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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MGZR

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 **04/30/2018** (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 :
Susanne Reuss, Unit Supervisor 05/03/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 05/03/2018 (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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245200

May 3, 2018

Ms. Amanda Gentilli, Administrator
Birchwood Health Care Center
604 - 1st Street NE
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 25, 2018 the above facility is 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 3, 2018

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

RE: Project Number S5200028

Dear Ms. Gentilli:

On April 2, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 16, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On April 30, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 27, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 16, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 25, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 16, 2018, effective April 25, 2018 and therefore remedies outlined in our letter to you dated April 2, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MGZR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00853

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

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(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 **03/16/2018** (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
X 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 :
Sheila Placido, HFE NE II 04/13/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Amy Johnson, Enforcement Specialist 04/30/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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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

Electronically delivered
April 2, 2018

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

RE: Project Number S5200028

Dear Ms. Gentilli:

On March 16, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 25, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 16, 2018 (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 September 16, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	03/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 3/12/18-3/16/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 604		4/25/18

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

Electronically Signed | 04/12/2018

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 _____	03/16/2018

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 604	Continued From page 1 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 5 of 5 residents (R59, R76, R70, R109, R23,) were free from the use of physical restraints. Findings include: R59's quarterly minimum data set (MDS) dated 1/30/18, indicated she was severely cognitively impaired and required extensive assist with bed mobility and transfers. R59's care plan dated 2/12/18, identified limited physical mobility and a risk for falls related to a history of falling. The care plan directed staff to use body pillows in bed for positioning and ensure proper foot wear when up in wheel chair. During an observation on 3/12/18, at 12:30 p.m. R59 was lying in bed. The right side of the bed was against the wall. The left side of the bed had a body pillow extending from the grab bar to R59's mid- calf. A fall mat was on the floor next to	F 604	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 with respect to: 1. The body pillows in place for R59, R76, R70, and R 190 were removed and replaced with standard pillows placed in a manner that did not impair resident movement. R23 Elopement Risk Assessment completed 4/10/18 determined continued to need for wanderguard. 2. All other residents who previously used	

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 _____	03/16/2018

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 604	Continued From page 2 the bed. During observation on 3/14/18, at 7:24 a.m. R59 was lying in bed. The bed was positioned against the wall on the right side. On the left side of the bed, a body pillow was tucked under the fitted sheet and extended from the grab bar to R59's mid- calf. During observation on 3/15, at 6:39 a.m. R59 was again lying in bed with a body pillow tucked under the fitted sheet on her left side. R76's quarterly MDS dated 2/13/18, indicated she was severely cognitively impaired and required extensive assistance for bed mobility and transfers. R76's care plan identified limited physical mobility and a risk for falls. The care plan directed staff to us a mechanical stand for transfers but did not identify interventions related to fall prevention. A Birchwood Health Care Center Progress Noted dated 1/19/18, indicated: residents is wanting to get out of bed to get to the bank before they close. Has feet dangled off the side of the bed. During an observation on 3/15/18, at 6:46 a.m. R76 was lying in bed. The right side of the bed was positioned against the wall. On the left side of R76's bed a body pillow was tucked underneath the fitted sheet on her bed creating a barrier that extended from the grab bar to the lower leg. R70's quarterly MDS dated 2/6/18, indicated he was severely cognitively impaired required extensive assistance with bed mobility and transfers and ambulated independently on the	F 604	body pillows for positioning were evaluated for positioning needs. The use of body pillows as been discontinued and will continue to be assessed related to physical devices and care plans developed based on these assessments upon admission, quarterly and with significant change of conditions. Residents who require the use of wanderguard bracelets for elopement risk were reevaluated for appropriate use, and will continue to be assessed related to physical devices and care plans developed based on these assessments upon admission, quarterly and with significant change of conditions. 3. Body pillows will be removed from the facility to prevent future inappropriate use. Administrator/designee will ensure nursing staff will be re-educated to proper use of pillows for positioning. Nursing staff will be re-educated on Elopement Assessments and proper documentation of resident behaviors. Wanderguard use will be reviewed monthly at Interdisciplinary Team Meetings for appropriateness. Education and interventions will be completed by April 25, 2018. 4.Positioning audits will be completed by DNS/designee across all shifts three times per week for 1 month, then 2 times per week for 2 months. DNS/designee will audit Elopement Assessments 2 times per week for 3 months. The DNS/designee will present the data to the QAPI committee monthly for further recommendations regarding systems and continued monitoring.	

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unit. R70's care plan dated 1/21/18, identified limited physical mobility and a risk for falls. The care plan directed staff to ensure a safe environment, encourage exercise program and offer activities in dining room.

During an observation on 3/15/18, at 6:50 a.m. R70 was lying in his bed. The left side of the bed was placed against the wall. On the right outside of the bed there was a large lump indicating something had been placed under the fitted sheet. At 7:59 a.m. nursing assistant (NA)- D removed a pillow from under the fitted sheet on R70's bed.

R190's quarterly MDS dated 1/9/13, indicated she was severely cognitively impaired and required extensive assistance for bed mobility and transfers. R190's care plan dated 1/19/18, identified limited physical mobility and a risk for falls. The care plan directed staff to use pillows to reposition in bed and ensure a safe environment.

During an observation on 3/13/18, at 8:50 a.m. R190 was lying in bed. Her bed was positioned with the left side against the wall. R190 had a full length body pillow placed on her right side.

During observation on 3/14/18, at 7:26 a.m. R190 was lying in bed. A body pillow was placed on the right side of her, tucked under the fitted sheet and extended from the grab bar to her mid-calf.

During an observation on 3/15/18, at 6:40 a.m. R190 was again lying in bed with a body pillow tucked under the fitted sheet on her right side.

During an interview on 3/15/18, at 6:40 a.m. licensed practical nurse (LPN) - B stated the body

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pillows used in bed were fall interventions so the residents do not try to get themselves up. She stated the pillows should not be tucked under the sheets. LPN-B further stated both R59 and R190 try to crawl out of bed at night.

During interview on 3/15/18, at 6:52 a.m. NA-D stated the body pillows were used for positioning in bed. NA-D stated the pillows were not supposed to be tucked under the sheet.

During interview on 3/15/18, at 7:22 a.m. LPN - C stated the body pillows were placed so the residents did not attempt to get out of bed on their own. LPN-C stated staff put them under the fitted sheet to keep them in place.

During an interview on 3/15/18, at 7:43 a.m. the director of nursing (DON) stated the expectation for use of a body pillow was to maintain positioning in bed. She stated as a fall prevention, the focus was to keep them comfortable using the pillows. The DON stated staff should not be placing the body pillows under the fitted sheet in bed.

R23, during an observation on 3/13/18, was seated at a table in the dining room. R23 was noted to have a wander guard bracelet secured to her left ankle.

R23's quarterly MDS dated 12/19/17, indicated she was severely cognitively impaired and independent with ambulation. The MDS indicates R23 did not display wandering behaviors. R23's care plan dated 12/21/17, indicated the use of medications related to depression with psychotic features and Schizophrenia. The care plan did

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not identify any behaviors nor did it address the need for and/or use of a wander guard device.

An Elopement Risk Evaluation dated 3/9/18, indicated R23 was ambulatory, had no history of wandering or attempts to leave the unit/building, and did not ask to go home or to other destinations.

R23's Facility Progress Notes were reviewed from 12/16/17 through 3/16/18. The Progress Notes lacked evidence R23 displayed wandering behaviors and/or attempts to leave the unit unsupervised.

During an interview on 3/15/18, at 1:38 a.m., the director of nursing stated she was not aware of any attempts by R23 to leave the building and could not recall R23 being the focus of any conversations related to negative behaviors. In regard to ongoing assessment for use of a wander guard,the DON stated R23 wore a wander guard bracelet because she had risk factors for elopement. She stated the interdisciplinary team reviewed all residents on a monthly basis and discuss resident changes and behaviors.

During an interview on 3/15/18, at 1:48 p.m. licensed social worker (LSW)-A stated she had never been involved in any discussion regarding R23's need for a wander guard. LSW-A stated R23 displayed behaviors that included rummaging in her roommates drawer and displayed anxious behaviors but stated she was not aware of any attempts to leave the unit or the building.

On 3/15/18, at 1:51 p.m. licensed practical nurse

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F 604	Continued From page 6 (LPN)-C stated R23 went into other residents rooms on the unit but stated she was easily re-directed. LPN-C stated she had never seen R23 attempt to get on the elevator and stated she does not talk about leaving, During interview on 3/15/18, at 1:51 p.m. nursing assistant (NA)-G stated R23 never attempted to leave the building or enter the elevator. During an interview on 3/16/18, at 9:44 a.m. the facility pastor stated R23 left the unit for activities. He stated when R23 first admitted to the facility she would ask to leave the activity and return to the unit but stated she now is content to stay for the entire activity. He stated he had never seen her try to leave the building. A facility policy titled Birchwood Health Care Center Physical Device Assessment dated 6/18/14 was reviewed. The policy indicated the assessment would be completed for all residents who utilize a side rail, grab bar or other physical device. The policy directed staff to routinely (quarterly, annually and significant changes) determine the continued appropriateness of the device and indicated decisions to continue or discontinue use should be made in the context of an individualized assessment.	F 604		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F 645		4/25/18

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F 645	Continued From page 7 (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a	F 645		

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F 645	Continued From page 8 hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow up with the county for Level II Preadmission Screening and Resident Review (PASARR) screening for 1 of 1 resident (R35) who was admitted with Mental Health diagnosis. Findings include: R35 was admitted on 12/9/15 with an admission history of Bipolar disorder, Major Depressive Disorder -recurrent, insomnia, and Dementia with behavioral disturbance. A Senior Linkage Line dated 12/9/15, had a box checked that indicated "If this box is checked the Senior Linkage Line did not complete the PAS and forwarded the PAS request to a	F 645	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 with respect to: 1. R35 has a new Level II Preadmission Screening and Resident Review (PASARR) in progress with the local county agency.	

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F 645	Continued From page 9 county/managed care organization for processing. Medicaid waiver policy or necessary activities. If you have questions regarding the PAS or the referral, you can contact the lead agency listed below (Medical). There was no documentation of a Level II PASARR referral to the county case worker (as described in the Senior Linkage Line document). 03/14/18 12:52 p.m., LSW-B was interviewed regarding the lack of a PASARR level II in the chart. LSW-B stated she was the social worker when R35 was admitted, stated she suspected the county never responded (partial PASARR I), for MI portion of PASARR II, and she had not followed up with the county. LSW-B would pass information on to co-worker LSW-A who was now assigned to R35 for social work services. -At 2:32 p.m. LSW-C,was contacted by LSW-B. According to LSW-B, stated she had called LSW-C who said she would never have done a level II based on R35's diagnosis and elderly waiver. Notes provided on 3/15/17, by LSW-B for a Care Conference note dated 12/23/16, was attended by LSW-C (a Fairview Health Services social worker), indicated R35 was new to Fairview. The note went on to say the Elderly Waiver (EW) would be closed, and 30 day notice on ALF apartment. LSW-B stated she was able to get her notes from the care conference and also the case manager notes. LSW-B and case manager LSW-C were here for care conference on 12/23/15, and did not refer for Level II PASARR.	F 645	2. All residents will be screened for diagnoses that reflect a Level II Review and facility will ensure that they are complete. Residents identified as having a serious mental illness will have PASARR determinations in place prior to admission. 3. Administrator/designee will ensure Admissions team, Licensed Social Workers and RN's screening referrals will be re-educated to the Pre-Admission Screening policy. Education and interventions will be completed by April 25, 2018. 4. SS Director/designee will monitor through observation of admissions process and auditing of new resident diagnoses. The SS Director/designee will present the data to the Quality Assurance Performance Improvement Committee monthly for further recommendations regarding systems and continued monitoring.	

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F 645	Continued From page 10 3/15/18 09:31 a.m. LSW-B, pulled notes from care conference attended and also case manager note, spoke of R35's behavioral psychologist in house, stated R35 also goes out to Nystrom for psych services, neither note addressed the Level I referral to the county for a Level II PASARR. The Pre-Admission Screening policy dated 8/9/16 and revised 5/17, identified the nursing facility must not admit any new resident with a serious mental illness who had not received a PASARR determination. The nursing facility is responsible for having a copy of the Level 1 and Level II on file in the active resident record.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		4/25/18

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F 656	Continued From page 11 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan to address dental status for 1 of 2 residents (R16) reviewed for dental pain management. Findings include: On 3/13/18, at 9:20 a.m. R16 was observed sitting up in bed eating scrambled eggs, bacon, toast and orange juice. R16 stated his only concern was that his teeth are loose, hurt mainly when he ate and had been that way for about "2 to 3 weeks." R16 further stated "they said they made an appointment for a dentist that is going to come here, but I don't know when."	F 656	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 with respect to: 1. R16's oral status has been reassessed and care plan has been updated to accurately address any dental issues, including preferences and right to refuse	

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F 656	Continued From page 12 The Annual Minimum Data Set (MDS) dated 6/8/17, indicated R16 had moderate cognitive impairment and no natural teeth or tooth fragments, no abnormal mouth tissue, no obvious or likely cavity or broken natural teeth, no inflamed or bleeding gums or loose natural teeth, no mouth or facial pain and/or discomfort or difficulty with chewing. An Oral/Dental Evaluation dated 3/3/18, indicated R16 had broken, missing and loose teeth with obvious or likely cavities. No pain was noted. A MDS 3.0 Oral/Dental Assessment Form dated 12/13/17, indicated R16 had cavities and broken teeth with root tip, missing teeth, inflamed and bleeding gums, did not allow staff to assist with oral care and had recommendation for routine dental referral and "resident has non-urgent dental care needs." A MDS 3.0 Oral/Dental Assessment Form dated 12/14/16 indicated broken and decayed teeth with heavy plaque buildup and recommended R16 would benefit from professional dental cleaning and should be see the dentist for broken teeth. Review of Birchwood Health Care Center Progress notes dated 3/6/18, indicated an oral/dental inspection showed "no oral/dental issues. Has Own Teeth. Lips are pink dry. Mucosa is pink moist. Gums are within normal limits. Denies mouth pain." R16's care plan did not include any issue or staff direction for dental care even though assessments indicated multiple dental issues. Review of an email dated 3/9/18, at 9:25 a.m.	F 656	treatment. 2. All residents are comprehensively assessed and care plans developed based on these assessments upon admission, quarterly and with significant change of conditions. 3. Administrator/designee will ensure licensed staff will be educated on the process of accurate oral observation, documentation, care plan updating, and referral processes. Education and interventions will be completed by April 25, 2018. 4. Audits of oral/dental assessments and care plan accuracy will be completed by DNS/designee twice per week for one month, then once per week for 2 months. The ED/designee will present the data to the QAPI committee monthly for further recommendations regarding systems and continued monitoring.	

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F 656	Continued From page 13 sent to the health information coordinator (HIC) and copied to registered nurse (RN)-A, indicated R16 "is complaining of tooth pain. If he is not already, will you add him to the list for dental." During interview on 3/14/18, at 10:15 a.m. licensed social worker (LSW)-A stated that R16 had told her last Thursday or Friday that his teeth hurt and HIC was to put him on the list to see a dentist, "but I don't know when." LSW-A stated she sent the email to RN-A, because she doesn't chart in the electronic record, " I email." During interview on 3/14/18, at 10:18 a.m. RN-A stated she was not aware the resident was having tooth pain, but when shown email from LSW-A, stated "I must have not gotten to that one."	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure accurate administration of insulin for 1 of 1 resident (R341) reviewed for insulin administration with an insulin pen. Findings include: R341's Admission Record dated 3/15/18, indicated a diagnosis of diabetes mellitus type 2 without complications, insulin dependent.	F 658	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	4/25/18

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

(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 658	Continued From page 14 During observation on 3/15/18, at 8:13 a.m. licensed practical nurse (LPN)-A prepared R341's Novolog Insulin pen for administration. LPN-A did not prime the needle with 2 units of insulin prior to injecting the insulin into R341's abdomen. At 8:16 a.m. during an interview LPN-A stated the protocol for priming the insulin pen was done only when a new pen was started. When asked about priming with each new needle LPN-A stated, "I was never told to prime the needle each time it was given." During an interview on 3/15/18, at 8:31 a.m. registered nurse (RN)-B stated to the best of her knowledge the insulin pen was primed when you start a new pen. On 3/16/18, at 9:41 a.m. the director of nursing (DON) stated the insulin pens needed to be primed with 2 units of insulin when opened and each time a new needle was placed on the pen. The DON further stated the staff was trained when the facility switched over to the insulin pen. The Thrifty White Pharmacy Insulin Administration - Pen policy dated April 2014, directed: Verify right resident, medication, dose, dosage form, frequency, and route. Remove the cap from the pen and wipe the rubber stopper with an alcohol wipe. Attach a need to the insulin pen. Perform an air shot. Turn the dose selector to "2" units, holding pen with the needle point up, tap the cartridge. This moves any collected air to the top of the cartridge. Press the injection button all the way in until the dose selector is back to "0". A stream or drop of insulin should appear at the tip of the needle.	F 658	with respect to: 1. Dosage accuracy of Insulin pen administration for R341 has been addressed and new needles are primed prior to each administration of insulin. 2. All residents receiving insulin via pen have been identified and have had their insulin administered per protocol. 3. Administrator/designee will ensure all nurses administering insulin via pen will be educated on insulin pen priming and administration procedures and competencies. Education and interventions will be completed by April 25, 2018. 4. Audits involving observation and competency of insulin pen administration procedures will be completed by DNS/designee twice per week The ED/designee will present the data to the QAPI committee monthly for further recommendations regarding systems and continued monitoring.	

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F 658	Continued From page 15 The Novo Nordisk Novolog Flex Pen instructions, provided by the facility, were dated May 2016. The instructions indicated: always use a new needle, turn the dose selector to 2 units, hold the pen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top. Press the push button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle. Priming the needle was important to avoid injecting air and to ensure correct dosing of the insulin.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess for causes and develop care planned interventions for 1 of 1 residents (R190) reviewed with a patterns of bruising and skin tears. Findings include: R190's quarterly minimum data set (MDS) dated 1/9/18, indicated she was severely cognitively	F 684	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	4/25/18

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F 684	Continued From page 16 impaired and was dependent on staff for all activities of daily living. R190's care plan dated 1/19/18, identified a potential for skin impairment related to incontinence, neuropathy and cognitive and functional decline. The care plan directed staff to encourage god nutrition and hydration, encourage repositioning and provide pressure relieving support surfaces. Review of facility documents titled Treatments dated October 2017 through March 2018 identified multiple bruises and skin tears and included the following interventions: Geri - sleeves to bilateral arms at all times and lotion hands twice daily. A review of facility documents titled Resident Incident Report, documents titled Injuries of Unknown Origin Investigation and facility Body Audits identified the following: 9/1/17 - Incident Report - 2.5 cm x .5 cm skin tear on left forearm. Wheel chair evaluation for height under dining room table, fingerless gloves and encourage long sleeves. 9/2/17 - injury of unknown origin - 1 centimeter (cm) x 1 cm bruise located between pointer and middle finger. Previous skin tears/bruises, yes, skin tear on left forearm, bruise on left finger next to index finger, bruise top of left hand, bruise on third digit of right hand. Assist to propel wheel chair, lotion hands and fingerless gloves. 9/15/17 - Body Audit - bruising to left forearm 1 cm x 1 cm, skin tear to left forearm .1 cm x 3 cm. 9/22/17 - Body Audit - right arm bruises 2 cm x 2 cm 9/29/17 - Body Audit - left and right forearms have	F 684	the foregoing statement, the facility states with respect to 1. A comprehensive review of R190's care plan was completed for appropriate interventions. Multiple interventions related to skin integrity were implemented throughout her stay were reviewed for effectiveness. 2. Facility will review residents with noted bruising over the past three months for patterns and environmental and revise care plans as needed to ensure appropriate interventions are in place. All residents are assessed for comprehensive skin risks upon admission, quarterly, and with changes in condition. Facility will review incidents related to skin integrity for all residents monthly during Interdisciplinary Team Meetings. Incident report tracker will be reviewed for trends weekly with Clinical Leadership. 3. Administrator/designee will ensure licensed staff will be re-educated on Body Audit and Incident Report process. Education and interventions will be completed by April 25, 2018. 4. DNS/designee will complete resident care audits 3 times per week for 3 months of resident care plans, NAR team sheets, interventions and physical observations to ensure compliance. DNS/designee will present the data to the Quality Assurance Performance Improvement Committee monthly for further recommendations regarding systems and continued monitoring.	

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F 684	Continued From page 17 small bruises. 10/3/17 - Incident Report - skin tear to left elbow 4 cm x .2 cm. Geri - sleeves and long sleeves encouraged. 10/13/17 - Body Audit - left hand palm bruise, right hand back bruise, left hand back bruise. 11/10/17 - Injury of unknown origin - bruise to left ankle. Foot pedal on at all times, occupational therapy to screen for elevating feet. 11/10/17 - Body Audit - right hand back, purplish area, left outer ankle bruise. 11/13/17 incident report - bruises to left outer ankle measuring 6 cm x 5 cm and 4 cm x 1.3 cm, area is swollen. 12/6/17 - Injury of Unknown origin - bruise to left ring finger. Incident report, bruise to finger measuring 2 cm x 2 cm. Encourage fingerless gloves. 12/15/17 - Body Audit - right elbow skin tear. Arm sleeve supply replenished. 12/20/17 - Incident report - skin tear to left forearm. 12/29/17 - Body Audit - Left forearm new skin tear and scabbed area just above. 1/2/18 - Incident report - skin tear to left forearm measuring 3 cm x 1 cm. 1/12/18 - Body Audit - bruised area to left outer wrist, healing skin tears to left forearm.	F 684		

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F 684	Continued From page 18 1/19/18 - Injury of unknown origin - bruise on right inner ankle measuring 13 cm x 8 cm. Therapy evaluation. 1/22/18 - Incident report - skin tear to left pinky measuring approximately 1/4 inch. Therapy evaluation for transfers. 2/2/18 - Body Audit - healing scab area to right elbow and left forearm. 2/10/18 - incident report - 3 cm x 3.5 cm bruise left middle finger. Encourage fingerless gloves. 3/11/18 - Incident report - .8 cm x .7 cm bruise on right arm by wrist. The documentation lacked evidence an analysis had been performed in an attempt to determine causal factors of the bruising and skin tears. Review of physical and occupation Therapist Progress and Discharge Summaries dated 9/12/17, indicated the following recommendations: patient provided hand gloves that can be worn as needed, grab rail padded with success. During an observation on 3/15/18, at 1:15 p.m. R190 was lying in bed. Grab bars were affixed to both sides of the bed. No padding was noted on either grab bar. R190 was wearing geri- sleeves on bilateral hands. During an observation on 3/16/18, at 10:08 a.m., R190 was seated in a reclining wheel chair with padded shoulder supports that extended past her shoulders. The foot pedals had a padded support	F 684		

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F 684	Continued From page 19 behind the calf area. R190 was sitting with her hands in her lap and her eyes closed. nursing assistant (NA) - E stated R190 had been using the wheel chair for several months. NA-E further stated staff use a mechanical stand and two staff to transfer R190 and she hung on with both hands and had no difficulty transferring. During an interview on 3/16/18, at 9:29 a.m. the director of nursing (DON) stated she was aware R190 had multiple bruises noted to her hands, fingers and ankles. She stated an environmental review was completed and therapy evaluated her. The DON stated the care plan identified a potential for impaired skin integrity and felt that included bruising and skin tears. She was not aware of why the grab bar was not padded as identified in the therapy notes and stated, "if we have it, we want them to be able to use it." At 10:23 a.m. the DON stated she found an audit form "back a ways" that looked at room order. She stated as far as keeping track and looking at trends she used an incident tracker broken down by month. She stated she looked at it weekly for trends. The DON was unable to articulate what had been identified regarding R190's skin concerns. At 1:48 p.m. the DON stated she had asked nurses to do care audits before but was not sure if they were documented. A facility policy related to non- pressure skin conditions was requested but not received.	F 684		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 697		4/25/18

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F 697	Continued From page 20 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services to manage dental pain for 2 of 3 residents (R16, R18) reviewed for dental. Findings include: R16, on 3/13/18, at 9:20 a.m. was observed sitting up in bed eating scrambled eggs, bacon, toast and orange juice. R16 stated his only concern was that his teeth are loose, hurt mainly when he ate and had been that way for about "2 to 3 weeks." R16 further stated "they said they made an appointment for a dentist that is going to come here, but I don't know when." The Annual Minimum Data Set (MDS) dated 6/8/17, indicated R16 had moderate cognitive impairment and no natural teeth or tooth fragments, no abnormal mouth tissue, no obvious or likely cavity or broken natural teeth, no inflamed or bleeding gums or loose natural teeth, no mouth or facial pain and/or discomfort or difficulty with chewing. An Oral/Dental Evaluation dated 3/3/18, indicated R16 had broken, missing and loose teeth with obvious or likely cavities. No pain was noted. A MDS 3.0 Oral/Dental Assessment Form dated 12/13/17, indicated R16 had cavities and broken teeth with root tip, missing teeth, inflamed and bleeding gums, did not allow staff to assist with oral care and had recommendation for routine	F 697	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 with respect to 1. Pain interviews and assessments have been completed for R16 and R18 with a focus on their dental concerns and care plans updated. Dental referrals have been made as indicated. 2. All residents are comprehensively assessed for pain and care plans developed based on these assessments upon admission, quarterly and with significant change of conditions. Care plans are updated as needed. 3. Administrator/designee will ensure all staff will be educated on appropriate communication of resident reports of pain, dental referral processes, and care planning of personalized pain needs. Education and interventions will be completed by April 25, 2018. 4. Audits of accurate pain assessment completion will be completed by DNS/designee twice per week for one	

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F 697	Continued From page 21 dental referral and "resident has non-urgent dental care needs." A MDS 3.0 Oral/Dental Assessment Form dated 12/14/16 indicated broken and decayed teeth with heavy plaque buildup and recommended R16 would benefit from professional dental cleaning and should be see the dentist for broken teeth. Review of Birchwood Health Care Center Progress notes dated 3/6/18, indicated an oral/dental inspection showed "no oral/dental issues. Has Own Teeth. Lips are pink dry. Mucosa is pink moist. Gums are within normal limits. Denies mouth pain." R16's care plan did not include any issue or staff direction for dental care. Review of an email dated 3/9/18, at 9:25 a.m. sent to the health information coordinator (HIC) and copied to registered nurse (RN)-A, indicated R16 "is complaining of tooth pain. If he is not already, will you add him to the list for dental." During interview on 3/14/18, at 10:15 a.m. licensed social worker (LSW)-A stated that R16 had told her last Thursday or Friday that his teeth hurt and HIC [health unit coordinator] was to put him on the list to see a dentist, "but I don't know when." LSW-A stated she sent the email to RN-A, because she doesn't chart in the electronic record, " I email." During interview on 3/14/18, at 10:18 a.m. RN-A stated she was not aware the resident was having tooth pain, but when shown email from LSW-A, stated "I must have not gotten to that one."	F 697	month, then once per week for 2 months. The ED/designee will present the data to the QAPI committee monthly for further recommendations regarding systems and continued monitoring.	

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F 697	Continued From page 22	F 697		

During interview on 3/15/18, at 10:25 a.m. the director of nursing, DON stated she expected that any resident information should go to the nursing and in particular the nurse who is taking care of him.

During interview on 3/15/18, at 10:42 a.m. the HIC stated R16 had been asking about seeing a dentist in the last week, the dental group was emailed yesterday and he is on the 3/20/18 schedule now to be seen.

R18 on 3/13/18, at 10:08 a.m. during interview stated her teeth hurt, "I have a tooth on bottom front that is jutting out and it cuts into my lip." R18 further stated it made her jaw hurt, "it sometimes swells up, I think I need braces, but the dentist told me it was too expensive." R18 stated she told LSW-A who told her it is a medical expense and should be covered.

The Quarterly MDS dated 12/21/17, indicated R18 was cognitively intact and had mouth or facial pain with discomfort or difficulty with chewing.

An Apple Tree Chart Progress Notes dated 12/5/17, indicated R18 had three recurrent cavities under crowns and received conservative treatment of the teeth with a topical medication due to R18 deferring new crowns at the time.

An Oral/Dental Evaluation dated 3/13/18, at 1:56 p.m. reported to be conducted approximately four hours after interviewing R18, indicated R18 had no broken, missing or loose teeth with no pain noted.

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F 697	Continued From page 23	F 697		

Review of Birchwood Health Care Center Progress notes dated 3/14/18, indicated "Spoke with resident about tooth pain and needing braces. Per resident "the lower tooth pushes put [up] into my lips and sometimes when I wake up there is blood on my lip, my jaw cracked and moved everything." Mouth inspected right side of mouth bottom teeth does have a tooth that pushes out toward her lip. When did your jaw crack? "about 2-3 months ago and seen the dentist at that time and was told that braes would be to [too] expensive." Would like like a mouth guard ordered to protect your lips? "No, they wouldn't help." Would you like to be seen by the dentist on March 20th? "yes" HIC notified to make appointment for resident when they come.

During interview on 3/14/18, at 10:26 a.m. LSW-A stated she was not aware about mouth pain or any other issues.

During interview on 3/14/18, at 2:50 p.m. R18 was observed eating ice cream in the dining room. R18 stated she did not remember anyone coming in her room yesterday and completing a tooth exam, "I was sleeping and don't remember anyone waking me up, I would remember that, I hope this ice cream makes it feel better."

During interview on 3/15/18, at 10:34 a.m. when showed the Oral/Dental Evaluation dated 3/13/18, the director of nursing stated "I can't explain this, its a licensed person who said she did these things, I tend to believe the person who filled this out, but you are right [R18] is pretty sharp, I don't have an answer for you."

Review of the Birchwood Health Care Center Dental Care facility policy with revision date of

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F 697	Continued From page 24 8/2017, indicated dental services will be offered routinely and assistance will be provided to access 24 hour emergency dental care.	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that there was enough facility staff and/or staff utilized from a	F 725	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	4/25/18

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F 725	Continued From page 25 staffing pool agency that were trained to specifically meet the needs of residents who resided in the facility. This affected 11 residents (R17, R18, R32, R63, R65, R35, R42, R21, R77, R8, R4) of 77 residents who required assistance with activities of daily living and had the potential to affect other residents in the facility. Findings include: A resident council meeting was held in the facility on 3/13/18, at 3:12 p.m. R17, R18, R32, R63 and R65 attended the meeting. When asked if there was enough staff to meet the needs of the residents, several of the residents in the council meeting voiced concerns related to the facility staffing and the use of pool staff. R35 stated sometimes they wait 30 minutes for a call light to be answered, and stated longer if the lights were out of order. R35 stated it happens when the facility was short of help "which is often." R35 further stated, "we need aides, we need lots of aides," sometimes there only two or three aides on on the west unit. (the west unit had 42 residents at the time of the survey) R32 stated the facility rotated the nursing assistants (NA)'s through the facility and stated often people they had never seen before were taking care of them. R32 stated on several occasions her medications had not been completed at night and stated it had happened more than once. She stated some nights there was such a shortage of help she didn't know how people got taken care of. R32 stated staff responded to lights and would say "I'm don't know if we can get back to you." She stated it happened on all three shifts. R32 further stated	F 725	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 with respect to: 1. R35, R32, R63, R17, R42, R21, R77, R8, and R4 needs are met. 2. All residents have daily needs met by facility staff. 3. Administrator/designee will ensure all staff will be educated on customer service, call light response, and meeting ADL and other needs of residents. Facility will continue to focus on recruitment efforts and use supplemental staffing agencies as needed to ensure adequate staffing levels. Facility will identify recurring agency staff members for additional competency training and education. Education and interventions will be completed by April 25, 2018. 4. DNS/designee will monitor via observations and resident interviews 2 times per week for 3 months to ensure resident needs are being met. DNS /designee will present the data to the Quality Assurance Performance Improvement Committee monthly for further recommendations regarding systems and continued monitoring.	

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	245200	A. BUILDING _____ B. WING _____	03/16/2018

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some of the staff in the facility were wonderful and some "should be selling shoes."

R63 stated the staff have brought her the wrong Tylenol. She stated she can't swallow it because it sticks in her throat. R63 stated it only happened with the pool staff.

R17 stated there were occasions when she had to use the bathroom "so bad" and there were three people ahead of her. She stated one night she had to have a bowel movement and staff told her, "S*** in your pants, we'll clean you up later." R17 stated may of the staff work a lot of double shifts and stated one girl barely goes home. R17 further stated the resident council had brought up these concerns many times and stated they get tired of hearing the facility say they are working on it.

A review of facility documents titled Feedback Form, Grievance/Comments/Suggestions identified the following concerns:

2/2/18 - R42 stated staff did not get her out of bed until just a little while ago, it is now 11:20 a.m. She stated a man came in first who "irritated" her then a a girl came in and wouldn't talk. R42 stated the girl "wasn't nice" and "made her feel S*****." She further stated the staff were rough with her when getting dressed and hurt her arm. Pool staff education.

2/6/18 - on 2/6/18, R21's daughter stated she was in the facility at 6:30 p.m. She stated R21 was in her wheel chair in her room still wearing her clothing protector from dinner. She stated her oxygen was not on and R21 was trying to get the tubing off the floor when she arrived. She was

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afraid R21 would fall out of her chair. Family put the call light on at 7:00 p.m. and no one came. At 8:10 p.m., family went into the hall and asked a nurse for assistance. The nurse said she would get someone. Family stated the nurse was not someone they had seen before. Family states it happened all the time when she visited R21. She stated she always had to go out in the hall to find help.

2/19/18 - R77 put on his call light Sunday at 8:00 p.m., at 8:30 p.m. a male aide came in and shut the light off. R77 stated he put his light back on and nobody came back for two hours. He further stated on the morning of 2/19/18 it tool an hour and a half for a NA to come and get him up. Pool staff educated.

3/5/18 - R77 turned his bathroom light on at 11:00 p.m. and staff did not respond until 11:50 p.m. He stated his bottom hurt from sitting on the toilet that long.

3/6/18 - R8 stated at 5:00 p.m. a NA was in her room texting on her cell phone. R8 stated she had to ask for help three times before the NA put her phone away.

3/7/18 - R4 stated at 5:00 a.m. she asked for assistance from staff to use the commode. Staff stated, "No, you can do it yourself." R4 also stated she did not get help with her socks and felt like she was going to fall doing it herself. Pool staff educated.

During an interview on 3/16/18, at 1:33 p.m. the director of nursing (DON) stated she was aware of some concern by residents regarding the pool staff as well as concerns there was not enough

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staff. She stated most of the concerns were related to residents indicating they did not know the staff caring for them. She stated the facility reviews incident reports and looks for trends related to staff, but was unable to provide evidence the reports had been reviewed. The DON stated she has asked the nurses to observe care but was not sure if it was documented. At 2:05 p.m. the DON stated the pool staff have an orientation binder that is reviewed with them when they come into the facility but stated there was no formal program for mentoring or a skills checklist.

Review of the the Facility Assessment -Staff Profile listed average or range per day of 13 licensed nurses providing direct care and 23 nursing assistants. During a review of 14 days of consecutive actual staffing, and an additional 10 days of randomly selected actual staffing, the facility had worked short on at least one shift all 24 of 24 days reviewed from the past 3 months, only 8 of 72 shifts were fully staffed.

On 3/16/18, at 10:00 a.m. a review of 5 days of actual staffing sheets with the staffing coordinator verified that shifts did run short when they could not fill internally or bring in pool for the shift. It was noted on review of the facility actual staffing sheets that if other units were short of care workers, then nursing assistants were transferred from the transitional care unit to other units in the facility, making the transitional care unit short of workers.

On 3/16/18, at 11:20 a.m. the director of nursing (DON) and consultant nurse (CN) were interviewed regarding staffing, the facility had a

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F 725	Continued From page 29 65% turnover rate. DON was not aware of a skills demonstration checklist for agency staff. the consultant nurse stated that there was a skills checklist for agency staff (requested by not provided).	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		4/25/18

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F 732	Continued From page 30 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to update the staff posting when census changes or when staffing changed. Findings include On 3/16/18, at 10:00 a.m. the staffing coordinator (SC) stated "I did not know we were supposed to update the staff posting, I just found that out today". Staff postings and schedules were reviewed from 12/17/17 to 3/14/17, no staff postings were updated, even when staffing changes occurred on the actual staffing. SC stated before she left on Fridays she would hand the planned staffing and census sheets through Monday, and on other days she hung them before she left. SC was not aware of a process to update the staff postings.	F 732	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 with respect to: 1. The facility nursing staffing hours posting was updated to reflect changes in staffing assignments on 3/16/18 prior to the survey exit. 2. The Staffing Coordinator will receive education regarding the requirement for posting the Nursing Hours in a timely manner. 3. Administrator/designee will ensure the guideline for Posting Nursing Hours has been reviewed and revised for implementation. Education and interventions will be completed by April 25, 2018. 4. The Administrator and/or designee will audit the posting for accuracy and timelines each week for three months to assure compliance. The ED/designee will	

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F 732	Continued From page 31	F 732	present the data to the QAPI committee monthly for further recommendations regarding systems and continued monitoring.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow food safety procedures in the main kitchen and 3 of 3 kitchenette refrigerators having the potential to affect all 15 residents receiving house supplements. Findings include: During the tour of the kitchen on 3/12/18, at 12:15	F 812	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	4/25/18

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F 812	Continued From page 32 p.m. the following food safety concerns were observed and confirmed by the registered dietitian (RD) and Cook (C)-A. - the walk in kitchen cooler was observed to contain thawed house supplements that were either expired or undated sitting on a plastic tray in a thin film of a light colored liquid on the bottom of the tray. 12 four ounce (oz) Mighty Shakes (six undated, three dated 2/11/18, two dated 2/22/18, one dated 2/24/18), and two 16 oz undated Protein Energy Shake Plus. - The Lodge kitchenette refrigerator was observed to contain thawed house supplements that were either undated or expired. Three 4 oz Mighty Shakes (2 undated, 1 dated 2/11/18), two 6 oz and three 16 oz orange nutritional juice drinks were undated. - The Fireside kitchenette refrigerator was observed to contain one thawed, undated 16 oz Protein Energy Shake Plus supplement. - The main dining room refrigerator was observed to contain thawed house supplements that were either undated or expired. One 16 oz Protein Energy Shake Plus was undated and one - four oz Mighty Shake dated 2/22/18. During interview on 3/12/18, at 12: 25 p.m. the RD verified all supplements come in frozen, but once thawed should have had a date on them when they were taken from freezer. Both C-A and RD, stated they did not know what the liquid was on the bottom of the tray the supplements were sitting in. C-A verified it was the responsibility of the dietary department to mark and check dates on the thawed supplements and stated "they	F 812	the foregoing statement, the facility states with respect to: 1. All thawed house supplements that were either undated or expired were discarded immediately. All dietary staff were re-educated immediately on the facility's Food Storage Guidelines. 2. All thawed house supplements that were either undated or expired were discarded immediately. All dietary staff were re-educated immediately on the facility's Food Storage Guidelines. All residents are comprehensively assessed and care plans developed based on these assessments upon admission, quarterly and with significant change of conditions. 3. Administrator/designee will ensure all dietary and nursing staff will be re-educated on the Food Storage Guidelines policy. Education and interventions will be completed by April 25, 2018. 4. Dietary Manager/designee will monitor via refrigerator audits and observations 2 times per week for 3 months to ensure compliance with the policy. Dietary Manager/designee will present the data to the Quality Assurance Performance Improvement Committee monthly for further recommendations regarding systems and continued monitoring.	

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F 812	Continued From page 33 should have been dated." Review of the Birchwood Health Care Center Food Storage Guidelines policy with revision date of 4/30/15, indicated "Frozen Supplements: unopened, frozen have twelve month shelf life. Once thawed, container is to be dated as of thaw date and disposed 14 days after opening."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		4/25/18

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F 880	Continued From page 34 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 880	The preparation of the following plan of	

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F 880	Continued From page 35 review the facility failed to follow transmission based precautions to prevent facility acquired infection for 2 of 2 residents (R82, R64). In addition the facility failed to perform appropriate hand hygiene during dressing changes for 1 of 2 residents (R79), and failed to use appropriate hand hygiene during cares for 1 of 3 residents (R15). Findings include: On 3/13/18, at 9:06 a.m. Both R64 and R82 had three drawer plastic storage containers outside their rooms. Inside each container were yellow barrier gowns and masks. On top of the containers were boxes of gloves and sanitizing wipes. On the door frames there were green magnets with instructions to see the nurse prior to entering the room. -9:10 a.m. registered nurse (RN)-B was interviewed and stated that both residents had infections and had acquired clostridium difficile (C-diff) within the facility. C Diff is a contagious spore forming bacterium that causes diarrhea and more serious intestinal conditions such as colitis. Contact/transmission based precautions including PPE [Personal Protective Equipment] such as barrier gown, gloves, and mask when spores may be in the air, such as changing linens. Hand washing with soap and water are required to remove the C-diff spores to prevent cross-contamination to staff or other residents, alcohol based hand sanitizers are not effective for C-diff. RN-B stated R64 had been treated in January for C-diff and then was off transmission based precautions for about 48 hours but had relapsed and was placed back on precautions again. RN-B stated R82 was placed on	F 880	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 with respect to: 1. Transmission based precautions have been discontinued as clinically indicated for R64 and R82 per MDH Clostridium difficile Algorithms for Long-term Care. R79 and R15 are receiving cares from staff that included appropriate standard precautions. 2. Transmission based precautions will continue to follow MDH guidance per the MDH Clostridium difficile Algorithms for Long-term Care. Standard precautions will continue to be in place for all resident interactions. 3. Administrator/designee will ensure all staff will receive education regarding standard and transmission based precautions, hand hygiene, and dressing change procedures. Education and interventions will be completed by April 25, 2018. 4. DNS/designee will audit standard precautions, hand hygiene, and dressing change procedures twice each weekly for one month, then once each weekly for two months. Observation audits of transmission based precautions will be completed if present twice weekly for one	

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F 880	Continued From page 36 transmission based precautions in February for C-diff. R64's Admission Record dated 3/15/18, indicated she was re-admitted to the facility from the hospital following treatment for a broken left femur and closed head injury. The Progress Notes dated 1/26/18, indicated R64 had three dark diarrhea stools. Progress Note dated 2/9/18, indicated R64 was taken off transmission based precautions. Progress Note dated 2/14/18, indicated that R64 had loose mucousy brownish green stool and complained of abdominal cramps. R64's Physician Orders (PO) dated 1/27/18, noted an order for metronidazole (Flagyl) 500 milligrams (mg) three times a day for 10 days for C-diff. A PO dated 2/14/18, indicated another test for C-diff and vancomycin was ordered. R64's Laboratory Results dated 2/14/18, indicated positive finding for C-diff strain 027/NAO1BI. A Nursing assistant (NA) Care Plan dated 3/9/18, indicated that R64 was on contact precautions. R82's Admission Record dated 3/15/18, indicated diagnosis of left femur fracture and acute post hemorrhagic anemia. R82's PO dated 2/24/18, indicated an order for stool sample to check for C-diff. PO dated 2/26/18, indicated an order for Flagyl 500 mg three times a day for 14 days for C-diff. PO dated 3/1/18, discontinued the Flagyl and order Vancomycin 125mg 4 times a day for 10 days. R82's Laboratory Result dated 2/24/18, indicated that R82's stool was positive for C-diff strain 027/NAP1BI. NA Care Plan dated 3/9/18, indicated R82 was on contact precautions.	F 880	month, then once weekly for two months. DNS /designee will present the data to the Quality Assurance Performance Improvement Committee monthly for further recommendations regarding systems and continued monitoring.	

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	245200	A. BUILDING _____ B. WING _____	03/16/2018

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 880	Continued From page 37	F 880		

During observation on 3/13/18, at 9:17 a.m. two staff members entered R82's room with gowns and gloves on. At 9:20 a.m. NA-F came out into the hall still wearing a gown/gloves, and began to remove them in the hall, stopped, turned around, and stepped back into R82's room. Less than 30 seconds later NA-F came out without the gown and gloves on and without washing her hands. NA-F retrieved a mechanical stand lift from a common area of the unit and brought the lift into R82's room. Prior to entering the room NA-F put on a clean gown and gloves.

At 9:48 a.m. licensed practical nurse (LPN)-A put on a pair of gloves but no gown and entered R82's room to bring R82 some yogurt and left the room. At 9:55 a.m. LPN-A was interviewed regarding C-diff precautions and explained that a gown and gloves were to be worn when giving cares, and explained further that when she entered R82's room she only wore gloves because she was just dropping off some yogurt for R82. LPN-A stated the gloves were removed and hand hygiene was performed prior to leaving R82's room. When asked about how staff are educated about precautions, LPN-A stated staff were told in report about what type precautions. LPN-A stated it was not ok for a staff member to come into the hall with gown and gloves on. The gloves and gown needed to be removed prior to leaving the room and the staff member needed to wash their hands. LPN-A stated that the staff received training on different types of infections and had mandatory classes on the computer.

On 3/14/18, at 7:27 a.m. occupational therapist (OT)-A came out of R82's room with the mechanical stand lift and left it in the hall outside

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F 880	Continued From page 38	F 880		

the room. Nursing assistant (NA)-C brought R82 out of her room to weigh her on the chair scale. NA-C wheeled R82 back into her room without donning PPE.

NA-C was interviewed at approximately 7:37 a.m. about the precautions. NA-C stated that R82 was on precautions for C-diff and that meant staff were supposed to follow precautions. NA-C also stated no gown or gloves were put on prior to going into R82's room to provide cares and explained, "we were told in report that R82 might be coming off precautions today, so I didn't think I needed to put them on." When asked if the precautions had been discontinued NA-C stated no they had not been discontinued. When asked what had been taught about precautions NA-C stated, "I am supposed to put on gown and gloves," When asked if precautions had been followed NA-C stated, "no I did not put on gown and gloves."

At 7:37 a.m. OT-A brought R82 out of room in a wheelchair and took 82 to the therapy room.

At 7:55 a.m. the director of nursing (DON) was interviewed, and when told about staff going in and out of R82's room without following transmission based precautions the DON stated the staff needed to be putting on the appropriate PPE until nursing discontinued precautions.

At 9:56 a.m. the OT-A was interviewed and stated she had not donned PPE until she noted that R82 was using the toilet. She came out and donned PPE and went back into the room to assist with R82's care. OT-A went on to explain that C-diff was an infection in the fecal matter and can be spread very easily. OT-A explained that gowns

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F 880	Continued From page 39	F 880		

and gloves were only needed if the staff was going to be doing direct care activities. When asked if she put on PPE prior to going into the resident's room OT-A stated no. When asked about transmission based precaution training the OT-A stated training was given when hired and annually after that. When asked about hand hygiene the OT-A stated that with C-diff hands needed to be washed with soap and water and dried thoroughly.

A Feedback Form dated 3/1/18, written by R82's family member indicated the family was concerned about staff helping R82 to wash hands with soap and water.

During an interview on 3/16/18, at 9:41 a.m. the DON stated the expectation was for staff to follow transmission based precautions according to the facility guidelines and protocols until nursing discontinued the precautions.

Birchwood Health Care Center Practice Guideline and Procedure for Transmission Based Precautions dated 9/17, indicated remain in effect until culture or antigen-detection test results document eradication of the pathogen and, symptomatic disease is resolved.

R79
R79's Admission Record dated 3/15/18, indicated R79 had diagnoses of a cerebral infarction with paralysis on the dominant side and aphasia (difficulty speaking).

R79's Orders Discharge Report from St Cloud Hospital dated 12/23/17, indicated that R79 had a percutaneous endoscopic gastrostomy (PEG)

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F 880	Continued From page 40	F 880		

tube placed in his abdomen for nutrition and medication administration.

R79's Treatment Administration Record (TAR) from December 2017 through March 2018 indicated the dressing around R79's PEG tube was changed twice a day.

On 3/15/18, at 8:00 a.m. licensed practical nurse (LPN)-A prepared to change the dressing on R79's PEG tube site. LPN-A performed hand hygiene and put on clean gloves. LPN-A removed the soiled dressing, washed the site with a spray solution, patted the area with a gauze wipe, put on a clean split dressing, and taped it into place. LPN-A did not change gloves or perform hand hygiene at any time during the observation of the dressing change. Immediately following the observation LPN-A was asked about the facility protocol regarding hand hygiene and changing of gloves during a dressing change and stated, "I should have changed my gloves before putting on the clean dressing."

During an interview on 3/16/18, at 9:41 a.m. the director of nursing (DON) stated the expectation was for staff to perform hand hygiene and put on clean gloves after removing a soiled or old dressing and before putting on a clean dressing.

Birchwood Health Care Center Practice Guideline and Procedure for Hand Hygiene dated 10/13/17, indicated that gloves must be changed between different cares with proper hand hygiene including for the same resident.

Birchwood Health Care Center Practice Guideline and Procedure for Non-Sterile Dressing dated 6/14, indicated that after removing the soiled

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F 880	Continued From page 41	F 880		

dressing gloves should be removed and placed in the trash with the soiled dressing. Hand hygiene needs to be performed and clean gloves put on.

03/16/18 at 11:00 a.m. the director of nursing/infection preventionist (DON/IP) stated there had been an investigation for facility acquired C-Diff, R64 and R79 were located directly across the hall from each other, both residents had facility acquired C-diff with identical strain 027/NAP1/BI. The DON stated staff should be using PPE for residents with transmission based precautions, during direct care and equipment should be dedicated and stay in resident room, and staff should be following hand hygiene and glove changes per policy.

the Birchwood Health Care Center Practice Guideline and Procedure dated 10/13/17, directed: Hand washing shall be performed by all employees, as necessary, between tasks and procedures, and after bathroom use to prevent cross-contamination.

The Guideline: PPE Selection and Use policy dated 9/26/17, "To establish and maintain a program designed to provide a safe and sanitary environment for all residents, tenants, patients, their families, volunteers, visitors and staff. " The infection preventionist shall develop, implement comply with and review at least annually, written polices and procedures regarding infection prevention and control which are consistent with Center for Disease Control (CDC) guidelines for hand washing, environmental control, isolation precautions.

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F 880	Continued From page 42	F 880		

R15 during continuous observations, on 3/14/18 from 11:09 a.m. to 11:30 a.m. nursing assistant (NA)-A and NA-B were observed to assist R15 with morning cares. NA-A and NA-B both had gloves on when the observation began. NA-A washed R15's face and then upper body with a warm washcloth. Both aides pulled arm sleeves on both arms, assisted R15 in a shirt and positioned pants under lower body after removing R15's urine soaked incontinent pad. NA-A used same washcloth to wipe R15's front side peri area at which time both aides rolled R15 on her right side. NA-B then took the washcloth and wiped R15's back side, and with NA-A's assistance placed a clean incontinent pad on, pulled pants up and secured them. Both aides then placed a mesh sling under R15 by rolling R15 back and forth. NA-B took off her gloves disposing them in a waste basket lined with a plastic bag and without washing her hands obtained a mechanical lift from the hallway. NA-A then took off her gloves, threw them in the waste basket and did not wash her hands. Both aides then positioned R15 in the sling, NA-A raised it up by touching the controls on the stand and placed R15 in her wheelchair. While NA-A started to groom R15's hair, NA-B started making R15's bed and fluffing up the pillows. NA-B then took the plastic bags of dirty clothing and wastebasket contents down the hall to dirty linen utility room and deposited the bags. NA-B did not wash her hands, came back into R15's room, took the washbasin to the bathroom, dumped the water and stated she washed her hands. NA-A then finished R15's hair grooming, repositioned her in the wheelchair and started wheeling R15 out of the room. At this time surveyor asked NA-A when she would wash her hands and NA-A explained they should be washed before she leaves the

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F 880	Continued From page 43 room. NA-B stated "I should have washed them after taking gloves off and before leaving the room, before and after peri cares." NA-B verified should not have fluffed pillows and made the bed with unwashed hands after conducting peri cares. During interview on 3/14/18, at 11:40 a.m. registered nurse (RN)-A stated she would expect staff to wash hands before starting to work with a resident, before and after peri cares, and "anytime putting gloves on and off you should be washing your hands."	F 880		

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K 000	INITIAL COMMENTS	K 000		

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 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, State Fire Marshal Division. At the time of this survey Birthwood HCC 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 (K-TAGS) TO:

IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/12/2018

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and 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 85 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 363		4/25/18

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K 363	Continued From page 3 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.6.3) This deficient practice could affect the safety of all (24) the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 3/13/2018, observations and staff interview revealed the following: Found corridor door located by room 155 with a gap larger than 3/8" per NFPA 80 4.8.4. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states with respect to: 1. Director of Environmental Services ordered materials from a vendor that will correct the Link Corridor Door air gap and bring the door into compliance. The materials were ordered on March 30, 2018. 2. Materials are expected to ship April 11, 2018 and will be installed by Environmental Services Director by April 13, 2018. 3. Administrator/designee will ensure environmental services staff will be reeducated on fire door compliance guidelines. 4. Director of Environmental Services will add the Link Corridor Door to the monthly inspection and will document the results of the inspection. Environmental Services Director/designee will present the data to the Quality Assurance Performance Improvement Committee monthly for	

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K 363	Continued From page 4	K 363	further recommendations regarding systems and continued monitoring.	