DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 11, 2022

CMS Certification Number (CCN): 24E166

Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, MN 55408

Dear Administrator:

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 March 2, 2022 the above facility is certified for:

60 Nursing Facility II Beds

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

Your request for waiver of F727 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 11, 2022

Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, MN 55408

RE: CCN: 24E166
Cycle Start Date: March 2, 2022

Dear Administrator:

On April 14, 2022, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under F727 at the time of the March 2, 2022 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 11, 2022

Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, MN 55408

Re: Reinspection Results
Event ID: TQT712

Dear Administrator:

On April 14, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 2, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
March 15, 2022

Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, MN 55408

RE: CCN: 24E166
Cycle Start Date: March 2, 2022

Dear Administrator:

On March 2, 2022, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B District Office
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: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

If substantial compliance with the regulations is not verified by June 2, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by September 2, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
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

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 _____	C 03/02/2022

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
E 000	Initial Comments On 2/28/22 through 3/2/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/28/22 through 3/2/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: HE166042C (MN00073612) and HE166041C (MN00078897). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/20/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING _____ B. WING _____	C 03/02/2022

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 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced	F 676		4/8/22

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 _____	C 03/02/2022

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 676	Continued From page 2 by: Based on observation, interview, and document review, the facility failed to provide assistance removing facial hair for 1 of 1 resident (R39) who was observed to have visible facial hair growth. Findings include: R39's admission Minimum Data Set (MDS) dated 1/4/22, indicated R39 was cognitively intact and required supervision with personal hygiene including combing hair, brushing teeth, shaving, and washing/drying face and hands. The MDS lacked indication R39 had refused cares. R39 had a diagnosis of schizophrenia. R39's Care Area Assessment (CAA) dated 1/10/22, indicated R39 required cues/reminders and hands-on assistance for activities of daily living. R39's care plan dated 3/1/22, indicated R39 was independent with activities of daily living (ADLs), needed cues, reminders, and supervision with bathing. Staff were instructed to offer cues, reminders, and supervision for follow through and to provide assistance of one staff as needed. The care plan lacked indicated R39 refused cares. During an interview on 2/28/22, at 12:04 p.m. R39 was observed lying in bed with several gray hairs, approximately 3/4 inch long, on her chin. The hairs were observed from one corner of R39's mouth to the other and extended down under her chin to the neck. R39 stated she would like the hairs removed if it was not "too much burden," and asked, "can you do that for me?" R39 stated she asked staff once or twice, and it had been a long time since the hairs were removed.	F 676	Chin hair was shaved for R39 on date of survey. An audit of all residents for unwanted facial hair preference has been completed as of 3/24/22 and those found to have unwanted facial hair were shaved per resident approval. Every Thursday an additional audit and shave will be performed for those who have unwanted facial hair and documented on daily worksheet. Any refusal will be documented and added to resident care plan. Staff has been educated as of 3/24/22 on carrying out facial hair preferences on Thursdays and PRN for compliance. The DON or designee will audit 3 residents per week for 2 weeks then 2 residents per week for 2 weeks then 2 residents bimonthly for one month. Responsible party will be NAR, Charge nurse, Staff Development Coordinator, DON. Completion date: 4/8/22	

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 _____	C 03/02/2022

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 676	Continued From page 3 During an interview on 3/1/22, at 4:09 p.m. nursing assistant (NA)-D stated stated the facility had disposable and electric razors available. NA-D stated some staff helped residents shave because they were good at it, and other staff did not. She stated she had not seen any women with facial hair, including R39, but if R39 wanted help staff could shave her chin. Upon viewing R39's chin hairs on 3/1/22, at 5:19 p.m. NA-D stated it was hard to see them under a mask, but confirmed facial hair was present. R39 then verbalized, "Do I need a shave?" Further, it could be done "any day now." During an interview on 3/1/22, at 4:31 p.m. licensed practical nurse (LPN)-B stated there were several females with facial hair and there was an obvious need for grooming staff asked residents if they needed help. LPN-B stated NAs' should be looking for any resident needs, including shaving, as part of resident cares. LPN-B stated she assisted R39 washing up two days prior and told R39 she would like to give her a shave to which R39 agreed. LPN-B stated it was her intention to shave R39, but there were only two staff and when she went to obtain an electric shaver the battery was dead. R39's medical record lacked documentation of refusal to shave. During an interview on 3/2/22, at 12:27 p.m. the director of nursing (DON) stated staff assessed the need for shaving when supervising resident cares and should shave a resident as needed. R39 resided at the facility because she needed supervisor for cares. The DON stated it would be best if staff looked for facial hair every day, and if	F 676		

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 _____	C 03/02/2022

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 676	Continued From page 4 they saw the need, it should had been taken care of. The facility Nursing Assistant Job Description (undated) indicated NAs were to provide daily reminders and hands-on care when reminders were not followed through and must document any hands-on cares.	F 676		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight hours per day. This had the potential to affect all 59 residents who resided at the facility. Findings include: Review of the facility Staffing Schedules dated 12/1/21, through, 3/2/22, revealed there was not eight consecutive hours of RN coverage for the	F 727	Policies and Procedures were reviewed and revised. See 727 attachments: Request for RN waiver letter, P & P of Posting of nurse staffing information, P & P for Nursing staff standards for RN staffing. Census is posted each day with RN/LPN hours listed. DON monitors scheduling on a daily basis. All staff was educated on process 3/24/22	4/8/22

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 _____	C 03/02/2022

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 727	Continued From page 5 following dates: - 12/11/21, 12/12/21, 12/15/21, and 12/26/21. - 1/8/22, 1/9/22, 1/22/22, and 1/23/22. - 2/5/22, 2/6/22, 2/19/22, and 2/20/22. During an interview on 3/2/22, at 9:19 a.m. the director of nursing (DON) verified the facility did not have eight consecutive hours of RN coverage every other weekend. The DON stated it was expected to have RN coverage every day of the week and every other weekend should had been covered with an RN. The Nursing Services policy (undated) indicated a RN would be scheduled for eight (8) consecutive hours per day, whenever possible, unless wavered per Federal Regulations.	F 727	at All Staff meeting. Responsible party will be Night nurse, Staff Development Coordinator, MDSC, DON. Date of completion 4/8/22.	
F 730 SS=C	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance reviews for 3 of 5 nursing assistants (NA-A, NA-B, and NA-C) whose employee files were reviewed. The had the potential to affect all 59 residents who resided at the facility. Findings include:	F 730	See Attachment F730 and F756. Annual in-services are being monitored quarterly for compliance with staff names posted for missed in-services to be made up if missed. Audits have been done for mandatory in-services and a new In-service binder has been developed for better tracking purposes. Copy of Employee In-service	4/8/22

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 _____	C 03/02/2022

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 730	Continued From page 6 An facility provided document which was unnamed (undated) identified NA-A was hired on 12/17/07, NA-B was hired on 7/7/20, and NA-C was hired on 5/11/12. Performance reviews were requested from the respective employee files of NA-A, NA-B, and NA-C, however, not provided by the facility. During an interview on 3/2/22, at 11:36 a.m. the director of nursing (DON) verified she did not complete staff performance evaluations in 2021. Further, The DON stated performance evaluations should had been completed annually so she was aware of the training needs of staff. During an interview on 3/2/22, at 1:55 p.m. the administrator stated employee performance evaluations should be completed annually so the supervisor was aware of training needs of staff. A Performance Evaluation procedure (undated) indicated performance evaluations were scheduled approximately every 12 months and conceded with the anniversary of the employee's original date of hire. Further, performance evaluations were conducted to provide both supervisors and employees the opportunity to discuss job tasks, identify and correct weaknesses's, encourage and recognize strengths, and discuss's positive, purposeful approaches for meeting goals.	F 730	log attached, see attachment 730. All in-services are scheduled and designated for the next year. Staff Development Coordinator will monitor for compliance. Audits will be done by Staff Development Coordinator monthly x 6 months with notices to those who missed for compliance. Results will be reviewed quarterly at Quality Assurance. All staff evaluations will be completed by 4/8/22 and then Annually per regulations. A reminder on E-Calendar has been set for one month prior to due dates of Annual Evaluations for timely completion. Solutions will be sustained by E-calendar scheduling and reminders. Annual evaluations will be used to discuss job tasks and identify and correct weaknesses, encourage and recognize strengths and discuss positive purposeful goals. Reports on any new hires and Annual performance evaluations will be reported quarterly at QA. Education for all staff has been provided on 3/24/22 on processes and reports will be reviewed quarterly at QA. Responsible party will be Staff Development Coordinator, MDSC, DON. Completion date will be 4/8/22.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a	F 756		4/8/22

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 _____	C 03/02/2022

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 756	Continued From page 7 licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(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. §483.45(c)(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 interview and document review, the facility failed to ensure a timely response to pharmacy recommendations for 1 of 5 residents	F 756	See attachments F756: See 5 Consultation reports attached addressing concerns about medications and labs for	

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 _____	C 03/02/2022

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 756	Continued From page 8 (R16) who was reviewed for unnecessary medications. Findings include: R16's quarterly Minimum Data Set (MDS) dated 12/3/21, indicated intact cognition. R16's diagnoses include malignant neoplasm of bronchus and lung (lung cancer). R16's March 2022 Medication Administration Record included: - Guaifenesin Syrup (generic form of Mucinex; a cough suppressant) 100 mg [milligrams]/5mL [milliliters] give 10 mL twice daily ordered on 11/1/21. - Mucinex ER (extended release) 600 mg twice daily ordered 11/1/21 - Guaifenesin 100mg/5mL give 10 mL every 4 hours PRN (as needed) for cough ordered 10/1/20 - Mucinex ER 600 mg every 4 hours PRN ordered 11/1/21 - Magnesium Oxide (dietary supplement) 400 mg tablet give 1-2 tablets as needed for hard stools R16's Pharmacist Consultation Report dated 11/19/21, included the following recommendations: - Discontinue one form of "ROUTINE" orders for guaifenesin to avoid duplicate therapy. - Add stop date for "ROUTINE" order(s) since appears added for acute illness. - If Mucinex ER PRN to continue, change frequency to every 12 hours PRN. R16's Pharmacist Consultation Report dated 1/27/22, included the following recommendations: - A1c (blood test for diabetes) on the next	F 756	R16. Last AVS with Psychiatrist 3/18/22 attached. Antipsychotic PRN facility procedure attached and copy of letter of Federal regulations. GDR for Magnesium Oxide attached. Resident is on Hospice, Hospice provider to be notified of any irregularities noted in monthly audit/ new orders. DON and Consultant pharmacist reviewed citation and Policy and procedure. Nursing staff and Consultant will identify all unnecessary medications. Med review recommendations will be sent to prescriber for all those PRN Psychotropic orders identified that need additional information to comply with Federal regulation. Plans to monitor performance to make sure that solutions are sustained: The DON or designee will do random audits of 3 residents per week for 2 weeks then 2 residents per week for 2 weeks then 2 residents bimonthly for one month. Audit was completed by Consultant Pharmacist on 3/24/22 and recommendations as follows: Med review recommendations will be sent to provider for all unnecessary medications identified that need additional information to comply with the Federal regulations. After 30 days any unanswered Faxes will be resent and MD will be called to ensure proper response time with MRR's. Pharmacy Consultant will complete Pharmacy audits with monthly medication review.	

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 _____	C 03/02/2022

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 756	Continued From page 9 convenient lab date. - Update Magnesium Oxide order with specific frequency. R16's Pharmacist Consultation Report dated 2/26/22, included the following recommendations: - Follow up with the recipients of the outstanding pharmacy recommendations to ensure compliance. Prioritize the recommendation from 11/19/21 and addresses duplicate therapy which was 94 days after the initial recommendation dated 11/19/21. R16's medical record contained no indication the pharmacist's recommendations had been reviewed or addressed by R16's primary care provider. During an interview on 3/1/22, at 7:01 p.m. the director of nursing (DON) explained when Pharmacist Consultation Reports were received, they were faxed to the identified physician. The DON stated she would like to receive a response from the physician within 30 days but, "the doctors don't always cooperate." The DON further stated, "I guess you could try to call the physician, but I don't think it would make them go any faster." During an interview on 3/2/22, at 8:57 a.m. the pharmacist stated she would defer to facility policy to determine an appropriate timeframe for a physician to respond to Pharmacy Consultation Reports. Facility policy, Medication Regimen Review, dated 11/29/16, directed, "The facility should alert the medical Director when MRRs are not addressed by the attending physician in a timely	F 756	All nursing staff have been educated on unnecessary/ duplicate medication orders. Responsible party will be Pharmacy Consultant, Charge nurse, Staff Development Coordinator, MDSC, DON. Completion date will be 4/8/22 of initial audit.	

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 _____	C 03/02/2022

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 756	Continued From page 10 manner." Further, "The attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident, either 30 or 60 days per applicable regulation."	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(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 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(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; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		4/8/22

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 _____	C 03/02/2022

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 758	Continued From page 11 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to re-evaluate the continued use of an as needed (PRN) antipsychotic medication for 1 of 5 residents (R33) reviewed for unnecessary medications. Findings include: R33's annual Minimum Data Set (MDS) dated 12/17/21, identified R33 was cognitively intact. R33 had diagnosis of schizophrenia. R33 received antipsychotic medication on a routine and PRN (as needed) basis. Further, the MDS identified no gradual dose reduction (GDR) had been completed and no documentation by a physician as clinically contraindicated. R33's Medication Review Report dated 3/2/22, identified R33 was prescribed Olanzapine (Zyprexa) 10 milligrams (mg) tablet by mouth to	F 758	See attachments F758: Last Psych follow up referral 3/24/22, Faxed documentation for F33 sent to Dr. Gorbantenko regarding Federal regulations for PRN Antipsychotic Olanzapine. Received back physician's response to add duration of 3 months to Olanzapine PRN order and agreed with comment "declined discontinuation of PRN Antipsychotic due to need for aggression." Antipsychotic PRN facility procedure also attached. How the facility will correct the deficiency for R33: Will contact Psychiatric MD 3/8/22 AM to determine whether she wants to discontinue the PRN Olanzapine or set up for an appointment every two weeks to evaluate per regulations for PRN refills and/or have Psychiatric MD consider a	

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 _____	C 03/02/2022

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 758	Continued From page 12 be given every 24 hours PRN for agitation originated on 6/11/21. No end dated was noted. R33's Medication Administration Record (MAR) for the months of January 2022 and February 2022 identified R33 received PRN Zyprexa twice during the month of January and none during the month of February. Review of R33's medical record lacked evidence R33 was re-evaluated for continued use of PRN Zyprexa, rational for continued use, and an order duration. During an interview on 3/1/22, at 2:41 p.m. the director of nursing verified R33's pharmacy consultation reports did not address Zyprexa. During an interview on 3/1/22, at 6:16 p.m. the pharmacy consultant stated R33's Zyprexa order had been addressed, however, the psychiatrist declined to complete a 14-day assessment. Further, she verified she had not addressed the 14-day assessment requirement on a pharmacy consultation report in the past year. The Interdisciplinary Antipsychotic Reduction policy dated 7/18, indicated residents who received antipsychotic medications benefit from the continued assessment of their medications to best care for their mental health needs.	F 758	non Antipsychotic PRN. A complete PRN audit for second floor was completed on 3/22/22 and third floor 3/30/22 by Social Service Department. DON and Consultant pharmacist reviewed citation. Nurse staff and Consultant Pharmacist will identify all PRN Psychotropic orders in March 2022 and evaluate for compliance with Federal regulations. Med review recommendations will be sent to prescriber for all those PRN Psychotropic orders identified that need additional information to comply with Federal regulations. Consultant pharmacist will audit/ review PRN Antipsychotics for diagnosis, duration and rationale during monthly medication reviews. See Antipsychotic PRN procedure. This will occur on an ongoing basis as long as the PRN order is in effect. All staff were educated on need or necessity of PRN rationale and stop date or discontinuance of any PRN Antipsychotic medication and will be monitored upon any admission or readmission and quarterly during MDS/ Care conferences. Nursing will monitor and identify all new admits or readmit Psychotropic orders to ensure initial order meets Federal Regulations. Any abnormal findings will be sent out to MD's on a monthly basis. Any MRR's without response from MD will be resent to MD with a phone call requesting a	

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 _____	C 03/02/2022

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 758	Continued From page 13	F 758	prompt response. Consultant pharmacist will attend QA and give report on GDR's including PRN Antipsychotic use on a quarterly basis. Responsible party will be Pharmacy Consultant, Charge nurse, MDSC, Staff Development Coordinator, DON. Completion date 4/8/22.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		4/8/22

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 _____	C 03/02/2022

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 883	Continued From page 14 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an influenza vaccination was offered for 2 of 5 residents (R7, R39) reviewed for immunizations. Findings include: R7's admission Minimum Data Set (MDS) dated 11/24/21, indicated R7 was moderately cognitively impaired, had diagnoses of kidney failure, diabetes, and depression, and did not reject care.	F 883	See attachments 0883: Policy and Procedures reviewed and revised. All new admissions will be offered Influenza/ Pneumococcal vaccines per clinic/ MD appointment or in house if indicated. A Flu shot clinic is held each year at the beginning of Influenza season. Any resident who is not in the building during Flu shot clinic an MD appointment	

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 _____	C 03/02/2022

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 883	Continued From page 15 The MDS indicated R7 did not receive the influenza (flu) vaccine in this facility for the 2021 flu season and identified R7 was not in this facility during this year's flu vaccination season. R7's medical record lacked evidence of flu vaccination or refusal of flu vaccination since admission in November 2021. R7's Order Summary Report dated 3/2/22, included an order for BWCH S.O. (Birchwood Care Home - Standing Orders) with no exceptions per signed copy/chart. Further, Birchwood Care Home - Standing Orders revised 1/30/20, included "Annual Flu Vaccine per CDC administration guidelines unless contraindicated." R39s admission MDS dated 1/4/22, indicated R39 was cognitively intact, had a diagnosis of schizophrenia, and did not reject care. The MDS indicated R39 did not receive the flu vaccine in this facility for the 2021 flu season and identified R39 was not in this facility during this year's flu vaccination season. R39's medical record lacked evidence of flu vaccination or refusal of flu vaccination since admission in December 2021. R39's Order Summary Report dated 3/2/22, included an order for BWCH S.O. (Birchwood Care Home - Standing Orders) with no exceptions per signed copy/chart. Further, Birchwood Care Home - Standing Orders revised 1/30/20, included "Annual Flu Vaccine per CDC administration guidelines unless contraindicated." During interview on 3/2/22, at 11:26 a.m. licensed practical nurse (LPN)-A stated she did not know if	F 883	will be made for vaccination or it will be offered in the facility if indicated. Corrective Action for R7: R7 has an appt 4/12/2022 at 10:10am for an influenza vaccination at HCMC Internal Medicine clinic. Confirmation of vaccination will be documented in his immunization record in the E-chart and progress notes will be entered to cover this process. Plans to monitor its performance to make sure that solutions are sustained: If resident refuses, it will be documented in the chart as refused under Immunizations and in progress notes for reference and MD will be notified. Staff was educated on updated procedure on 3/24/22 at All Staff meeting. Frequency of auditing due to the duration of Flu season: Audits will be done quarterly during Influenza season and reported at QA. The following responsible parties trained in updated plan on 3/29/22: Responsible party: Charge nurse, Staff Development Coordinator, MDSC, DON Completion date 4/8/22.	

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 _____	C 03/02/2022

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 883	Continued From page 16 R7 or R39 had orders for the flu vaccine, but if it was not on the admission orders, they did not have one. She stated there was no process in place to offer the flu vaccine. Upon review of the Birchwood Care Home - Standing Orders she confirmed there was an order for annual flu vaccine unless contraindicated. During interview on 3/2/22, at 12:27 p.m. director of nursing (DON) stated the facility conducted a yearly one-day flu vaccine clinic and it "covers the flu season." She stated the last one was 9/16/21. She stated if a resident was admitted after that date the resident would require an appointment with their physician to receive the vaccine. She stated staff recorded all immunizations under the immunization tab in the EHR, including those completed elsewhere as confirmed through MIIC (Minnesota Immunization Information Connection). She stated if the influenza vaccine was offered and refused it should have been documented in the progress notes. She confirmed the facility did not offer the influenza vaccine outside of the flu clinic, and R7 and R39 did not receive the influenza vaccine and did not have documentation of refusal. The facility policy Influenza and Pneumococcal Immunizations dated 5/2/07, indicated each resident will be offered an influenza immunization October 1st through March 31st annually unless the immunization was medically contraindicated, or the resident has already been immunized during this time period. The residents medical record will reflect the resident either received the influenza immunization or did not receive the immunization due to medical contraindication or refusal.	F 883		

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 _____	C 03/02/2022

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 914	Continued From page 17	F 914		
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a privacy curtain was provided for 1 of 1 resident (R30) who had a shared room. Findings include: R30's quarterly Minimum Data Set (MDS) dated 12/24/21, indicated R30 was cognitively intact and was independent with mobility, toileting, and transfers. R30 had a diagnosis of schizophrenia. R30's Room Change Form dated 11/15/21, indicated R30 transferred to a semi-private room in November 2021. During an interview on 2/28/22, at 1:03 p.m. R30 stated she would like a room curtain for more privacy and had not had one since she was moved to her current room. Upon observation, R30's bed was located in the back half of the room next to a window and bathroom door. There was a privacy curtain track on the ceiling, but lacked a privacy curtain. R30 stated she did not like that her ambulatory roommate had to walk by	F 914	R30 Privacy curtain was replaced same day of survey 3/2/22. Audit for all rooms to be with Privacy curtains was completed 3/22/22. All residents will have Privacy curtains in place at all times. If one is taken down for any reason, another will be replaced immediately. Replacements will be on hand consistently. See attachments F914: Privacy curtain audit done 3/21/22, Purchase order for extra privacy curtains 3/21/22. All rooms are monitored daily to ensure privacy curtains are present by housekeeping and NAR staff. All staff were educated on procedure 3/24/22. Responsible party: Housekeeping staff, Director of Housekeeping, NAR, maintenance staff, Director of maintenance. Date of completion 4/8/22.	4/8/22

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 _____	C 03/02/2022

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 914	Continued From page 18	F 914		

her bed while she was sleeping to use the bathroom. R30 stated she told maintenance, but no one put a curtain up.

During an interview on 3/2/22, at 7:42 a.m. nursing assistant (NA)-E observed R30's room and confirmed R30 did not have a privacy curtain and stated she was not sure why. NA-E thought housekeeping may had taken it down to be cleaned, but had not replaced it. At this time, R3 reiterated she would like a privacy curtain for more privacy.

During an interview on 3/2/22, at 8:07 a.m. maintenance (M)-A stated if privacy curtains were taken down for washing, they were replaced the either the same or next day.

During an interview on 3/2/22, at 8:59 a.m. the housekeeping director stated every resident should have a privacy curtain and recalled the resident who resided in the room prior to R30 did not care for the curtain. In such case, they would not remove the privacy curtain, rather tuck it to the side. The housekeeping director stated she asked R30 why she did not say anything to staff, and R30 reported to her she could not recall the name of the individual she informed.

During an interview on 3/2/22, at 12:27 p.m. the director of nursing (DON) stated all residents had privacy curtains in their rooms and her expectation was the privacy curtains were to be replaced as soon as possible if taken down for cleaning. The DON stated she was not aware R30 did not have a privacy curtain since November and could not explain why it was not there.

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 _____	C 03/02/2022

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 914	Continued From page 19 The facility Privacy and Confidentiality Policy dated 5/2/7, indicated residents had the right to privacy which should include visual and auditory privacy. Door should be closed when cares were provided, and cubicle curtains should be used as necessary.	F 914		

Electronically delivered
March 15, 2022

Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, MN 55408

Re: State Nursing Home Licensing Orders
Event ID: TQT711

Dear Administrator:

The above facility was surveyed on February 28, 2022 through March 2, 2022 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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 immediately contact:

Jamie Perell, Unit Supervisor
Metro B District Office
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: jamie.perell@state.mn.us
Office: (651) 245-8094

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
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: On 2/28/22 through 3/2/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders	3 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
3 000	Continued From page 1 and identify the date when they will be completed. The following complaint was found to be UNSUBSTANTIATED: HE166042C (MN00073612) and HE166041C (MN00078897) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota Rules, Chapter 4655 for Boarding 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. PLEASE DISREGARD THE HEADING OF THE	3 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
3 000	Continued From page 2 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. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software for Minnesota Rules, Chapter 4655 for Boarding Care Homes. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	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.	3 601		3/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
3 601	Continued From page 3 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: Based on interview and document review, the facility failed to ensure tuberculosis (TB) symptom screening was fully completed for 1 of 5 staff (NA-F) and 3 of 5 residents (R14, R39, R53). Further, the facility failed to administer and read a first and second step tuberculin skin test (TST) for 4 of 5 residents (R7, R14, R39, R53) reviewed for TB screening and testing. Findings include: An untitled facility document revealed nursing assistant (NA)-F's hire date was 2/28/22. NA-F was observed caring for residents on 3/2/22. NA-F's employee file included a TB blood test, however lacked evidence of TB symptom screening prior to start date. R7's Admission Record printed 3/2/22, indicated he was admitted to the facility in November 2021. R7's Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents dated 11/18/21, indicated R7 had a first step TST completed on 11/20/21, but lacked evidence of a second step TST.	3 601	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
3 601	Continued From page 4 R14's Admission Record printed 3/2/22, indicated she was admitted to the facility in May 2021. R14's Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents dated 5/28/21, indicated R14 had a first step TST completed on 5/27/21, but lacked evidence of a second step TST. Further the form lacked documentation of symptom screening and past TST skin test results. R39's Admission Record printed 3/2/22, indicated she was admitted to the facility on December 2021. R39's Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents dated 12/28/21, indicated R14 had a first step TST started on 12/28/21, but not completed. Further, the form lacked evidence of a symptom screening and second step TST. R53's Admission Record printed 3/2/22, indicated he was admitted to the facility on November 2021. R53's electronic health record (EHR) lacked evidence of a Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents. The record included a Birchwood Care Home: TB Screening dated 11/9/21, which addressed health care workers who have had a past positive TST. R53 was not an employee, nor was there evidence supporting R53 had a past positive TST or and/or chest x-ray in the EHR. During interview on 3/2/22, at 11:18 a.m. licensed practical nurse (LPN)-A and director of nursing (DON) stated neither knew staff needed to be screened for symptoms when they presented	3 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
3 601	Continued From page 5 evidence of a negative TB blood test. During interview on 3/2/22, at 12:27 p.m. DON stated new employees were asked to provide any previous TSTs or TB blood tests, and if they did not have them completed they received a first step Mantoux during orientation and a second step approximately 10 days later. She stated staff did not usually work with residents until the results of their first TST were recorded. DON stated new residents were administered a two-step TST or a TB blood test at admission, or if a resident had a previous positive TST they received a chest x-ray. She stated screening of all residents was required regardless of the testing type. The Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH (Minnesota Department of Health) dated 1/16/21, indicated all staff in all departments received annual TB screening, and baseline TB screening of residents was performed at time of admission. Baseline TB screening was defined as 1) two step TST or single blood test, 2) TB symptom screen, and 3) assessment of risk factors for TB exposure and progression. The facility Mantoux Test Policy dated 5/2/07, indicated new residents were to receive "a standard, intradermal mantoux test" to provide TB screening for all residents and staff. SUGGESTED METHODS OF CORRECTION: The director of nursing, or designee, could review their policies and procedures regarding TB screening/testing of staff and residents to ensure the are completed. The director of nursing/designee could educate staff on policies and procedures and could develop a monitoring	3 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
3 601	Continued From page 6 system to ensure compliance. Audits could be completed and reported to the Quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 601		
3 805	MN Rule 4655.4400 G Employees Personnel Records A current personnel record shall be maintained for each employee and placed on file in a locked cabinet in the office of the administrator, person in charge, or the business office. These records shall be available to representatives of the department and shall contain the following information: G. at least annual evaluations concerning employee's work performance; and This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance reviews for 3 of 5 nursing assistants (NA-A, NA-B, and NA-C) whose employee files were reviewed. The had the potential to affect all 59 residents who resided at the facility. Findings include: An facility provided document which was unnamed (undated) identified NA-A was hired on 12/17/07, NA-B was hired on 7/7/20, and NA-C was hired on 5/11/12. Performance reviews were requested from the	3 805	Corrected.	3/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
3 805	Continued From page 7 respective employee files of NA-A, NA-B, and NA-C, however, not provided by the facility. During an interview on 3/2/22, at 11:36 a.m. the director of nursing (DON) verified she did not complete staff performance evaluations in 2021. Further, The DON stated performance evaluations should had been completed annually so she was aware of the training needs of staff. During an interview on 3/2/22, at 1:55 p.m. the administrator stated employee performance evaluations should be completed annually so the supervisor was aware of training needs of staff. A Performance Evaluation procedure (undated) indicated performance evaluations were scheduled approximately every 12 months and conceded with the anniversary of the employee's original date of hire. Further, performance evaluations were conducted to provide both supervisors and employees the opportunity to discuss job tasks, identify and correct weaknesses's, encourage and recognize strengths, and discuss's positive, purposeful approaches for meeting goals. SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing could review policies and procedures related to employee evaluations; develop a system to track, and conduct audits to ensure employee evaluations were completed in a timely manner. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 805		
3 965	MN Rule 4655.6400 Subp. 2D Adequate Care; Assist with shaving	3 965		3/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
3 965	Continued From page 8 Subp. 2. Criteria for determining adequate care. Criteria for determining adequate and proper care shall include: D. Assistance with or supervision of shaving of men patients or residents as necessary to keep them clean and well-groomed This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance removing facial hair for 1 of 1 resident (R39) who was observed to have visible facial hair growth. Findings include: R39's admission Minimum Data Set (MDS) dated 1/4/22, indicated R39 was cognitively intact and required supervision with personal hygiene including combing hair, brushing teeth, shaving, and washing/drying face and hands. The MDS lacked indication R39 had refused cares. R39 had a diagnosis of schizophrenia. R39's Care Area Assessment (CAA) dated 1/10/22, indicated R39 required cues/reminders and hands-on assistance for activities of daily living. R39's care plan dated 3/1/22, indicated R39 was independent with activities of daily living (ADLs), needed cues, reminders, and supervision with bathing. Staff were instructed to offer cues, reminders, and supervision for follow through and to provide assistance of one staff as needed. The care plan lacked indicated R39 refused cares. During an interview on 2/28/22, at 12:04 p.m. R39	3 965	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
3 965	Continued From page 9 was observed lying in bed with several gray hairs, approximately 3/4 inch long, on her chin. The hairs were observed from one corner of R39's mouth to the other and extended down under her chin to the neck. R39 stated she would like the hairs removed if it was not "too much burden," and asked, "can you do that for me?" R39 stated she asked staff once or twice, and it had been a long time since the hairs were removed. During an interview on 3/1/22, at 4:09 p.m. nursing assistant (NA)-D stated stated the facility had disposable and electric razors available. NA-D stated some staff helped residents shave because they were good at it, and other staff did not. She stated she had not seen any women with facial hair, including R39, but if R39 wanted help staff could shave her chin. Upon viewing R39's chin hairs on 3/1/22, at 5:19 p.m. NA-D stated it was hard to see them under a mask, but confirmed facial hair was present. R39 then verbalized, "Do I need a shave?" Further, it could be done "any day now." During an interview on 3/1/22, at 4:31 p.m. licensed practical nurse (LPN)-B stated there were several females with facial hair and there was an obvious need for grooming staff asked residents if they needed help. LPN-B stated NAs' should be looking for any resident needs, including shaving, as part of resident cares. LPN-B stated she assisted R39 washing up two days prior and told R39 she would like to give her a shave to which R39 agreed. LPN-B stated it was her intention to shave R39, but there were only two staff and when she went to obtain an electric shaver the battery was dead. R39's medical record lacked documentation of refusal to shave.	3 965		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
3 965	Continued From page 10 During an interview on 3/2/22, at 12:27 p.m. the director of nursing (DON) stated staff assessed the need for shaving when supervising resident cares and should shave a resident as needed. R39 resided at the facility because she needed supervisor for cares. The DON stated it would be best if staff looked for facial hair every day, and if they saw the need, it should had been taken care of. The facility Nursing Assistant Job Description (undated) indicated NAs were to provide daily reminders and hands-on care when reminders were not followed through and must document any hands-on cares. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could audit all current residents for facial hair to ensure shaving preferences are being carried out. They could then in-service staff to ensure shaving preferences are acted upon timely then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 965		
31035	MN Rule 4655.7000 Subp. 1F Patient or Resident Units; Cublicle curtains Subpart 1. Requirements. The following items shall be provided for each patient or resident: F. Cubicle curtains to afford privacy in all multibed rooms. Existing boarding care homes in converted dwellings may continue to use bed screens. Each window shall have shades or equivalent in good repair.	31035		3/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
31035	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a privacy curtain was provided for 1 of 1 resident (R30) who had a shared room. Findings include: R30's quarterly Minimum Data Set (MDS) dated 12/24/21, indicated R30 was cognitively intact and was independent with mobility, toileting, and transfers. R30 had a diagnosis of schizophrenia. R30's Room Change Form dated 11/15/21, indicated R30 transferred to a semi-private room in November 2021. During an interview on 2/28/22, at 1:03 p.m. R30 stated she would like a room curtain for more privacy and had not had one since she was moved to her current room. Upon observation, R30's bed was located in the back half of the room next to a window and bathroom door. There was a privacy curtain track on the ceiling, but lacked a privacy curtain. R30 stated she did not like that her ambulatory roommate had to walk by her bed while she was sleeping to use the bathroom. R30 stated she told maintenance, but no one put a curtain up. During an interview on 3/2/22, at 7:42 a.m. nursing assistant (NA)-E observed R30's room and confirmed R30 did not have a privacy curtain and stated she was not sure why. NA-E thought housekeeping may had taken it down to be cleaned, but had not replaced it. At this time, R3 reiterated she would like a privacy curtain for	31035	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
31035	Continued From page 12 more privacy. During an interview on 3/2/22, at 8:07 a.m. maintenance (M)-A stated if privacy curtains were taken down for washing, they were replaced the either the same or next day. During an interview on 3/2/22, at 8:59 a.m. the housekeeping director stated every resident should have a privacy curtain and recalled the resident who resided in the room prior to R30 did not care for the curtain. In such case, they would not remove the privacy curtain, rather tuck it to the side. The housekeeping director stated she asked R30 why she did not say anything to staff, and R30 reported to her she could not recall the name of the individual she informed. During an interview on 3/2/22, at 12:27 p.m. the director of nursing (DON) stated all residents had privacy curtains in their rooms and her expectation was the privacy curtains were to be replaced as soon as possible if taken down for cleaning. The DON stated she was not aware R30 did not have a privacy curtain since November and could not explain why it was not there. The facility Privacy and Confidentiality Policy dated 5/2/7, indicated residents had the right to privacy which should include visual and auditory privacy. Door should be closed when cares were provided, and cubicle curtains should be used as necessary. SUGGESTED METHOD OF CORRECTION: The housekeeping director, or designee, could verify all semi-private resident rooms had privacy curtains in-place; educate staff on the requirement; and, conduct random audits to	31035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	C 03/02/2022

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) COMPLETE DATE
31035	Continued From page 13 ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	31035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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
K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/01/2022. At the time of this survey, Birchwood Care Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 03/20/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Birchwood Care Home is a 2-story building with a full basement. The building was constructed at three different times. The original two-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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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
K 000	Continued From page 2 the two 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 59 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors with self-closing devices per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3. This deficient finding could have an isolated impact on the residents	K 223	See attachment K-223 Birchwood Fire and Safety Inspection Sheet Closer mechanism was adjusted and replaced 3/18/22 by Director of Maintenance.	3/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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
K 223	Continued From page 3 within the facility. Findings include: On 03/01/2022 at 9:50 AM, it was revealed by observation that the Soiled Laundry Room door did not latch close when tested. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery	K 223	Audit to be completed by 3/24 22 of all self closing devises/doors. Door closer working without complication. Added Checking of self closing doors to checklist to ensure there are no gaps and that doors close properly. Checklists will be audited quarterly and reviewed at QA meetings. Responsible party; Director of Maintenance and maintenance staff, Administrator.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3 and 9.6.1.5 and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/01/2022 at 9:30 AM, it was revealed by a review of available documentation that the facility	K 345	Start semi annual inspections in August 2022. Last inspection was February 2022-First inspection. First Bi Annual inspection will begin August 2022-Second inspection. Completed by Director of Maintenance.	3/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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
K 345	Continued From page 4 has not completed its semi-annual fire alarm inspection. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 345		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/01/2022 at 9:35 AM, it was revealed by a review of available documentation that the facility did not have a fire alarm system out of service policy located in the Life Safety Book. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 346	See attached Fire watch tour log sheets and Fire Alarm or Automatic Sprinkler Systems Out of Service Policy. Both attachments numbered K346 (2). Alarm outage tour log sheet added to documentation book, inspection book. Audit quarterly and report at QA. Completed by Director of Maintenance, Maintenance staff.	3/22/22
K 353	Sprinkler System - Maintenance and Testing	K 353		3/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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
K 353 SS=D	Continued From page 5 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.7, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.5.6.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/01/2022 at 10:10 AM, it was revealed by observation that the facility had storage blocking	K 353	See attachment K353. Removed items from 18 inches from sprinkler heads. Signs were placed to remind staff to keep area clear. Staff education to be done 3/24/22 at All Staff meeting. Completed by Director of Maintenance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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
K 353	Continued From page 6 the fire sprinkler heads in the dry good room, which is located in the kitchen. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 353		
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement an automatic sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.7.6, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Chapter 15. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 354	See attachments K354 (2) Fire watch tour log sheet and Fire Alarm or Automatic Sprinkler Out of Service Policy. Added outage sheet to documentation book for possibility of future outages 3/18/22. Will audit quarterly and review at QA. Completed by Director of Maintenance and Maintenance staff.	3/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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
K 354	Continued From page 7 On 03/01/2022 at 9:40 AM, it was revealed by a review of available documentation that the facility did not have an out of service policy for the fire sprinkler system located in the Life Safety book. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 354		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test & inspect fire-rated door assemblies per NFPA 101 (2012 edition), Life Safety Code, section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility.	K 761	See attachment K0761 Annual Inspection of Swinging Fire door Assemblies. Restart door inspections March 2022. Begin 3/21/22. Complete by 3/23/22. Completed by Responsible parties Director of Maintenance and Maintenance staff.	3/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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
K 761	Continued From page 8 Findings include: On 03/01/2022 at 10:30 AM, a review of the available documentation revealed that the facility did not have a current fire door inspection report for 2020 or 2021. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 761		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920		3/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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
K 920	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to prohibit improper extension cords per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2.3.1.1 and 10.2.4, and NFPA 70 (2011 edition), National Electrical Code, sections 400.8 and 590.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/01/2022 at 10:10 AM, it was revealed by observation that outside by the generator, an extension cord running from inside the boiler room to a fan unit outside is being used for permanent power. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 920	Remove cord and fan unit. Remind staff to put away items after use. Removed cord and fan unit from Generator area on 3/14/22. Will educate all staff put away items after use and non use of power cords at All staff meeting 3/24/22. Will be audited and reviewed quarterly at QA. Completed by Director of Maintenance.	