.

During observation on 2/23/17, at 1:41 p.m. R12

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 _____	02/24/2017

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 314	Continued From page 6	F 314		

was observed to be sleeping on her left side. The overlay was inflated.

During continuous observation on 2/24/17, between 5:35 a.m. to 8:25 a.m. R12 was observed to be sleeping in bed on her back with the mattress overlay inflated. At 6:57 a.m. LPN-A and RN-A knocked and entered the room telling R12 that she needed to be repositioned. RN-A entered the room and LPN-A and RN-A repositioned R12 onto her right side, and elevated her feet on pillows. R12 had soft boots on her feet bilaterally. RN-A nor LPN-A checked R12 for incontinence or offered to assist her with toileting. R12 remained on her right side. At 8:19 a.m. LPN-A brought R12 her medications, but R12 did not want to wake up. LPN-A asked a nursing assistant to help boost R12 in bed. The nursing assistant and LPN-A boosted R12 in bed and straightened her pillows. Neither LPN-A or the nursing assistant checked R12 for incontinence. At 8:25 a.m., the state surveyor intervened and asked whether R12 had been checked for incontinence. LPN-A put gloves on and checked R12 for incontinence and stated R12 was wet. LPN-A also stated the boots on R12's heels did not have a heel cut out to relieve pressure. At that time, the nursing assistant and LPN-A assisted with removing R12's soiled brief and the dressing to R12's left buttock was saturated and loose.

During follow up interview on 2/24/17, at 10:31 a.m. RN-A stated the frequency of R12's toileting and incontinence changes had not been reassessed since the development of the blister or any time after. RN-A stated she was not sure if three hours was too long to not have a brief changed with her skin condition and dressing in

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 _____	02/24/2017

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 314	Continued From page 7	F 314		

the area.

During interview on 2/24/17, at 10:47 a.m. the DON (director of nursing) stated initially the blister was a result of trauma from the toilet seat and not due to pressure. The DON stated the wound had been caused by R12's skin sticking to the toilet seat. The DON further stated OT had been initiated to assist with R12's positioning as R12 spends a lot of her time in her wheelchair at activities during the day, and was rarely in bed. The DON stated, "Our goal for her, regardless of skin impairment, is that she can participate in activities as it is important to her and her family." She confirmed a risk versus benefits had not been discussed, and stated there had been no comprehensive skin assessment completed following the development of the blister and subsequent worsening of the pressure ulcer, to assess the appropriateness of toileting and repositioning frequency and the appropriateness of R12's mattress.

During interview on 2/24/17, at 3:21 p.m. R12 stated she went to bed around 8:30 p.m. to 9:00 p.m. and got up around 9:30 a.m.

The facility's policy Pressure Ulcer Prevention dated 10/15, indicated a comprehensive evaluation of the resident's clinical condition and pressure ulcer risk factors were to be completed on admission and as required throughout the resident's stay. Evaluation of the individual risk factors and determination, based on clinical judgement, selection of risk reduction strategies to stabilize, reduce or remove the underlying risk factors identified on the assessment. The policy also indicated documentation requirements of "SBAR" (communication tool) for any new or

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 _____	02/24/2017

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 314	Continued From page 8 worsening alteration in skin integrity, daily monitoring, and body audit form completed, skin observation in "POC" (point of care) and a comprehensive skin and positioning evaluation. The policy indicated comprehensive skin and positioning evaluations would be completed on admission, quarterly, annually and with any significant change in status, or with any new alteration in skin integrity. The undated Direct Supply Panacea Clinical and Clinical Plus Mattress information form, indicated the pressure redistribution support surfaces are appropriate for use as part of an overall care plan to prevent and treat decubitus ulcers. The form further indicated resident specific assessment could alter the particular usage of the mattresses. The undated Air Pro Series Alternating Pressure Pad and Pump Overlay Mattress Systems information form, identified an Air Pro plus 4200 that was a bubble style , with more touch points for effective weight distribution. The Posey Heel Pillows information sheet dated 2009, indicated the heel pillows helped protect heels and ankles from skin irritation and friction burns. The Posey guidance recommended to follow facility policies and guidelines for frequency of patient monitoring and that the product should be removed at least every two hours to check skin integrity, proper circulation and range of motion.	F 314		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LYS5

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/01/2007**

6. DATE OF SURVEY **02/24/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

* Code: B* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Christine Bodick-Nord, HFE NE II — 03/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 04/27/2017 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 13, 2017

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

RE: Project Number S5200027

Dear Ms. Gentilli:

On February 24, 2017, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

Potential Consequences - the consequences of not attaining substantial compliance 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one of the criteria and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective March 18, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 remedy be imposed:

- 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 24, 2017 (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 August 24, 2017 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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. 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,

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(s)
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 02/24/2017

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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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.	F 000		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the skin to promote healing of a facility acquired pressure ulcer, as well as prevent	F 314	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	4/1/17

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

Electronically Signed | 03/22/2017

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 02/24/2017

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 314	Continued From page 1 further pressure ulcers from developing. In addition, the facility failed to ensure care planned interventions were implemented as directed for 1 of 1 residents (R12) reviewed for pressure ulcers. This resulted in actual harm to R12 due to worsening of a pressure ulcer to the buttock, and development of a new heel pressure ulcer. Findings include: R12's annual Minimum Data Set (MDS) dated 12/15/16, indicated R12 had moderate cognitive impairment and required extensive assistance for bed mobility and transfers. The MDS further identified R12 as frequently incontinent of bladder and occasionally incontinent of bowel and identified diagnoses including: dementia, anemia, diabetes and renal insufficiency. The MDS also identified R12 as at risk to develop pressure ulcers and indicated R12 did not have current pressure ulcers. Interventions identified on the MDS included a pressure reducing device in the bed and chair, and application of ointments or medications to areas other than the feet. R12's pressure ulcer Care Area Assessment (CAA) dated 12/19/16, indicated R12 had a potential for pressure ulcer development related to cognitive deficits, mobility limitations, poor nutrition, incontinence, diabetes and renal failure. The CAA identified a need for a special mattress or seat cushion to reduce or relieve pressure, and identified a care plan was to be developed to minimize risks. R12's care plan dated 12/30/16, indicated R12 had the potential for pressure ulcer development and included a goal: to have intact skin, free of redness, blisters or discoloration by/through the	F 314	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 #12: a Comprehensive Skin and Positioning Evaluation was completed on 2/23/17. On 3/3/17 due to continued decline in condition, R12 was enrolled in hospice. She was seen by certified wound specialist on 3/8/17 and diagnosed with a Kennedy Terminal Ulcer to her buttock wound. R12 expired 3/13/17. 2) All residents with high risk Braden Assessments have had a new Comprehensive Skin and Positioning Evaluation completed with revisions to the resident plan of care as indicated. 3) All nursing staff will be re-educated on the Pressure Ulcer Guidelines by 4/1/17; Weekly Wound Rounds are conducted ongoing for review of wound assessment and treatment progress 4) The Director of Nursing and/or designee will audit two residents each week for one month and one resident each week for the following two months regarding wound care and assessment 5) The data collected will be presented at QAPI by the Director of Nursing. Data will be reviewed/discussed at the monthly Quality Assurance meeting. At this time, the committee will make the decision/recommendation regarding any	

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 02/24/2017

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 314	Continued From page 2 review date of 1/4/17. Interventions included: encourage reposition/position changes during customer service rounds, observe/document/report to medical practitioner changes in skin status, and a pressure relieving support surface in bed and chair. R12's Nursing Assistant Care Plan dated 2/15/17, indicated to reposition R12 every two to three hours, as R12 was frequently incontinent, and to assist to the bathroom every two to three hours and per request. The Nursing Assistant Care Plan also included to encourage R12 to lay down after lunch and that R12 preferred to go to bed by 8:30 p.m. R12's progress noted were reviewed and indicated the following: On 1/26/17, at 9:30 p.m. a blister was discovered on the resident's left buttock during evening cares. The blister measured 1.4 centimeters (cm) x 1 cm. Aloe Vesta lotion was applied and the resident was repositioned. The note indicated a message had been left for the medical practitioner. On 1/29/17, at 10:02 p.m. the blister on the left buttock opened up and was covered with a bandage. The bandage became soiled so the area was cleaned and the bandage replaced. The blister area was noticeably larger with a painful red area around it and measured 5.1 cm x 5.1 cm. The resident was given morphine for pain and repositioned off the sore area. However, there was no assessment of the skin despite the development of a new pressure ulcer.	F 314	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 02/24/2017

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 314	Continued From page 3	F 314		

On 2/10/17, at 12:40 p.m. the registered dietician provided education on the need for increased calories and protein to promote healing. Resident agreed to increase protein with larger portions at meals and try 30 cubic centimeters (cc) of Prostat twice a day.

On 2/22/17, at 9:00 p.m. a blister like area was found on R12's left heel approximately 2 cm x 3 cm, about quarter sized. Floating feet on pillows off the mattress and monitoring every shift. Updated nurse practitioner (NP) and the nurse manager via voicemail and updated the resident's daughter. However, there was no assessment of the skin despite the development of a new pressure ulcer to determine if appropriate interventions were in place.

On 2/23/17, at 2:51 a.m. the resident continued with a purple blister to the left heel, with dark pink mushy skin next to the blister, heels floated in bed.

R12's Wound Assessment Detail Reports were reviewed and indicated the following:

On 2/1/17, at 8:37 a.m. the wound assessment indicated a facility acquired vascular blister on the left iliac crest with partial thickness with 90 percent intact skin and 10 percent bright beefy red skin tissues. The wound assessment indicated light serosanguinous drainage, peri wound had erythema and edema and the wound edges were distinct and attached. The area measured 5.5 cm x 4.8 cm. The wound assessment indicated a deflated blister on resident's "right" upper buttock and that the resident complained of pain in the area. Staff indicated this happened when the resident's

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 02/24/2017

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 314	Continued From page 4	F 314		

buttock "sticks" to the toilet. Resident is on occupational therapy (OT) services for toileting and positioning. Current treatment of skin prep and cover with a large Mepilex dressing. The wound assessment indicated R12's last Braden assessment indicated a moderate risk to develop pressure ulcers.

On 2/8/17, at 7:53 a.m. the wound assessment indicated a facility acquired vascular blister on the left iliac crest with 10 percent beefy red and 90 percent non adherent skin tissues. The wound assessment indicated moderate serosanguinous drainage, peri wound had erythema and edema and the wound edges were distinct and attached. The area measured 6.7 cm x 5.5 cm with an unknown depth. The wound assessment did not indicate the current order of treatment, but a dressing was present.

On 2/16/17, at 7:44 a.m. the wound assessment indicated a facility acquired vascular blister on the left iliac crest with 10 percent non adherent slough and 90 percent skin tissues. The wound assessment indicated moderate serosanguinous drainage, peri wound had erythema and edema and the wound edges were distinct and attached. The area measured 5.5 cm x 6.0 cm with an unknown depth. The wound assessment indicated that the area was determined to be pressure due to R12's wheelchair. The resident is on OT services and did have a wheelchair change to a tilt and space and will provide more offloading during the day. Current treatment of Calcium Alginate to cover wound bed and to provide debridement and cover with Primapore daily. No odor noted to drainage at this time.

On 2/23/17, at 8:49 p.m. the wound assessment

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 02/24/2017

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 314	Continued From page 5	F 314		

indicated a facility acquired pressure ulcer that was unstageable with 20 percent non adherent slough and 80 percent necrotic tissues. The wound assessment indicated moderate serosanguinous drainage, peri wound had erythema and edema and the wound edges were distinct and attached. The area measured 5.8 cm x 5.3 cm with an unknown depth. The wound assessment indicated a slight decrease in width. The peri wound was red and firm at the time and is blanchable. Dressing was changed to Santyl for more debridement. Foul smelling drainage at this time. Will continue with BID dressing changes and assess weekly. However, there was no assessment of the pressure ulcer despite worsening condition.

On 2/23/17, at 9:43 a.m. the wound assessment indicated a facility acquired left heel unstageable pressure ulcer which measured 2.6 cm x 2.0 cm with intact skin.

During observation on 2/22/17, at 3:09 p.m. R12's bed was observed, while resident was not in bed, and an Air Pro mattress overlay was noted to be on R12's bed. The pump was running, however, the bed was not inflated.

During continuous observation on 2/23/17, from 6:59 a.m. to 7:38 a.m. R12 was observed in bed on her left side with a body pillow behind her back that was half on the bed and half hanging off the bed. During this period of observation R12 tried several times to reposition herself by reaching up to her grab bar and attempting to move herself but was unable. No staff members entered R12's room during this time. Although the pump was running, R12's mattress overlay was not inflated.

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 02/24/2017

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 314	Continued From page 6	F 314		

During observation on 2/23/17, at 7:52 a.m. nursing assistant (NA)-A and NA-B knocked and entered R12's room and told R12 that they were there to reposition her. NA-A pulled down R12's blankets and R12's left heel was observed to be resting directly on the mattress with her ankles crossed, with the right foot over the left. There was no pillow near her feet so her heels were not floated. NA-A stated that she should have a pillow under her feet. NA-A and NA-B repositioned R12 to her right side and put a body pillow behind her and elevated her heels off the mattress with pillows. NA-A stated to R12 that they would be back after a bit to get her ready for the day. The state surveyor intervened and asked about the air mattress. NA-A then felt the air mattress and verified that is was flat and not inflated and stated she would go and let the nurse know. NA-A stated that she is repositioned and toileted at least every two hours unless she refused. NA-A left the room and returned at 8:07 a.m. and stated to R12 that she needed to get ready and get out of bed as her air mattress needed to be checked. NA-A and NA-B assisted R12 with morning cares and NA-B stated R12 had a medium amount of urine in her brief. The dressing to R12's left buttock was observed to be intact at the time, with some drainage observed on the dressing.

During observation on 2/23/17, at 8:30 a.m. registered nurse (RN)-A told R12 she was going to conduct a dressing change to her bottom. RN-A with gloved hands removed R12's dressing, which had a moderate amount of bloody watery drainage on it. The wound was observed to have necrotic and slough tissue in the wound bed and had a foul odor. The peri wound was red. RN-A cleansed the wound with wound cleanser and measured the wound. The wound measured 5.8

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 02/24/2017

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 314	Continued From page 7	F 314		

cm x 5.3 cm and RN-A stated she was unable to measure the depth. RN-A placed Santyl in the wound bed with a cotton swab and placed a Primapore dressing over the wound. RN-A then assessed the left heel and stated the heel was boggy and blistered, when RN-A touched R12's left heel R12 moved her foot and stated it hurt. The left heel blister measured 2 cm x 2.7 cm and the skin was noted to be intact. RN-A stated that it was a deep tissue injury and would update the NP (nurse practitioner) again today and in the meantime would float R12's heels and get heel protectors.

During interview on 2/23/17, at 8:49 a.m. RN-A stated ideally observation of the air mattress overlay should be made prior to staff placing the resident on the bed. RN-A stated that the air overlay was flat and she would have maintenance look at it right away. RN-A further stated she had placed the air mattress overlay on R12's mattress on 2/22/17, and could not recall if it was inflated or not. RN-A stated she did not believe a comprehensive skin assessment had been completed to determine risk factors, and to assess whether R12's current interventions to prevent pressure ulcers had been reviewed after R12 had developed the blister on her buttocks, or as the wound worsened. RN-A stated it had been determined that R12's old wheelchair was creating the problem and that R12 was in OT for positioning. She stated they had just gotten her a trial tilt and space wheelchair. RN-A stated there was not a specific assessment to determine how frequently a resident should be repositioned. RN-A stated if a resident had an open area, or was dependent on staff, the resident should be repositioned every two hours. However, the care plan directed staff to provide repositioning every

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 02/24/2017

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 314	Continued From page 8	F 314		

2-3 hours, and did not address floating the heels. RN-A also stated a new Braden (skin assessment) had not been completed for R12 after the development of the pressure ulcer on R12's buttocks, and subsequent heel pressure ulcer. RN-A stated the NP had been informed of both areas and followed R12 regularly, however, RN-A was unsure whether the NP had assessed R12's ulcer. RN-A stated she did not feel the ulcer was infected despite the foul smell, and stated she thought the odor was due to R12's wound debridement dressing.

During follow up interview on 2/23/17, at 9:52 a.m. RN-A stated the tilt and space wheelchair had been initiated for R12 on 2/14/17. RN-A also stated that she'd found a checklist for pressure ulcers that indicated staff should complete a skin and wound note, complete a body audit assessment, complete a comprehensive skin and evaluation assessment, update the NP or physician, and should add daily monitoring of the wound to the treatment sheets as well as notifying the family, director of nursing (DON), dietician and therapy. RN-A stated she would look for the assessment.

During observation on 2/23/17, at 11:25 a.m. R12 was observed in the dining room seated in the tilt and space wheelchair with non-skid socks on each foot. Her feet were on the foot pedals, but her heels were not in contact directly with the foot pedals.

During a follow up interview on 2/23/17, at 11:26 a.m. RN-A stated that R12 had received an order for OT to evaluate and treat R12 on 2/1/17, and that OT had started on 2/2/17. RN-A stated initially the buttock wound was not documented

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 02/24/2017

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 314	Continued From page 9	F 314		

as pressure, and they had thought it was due to trauma from the toilet seat. Interventions prior to development of the wound included: a pressure reduction cushion in the wheelchair, and to encourage every two hour repositioning along with customer service rounds hourly, to see if the resident needed something, unless observed to be sleeping. RN-A stated the wound had been observed daily for changes and that the NP had been updated on the changes of the skin. RN-A stated that because she initially thought the wound had been caused from trauma, there had been no changes to R12's repositioning schedule, but that staff had been successful at encouraging R12 to lay down more. A treatment to the blister was initiated on 1/27/17, to cleanse the blister with wound cleanser and dry and cover with Allevyn dressing every three days and as needed (PRN). The treatment had been changed on 2/1/17, to use skin prep and cover with Mepilix every three days and PRN, because the blister had opened up. On 2/8/17, the wound treatment had been modified again to place Calcium Alginate to the wound bed and cover with Primapore daily due to wound changes. On 2/20/17, the order was changed to use Santyl in the wound bed to debride the wound. The dressing change was also increased to BID. RN-A also stated that wound rounds are completed weekly to assess the wound, and that the wound team discusses interventions during rounds which may not be documented. RN-A confirmed at this time there had been no comprehensive assessment completed, no formal changes to R12's toileting and repositioning schedule, and no reassessment of R12's mattress. RN-A stated the overlay mattress had been placed on R12's bed on 2/22/17, because she had realized she had forgotten to

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 02/24/2017

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 314	Continued From page 10	F 314		

implement and place the mattress earlier. RN-A further stated that she did not test the air overly to see if it was functioning. RN-A stated otherwise the mattress on R12's bed is the standard mattress every resident has. RN-A stated that wound treatments were changed as the wound worsened and that the dietician and therapy had been consulted. RN-A stated that a wound clinic referral had not been discussed by the wound team. RN-A added that nursing assistants observe the skin daily and that a licensed nurse observes the skin weekly and documents irregularities. Anything that is abnormal, and any interventions initiated, are communicated through report verbally and on the communication report.

During interview on 2/23/17, at 1:07 p.m. the NP stated she had never seen R12's wound. The NP stated she only observed wounds if the nursing team asked her specifically to assess it. The NP stated that the nurses had suggested new treatments to the wound and orders for an OT assessment and that she had agreed and signed off on the orders. The NP confirmed that due to the location of the wound, she would suspect it was pressure related. The NP further added that R12 had been declining and had multiple co-morbidities. She stated R12 had been on hospice but was not any longer, as she was not actively in the dying process. The NP also stated no one had told her there was necrotic tissue in the wound bed and if she had known she could have helped the facility look at further interventions. The NP added that it appeared a couple of pieces were missing.

During interview on 2/23/17, at 1:24 p.m. the occupational therapist (OT)-A stated R12 had been referred to OT for positioning and toileting.

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 02/24/2017

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 314	Continued From page 11	F 314		

OT-A stated that during the assessment it had been noted that a blue foam backrest in R12's wheelchair was creating pressure, so she had assessed R12 for a tilt and space wheelchair. OT-A stated on 2/16/17, a recommendation had been made to reposition R12 every two hours at night. OT-A stated she had not assessed R12's mattress at this time and stated it had been reported that R12 had developed a heel ulcer and would be looking into interventions for that.

During observation on 2/23/17, at 1:41 p.m. R12 was observed to be sleeping on her left side. The overlay was inflated.

During continuous observation on 2/24/17, between 5:35 a.m. to 8:25 a.m. R12 was observed to be sleeping in bed on her back with the mattress overlay inflated. At 6:57 a.m. LPN-A and RN-A knocked and entered the room telling R12 that she needed to be repositioned. RN-A entered the room and LPN-A and RN-A repositioned R12 onto her right side, and elevated her feet on pillows. R12 had soft boots on her feet bilaterally. RN-A nor LPN-A checked R12 for incontinence or offered to assist her with toileting. R12 remained on her right side. At 8:19 a.m. LPN-A brought R12 her medications, but R12 did not want to wake up. LPN-A asked a nursing assistant to help boost R12 in bed. The nursing assistant and LPN-A boosted R12 in bed and straightened her pillows. Neither LPN-A or the nursing assistant checked R12 for incontinence. At 8:25 a.m., the state surveyor intervened and asked whether R12 had been checked for incontinence. LPN-A put gloves on and checked R12 for incontinence and stated R12 was wet. LPN-A also stated the boots on R12's heels did not have a heel cut out to relieve pressure. At that

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 02/24/2017

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 314	Continued From page 12	F 314		

time, the nursing assistant and LPN-A assisted with removing R12's soiled brief and the dressing to R12's left buttock was saturated and loose.

During follow up interview on 2/24/17, at 10:31 a.m. RN-A stated the frequency of R12's toileting and incontinence changes had not been reassessed since the development of the blister or any time after. RN-A stated she got the boots for R12 from the laundry and would have to ask if they were pressure relieving as she did not know. RN-A stated she was not sure if three hours was too long to not have a brief changed with her skin condition and dressing in the area.

During interview on 2/24/17, at 10:47 a.m. the DON (director of nursing) stated initially the blister was a result of trauma from the toilet seat and not due to pressure. The DON stated the wound had been caused by R12's skin sticking to the toilet seat. The DON further stated OT had been initiated to assist with R12's positioning as R12 spends a lot of her time in her wheelchair at activities during the day, and was rarely in bed. The DON stated, "Our goal for her, regardless of skin impairment, is that she can participate in activities as it is important to her and her family." She confirmed a risk versus benefits had not been discussed, and stated there had been no comprehensive skin assessment completed following the development of the blister and subsequent worsening of the pressure ulcer, to assess the appropriateness of toileting and repositioning frequency and the appropriateness of R12's mattress.

During interview on 2/24/17, at 3:21 p.m. R12 stated she went to bed around 8:30 p.m. to 9:00

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 02/24/2017

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 314	Continued From page 13 p.m. and got up around 9:30 a.m. The facility's policy Pressure Ulcer Prevention dated 10/15, indicated a comprehensive evaluation of the resident's clinical condition and pressure ulcer risk factors were to be completed on admission and as required throughout the resident's stay. Evaluation of the individual risk factors and determination, based on clinical judgement, selection of risk reduction strategies to stabilize, reduce or remove the underlying risk factors identified on the assessment. The policy also indicated documentation requirements of "SBAR" (communication tool) for any new or worsening alteration in skin integrity, daily monitoring, and body audit form completed, skin observation in "POC" (point of care) and a comprehensive skin and positioning evaluation. The policy indicated comprehensive skin and positioning evaluations would be completed on admission, quarterly, annually and with any significant change in status, or with any new alteration in skin integrity. The undated Direct Supply Panacea Clinical and Clinical Plus Mattress information form, indicated the pressure redistribution support surfaces are appropriate for use as part of an overall care plan to prevent and treat decubitus ulcers. The form further indicated resident specific assessment could alter the particular usage of the mattresses. The undated Air Pro Series Alternating Pressure Pad and Pump Overlay Mattress Systems information form, identified an Air Pro plus 4200 that was a bubble style , with more touch points for effective weight distribution.	F 314		

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 02/24/2017

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 314	Continued From page 14 The Posey Heel Pillows information sheet dated 2009, indicated the heel pillows helped protect heels and ankles from skin irritation and friction burns. The Posey guidance recommended to follow facility policies and guidelines for frequency of patient monitoring and that the product should be removed at least every two hours to check skin integrity, proper circulation and range of motion.	F 314		

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 _____	**02/22/2017**

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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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	EPOC	

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

Electronically Signed | 03/22/2017

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 _____	**02/22/2017**

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 61 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 920	NFPA 101 Electrical Equipment - Power Cords	K 920		4/1/17

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 _____	**02/22/2017**

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 920 SS=D	Continued From page 2 and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920	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:	

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 _____	**02/22/2017**

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 920	Continued From page 3 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/22/2017, based on observation and interview revealed that an extension cord was found in the lower level Employee Lounge connected to a TV monitor. This deficient practice could affect the safety of up 10 staff within the room of the building. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	1) The deficiency was corrected by contracting with and electric company to install an additional outlet in this area on 2/27/17 to ensure that an extension cord is not necessary to power the appliance. 2)On 2/27/17, an additional outlet was installed by Mercury Electric in the area where the extension cord was in use. 3) The Environmental Services Director and/or designee will audit the facility for extension cord use weekly for the next three months to ensure extension cords are only used for temporary purposes and removed immediately after the completion of the purpose for which they were installed. 4) All maintenance staff will be re-educated on the proper usage of extension cords by April 1, 2017. Audit results will be discussed monthly with the interdisciplinary team in Quality Assurance meetings.	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
March 13, 2017

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5200027

Dear Ms. Gentilli:

The above facility was surveyed on February 21, 2017 through February 24, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact 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.

Please feel free to call me with 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

Enclosure(s)
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
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: EPOC: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 21-24, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the skin to promote healing of a facility acquired pressure ulcer, as well as prevent further pressure ulcers from developing. In addition, the facility failed to ensure care planned interventions were implemented as directed for 1 of 1 residents (R12) reviewed for pressure ulcers. This resulted in actual harm to R12 due to worsening of a pressure ulcer to the buttock, and development of a new heel pressure ulcer.	2 900	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	4/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 3 Findings include: R12's annual Minimum Data Set (MDS) dated 12/15/16, indicated R12 had moderate cognitive impairment and required extensive assistance for bed mobility and transfers. The MDS further identified R12 as frequently incontinent of bladder and occasionally incontinent of bowel and identified diagnoses including: dementia, anemia, diabetes and renal insufficiency. The MDS also identified R12 as at risk to develop pressure ulcers and indicated R12 did not have current pressure ulcers. Interventions identified on the MDS included a pressure reducing device in the bed and chair, and application of ointments or medications to areas other than the feet. R12's pressure ulcer Care Area Assessment (CAA) dated 12/19/16, indicated R12 had a potential for pressure ulcer development related to cognitive deficits, mobility limitations, poor nutrition, incontinence, diabetes and renal failure. The CAA identified a need for a special mattress or seat cushion to reduce or relieve pressure, and identified a care plan was to be developed to minimize risks. R12's care plan dated 12/30/16, indicated R12 had the potential for pressure ulcer development and included a goal: to have intact skin, free of redness, blisters or discoloration by/through the review date of 1/4/17. Interventions included: encourage reposition/position changes during customer service rounds, observe/document/report to medical practitioner changes in skin status, and a pressure relieving support surface in bed and chair. R12's Nursing Assistant Care Plan dated 2/15/17,	2 900	that: 1) With respect to resident #12: a Comprehensive Skin and Positioning Evaluation was completed on 2/23/17. On 3/3/17 due to continued decline in condition, R12 was enrolled in hospice. She was seen by certified wound specialist on 3/8/17 and diagnosed with a Kennedy Terminal Ulcer to her buttock wound. R12 expired 3/13/17. 2) All residents with high risk Braden Assessments have had a new Comprehensive Skin and Positioning Evaluation completed with revisions to the resident plan of care as indicated. 3) All nursing staff will be re-educated on the Pressure Ulcer Guidelines by 4/1/17; Weekly Wound Rounds are conducted ongoing for review of wound assessment and treatment progress 4) The Director of Nursing and/or designee will audit two residents each week for one month and one resident each week for the following two months regarding wound care and assessment 5) The data collected will be presented at QAPI by the Director of Nursing. Data will be reviewed/discussed at the monthly Quality Assurance meeting. At this time, the committee will make the decision/recommendation 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
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 4 indicated to reposition R12 every two to three hours, as R12 was frequently incontinent, and to assist to the bathroom every two to three hours and per request. The Nursing Assistant Care Plan also included to encourage R12 to lay down after lunch and that R12 preferred to go to bed by 8:30 p.m. R12's progress noted were reviewed and indicated the following: On 1/26/17, at 9:30 p.m. a blister was discovered on the resident's left buttock during evening cares. The blister measured 1.4 centimeters (cm) x 1 cm. Aloe Vesta lotion was applied and the resident was repositioned. The note indicated a message had been left for the medical practitioner. On 1/29/17, at 10:02 p.m. the blister on the left buttock opened up and was covered with a bandage. The bandage became soiled so the area was cleaned and the bandage replaced. The blister area was noticeably larger with a painful red area around it and measured 5.1 cm x 5.1 cm. The resident was given morphine for pain and repositioned off the sore area. However, there was no assessment of the skin despite the development of a new pressure ulcer. On 2/10/17, at 12:40 p.m. the registered dietician provided education on the need for increased calories and protein to promote healing. Resident agreed to increase protein with larger portions at meals and try 30 cubic centimeters (cc) of Prostat twice a day. On 2/22/17, at 9:00 p.m. a blister like area was found on R12's left heel approximately 2 cm x 3	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 5 cm, about quarter sized. Floating feet on pillows off the mattress and monitoring every shift. Updated nurse practitioner (NP) and the nurse manager via voicemail and updated the resident's daughter. However, there was no assessment of the skin despite the development of a new pressure ulcer to determine if appropriate interventions were in place. On 2/23/17, at 2:51 a.m. the resident continued with a purple blister to the left heel, with dark pink mushy skin next to the blister, heels floated in bed. R12's Wound Assessment Detail Reports were reviewed and indicated the following: On 2/1/17, at 8:37 a.m. the wound assessment indicated a facility acquired vascular blister on the left iliac crest with partial thickness with 90 percent intact skin and 10 percent bright beefy red skin tissues. The wound assessment indicated light serosanguinous drainage, peri wound had erythema and edema and the wound edges were distinct and attached. The area measured 5.5 cm x 4.8 cm. The wound assessment indicated a deflated blister on resident's "right" upper buttock and that the resident complained of pain in the area. Staff indicated this happened when the resident's buttock "sticks" to the toilet. Resident is on occupational therapy (OT) services for toileting and positioning. Current treatment of skin prep and cover with a large Mepilex dressing. The wound assessment indicated R12's last Braden assessment indicated a moderate risk to develop pressure ulcers. On 2/8/17, at 7:53 a.m. the wound assessment indicated a facility acquired vascular blister on the	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 6 left iliac crest with 10 percent beefy red and 90 percent non adherent skin tissues. The wound assessment indicated moderate serosanguinous drainage, peri wound had erythema and edema and the wound edges were distinct and attached. The area measured 6.7 cm x 5.5 cm with an unknown depth. The wound assessment did not indicate the current order of treatment, but a dressing was present. On 2/16/17, at 7:44 a.m. the wound assessment indicated a facility acquired vascular blister on the left iliac crest with 10 percent non adherent slough and 90 percent skin tissues. The wound assessment indicated moderate serosanguinous drainage, peri wound had erythema and edema and the wound edges were distinct and attached. The area measured 5.5 cm x 6.0 cm with an unknown depth. The wound assessment indicated that the area was determined to be pressure due to R12's wheelchair. The resident is on OT services and did have a wheelchair change to a tilt and space and will provide more offloading during the day. Current treatment of Calcium Alginate to cover wound bed and to provide debridement and cover with Primapore daily. No odor noted to drainage at this time. On 2/23/17, at 8:49 p.m. the wound assessment indicated a facility acquired pressure ulcer that was unstageable with 20 percent non adherent slough and 80 percent necrotic tissues. The wound assessment indicated moderate serosanguinous drainage, peri wound had erythema and edema and the wound edges were distinct and attached. The area measured 5.8 cm x 5.3 cm with an unknown depth. The wound assessment indicated a slight decrease in width. The peri wound was red and firm at the time and is blanchable. Dressing was changed to Santyl for	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 7 more debridement. Foul smelling drainage at this time. Will continue with BID dressing changes and assess weekly. However, there was no assessment of the pressure ulcer despite worsening condition. On 2/23/17, at 9:43 a.m. the wound assessment indicated a facility acquired left heel unstageable pressure ulcer which measured 2.6 cm x 2.0 cm with intact skin. During observation on 2/22/17, at 3:09 p.m. R12's bed was observed, while resident was not in bed, and an Air Pro mattress overlay was noted to be on R12's bed. The pump was running, however, the bed was not inflated. During continuous observation on 2/23/17, from 6:59 a.m. to 7:38 a.m. R12 was observed in bed on her left side with a body pillow behind her back that was half on the bed and half hanging off the bed. During this period of observation R12 tried several times to reposition herself by reaching up to her grab bar and attempting to move herself but was unable. No staff members entered R12's room during this time. Although the pump was running, R12's mattress overlay was not inflated. During observation on 2/23/17, at 7:52 a.m. nursing assistant (NA)-A and NA-B knocked and entered R12's room and told R12 that they were there to reposition her. NA-A pulled down R12's blankets and R12's left heel was observed to be resting directly on the mattress with her ankles crossed, with the right foot over the left. There was no pillow near her feet so her heels were not floated. NA-A stated that she should have a pillow under her feet. NA-A and NA-B repositioned R12 to her right side and put a body pillow behind her and elevated her heels off the mattress with	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 8 pillows. NA-A stated to R12 that they would be back after a bit to get her ready for the day. The state surveyor intervened and asked about the air mattress. NA-A then felt the air mattress and verified that is was flat and not inflated and stated she would go and let the nurse know. NA-A stated that she is repositioned and toileted at least every two hours unless she refused. NA-A left the room and returned at 8:07 a.m. and stated to R12 that she needed to get ready and get out of bed as her air mattress needed to be checked. NA-A and NA-B assisted R12 with morning cares and NA-B stated R12 had a medium amount of urine in her brief. The dressing to R12's left buttock was observed to be intact at the time, with some drainage observed on the dressing. During observation on 2/23/17, at 8:30 a.m. registered nurse (RN)-A told R12 she was going to conduct a dressing change to her bottom. RN-A with gloved hands removed R12's dressing, which had a moderate amount of bloody watery drainage on it. The wound was observed to have necrotic and slough tissue in the wound bed and had a foul odor. The peri wound was red. RN-A cleansed the wound with wound cleanser and measured the wound. The wound measured 5.8 cm x 5.3 cm and RN-A stated she was unable to measure the depth. RN-A placed Santyl in the wound bed with a cotton swab and placed a Primapore dressing over the wound. RN-A then assessed the left heel and stated the heel was boggy and blistered, when RN-A touched R12's left heel R12 moved her foot and stated it hurt. The left heel blister measured 2 cm x 2.7 cm and the skin was noted to be intact. RN-A stated that it was a deep tissue injury and would update the NP (nurse practitioner) again today and in the meantime would float R12's heels and get heel protectors.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 9 During interview on 2/23/17, at 8:49 a.m. RN-A stated ideally observation of the air mattress overlay should be made prior to staff placing the resident on the bed. RN-A stated that the air overlay was flat and she would have maintenance look at it right away. RN-A further stated she had placed the air mattress overlay on R12's mattress on 2/22/17, and could not recall if it was inflated or not. RN-A stated she did not believe a comprehensive skin assessment had been completed to determine risk factors, and to assess whether R12's current interventions to prevent pressure ulcers had been reviewed after R12 had developed the blister on her buttocks, or as the wound worsened. RN-A stated it had been determined that R12's old wheelchair was creating the problem and that R12 was in OT for positioning. She stated they had just gotten her a trial tilt and space wheelchair. RN-A stated there was not a specific assessment to determine how frequently a resident should be repositioned. RN-A stated if a resident had an open area, or was dependent on staff, the resident should be repositioned every two hours. However, the care plan directed staff to provide repositioning every 2-3 hours, and did not address floating the heels. RN-A also stated a new Braden (skin assessment) had not been completed for R12 after the development of the pressure ulcer on R12's buttocks, and subsequent heel pressure ulcer. RN-A stated the NP had been informed of both areas and followed R12 regularly, however, RN-A was unsure whether the NP had assessed R12's ulcer. RN-A stated she did not feel the ulcer was infected despite the foul smell, and stated she thought the odor was due to R12's wound debridement dressing. During follow up interview on 2/23/17, at 9:52	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 10 a.m. RN-A stated the tilt and space wheelchair had been initiated for R12 on 2/14/17. RN-A also stated that she'd found a checklist for pressure ulcers that indicated staff should complete a skin and wound note, complete a body audit assessment, complete a comprehensive skin and evaluation assessment, update the NP or physician, and should add daily monitoring of the wound to the treatment sheets as well as notifying the family, director of nursing (DON), dietician and therapy. RN-A stated she would look for the assessment. During observation on 2/23/17, at 11:25 a.m. R12 was observed in the dining room seated in the tilt and space wheelchair with non-skid socks on each foot. Her feet were on the foot pedals, but her heels were not in contact directly with the foot pedals. During a follow up interview on 2/23/17, at 11:26 a.m. RN-A stated that R12 had received an order for OT to evaluate and treat R12 on 2/1/17, and that OT had started on 2/2/17. RN-A stated initially the buttock wound was not documented as pressure, and they had thought it was due to trauma from the toilet seat. Interventions prior to development of the wound included: a pressure reduction cushion in the wheelchair, and to encourage every two hour repositioning along with customer service rounds hourly, to see if the resident needed something, unless observed to be sleeping. RN-A stated the wound had been observed daily for changes and that the NP had been updated on the changes of the skin. RN-A stated that because she initially thought the wound had been caused from trauma, there had been no changes to R12's repositioning schedule, but that staff had been successful at encouraging R12 to lay down more. A treatment to the blister	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 11 was initiated on 1/27/17, to cleanse the blister with wound cleanser and dry and cover with Allevyn dressing every three days and as needed (PRN). The treatment had been changed on 2/1/17, to use skin prep and cover with Mepilix every three days and PRN, because the blister had opened up. On 2/8/17, the wound treatment had been modified again to place Calcium Alginate to the wound bed and cover with Primapore daily due to wound changes. On 2/20/17, the order was changed to use Santyl in the wound bed to debride the wound. The dressing change was also increased to BID. RN-A also stated that wound rounds are completed weekly to assess the wound, and that the wound team discusses interventions during rounds which may not be documented. RN-A confirmed at this time there had been no comprehensive assessment completed, no formal changes to R12's toileting and repositioning schedule, and no reassessment of R12's mattress. RN-A stated the overlay mattress had been placed on R12's bed on 2/22/17, because she had realized she had forgotten to implement and place the mattress earlier. RN-A further stated that she did not test the air overly to see if it was functioning. RN-A stated otherwise the mattress on R12's bed is the standard mattress every resident has. RN-A stated that wound treatments were changed as the wound worsened and that the dietician and therapy had been consulted. RN-A stated that a wound clinic referral had not been discussed by the wound team. RN-A added that nursing assistants observe the skin daily and that a licensed nurse observes the skin weekly and documents irregularities. Anything that is abnormal, and any interventions initiated, are communicated through report verbally and on the communication report.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 12 During interview on 2/23/17, at 1:07 p.m. the NP stated she had never seen R12's wound. The NP stated she only observed wounds if the nursing team asked her specifically to assess it. The NP stated that the nurses had suggested new treatments to the wound and orders for an OT assessment and that she had agreed and signed off on the orders. The NP confirmed that due to the location of the wound, she would suspect it was pressure related. The NP further added that R12 had been declining and had multiple co-morbidities. She stated R12 had been on hospice but was not any longer, as she was not actively in the dying process. The NP also stated no one had told her there was necrotic tissue in the wound bed and if she had known she could have helped the facility look at further interventions. The NP added that it appeared a couple of pieces were missing. During interview on 2/23/17, at 1:24 p.m. the occupational therapist (OT)-A stated R12 had been referred to OT for positioning and toileting. OT-A stated that during the assessment it had been noted that a blue foam backrest in R12's wheelchair was creating pressure, so she had assessed R12 for a tilt and space wheelchair. OT-A stated on 2/16/17, a recommendation had been made to reposition R12 every two hours at night. OT-A stated she had not assessed R12's mattress at this time and stated it had been reported that R12 had developed a heel ulcer and would be looking into interventions for that. During observation on 2/23/17, at 1:41 p.m. R12 was observed to be sleeping on her left side. The overlay was inflated. During continuous observation on 2/24/17, between 5:35 a.m. to 8:25 a.m. R12 was	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 13 observed to be sleeping in bed on her back with the mattress overlay inflated. At 6:57 a.m. LPN-A and RN-A knocked and entered the room telling R12 that she needed to be repositioned. RN-A entered the room and LPN-A and RN-A repositioned R12 onto her right side, and elevated her feet on pillows. R12 had soft boots on her feet bilaterally. RN-A nor LPN-A checked R12 for incontinence or offered to assist her with toileting. R12 remained on her right side. At 8:19 a.m. LPN-A brought R12 her medications, but R12 did not want to wake up. LPN-A asked a nursing assistant to help boost R12 in bed. The nursing assistant and LPN-A boosted R12 in bed and straightened her pillows. Neither LPN-A or the nursing assistant checked R12 for incontinence. At 8:25 a.m., the state surveyor intervened and asked whether R12 had been checked for incontinence. LPN-A put gloves on and checked R12 for incontinence and stated R12 was wet. LPN-A also stated the boots on R12's heels did not have a heel cut out to relieve pressure. At that time, the nursing assistant and LPN-A assisted with removing R12's soiled brief and the dressing to R12's left buttock was saturated and loose. During follow up interview on 2/24/17, at 10:31 a.m. RN-A stated the frequency of R12's toileting and incontinence changes had not been reassessed since the development of the blister or any time after. RN-A stated she got the boots for R12 from the laundry and would have to ask if they were pressure relieving as she did not know. RN-A stated she was not sure if three hours was too long to not have a brief changed with her skin condition and dressing in the area. During interview on 2/24/17, at 10:47 a.m. the DON (director of nursing) stated initially the blister	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 14 was a result of trauma from the toilet seat and not due to pressure. The DON stated the wound had been caused by R12's skin sticking to the toilet seat. The DON further stated OT had been initiated to assist with R12's positioning as R12 spends a lot of her time in her wheelchair at activities during the day, and was rarely in bed. The DON stated, "Our goal for her, regardless of skin impairment, is that she can participate in activities as it is important to her and her family." She confirmed a risk versus benefits had not been discussed, and stated there had been no comprehensive skin assessment completed following the development of the blister and subsequent worsening of the pressure ulcer, to assess the appropriateness of toileting and repositioning frequency and the appropriateness of R12's mattress. During interview on 2/24/17, at 3:21 p.m. R12 stated she went to bed around 8:30 p.m. to 9:00 p.m. and got up around 9:30 a.m. The facility's policy Pressure Ulcer Prevention dated 10/15, indicated a comprehensive evaluation of the resident's clinical condition and pressure ulcer risk factors were to be completed on admission and as required throughout the resident's stay. Evaluation of the individual risk factors and determination, based on clinical judgement, selection of risk reduction strategies to stabilize, reduce or remove the underlying risk factors identified on the assessment. The policy also indicated documentation requirements of "SBAR" (communication tool) for any new or worsening alteration in skin integrity, daily monitoring, and body audit form completed, skin observation in "POC" (point of care) and a comprehensive skin and positioning evaluation. The policy indicated comprehensive skin and	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 15 positioning evaluations would be completed on admission, quarterly, annually and with any significant change in status, or with any new alteration in skin integrity. The undated Direct Supply Panacea Clinical and Clinical Plus Mattress information form, indicated the pressure redistribution support surfaces are appropriate for use as part of an overall care plan to prevent and treat decubitus ulcers. The form further indicated resident specific assessment could alter the particular usage of the mattresses. The undated Air Pro Series Alternating Pressure Pad and Pump Overlay Mattress Systems information form, identified an Air Pro plus 4200 that was a bubble style , with more touch points for effective weight distribution. The Posey Heel Pillows information sheet dated 2009, indicated the heel pillows helped protect heels and ankles from skin irritation and friction burns. The Posey guidance recommended to follow facility policies and guidelines for frequency of patient monitoring and that the product should be removed at least every two hours to check skin integrity, proper circulation and range of motion. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure identified quality of care concerns with pressure ulcer treatment and prevention and are reviewed by the quality assessment and assurance committee and action plans developed to address the concerns. The administrator or designee could educate all appropriate staff on	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00853	A. BUILDING: _____ B. WING _____	C 02/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 16 the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		