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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MKX9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00168

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2004**

6. DATE OF SURVEY **12/12/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

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

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
		60		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susie Haben, Unit Supervisor 01/16/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/16/2018 (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
03/31/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/18/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 24E166

January 16, 2018

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

Dear Mr. Hagemeyer:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to the Minnesota Department of Human Services that your facility be recertified for participation in the Medicaid program.

Effective December 1, 2017 the above facility is certified for:

60 Nursing Facility II 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 16, 2018

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

RE: Project Number SE166027

Dear Mr. Hagemeyer:

On November 22, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 2, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On December 12, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 2, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 1, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 2, 2017, effective December 1, 2017 and therefore remedies outlined in our letter to you dated November 22, 2017, 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MKX9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00168

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2004**

6. DATE OF SURVEY **11/02/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
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
		60		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Thomas Obrien, HFE NEII 12/04/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/18/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/31/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: MKX9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00168

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5. Validation 6. Complaint
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5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2004**

6. DATE OF SURVEY **11/02/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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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

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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
		60		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Thomas Obrien, HFE NEII — 12/04/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 12/18/2017 (L20)

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

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_____

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03/31/1974 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

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27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
12/18/17 (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

Electronically delivered
November 22, 2017

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

RE: Project Number SE166027

Dear Mr. Hagemeyer:

On November 7, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the 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 a "F" tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
Metro D 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: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 17, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 17, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 2, 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 May 2, 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies is 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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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
	24E166	A. BUILDING _____ B. WING _____	11/02/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/30, 10/31, 11/1 and 11/2/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F 329		12/1/17

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

Electronically Signed | 12/04/2017

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	24E166	A. BUILDING _____ B. WING _____	11/02/2017

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

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F 329	Continued From page 1 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure gradual dose reduction (GDR) of antipsychotic medications was attempted for 3 of 5 residents (R32, R49, R15) and failed to monitor Tardive Dyskinesia (TD) for 2 of 5 residents (R32, R49). In addition, the facility failed to monitor target behaviors for 2 of 5 residents (R4, R26) reviewed for unnecessary medicationsi. Findings include: R32's most recent admission to the facility was	F 329	TD monitoring was completed for R49 and R32. An audit was done for all resident's TD monitoring and all are complete. The Consultant Pharmacist and MDS Coordinator will track for timely completion during the monthly MRR and during the quarterly MDS process. We will continue to attempt to have psychiatrists complete TD monitoring at scheduled appointments as able. If unable, will have charge nurse who is trained in TD monitoring complete. We will be sending some of the charge nurses	

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F 329	Continued From page 2 11/17/16. The resident record indicated R32 had intact cognition and diagnoses including Bipolar and Schizoaffective Disorder. R32's medication administration record (MAR) indicated Olanzapine 7.5 mg (an antipsychotic medication) was to be given once daily at bedtime. Further review of R32's medical record revealed no attempt at a gradual dose reduction nor physician documented clinical contraindication was completed. In addition, there was no documentation of TD monitoring having been completed in the past year. R49's was most recently readmitted to the facility 4/25/13, with intact cognition and diagnoses including Post traumatic Stress Disorder (PTSD), generalized anxiety disorder, adjustment disorder and depression. R49's MAR indicated Risperdal 1 mg (an antipsychotic medication) was to be given two times each day. Further review of R49's medical record indicated no attempt at a gradual dose reduction or physician documented clinical contraindication had been completed. In addition, there was no documentation of TD monitoring having been completed in the past year. During interview with the consultant registered pharmacist (RPH) on 11/2/17, at 10:40a.m. the RPH confirmed there was no recommendation for GDR documented for residents R32 or R49. R15's face sheet indicated the most recent admission to facility was 2/10/15. A minimum data set (MDS) dated 8/18/17, indicated R15 had a diagnosis of paranoid schizophrenia and was	F 329	to a TD monitoring class so we have more staff capable of completing the TD monitoring when we are unable to get them from the psychiatrists. An audit of GDR documentation has been completed and GDR documentation is being requested by the Consultant Pharmacist for all resident's. The Consultant Pharmacist will continue to track this and provide the DON with the request for the annual GDR as they become due. These will all be completed within the next 60 days for the current year. GDR attempts or documentation of clinical rationale why not to do a GDR will also be tracked and discussed during each resident's quarterly care conference process. All resident care plans have been audited to be sure they have Target behaviors listed. Target Behavior monitoring policy has been revised and a Target Behavior monitoring book has been developed for the Nursing Staff to document Target behaviors including a copy of the care plan with the Target behaviors and interventions listed. A target behavior monitoring form has been developed for R15, R4 and R26. Target behaviors will continue to be reviewed on a monthly basis. Consultant Pharmacist will track and notify nursing if a target behavior is missing or if target behavior monitoring does not meet expectations. See copy of revised Target behavior policy attached. Director of Nursing, Resident Care Coordinator and Staff Development Coordinator will be responsible for tracking and auditing these processes.	

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cognitively intact. R15's MAR indicated Clozapine 300 milligrams was to be administered daily at bedtime for paranoid schizophrenia.

Review of the monthly pharmacist review notes did not indicate any gradual dose reduction recommendations for R15's antipsychotic medication in the past 12 months.

During interview on 11/1/17, at 9:45 a.m. the Director of Nursing (DON) stated the facility's previous consultant pharmacist did not think GDR's needed to be recommended if a resident was also under the care of a psychiatrist. Additionally, the DON stated she'd recognized the facility was not up to date with GDR's for residents including R32, R49 and R15. The DON stated her expectation was that the new pharmacist would ensure GDR's were completed at least annually with supporting documentation in the residents' chart, she verified the GDR's have not been discussed at interdisciplinary meetings, or quality assurance meetings, but they will be now. The DON also stated R49 and R32 were due for DISCUS (Tardive Dyskinesia) monitoring, and subsequently contacted the nurse practitioner (NP) for a referral. The DON stated DISCUS were expected to be completed annually.

R4's annual MDS dated 7/28/17, indicated R4's cognition was intact with inattention, disorganized thinking and delusions occuring. The MDS also indicated R4 had diagnoses of Schizophrenia and Depression and took antipsychotic and antidepressant medications.

R4's Medication Review Report (MRR) dated 11/1/17, indicated R4 was taking Abilify (an

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antipsychotic medication) 5 mg one time a day since 6/1/12. R4's MRR indicated R4 was taking Celexa (an antidepressant medication) 20 mg once a day r/t to Major Depressive Disorder, Recurrent, Unspecified with an order date of 6/29/05, and a day. The MRR also indicated R4 was taking Olanzapine (an antipsychotic medication) 35 mg one time a day since 6/1/12. November's 2017 MAR verified R4 received Abilify 5 mg daily, Celexa 20 mg daily and Olanzapine 35 mg daily.

R4's Care Area Assessment (CAA) Psychotropic Medications dated 7/28/17, indicated R4 was being treated long term with psychotropic medications for active delusional status as well as an antidepressant for personal best in mental health stability and indicated R4's altered thought processes interfered with abilities related to task management, decisions, judgements and choices.

During interview with the DON on 11/2/17, at 2:00 p.m. the DON stated R4's target behaviors for use of the antipsychotic were identified on the care plan. The DON stated R4's target behaviors were dumpster diving, going out into the community, and thinking he is at work. The DON stated R4 was delusional and staff completed daily room checks to see whether R4 had brought anything back from outings. When asked how often R4 dumpster dived, the DON stated staff completed daily room checks to see whether R4 had brought anything back with him, but verified these checks were not documented. The DON stated staff communicated their findings between themselves "verbally".

R4's monthly pharmacist review notes did not

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include recommendations for target behavior monitoring in the past 10 months.

During interview with the facility's consultant RPH on 11/2/17, at 9:24 a.m. the RPH stated she didn't look for GDR's for residents on antipsychotics during her monthly medication review and stated she had discussed with DON about how often DISCUS should be completed and the policy for the facility was annually. The RPH stated she would look at R4's DISCUS and if the score had increased, she'd look at the trends to see whether the DISCUS should be completed more frequently. The RPH stated she had only been coming to the facility for three months and had not yet looked into all the residents' behaviors but verified behaviors did need to be looked into. R26's specific target behaviors were not being monitored for depression, "insomnia" or anxiety.

R26's quarterly Minimum Data Set (MDS) dated 6/30/17, indicated R26 had intact cognition, did not display any physical, verbal or other behaviors including rejection of care or wandering, and took antianxiety and antidepressant medications on a daily basis.

R26's physician orders dated 11/1/17, indicated R26 was administered the following medications: Ambien (hypnotic) 10 mg PO every evening insomnia since 11/16/15; Trazodone 100 mg, PO every evening for insomnia since 11/16/15; and Trazodone 100 mg PO three times a day related to recurrent severe major depressive disorder without psychotic features since 11/16/15. The physician order lacked identification of specific behaviors to monitor for the resident while taking antidepressant and hypnotic medications.

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R26's care plan initiated 4/27/08, indicated R26 made repetitive complaints related to peers, staff and family. Further, the care plan indicated R26's moods were low energy, that R26 isolated himself, R26 does not eat meals well and that R26 did not wish to live when depressed. The facility was unable to identify how they monitored R26'S target behaviors.

When interviewed on 11/1/17, at 9:02 a.m. Nursing Assistant (NA)-A stated the care guide for R26 included activity of daily living directions but did not identify directions for monitoring/intervening for resident behaviors.

On 11/1/17, at 2:38 p.m. LPN-A and RN-A stated the nurse aides do not have access to the worksheet for target behavior monitoring however, they can report any new behaviors to the nurse and the nurse can chart.

During an interview with the consultant pharmacist on 11/2/17, at 9:59 a.m. she stated, "I expect the facility to monitor target behaviors related to resident diagnosis and medications."

The facility's Consultant Pharmacy Medication Regimen Review policy and procedure dated May 2009, indicated residents who used antipsychotic drugs should receive monitoring of medications for efficacy and clinical significant adverse consequences, gradual dose reductions, and behavioral interventions, unless contraindicated in an effort to discontinue these drugs. Forms requesting the physician's response to changing a dose up or down of a specific medication, the discontinuance of a specific medication, the rational for the continued long term dose or the

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F 329	Continued From page 7 use of multiple medications of same classification of medications will be reviewed with the Charge Nurse and then given to the Director of Medical Records for sending to the physician for reply. When the facility receives a physician's reply to the pharmacist it will be given to the DON/designee for signing and filing after reviewing the physician's response. Physician's responses will be charged in the interdisciplinary notes in Point Click Care (PCC) under the specific resident identified. Facilities undated Tardive Dyskinesia (TD) Monitoring policy indicated TD monitoring would be done on those residents receiving antipsychotic medications at least one time yearly, or more frequently as conditions warrant. The Dyskinesia Monitoring Record will be kept in the individual medical record.	F 329		
F 428 SS=E	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.	F 428		12/1/17

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F 428	Continued From page 8 (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the consultant pharmacist identified irregularities in resident medication regimens for 4 of 5 residents (R32,	F 428	Same as corrections to F329	

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F 428	Continued From page 9 R49, R15, R4) reviewed for unnecessary medications. Findings include: During interview with the consultant registered pharmacist (RPH) on 11/2/17, at 10:40a.m. the RPH confirmed there was no recommendation for gradual dose reduction (GDR) or tardive dyskinesia (TD) monitoring documented for residents R32 or R49. The RPH stated she had recently started at the facility and would address these concerns. R32's most recent admission to the facility was 11/17/16. The resident record indicated R32 had intact cognition and diagnoses including Bipolar and Schizoaffective Disorder. R32's medication administration record (MAR) indicated Olanzapine 7.5 mg (an antipsychotic medication) was to be given once daily at bedtime. Further review of R32's medical record revealed no attempt at a gradual dose reduction nor physician documented clinical contraindication was completed. In addition, there was no documentation of TD monitoring having been completed in the past year. R49's was most recently readmitted to the facility 4/25/13, with intact cognition and diagnoses including Post traumatic Stress Disorder (PTSD), generalized anxiety disorder, adjustment disorder and depression. R49's MAR indicated Risperdal 1 mg (an antipsychotic medication) was to be given two times each day. Further review of R49's medical record indicated no attempt at a gradual dose reduction or	F 428		

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physician documented clinical contraindication had been completed. In addition, there was no documentation of TD monitoring having been completed in the past year.

Review of the monthly pharmacist review notes did not indicate any gradual dose reduction recommendations for R15's antipsychotic medication in the past 12 months.

R15's face sheet indicated the most recent admission to facility was 2/10/15. A minimum data set (MDS) dated 8/18/17, indicated R15 had a diagnosis of paranoid schizophrenia and was cognitively intact. R15's MAR indicated Clozapine 300 milligrams was to be administered daily at bedtime for paranoid schizophrenia.

During interview on 11/1/17, at 9:45 a.m. the Director of Nursing (DON) stated the facility's previous consultant pharmacist did not think GDR's needed to be recommended if a resident was also under the care of a psychiatrist. Additionally, the DON stated she'd recognized the facility was not up to date with GDR's for residents including R32, R49 and R15. The DON stated her expectation was that the new pharmacist would ensure GDR's were completed at least annually with supporting documentation in the residents' chart, she verified the GDR's have not been discussed at interdisciplinary meetings, or quality assurance meetings, but they will be now. The DON also stated R49 and R32 were due for DISCUS (Tardive Dyskinesia monitoring), and subsequently contacted the nurse practitioner (NP) for a referral. The DON stated DISCUS were expected to be completed annually.
Review of the monthly pharmacist review notes

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did not indicate any gradual dose reduction recommendations for R15's antipsychotic medication in the past 12 months.

R15's face sheet indicated the most recent admission to facility was 2/10/15. A minimum data set (MDS) dated 8/18/17, indicated R15 had a diagnosis of paranoid schizophrenia and was cognitively intact. R15's MAR indicated Clozapine 300 milligrams was to be administered daily at bedtime for paranoid schizophrenia.

During interview on 11/1/17, at 9:45 a.m. the Director of Nursing (DON) stated the facility's previous consultant pharmacist did not think GDR's needed to be recommended if a resident was also under the care of a psychiatrist. Additionally, the DON stated she'd recognized the facility was not up to date with GDR's for residents including R32, R49 and R15. The DON stated her expectation was that the new pharmacist would ensure GDR's were completed at least annually with supporting documentation in the residents' chart, she verified the GDR's have not been discussed at interdisciplinary meetings, or quality assurance meetings, but they will be now. The DON also stated R49 and R32 were due for DISCUS (Tardive Dyskinesia) monitoring, and subsequently contacted the nurse practitioner (NP) for a referral. The DON stated DISCUS were expected to be completed annually.
During interview with the facility's consultant RPH on 11/2/17, at 9:24 a.m. the RPH stated she didn't look for GDR's for residents on antipsychotics during her monthly medication review and stated she had discussed with DON about how often DISCUS should be completed and the policy for the facility was annually. The RPH stated she

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would look at R4's DISCUS and if the score had increased, she'd look at the trends to see whether the DISCUS should be completed more frequently. The RPH stated she had only been coming to the facility for three months and had not yet looked into all the residents' behaviors but verified behaviors did need to be looked into. The monthly pharmacist review notes for R4 did not include any recommendations for target behavior monitoring in the past 10 months.

R4's annual MDS dated 7/28/17, indicated R4's cognition was intact with inattention, disorganized thinking and delusions occuring. The MDS also indicated R4 had diagnoses of Schizophrenia and Depression and took antipsychotic and antidepressant medications.

R4's Medication Review Report (MRR) dated 11/1/17, indicated R4 was taking Abilify (an antipsychotic medication) 5 mg one time a day since 6/1/12. R4's MRR indicated R4 was taking Celexa (an antidepressant medication) 20 mg once a day r/t to Major Depressive Disorder, Recurrent, Unspecified with an order date of 6/29/05, and a day. The MRR also indicated R4 was taking Olanzapine (an antipsychotic medication) 35 mg one time a day since 6/1/12. November's 2017 MAR verified R4 received Abilify 5 mg daily, Celexa 20 mg daily and Olanzapine 35 mg daily.

During interview with the DON on 11/2/17, at 2:00 p.m. the DON stated R4's target behaviors for use of the antipsychotic were identified on the care plan. The DON stated R4's target behaviors were dumpster diving, going out into the community, and thinking he is at work. The DON stated R4 was delusional and staff completed

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F 428	Continued From page 13 daily room checks to see whether R4 had brought anything back from outings. When asked how often R4 dumpster dived, the DON stated staff completed daily room checks to see whether R4 had brought anything back with him, but verified these checks were not documented. The DON stated staff communicated their findings between themselves "verbally". The facility's Consultant Pharmacy Medication Regimen Review policy and procedure dated May 2009, indicated residents who used antipsychotic drugs should receive monitoring of medications for efficacy and clinical significant adverse consequences, gradual dose reductions, and behavioral interventions, unless contraindicated in an effort to discontinue these drugs. Forms requesting the physician's response to changing a dose up or down of a specific medication, the discontinuance of a specific medication, the rational for the continued long term dose or the use of multiple medications of same classification of medications will be reviewed with the Charge Nurse and then given to the Director of Medical Records for sending to the physician for reply. When the facility receives a physician's reply to the pharmacist it will be given to the DON/designee for signing and filing after reviewing the physician's response. Physician's responses will be charged in the interdisciplinary notes in Point Click Care (PCC) under the specific resident identified. Facilities undated Tardive Dyskinesia (TD) Monitoring policy indicated TD monitoring would be done on those residents receiving antipsychotic medications at least one time	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING _____ B. WING _____	11/02/2017

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

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F 428	Continued From page 14 yearly, or more frequently as conditions warrant. The Dyskinesia Monitoring Record will be kept in the individual medical record.	F 428		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		12/1/17

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F 431	Continued From page 15 instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin pens were stored according to manufacturer recommendations for 3 of 3 residents (R37, R43, R53) reviewed during medication storage review who utilized insulin pens. Findings include: R37 was admitted to the facility on 8/26/07, with medical diagnoses that included: type 2 diabetes, rash and other unspecified skin eruption, hypo-osmolality and hyponatremia. Review of R37's Medication Review Report (MRR) dated 9/26/17, indicated an order for Lantus insulin 100 unit/ milliliters(ml) inject 15 units subcutaneously in the evening related to type 2 diabetes mellitus.	F 431	All opened insulin pens were removed from the refrigerator and are being stored at room temperature. All nursing staff have been educated on taking insulin pens out of refrigerator 1 to 2 hours before first injection and then after being opened to be stored at room temperature. A note has been placed on the case that the refrigerated insulin pens are stored in for a reminder. Director of Nursing, Resident Services Coordinator and Staff Development Coordinator will monitor for compliance.	

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F 431	Continued From page 16	F 431		

R43 was admitted to the facility on 11/17/08, with medical diagnoses that included: type 2 diabetes, seborrhea dermatitis, hypo-osmolality and hyponatremia, and cellulitis of unspecified orbit. R43's MRR dated 9/26/17, revealed orders for Lantus SoloStar solution pen-injector inject 48 units subcutaneously in the afternoon for type 2 diabetes mellitus, NovoLog Flex pen solution inject 14 units subcutaneously for type 2 diabetes mellitus with meals and, NovoLog Flex pen solutions inject per sliding scale: 150-200=3 units; 201-250= 6 units; 251-300=9 units; 301 -350=12 units; 350-400=15 units; 401-450 18 units; 451-500 =21 unit subcutaneously three times a day for type 2 diabetes mellitus.

R53 was admitted to the facility on 7/28/14, with diagnoses that included: type 2 diabetes and hyperlipidemia. R53's MRR dated 8/8/17, revealed orders for Lantus SoloStar solution pen-injector 10 units subcutaneously at bed time.

During a review of medication storage on the first floor on 10/30/17, at 3:16 p.m. licensed practical nurse (LPN)-A stated the refrigerator temperature was 37 degrees Fahrenheit and verified it by showing the surveyor the thermometer. LPN-A stated the following insulin pens, which were currently open and being used, were stored in the refrigerator between doses: R37'S Lantus solution 100 unit/ml, R43'S Lantus SoloStar solution pen-injector 100 unit/ml, R53'S Lantus SoloStar solution pen-injector 100 unit/ml, and NovoLog Flex pen solutions pen injector 100 unit/ml.

During an interview with director of nursing (DON) on 10/30/17 at 5:05 p.m., the DON stated, "insulin must be kept in the refrigerator at all times except

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F 431	Continued From page 17 when we administer it". On 11/2/17 at 9:24 a.m., the facility's consulting pharmacist was interviewed and stated she expected facility staff to follow manufacturers' instructions for insulin storage. Review of pharmacy and manufacturer instructions included: The Omnicare pharmacy reference sheet Recommended Minimum Medication Storage Parameters, based on manufacturer guidance page 3, indicated insulin pens were recommended to be stored in the refrigerator prior to their first use. The Sanofi (insulin manufacturing company) Lantus SoloStar insert instructions included: "If your SoloStar is in cool storage, take it out 1 to 2 hours before you inject to allow it to warm up...Once you take your SoloStar out of cool use must not be stored in the refrigerator." The Novo Nordisk insert instructions for the NovoLog flex pen detailed storage instructions which indicated flex pens currently in use should be stored outside the refrigerator, at a temperature below 86 degrees Fahrenheit, for up to 28 days. The undated facility policy for Storage of Medications, indicated it was the policy of the facility to store all medications in a safe, secure and orderly manner.	F 431		
F 441 SS=F	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 441		12/1/17

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F 441	Continued From page 18 (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: (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 (facility assessment implementation is Phase 2); (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 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	F 441		

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F 441	Continued From page 19 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 review, the facility failed to develop, implement, and operationalize a program to prevent Legionella in the facility's water systems to prevent cases and outbreak of Legionnaires' disease. This had the potential to effect all 60 residents, visitors, and staff in the facility. In addition, the facility failed to ensure soiled linens were disposed of properly. Findings include:	F 441	Attached is a report about the city's water testing as well as a Water maintenance policy for the prevention of Legionnaire's and other pathogens. A PH and Chlorine testing kit has been ordered to monitor these levels. Preliminary water testing will be completed within 30 days, ongoing monitoring thereafter. Director of Maintenance, Director of	

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F 441	Continued From page 20 Legionnaire's: During interview with the Director of Nursing (DON) on 11/2/17, at 11:03 a.m. the DON stated the facility had been made aware of the June 2017 Federal memo regarding Legionnaire's disease and had formed a committee including, maintenance, Minimum Data Set Coordinator, the administrator and herself as DON. The DON stated an analysis of the water at the facility had been conducted and provided the analysis for review. The DON stated no policies/procedures had been developed nor had any water management plan been created. The DON stated she thought there was no need for anything other than the analysis since the analysis explained the water in the facility came from the city of Minneapolis and water chlorine levels exceeded guidelines. When asked about the city's water testing, the DON stated she did not have a report. Soiled Linens: On 10/30/17, at 1:29 p.m. R2 stated he changed his own bed sheets and took his dirty sheets down and placed them in the linen hamper in the hall. R2 stated he placed his dirty clothes in a basket in his closet where the staff picked up. At 2:43 p.m. on 10/30/17, an uncovered laundry hamper was observed in the middle of the hall on the 3rd floor. The hamper was noted to be 2/3 full, with dirty sheets and a bedspread observed in the open hamper. At 3:23 p.m. on 10/30/17, maintenance-A stated the linen hamper on 3rd floor held only dirty linens, towels and rags and no clothes. Maintenance-A stated nursing assistants (NAs) took the bag of dirty linen to laundry regularly so the dirty linens wouldn't end up on the floor.	F 441	Nursing and Infection Preventionist will be responsible for monitoring. New covered laundry hampers were ordered and have replaced the uncovered laundry hampers. Director of Laundry/ Housekeeping, Director of Nursing and Infection Preventionist will be responsible for monitoring.	

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F 441	Continued From page 21 At 5:07 p.m. on 10/30/17, the uncovered laundry hamper on the 3rd floor was observed again in the middle of the hall. The hamper remained 2/3 full, with a bedspread and dirty sheet observed in the open hamper. At 5:17 p.m. on 10/30/17, an plastic bag containing soiled linens was observed on the bottom shelf of the laundry rack, with the top of the bag open, lying on the floor. There were dirty towels spilling out, and a soiled towel hanging on the rack. On 10/31/17, at 8:14 a.m. an uncovered dirty linen bag was observed outside the shower room on the third floor with dirty linens inside. R17 walked up to open dirty linen bag, pulled out a wet towel, blew his nose with it, put it back in the bag and then walked into his room. On 10/31/17, at 8:45 a.m. R17 was again observed on 3rd floor walking up to an uncovered soiled linen hamper. The hamper was 2/3 full of dirty sheets, bedspread and towels. R17 was observed to remove a dirty towel from the hamper, blew his nose into the towel, and placed the towel back into the hamper. At 8:51 a.m. on 10/31/17, NA-A stated the hamper on 3rd floor was the hamper the facility used for soiled linens, and that once the bag was full, she'd take it downstairs to the laundry and replace the linen bag with a clean one. During observations on the 2nd floor on 10/31/17, at 9:05 a.m. an uncovered linen hamper was observed to be 2/3 full with dirty towels and another linen bag wrapped about the handrail.	F 441		

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F 441	Continued From page 22 On 11/1/17, at 7:24 a.m. open dirty linen bags noted were observed on the second and third floor with dirty linens in them. On 11/2/2017, at 8:27 a.m. open linen bags were observed noted on second and third floor with dirty linens in them. During an interview with the director of nursing (DON) on 11/2/17, at 10:45 a.m. the DON stated linens were sent out to be cleaned at a company and picked up from the 1st floor. The DON stated residents were encouraged to carry their own dirty linens in a bag to the 1st floor laundry room and that residents were able to place their dirty linens into linen hampers on the resident units. The DON acknowledged the facility currently used uncovered linen hampers, but could start using linen hampers with lids. The facility's undated policy SOILED LINEN HANDLING, included, "...resident is responsible to bring their soiled linens to the soiled linen cart placed on each floor ... Soiled linen is transported in a covered container ..."	F 441		

Electronically delivered
November 22, 2017

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

Re: State Nursing Home Licensing Orders - Project Number SE166027

Dear Mr. Hagemeyer:

The above facility was surveyed on October 30, 2017 through November 2, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Susie Haben, Unit Supervisor at (651) 201-3794 or at susie.haben@state.mn.us

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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
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3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are	3 000		

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3 000	Continued From page 1 delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 10/30, 10/31, 11/1 and 11/2/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Board and Care Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	3 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3 000		
3 601	MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control (a) A boarding care home must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of The guidelines. (b) Written compliance with this subdivision must be maintained by the boarding care home. This MN Requirement is not met as evidenced by:	3 601		12/1/17

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	00168	A. BUILDING: _____ B. WING _____	11/02/2017

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

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3 601	Continued From page 3 Based on interview and document review, the facility failed to ensure 3 of 5 residents (R7, R28, R29) and 5 of 5 employees (E1, E2, E3, E4, E5) reviewed, were screened for tuberculosis (TB), had timely TB skin tests and/or had properly documented TB skin tests. Findings include: Residents R7 was admitted to the facility on 7/6/17. A first step mantoux was administered on 7/6/17. The second step mantoux was administered 7/14, and was read 7/15/17 instead of after 48-72 hours R28 was admitted to the facility on 7/18/17. A first step mantoux was administered 7/19/17. The second step mantoux was administered on 7/26/17, and there were no results documented. R29 was admitted to the facility on 8/23/17. Review of R29's chart revealed no TB history/symptom screen was completed. Employees E1 was hired 7/6/17. E1's personnel file indicated a first step mantoux had been administered 7/8/17; and the second step mantoux was administered 7/21/17. Both mantoux results were identified as reading at 0-4 mm (millimeters), and had no interpretation of negative or positive identified. E2 was hired 10/10/17. E2's personnel file indicated a first step mantoux had been administered 10/11/17; and the second step mantoux was adminsitered 10/22/17. The second step mantoux results were identified as 0-4 mm and had no interpretation of negative or positive identified.	3 601	Corrected	

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3 601	Continued From page 4 E3 was hired on 8/17/17. E3's personnel file included a first step mantoux dated 8/17/17, which was read with no interpretation of positive or negative. E3's second step mantoux dated 8/26/17, included a reading of 0-4 mm marked with no interpretation. E4 was hired on 7/6/17. E4's personnel file included a first step mantoux dated 7/13/17, with no interpretation of results identified. There was no second step mantoux recorded as given. E5 was hired with the facility on 8/17/17. E5's personnel file indicated a first step mantoux dated 8/20/17, with no interpretation of results identified. There was no second step mantoux recorded as given. On 11/1/17, at 10:00 a.m. registered nurse (RN)-A verified the findings related to TB assessment and screening for the above residents and employees. RN-A stated the nurses were trained on the TB process and how to read a mantoux. RN-A stated she was unaware of the July 2013 Minnesota Department of Health TB Guidelines. On 11/2/17, at 10:57 a.m. the director of nursing (DON) stated she and the Infection Preventionist (IP) were responsible for resident and employee TB assessment and screening. IP stated she was aware of the July 2013 MDH TB Guidelines. The DON stated she had been unaware of the missing documentation for the residents and employees' mantoux readings, interpretations and screenings. The facility policy TB Testing of Residents dated 8/06, included: " ... New residents will be	3 601		

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3 601	Continued From page 5 screened using the two-step standard intradermal tuberculin test with purified protein derivative ..." The facility policy New Hire and Annual TB Screening undated, included: "... The employee will then be instructed that they will need to have the PPD (purified protein derivitive-a mantoux test) read within a period of 48-72 hours by any licensed nurse..." The MDH Regulations for TB Control in MN Health Care Settings dated July 2013 indicated TST results should be read 48-72 hours after given and included induration in mm, interpretation readings of the word negative or positive and also included TB history and TB signs/symptoms screenings completed for residents and employees. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or her designee could develop systems to ensure TB screenings are completed according to current recommendations. The DON or her designee could educate all appropriate staff on these systems. The DON or her designee could develop monitoring systems tto ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	3 601		
31180	MN Rule 4655.8300 Subp. 1&3 Linen; Soiled linen Subpart 1. Application. Subparts 2 to 6 apply to boarding homes only. Subp. 3. Soiled linen. Soiled linen shall be	31180		12/1/17

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31180	Continued From page 6 collected in a cleanable hamper, container, or bag for removal to the soiled linen collection room or to the laundry. Hampers, containers, or bags shall be cleaned or washed regularly. Easily cleanable laundry trucks or containers for off-the-floor storage and sorting of soiled linen shall be provided. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure soiled linens were disposed of properly. Findings Include: On 10/30/17, at 1:29 p.m. R2 stated he changed his own bed sheets and took his dirty sheets down and placed them in the linen hamper in the hall. R2 stated he placed his dirty clothes in a basket in his closet where the staff picked up. At 2:43 p.m. on 10/30/17, an uncovered laundry hamper was observed in the middle of the hall on the 3rd floor. The hamper was noted to be 2/3 full, with dirty sheets and a bedspread observed in the open hamper. At 3:23 p.m. on 10/30/17, maintenance-A stated the linen hamper on 3rd floor held only dirty linens, towels and rags and no clothes. Maintenance-A stated nursing assistants (NAs) took the bag of dirty linen to laundry regularly so the dirty linens wouldn't end up on the floor. At 5:07 p.m. on 10/30/17, the uncovered laundry hamper on the 3rd floor was observed again in the middle of the hall. The hamper remained 2/3	31180	Corrected	

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31180	Continued From page 7	31180		

full, with a bedspread and dirty sheet observed in the open hamper.

At 5:17 p.m. on 10/30/17, an plastic bag containing soiled linens was observed on the bottom shelf of the laundry rack, with the top of the bag open, lying on the floor. There were dirty towels spilling out, and a soiled towel hanging on the rack.

On 10/31/17, at 8:14 a.m. an uncovered dirty linen bag was observed outside the shower room on the third floor with dirty linens inside. R17 walked up to open dirty linen bag, pulled out a wet towel, blew his nose with it, put it back in the bag and then walked into his room.

On 10/31/17, at 8:45 a.m. R17 was again observed on 3rd floor walking up to an uncovered soiled linen hamper. The hamper was 2/3 full of dirty sheets, bedspread and towels. R17 was observed to remove a dirty towel from the hamper, blew his nose into the towel, and placed the towel back into the hamper.

At 8:51 a.m. on 10/31/17, NA-A stated the hamper on 3rd floor was the hamper the facility used for soiled linens, and that once the bag was full, she'd take it downstairs to the laundry and replace the linen bag with a clean one.

During observations on the 2nd floor on 10/31/17, at 9:05 a.m. an uncovered linen hamper was observed to be 2/3 full with dirty towels and another linen bag wrapped about the handrail.

On 11/1/17, at 7:24 a.m. open dirty linen bags noted were observed on the second and third floor with dirty linens in them.

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31180	Continued From page 8 On 11/2/2017, at 8:27 a.m. open linen bags were observed noted on second and third floor with dirty linens in them. During an interview with the director of nursing (DON) on 11/2/17, at 10:45 a.m. the DON stated linens were sent out to be cleaned at a company and picked up from the 1st floor. The DON stated residents were encouraged to carry their own dirty linens in a bag to the 1st floor laundry room and that residents were able to place their dirty linens into linen hampers on the resident units. The DON acknowledged the facility currently used uncovered linen hampers, but could start using linen hampers with lids. Policy provided by the facility SOILED LINEN HANDLING undated indicated, "... resident is responsible to bring their soiled linens to the soiled linen cart placed on each floor ... Soiled linen is transported in a covered container ..." SUGGESTED METHOD FOR CORRECTION: The administrator or designee could ensure appropriate receptacles were available for soiled linens, and could ensure linen was retrieved and taken to the laundry in a timely manner. They could develop an audit system to ensure complaince. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	31180		

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	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 07, 2017. At the time of this survey, Birchwood Care Home was found 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 and the 2012 edition of NFPA 99, the Health Care Facilities Code. Birchwood Care Home is a 2-story building with a full basement. The building was constructed at 3 different times. The original 2 story building was constructed in 1966 and was determined to be of Type II(222) construction. In 1971, a 20 bed addition was constructed and was determined to be of Type II(222) construction. In 2000, an addition was constructed to add an elevator as well as dry and cold storage to the East that was determined to be of Type II(222) construction. Because the original building and the 2 additions are of the same type of construction, the facility was surveyed as one building. This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 60 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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

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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	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2017**

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K 000	Continued From page 1 MET.	K 000		