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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MVIQ

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 **06/18/2014** (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:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Supervisor 06/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/27/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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

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

CCN: 24-5200

The facility was not in substantial compliance with Federal participation requirements at the time of the 05/01/14 standard survey. On 06/18/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 05/01/14, effective 06/10/14. Refer to the CMS-2567B for both health and life safety code.

Effective 06/10/14, the facility is certified for 110 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5200

Electronically Delivered: June 27, 2014

Mr. Tyler Donahue, Administrator
Birchwood Health Care Center
604 - 1st Street Northeast
Forest Lake, Minnesota 55025

Dear Mr. Donahue:

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

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 10, 2014, the above facility is certified 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. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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 about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: June 27, 2014

Mr. Tyler Donahue, Administrator
Birchwood Health Care Center
604 - 1st Street Northeast
Forest Lake, Minnesota 55025

RE: Project Number S5200024

Dear Mr. Donahue:

On May 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 1, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On June 18, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 1, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 1, 2014, effective June 10, 2014 and therefore remedies outlined in our letter to you dated May 14, 2014, 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 about this electronic notice.

Sincerely,

Anne Kleppe

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245200	A. Building B. Wing	6/18/2014

Name of Facility	Street Address, City, State, Zip Code
BIRCHWOOD HEALTH CARE CENTER	604 - 1ST STREET NE FOREST LAKE, MN 55025

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **06/10/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/10/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/10/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/10/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **06/10/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/10/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	06/27/2014	16022	06/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/1/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MVIQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00853

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(L1) **245200**
2.STATE VENDOR OR MEDICAID NO.
(L2) **250053000**

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

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

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

6. DATE OF SURVEY **05/01/2014** (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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Magdalene Jare, HFE NE II 05/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/27/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/27/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5200

At the time of the standard survey completed 05/01/14, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: May 14, 2014

Mr. Tyler Donahue, Administrator
Birchwood Health Care Center
604 - 1st Street NE
Forest Lake, Minnesota 55025

RE: Project Number S5200024

Dear Mr. Donahue:

On May 1, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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:

Gloria Derfus, Supervisor
Metro C Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Email: gloria.derfus@state.mn.us
Phone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 10, 2014, 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 August 1, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by November 1, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions about this electronic notice.

Sincerely,

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

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 _____	05/01/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 176 SS=D	Census 101 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine whether the practice of self-administration of nebulizer medication was safe for 1 of 1 resident (R4) observed self-administering medication during a random observation. Findings include: On 5/1/14, at 7:54 a.m. during a random observation as surveyor was walking past	F 176	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	6/10/14

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

Electronically Signed | 05/20/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. BUILDING _____ B. WING _____	05/01/2014

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 176	Continued From page 1 resident room with door wide open heard the nebulizer machine running. When surveyor looked into the room observed resident with nebulizer mask around his face lying on his back light out and eyes shut. -At 7:56 a.m. observed licensed practical nurse (LPN)-B going to R4's room then turned the nebulizer off and came right out. R4's diagnoses included chronic airway obstruction obtained from the Diagnosis Report dated 2/28/14. Physician Orders dated 4/7/14, indicated resident had order for Duoneb solution 0.5-2.5 (3) milligrams (mg)/3ml (milliliters-Ipratropium-Albuterol-inhalation breathing medication) 1 vial inhale orally two times a day related to chronic airway obstruction. The order lacked information R4 was able to self-administer nebulizer after set up. The cognition/communication care plan dated 1/15/14, indicated R4 had some confusion to higher details, diagnoses of dementia and with mild intellectual disabilities. The care plan directed staff to administer medications as ordered. When interviewed on 5/1/14, at 8:18 a.m. LPN-B stated she would check to see if R4 had order to self-administer a nebulizer after set up. When interviewed on 5/1/14, at 8:31 a.m. LPN-B stated she had looked and had verified R4 did not have an order to self-administer nebulizer treatment after set up but there was a clarification out to the provider to obtain the order as R4 had not attempted to remove the mask before. LPN-B	F 176	that: 1. With respect to resident R4; the nurse providing the medication was educated at the time the error occurred. The resident was assessed for their ability to self-administer their nebulizer after it was set up and a physician order was obtained. The resident care plan and Treatment Administration Records were revised accordingly. 2. All residents receiving nebulizer treatments were assessed to determine their ability to self administer their nebulizer treatments after set-up and a physician order was obtained when indicated. The Treatment Administration Record and care plans were revised accordingly. 3. All Staff has been educated regarding the policy and procedure for self administration of medications on June 10, 2014. 4. The Director of Nursing and/or designee will audit 2 residents each week for one month and one resident each week for two months for self administration of medications. 5. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA committee will make the decision/recommendation regarding any	

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F 176	Continued From page 2 acknowledged R4 should not have been left to self-administer medication (SAM) until the order had been obtained. When interviewed on 5/1/14, at 1:33 p.m. registered nurse (RN)-A stated the facility policy was to stay with resident until resident has an assessment and order to self-administer medication which had been obtained aftermath. When interviewed on 5/1/14, at 1:48 p.m. the director of nursing (DON) stated the nurse was supposed to stay with the R4. DON further stated LPN-B was under the impression R4 was able to SAM after set up which was not the case. The facility Self Administration Of Medication policy revised 4/09, indicated either the registered nurse or licensed nurse would inform a resident of his/her right to SAM and that the facility would administer medications while the resident's ability was being assessed. In addition, the policy indicated a physician order for the specific medication in question would be obtained and that would be documented in the Medication Administration Record (MAR) and in resident's record.	F 176	necessary follow-up studies.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282		6/10/14

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F 282	Continued From page 3 Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 1 resident (R22) with fluid restrictions reviewed for dialysis and the facility failed to follow a written care plan for 1 of 1 resident (R4) who did not want to self-administer his own medications. Findings include: On 4/30/14, at 7:03 a.m. R22 was observed lying in her bed and on R22's bedside pull table was observed with a pink water pitcher covered with a straw. On 4/30/14, at 8:28 a.m. to 9:15 a.m. R22 was observed eating breakfast on approximately 180 cubic centimeters (cc) cranberry juice. R22's dietary slip indicated R22 was on fluid restriction and had a renal diet. In addition the slip indicated "2 liquids at breakfast and offer 2 eggs every morning [AM]." On 4/30/14, at 10:18 a.m. observation noted a pink water pitcher with a straw and a clear plastic disposal cup approximately three quarters (3/4) filled with water sitting on top of the bedside pull table at the time licensed practical nurse (LPN)-A, director of nursing (DON) and registered nurse (RN)-A were all in the room completing an assessment. On 4/30/14, at 2:35 a.m. R22 was observed sitting on the wheelchair (w/c) at her bedside wearing head phones watching television. On R22's bedside pull table next to her left side a pink pitcher was observed. When asked if she was familiar with her fluid restrictions R22	F 282	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to resident R22, her care plan was updated to reflect resident's non-compliance with her fluid restriction based on requests of staff to obtain fluids outside of med passes and meals. A negotiated risk waiver was developed and signed by the resident that outlines the risks of her continued non-compliance. Techniques to encourage the resident to be more compliant with her fluid restriction have been developed and communicated to staff via the Nursing Assistant assignment sheets. 2. All residents with fluid restrictions have been reviewed and assessed for concerns related to compliance with their restriction. Care plans and Nursing Assistant assignment sheets were reviewed and updated with documentation and interventions for those with fluid restrictions. 3. In-service training of nursing staff on facility procedure for proper monitoring and implementation of resident fluid	

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F 282	Continued From page 4 indicated she was not sure as a memory was not that great. R22 further stated "I don't drink that much but I have water here always if I needed any." On 5/1/14, at 8:30 a.m. observed R22's sitting on her wheelchair by the door waiting for nursing assistant (NA)-A to wheel her out of her room to the dining room. Observation noted a pink water pitcher sitting on top of the bedside pull table with two other clear plastic disposal with small amounts of water approximately 30 to 40 milliliters (ml)/cc. R22's had diagnoses including end stage renal disease (ESRD), renal dialysis status, diabetes mellitus type II, heart failure, edema, dementia, and anemia with chronic kidney disease obtained from the Minimum Data Set (MDS) dated 3/19/14. In addition the MDS indicated R22 was receiving dialysis. The nutrition Care Area Assessment (CAA) dated 3/20/14, indicated R22 was on a therapeutic diet due to ESRD requiring dialysis, had a significant weight gain since admit. The Physician's Order dated 4/8/14, noted R22 was on 1500 ml/cc fluid restrictions every day as followed: "Dietary to provide 1060cc/day Breakfast= 360 cc Lunch = 360 cc Dinner = 360 cc Nepro [therapeutic nutrition specifically designed to help meet the nutritional needs of patients on dialysis] 4oz = 120 cc BID [twice daily] Give 120 cc at 2000 [8:00 p.m.] 80 cc additional fluids per day as needed [PRN]." The nutrition care plan dated 4/14/14, identified	F 282	restrictions conducted by June 10, 2014 with follow-up training as indicated. 4. The Director of Nursing and/or designee will complete two Resident Care Audits each week for one month and then one Resident Care Audit each week for two months to assure care is provided in accordance with the written plan of care. 5. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 282	Continued From page 5	F 282		

R22 had a nutritional problem or potential nutrition problem related to therapeutic diet due to ESRD requiring dialysis, and had a fluid restriction as of 1500 ml/cc per day, The care plan indicated R22 had a significant weight gain since admit and the weight fluctuations were likely fluid related due to dialysis status. Goal "Weight will stabilize ..." The care plan directed staff to observe for the 1500 ml/cc per day fluid restriction, observe weight per protocol or as ordered and record, and observe intake and record every meal.

When interviewed on 5/1/14, at 9:31 a.m. LPN-A stated the water pitcher was approximately 630 cc and approximated the water left in the room between the disposal cups and the pitcher was 250 cc. LPN-A indicated R22 fluid intake was documented in Medication Administration Record (MAR) and thought R22 was supposed to have a water pitcher in the room.
-At 9:34 a.m. LPN-A verified the water pitcher in the room was not included in the fluid restriction directions.

When interviewed on 5/1/14, at 10:56 a.m. via phone the facility consultant registered dietician (CRD) indicated R22 was on a 1500 cc/day fluid restriction, was receiving Nepro 4 ounces twice daily. CRD indicated R22 was not supposed to have a water pitcher in her room and was not aware R22 was getting the water pitcher in her room. CRD further stated she would be talking to the facility to make sure R22 did not get a water pitcher in her room as this was against the physician fluid restriction orders.

When interviewed on 5/1/14, at 1:36 p.m. registered nurse (RN)-A stated the water pitcher

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F 282	Continued From page 6 was not supposed to be in room. RN-A further indicated R22 was non-complaint and dialysis and family are aware of resident non-compliance but acknowledged R22 had not been given risks versus benefits information for not following the fluid restriction. RN-A indicated was not sure if the water pitcher was in the care. When interviewed on 5/1/14, at 1:51 p.m. DON stated the pitcher was not supposed to be in the room however if R22 wanted to have it then dialysis and physician would be updated. DON further stated R22 was non-compliant but acknowledged R22 ' s plan of care had not been followed. On 5/1/14, at 5/1/14, at 2:00 p.m. the dialysis policy was requested. On 5/1/14, at 2:32 p.m. RN-B stated the facility did not have a dialysis policy but provided a Dialysis Guideline dated 11/11, which directed "Fluid restrictions are divided out according to what the resident receives through meals and what nursing is allowed to provide each shift." The guideline lacked information on was to ensure fluid restriction was strictly followed and what was to be done if non-compliance had been identified. R4 was observed self-administering his breathing medication and the care plan indicated nursing to administer all medications. On 5/1/14, at 7:54 a.m. during a random observation as surveyor was walking past resident room with door wide open heard the nebulizer machine running. When surveyor looked into the room observed resident with nebulizer mask around his face lying on his back light out and eyes shut. -At 7:56 a.m. observed LPN-B going to R4's room	F 282		

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F 282	Continued From page 7 then turned the nebulizer off and came right out. R4's diagnoses included chronic airway obstruction obtained from the Diagnosis Report dated 2/28/14. Physician Orders dated 4/7/14, indicated resident had order for Duoneb solution 0.5-2.5 (3) milligrams (mg)/3ml (milliliters-Ipratropium-Albuterol-inhalation breathing medication) 1 vial inhale orally two times a day related to chronic airway obstruction. The order lacked information R4 was able to self-administer nebulizer after set up. The cognition/communication care plan dated 1/15/14, indicated R4 had some confusion to higher details, diagnoses of dementia and with mild intellectual disabilities. The care plan directed staff to administer medications as ordered. When interviewed on 5/1/14, at 8:18 a.m. LPN-B stated she would check to see if R4 had order to self-administer a nebulizer after set up. When interviewed on 5/1/14, at 8:31 a.m. LPN-B stated she had looked and had verified R4 did not have an order to self-administer nebulizer treatment after set up but there was a clarification out to the provider to obtain the order as R4 had not attempted to remove the mask before. LPN-B acknowledged R4 should not have been left to self-administer medication (SAM) until the order had been obtained. When interviewed on 5/1/14, at 1:33 p.m. RN-A stated the facility policy was to stay with resident until resident has an assessment and order to	F 282		

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F 282	Continued From page 8 self-administer medication which had been obtained aftermath. When interviewed on 5/1/14, at 1:48 p.m. the DON stated the nurse was supposed to stay with the R4. DON further stated LPN-B was under the impression R4 was able to SAM after set up which was not the case. The care plan was not followed as R4 self-administered the breathing medication and the staff was directed to administer the medication.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services related to fluid restrictions for 1 of 1 resident (R22) reviewed for dialysis. Findings include: The facility did not ensure physician's ordered fluid restrictions were implemented and encouraged, which potentially had contributed to R22's weight gain.	F 309	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 trutfacts 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	6/10/14

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F 309	Continued From page 9 On 4/30/14, at 7:03 a.m. R22 was observed lying in her bed and on R22's bedside pull table was observed with a pink water pitcher covered with a straw. On 4/30/14, at 8:28 a.m. to 9:15 a.m. R22 was observed eating breakfast on approximately 180 cc cranberry juice. R22's dietary slip indicated R22 was on fluid restriction and had a renal diet. In addition the slip indicated "2 liquids at breakfast and offer 2 eggs every morning [AM]." On 4/30/14, at 10:18 a.m. surveyor observed the pink water pitcher with a straw and a clear plastic disposal cup approximately three quarters (3/4) filled with water sitting on top of the bedside pull table at the time licensed practical nurse (LPN)-A, director of nursing (DON) and registered nurse (RN)-A were all in the room completing an assessment. On 4/30/14, at 2:35 a.m. R22 was observed sitting on the wheelchair (w/c) at her bedside wearing head phones watching television. On R22's bedside pull table next to her left side a pink pitcher was observed. When asked if she was familiar with her fluid restrictions R22 indicated she was not sure as a memory was not that great. R22 further stated "I don't drink that much but I have water here always if I needed any." On 5/1/14, at 8:30 a.m. observed R22's sitting on her wheelchair by the door waiting for nursing assistant (NA)-A to wheel her out of her room to the dining room. At that time surveyor observed a pink water pitcher sitting on top of the bedside pull table with two other clear plastic disposal with	F 309	that: 6. With respect to resident R22, her care plan was updated to reflect resident's non-compliance with her fluid restriction. A negotiated risk waiver was developed and signed by the resident that outlines the risks of her continued non-compliance. Techniques to encourage the resident to be more compliant with her fluid restriction have been developed and communicated to staff via the Nursing Assistant assignment sheets. 7. All residents with fluid restrictions have been reviewed and assessed for concerns related to compliance with their restriction. Care plans and Nursing Assistant assignment sheets were reviewed and updated with documentation and interventrions for those with fluid restrictions. 8. In-service training of nursing staff on facility procedure for proper monitoring and implementation of resident fluid restrictions conducted by June 10, 2014 with follow-up training as indicated. 9. The Director of Nursing and/or designee will complete one dialysis audit (contains fluid restrictions component) each week for one month and then one dialysis audit every other week for two months to include proper compliance with fluid restrictions procedures. 10. The data collected will be presented to the Quality Assurance committee by the	

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F 309	Continued From page 10 small amounts of water approximately 30 to 40 milliliter/cubic centimeters (ml/cc). R22's had diagnoses including end stage renal disease (ESRD), renal dialysis status, diabetes mellitus type II, heart failure, edema, dementia, and anemia with chronic kidney disease obtained from the Minimum Data Set (MDS) dated 3/19/14. In addition, the MDS indicated R22 was receiving dialysis. The nutrition Care Area Assessment (CAA) dated 3/20/14, indicated R22 was on a therapeutic diet due to ESRD requiring dialysis, had a significant weight gain since admit, no fluid restriction since admit and had some weight fluctuation likely related to fluid related to dialysis status. The Physician's Order dated 4/8/14, noted R22 was on 1500 ml/cc fluid restrictions every day as follows: "Dietary to provide 1060cc/day Breakfast = 360 cc Lunch = 360 cc Dinner = 360 cc Nepro [a nutritional supplement given to dialysis residents] 4oz = 120 cc BID [twice daily] Give 120 cc at 2000 [8:00 p.m.] 80 cc additional fluids per day as needed [PRN]." Review of R22's weights indicated the following: -3/13/14, 142.6# -3/14/14, 145.2# -3/17/14, 151.8# -3/19/14, 155.8# -3/24/14, 155# -3/26/14, 163.2# -3/28/14, 159.2# -3/30/14, 163# -3/30/14, 164.1# -3/30/14, 164.1# -3/31/14, 168#	F 309	Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 309	Continued From page 11 -4/2/14, 169.4# -4/6/14, 170.2# -4/8/14, 175.6# -4/10/14, 163# -4/11/14, 154# -4/12/14, 161.4# When interviewed on 5/1/14, at 9:31 a.m. LPN-A stated the water pitcher was approximately 630 cc and approximated the water left in the room between the disposal cups and the pitcher was 250 cc. LPN-A indicated R22 fluid intake was documented in Medication Administration Record (MAR) and thought R22 was supposed to have a water pitcher in the room. -At 9:34 a.m. LPN-A verified the water pitcher in the room was not included in the fluid restriction directions. When interviewed on 5/1/14, at 10:56 a.m. via phone the facility consultant registered dietician (CRD) indicated R22 was on a 1500 cc/day fluid restriction, was receiving Nepro 4 ounces twice daily. CRD indicated R22 was not supposed to have a water pitcher in her room and was not aware R22 was getting the water pitcher in her room. CRD acknowledged R22 had weight fluctuations but thought the weight gains were not necessary as a result of the extra water but thought was because of R22's non-compliance with not elevating her legs and had increased edema. CRD further stated she would be talking to the facility to make sure R22 did not get a water pitcher in her room as this was against the physician fluid restriction orders. When interviewed on 5/1/14, at 1:36 p.m. RN-A stated the water pitcher was not supposed to be in room. RN-A further indicated R22 was	F 309		

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F 309	Continued From page 12 non-complaint and dialysis and family are aware of resident non-compliance but acknowledged R22 had not been given risks versus benefits information for not following the fluid restriction. RN-A indicated was not sure if the water pitcher was in the care. When interviewed on 5/1/14, at 1:51 p.m. DON stated the pitcher was not supposed to be in the room however if R22 wanted to have it then dialysis and physician would be updated. DON further stated R22 was non-compliant but acknowledged R22 had not been given the risks versus benefits for not complying with the current fluid restriction. On 5/1/14, at 5/1/14, at 2:00 p.m. the dialysis policy was requested. On 5/1/14, at 2:32 p.m. RN-B stated the facility did not have a dialysis policy but provided a Dialysis Guideline dated 11/11, which directed "Fluid restrictions are divided out according to what the resident receives through meals and what nursing is allowed to provide each shift." The guideline lacked information on was to ensure fluid restriction was strictly followed and what was to be done if non-compliance had been identified.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		6/10/14

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	245200	A. BUILDING _____ B. WING _____	05/01/2014

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F 329	Continued From page 13 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic 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 Risperdal (Anti-psychotic medication) had an adequate indication for continued use and monitoring for 1 of 5 residents (R69) reviewed for unnecessary medications. Findings include: R69's diagnoses included senile dementia, depression, anxiety, Insomnia, and delusional disorder obtained from the quarterly Minimum Data Set (MDS) dated 2/27/14. In addition, the MDS indicated R69's Brief Interview for Mental Status (BIMS-tool used to measure cognition) score was 15 indicating intact cognition, the mood interview indicated she only had trouble sleeping and had no safety concerns which included self harm. The psychotropic medication care plan dated 12/23/13, identified R69 was using medication	F 329	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect: 1. Resident R69 had a pharmacy review and the physician notified for the continued use of/indication for Risperdal. The Behavior Monitoring Record was revised to include the indications for continued use of the medication and the resident's plan of care updated.	

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F 329	Continued From page 14 related to dementia with delusions and paranoia, psychosis, major depressive disorder and history of suicidal ideation. The care plan directed administer medications as ordered, consult with pharmacy, medical practitioner to consider dosage reduction when clinically appropriate and discuss with practitioner and family regarding ongoing need for use of medications. The Care Area Assessment (CAA) dated 12/16/13, indicated R69 used psychotropic medications Risperdal and Remeron (an anti-depressant) related to current diagnosis of insomnia and dementia with delusions and paranoia. R69's Physician order dated 4/7/14, indicated R69 received Risperdal 0.25 mg everyday (QD) at bedtime for dementia with delusions and paranoia. Review of the Treatment Administration Record (TAR's) and Medication Administration Record (MAR's) dated March 2014 through April 2014, revealed R69's Risperdal order had been discontinued on 3/4/14, and then restarted back on 3/17/14, and at the same time the order to check monthly orthostatic blood pressure had also been discontinue and was never reinstated when the medication was resumed on 3/17/14, until surveyor brought it to the attention of the facility. Review of the TAR's dated February 2014, through 3/4/14, revealed R69 behaviors that were being monitored were "#1 anxious statements, suicidal ideation" and had no behaviors documented. In addition the TAR's dated 3/4/14, through 4/11/14, had been left void for behavior charting and there was no behavior documentation in the Progress Notes dated 3/4/14, through 4/28/14, during the time medication had been discontinued until 4/29/14. The Physician Progress Notes dated 3/17/14,	F 329	2. All resident's receiving psychoactive medications will be reviewed to assure there are appropriate indications for the use of the medications, care plans will be updated and Behavior Monitoring or Sleep Pattern Diaries initiated as indicated. 3. All licensed staff will receive education regarding the requirements for monitoring for appropriate indications for use of psychoactive medications by June 10, 2014. 4. The Director of Nursing and/or designee will audit three resident medication regimens each week for one month and then two resident medication regimens for two months to assure there are appropriate indications for psychoactive medications. 5. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 329	Continued From page 15	F 329		

indicated R69 was paranoid about roommate status, was intrusive to family and patient visiting, was unable to redirect and had been worried the roommate was not receiving adequate care despite family reassurance that plan of care was appropriate for roommate. In addition, nursing had reported manic like behavior since Risperdal was discontinued on 3/4/14 and the plan was to restart the medication.

Merwin Long Term Care Pharmacy Record of Medication Regimen Review dated and signed on 3/21/14, by the consultant pharmacist (CP) indicated no irregularity but had documentation "Risperdal had been discontinued 3/4/14, and restarted 3/17/14, question mark- why? No charting."

The facility Consultant Pharmacist Communication to Nursing dated 4/11/14, indicated "Resident had Risperidone restarted 3/17/14, (had been discontinued 3/4/14) for unclear reasons. I am unable to locate evidence of ongoing monitoring in her chart. Please update." On the bottom the sheet had been signed by registered nurse (RN)-A on 4/14/14, indicating the behavior monitoring was in place in resident chart.

Review of the facility Side Effect [S/E] & Behavior Monitoring sheet started 4/12/14, through 4/30/14, revealed R69 was taking Risperdal for delusions and indicated the target behavior was "Angry outbursts" and R69 had no behaviors.

When interviewed on 5/1/14, at 11:01 a.m. R69 stated she "Am glad I still have my mind. My husband lived here until his death. Am happy here and know this will be my last home. I had a

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F 329	Continued From page 16	F 329		

roommate who was on hospice and I was glad the way the staff here and hospice staff took care of her and even changed her gown and made sure she was comfortable." When asked about any behavior or agitated behavior concerns R69 stated "I have my mind still sometimes I tell them what is not being done. I was very close to my mother in fact we were best friends and from that I have the heart to take care of others and be concerned of their well-being."
When interviewed on 4/30/14, at 1:17 p.m. registered nurse (RN)-A verified the orthostatic blood pressure was lacking and indicated it should be done every month. RN-A verified it had not been done but stated it had been discontinued on 3/4/14, but had not been restarted but "I will make sure it's done today for this month. "When asked about resident "Angry outburst" behavior RN-A stated the resident gets worked up and would accuse people of taking her stuff or not doing what they are supposed to do. When asked about behavior documentation not being completed between 3/4/14, through 4/11/14, RN-A stated behavior documentation during that time was done by exception during the time frame despite the resident medication had been discontinued on 3/4/14, but again restarted again 3/17/14, yet no behavior documentation had been done indicating the GDR was not successful. RN-A further indicated the nurse practitioner (NP) had seen resident and had decided to restart resident back on the Risperdal and also resident had reported to her about how she felt. Verified there was no behavior documentation completed between the times the medication had been discontinued.
The nurse practitioner (NP) was called on 5/1/14, at approximately 11:17 a.m. was unavailable.
On 5/1/14, at 1:42 p.m. the director of nursing

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F 329	Continued From page 17 acknowledged R69 medical record lacked an adequate indication for continued use. When interviewed on 5/1/14, at 2:20 p.m. via phone the consultant pharmacist stated the "Angry outburst" was a reasonable target behavior but not indication for use for the medication by itself. CP indicated he had questioned behavior documentation in his last pharmacy reviews. In regards to the monitoring of the orthostatic blood pressures CP stated "Orthostatic blood pressures are not necessarily indicated unless the resident had issues in the past but if they did not have any concerns it can be distressing checking them." The facility Behavior Documentation Guideline revised 3/9/2014, indicated the facility will make every effort to comply with state and federal regulation related to the use of psychopharmacological medications to include regular review for continued need, appropriate dose, side effects and risks versus benefits. The policy lacked direction regarding on going side effect monitoring of orthostatic blood pressure anti-psychotropic medications and who was responsible to ensure the monitoring was being completed per regulation.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356		6/10/14

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F 356	Continued From page 18 - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the nurse staffing information was posted on a daily basis. This had the potential to affect 101 of 101 residents who resided in the facility, along with families and visitors. Findings Include: During the initial tour of the facility, on 4/28/14, at 12:29 p.m. the Direct Care Staff Posting dated 4/23/14, (which was five days earlier), was observed posted on the wall behind the receptionist counter.	F 356	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to posting facility hours;	

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F 356	Continued From page 19 On 4/29/14, at 7:45 a.m. the Direct Care Staff Posting remained dated 4/23/14. During observation on 4/30/14, at 9:15 a.m. the Direct Care Staff Posting was dated 4/29/14. The posting, dated 4/29/14, remained on display on 5/1/14, at 7:25 a.m. When interviewed on 5/1/14, at 1:01 p.m. the administrator stated the staffing coordinator (SC)-D posts the Direct Care Staff Posting on a daily basis. When interviewed at 1:09 p.m. SC-D stated he posts a couple of days at a time and when he arrives the following day, if the posting was not the correct day he would change it. When interviewed on 5/1/14, at 1:22 p.m. the administrator stated, "We were clearly in the wrong in not updating the staff posting daily." The facility's policy entitled, Nurse Staffing Information Guidelines dated 12/11, indicated the facility will post the Nurse Staff Hours on a daily basis.	F 356	the actual hours worked were completed and posted on May 1, 2014, during the survey. 2. The Staffing Coordinator received education on May 14, 2014, regarding the requirement for posting the Nursing Hours in a timely manner. 3. The guideline for facility posting of hours has been reviewed on May 14, 2014 and the Director of Nursing and designee has been educated regarding the regulation and guideline for Posting Nursing Hours. 4. The Executive Director and/or designee will audit the posting for accuracy and timelines each week for three months to assure compliance. 5. The data collected will be presented at the Quality Assurance committee by the Executive Direcotr and/or designee. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA committee will make the decision/recommendation regarding any necessary follow-up studies.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428		6/10/14

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F 428	Continued From page 20 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility consultant pharmacist (CP) did not ensure ongoing monitoring for orthostatic blood pressure was in place for Risperdal (an anti-psychotropic) for 1 of 5 residents (R69) reviewed for unnecessary medications. Findings include: R69's diagnoses included senile dementia, depression, anxiety, Insomnia, and delusional disorder obtained from the quarterly Minimum Data Set (MDS) dated 2/27/14. In addition the MDS indicated R69's Brief Interview for Mental Status (BIMS-tool used to measure cognition) score was 15 indicating intact cognition. The mood interview indicated she only had trouble sleeping and had no safety concerns which included self harm. The psychotropic medication care plan dated 12/23/13, identified R69 was using medication related to dementia with delusions and paranoia, psychosis, major depressive disorder and history of suicidal ideation. The care plan directed administer medications as ordered, and consult with pharmacy. The Care Area Assessment (CAA) dated 12/16/13, indicated R69 used psychotropic medications (Risperdal and Remeron-a anti-depressant) related to current diagnosis of insomnia and dementia with delusions and paranoia. The care plan lacked	F 428	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect: 1. Resident R69 had a pharmacy review and the physician notified for the continued use of/indication for Risperdal. The Behavior Monitoring Record was revised to include the indications for continued use of the medication and the resident's plan of care updated 2. All resident's receiving psychoactive medications will be reviewed to assure there are appropriate indications for the use of the medications, care plans will be updated and Behavior Monitoring or Sleep Pattern Diaries initiated as indicated. 3. All licensed staff will receive education regarding the requirements for monitoring for appropriate indications for use of	

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F 428	Continued From page 21 direction to monitor orthostatic blood pressures on a monthly basis. R69's Physician order dated 4/7/14, indicated R69 was receiving Risperdal 0.25 Milligrams (mg) everyday at bedtime for dementia with delusions and paranoia. Review of the Treatment Administration Record (TAR's) and Medication Administration Record (MAR's) dated March 2014 through April 2014, revealed R69's Risperdal order had been discontinued on 3/4/14, and then restarted back on 3/17/14, and at the same time the order to check monthly orthostatic blood pressure had also been discontinue and was never reinstated when the medication was resumed on 3/17/14, until surveyor brought it to the attention of the facility. Review of the Merwin Long Term Care Pharmacy Record of Medication Regimen Review dated 3/21/14, and 4/11/14, revealed CP had completed two reviews since the medication had been restarted but had not identified the orthostatic blood pressure monitoring was lacking to determine side effects. When interviewed on 4/30/14, at 1:17 p.m. registered nurse (RN)-A verified the orthostatic blood pressure was lacking and indicated it should be done every month. RN-A verified it had not been done but stated it had been discontinued on 3/4/14, but had not been restarted but "I will make sure it's done today for this month. On 5/1/14, at 1:42 p.m. the director of nursing (DON) acknowledged R69 medical record lacked an adequate indication for continued use. On 5/1/14, at 1:42 p.m. the DON acknowledged R69 orthostatic blood pressure monitoring had been missed.	F 428	psychoative medications by June 10, 2014. 4. The Director of Nursing and/or designee will audit three resident medication regimens each week for one month and then two resident medication regimens for two months to assure there are appropriate indications for psychoactive medications. 5. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QA committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 428	Continued From page 22 When interviewed on 5/1/14, at 2:20 p.m. via phone CP stated orthostatic blood pressures are not necessary unless the resident had issues in the past but if they did not have any concerns it can be distressing checking them.	F 428		

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Birchwood Health Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 104 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is met.	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.