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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VZ3M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00853

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/22/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Angela Richey, HFE NE II 10/25/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 10/29/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/08/2012
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5200

At the time of the standard survey completed August 23, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On October 17, 2012, the Minnesota Department of Health and, on October 22, 2012, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on August 23, 2012, effective October 1, 2012. Therefore, the remedies outlined in our letter dated September 12, 2012, will not be imposed.
See attached CMS-2567B forms for the results of the October 17, 2012 and October 22, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5200 October 29, 2012

Ms. Diane Willette, Administrator
Birchwood Health Care Center
604 Northeast 1st Street
Forest Lake, Minnesota 55025

Dear Ms. Willette:

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 October 10, 2012 the above facility is certified for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 120 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 25, 2012

Ms. Diane Willette, Administrator
Birchwood Health Care Center
604 Northeast 1st Street
Forest Lake, Minnesota 55025

RE: Project Number S5200022

Dear Ms. Willette:

On September 12, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 23, 2012. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 17, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 22, 2012 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 23, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 1, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 23, 2012, effective October 1, 2012 and therefore remedies outlined in our letter to you dated September 12, 2012, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5200r112.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245200	A. Building B. Wing	10/17/2012

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	**10/01/2012**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	**10/01/2012**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**10/01/2012**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**10/01/2012**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	**10/01/2012**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	**10/01/2012**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	**10/01/2012**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**10/01/2012**	ID Prefix **F0441** Reg. # **483.65** LSC	**10/01/2012**
ID Prefix **F0492** Reg. # **483.75(b)** LSC	**10/01/2012**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/sd	10/24/12	30239	10/17/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/23/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245200	A. Building B. Wing **01 - MAIN BUILDING 01**	10/22/2012

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0025	**10/01/2012**	ID Prefix Reg. # **NFPA 101** LSC K0050	**09/21/2012**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/sd	10/25/12	12424	10/22/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/22/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VZ3M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00853

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

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

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

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/23/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
LouAnn Page, NFE NE II 09/28/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 10/04/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN# 24-5200

At the time of the standard survey completed August 23, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed.

See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 1126

September 12, 2012

Ms. Diane Willette, Administrator
Birchwood Health Care Center
604 Northeast 1st Street
Forest Lake, Minnesota 55025

RE: Project Number S5200022 & H5200030

Dear Ms. Willette:

On August 23, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 23, 2012 standard survey the Minnesota Department of Health completed an investigation of complaint number H5200030 that was found to be unsubstantiated.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus
Minnesota Department of Health
P.O. BOX 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 2, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 2, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 23, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 23, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

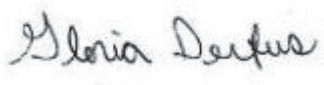
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. BUILDING _____ B. WING _____	08/23/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard recertification survey was conducted and a complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5200030 was completed. The complaint was unsubstantiated.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or	F 156	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to resident #32, a Determination of Continued Stay was given to the resident's son both orally and in writing. 2. All residents who were admitted in the last 3 months have been reviewed to assure the proper notification was given orally and in writing. A tool has been developed for assuring proper notifications has been given to residents upon admission, discharge from Medicare stays, and determinations of continued stay. 3. All admissions, billing, social service, and MDS staff and Nurse Management will receive education for proper notices to be given to residents throughout their stay in the facility. 4. The Administrator and/or designee will audit Medicare Denials for 3 months. 5. The data collected will be presented to the QA committee by the Administrator. The data will be reviewed/discussed at the monthly Quality Council Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies. 10-1-12	

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

Diane Willetto Executive Director 9-20-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. BUILDING _____ B. WING _____	08/23/2012

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F 156	Continued From page 1 at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements	F 156		

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F 156	Continued From page 2 specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide the Mandatory Medicare Denial Notice for 1 of 3 residents (R32) in the sample. Findings include: R32 did not receive the Mandatory Medicare Denial Notice upon discontinuation of their Medicare A coverage.	F 156		

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F 156	Continued From page 3 On 8/10/12, the facility determined the resident no longer qualified for Medicare A coverage. The facility provided a Notice of Medicare Non-Coverage on 8/10/12, which indicated the last covered day for Medicare A benefits was 8/13/12. The resident had Medicare days remaining and remained in the facility after 8/13/12. On 8/23/12, at 2:30 p.m. during interview with the administrator, she confirmed R32 should have received the Mandatory Medicare Denial Notice and that she was unable to locate it.	F 156		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the opportunity to make choices about morning schedules for 1 of 3 residents (R49) reviewed with concerns regarding choices. Findings include: R49 had identified preference to receive tub bath instead of shower, and a desire to sleep later in the mornings, and the facility did not	F 242	F 242 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to resident #49, staff was instructed to offer choice between showers and baths. The NAR Assignment Sheet was updated to include resident #49 preference for baths and wake times. Resident #49 has since completed her rehab treatments and has discharged to her home. 2. The NAR providing cares to resident #49 was provided verbal and written education to offer choices to all residents under her care.	

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F 242	Continued From page 4 accommodate R49's choices. R49 was admitted to the facility on 7/29/12, and resided on the Transitional Care Unit (TCU). R49 diagnoses included left wrist fracture and pelvic fracture. Per the care plan dated 8/16/12, R49 wished to return to her assisted living facility (ALF) apartment when she was done with the therapies. The admission Minimum Data Set (MDS) dated 8/6/12, indicated it was very important for R49 to "choose between between a tub bath, shower, bed bath, or sponge bath." The MDS also indicated R49 had moderately impaired cognition, and needed one one person physical assist with activities of daily living such as bathing, grooming and toileting. On 8/20/12, at 4:49 p.m. R49 stated her bathing preference was to take a bath, but she got only showers since she came to this facility. R49 also stated, "There is no choice because there is no tub. I wish there was a choice because I prefer too take a bath". R49 explained she told staff about her wish, but was told they did not have a tub. R49 also stated she loved to sleep in in the morning, and she usually got up at 10.00 a.m. and went to bed at 10:00 p.m. On 8/22/12, at 8:51 a.m. during random observation the following were observed. The nursing assistant (NA)-B knocked on R49's door. NA-B did not wait for an answer and walked into the room, and called R49 by her name and stated, "It's time to get up", "let's go take a shower". NA-B left door opened. Both residents were observed laying on the bed with their eyes	F 242	3. The admitting nurse will ask resident preferences within 24 hours of admission to include preferences for baths and/or showers as well as wake times. The resident Preferences Questionnaire will be added to the admissions packet and checklist and the nurse is to update the NAR Assignment Sheet with resident preferences. All employees will be educated regarding offering resident choices in regards to their cares. MDS Coordinators will also received education regarding the use of the NAR Assignment Sheet and Care Plan for communicating preferences identified during the MDS interviews/completion. 4. The Director of Nursing and/or designee will audit three residents by interview each week for one month and then two residents each week for two months for assuring that the resident is being offered choices in regards to their cares. 5. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Council Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies. 10-1-12	

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F 242	Continued From page 5 closed, and neither one of them moved. When R49 did not reply NA-B called out R49's name four times in a row, and stated again, "Let's go take a shower." NA-B had raspy deep voice. There was still no response from R49, and NA-B was overheard telling R49, "You gotta get up, get your hair done today, so come on." When R49 started moving NA-B asked her if she wanted to use the bathroom. R49 stated, "No." NA-B told R49 "Let's take a walk to the shower." At 8:54 a.m. R49 was observed walking out of the room while held on to the walker, R49 looked sleepy, and did not talk. NA-B accompanied R49 to the shower room, where R49 received a shower. At 9:05 a.m. R49 was observed walking back with NA-B to her room, and received breakfast served on a bedside table. NA-B took the covered plate, went to the dining room to warm it up. When NA-B was back entered the room without knocking on the door and told R49, "Here we go, eat up, looks pretty good." NA-B offered R49 her glasses, who did not want them. NA-B said "Oki doki", and walked out of the room. R49 was observed on 8/22/12, at 10:00 a.m. and at 11.00 a.m. in her room, R49 was sleeping covered with blankets. During interview on 8/22/12, at 1:25 p.m. NA-B stated she was aware that R49 did not like to wake up early, and that R49 liked to sleep until 10:00 a.m. NA-B stated she did not wake R49 up since R49 woke up by herself while NA-B took care of the roommate, and requested to go to the bathroom. NA-B further explained that after R49 was done in the bathroom she asked R49 if she	F 242		

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F 242	Continued From page 6 wanted to take her shower, and R49 agreed to do so. NA-B also stated she did not offer options to R49 to chose between tub bath and shower, since R49 did not have a tub at the ALF, and they wanted to keep her at baseline. NA-B's interview was contradictory to the 8:51 a.m. observation. On 8/22/12, at 1:04 p.m. R49 was interviewed and stated, "I am tired." R49 also stated, "I was woken up to take a shower". R49 stated again that she would have preferred to take a bath, but she was told before that she could not have a bath. R49 also stated she loved to get up 10:00 a.m. and thought she was tired since she got woken up. R49 also revealed she would have preferred an afternoon bath. R49's interview coincided with the 8:51 a.m. observation. The activities of daily living (ADL) care plan dated 8/16/12, indicated R49 needed 1-2 staff assistance with bathing, however there was no indication about R49's wake time and bathing preferences. The care also noted R49 was "able to communicate by: verbalizing wants and needs with staff." The care plan also directed staff to "allow adequate time to respond, repeat as necessary, do not rush, request feed back, clarification from the resident, to ensure understanding." Review of the nursing assistant assignment sheet revealed R49's preferences related to wake time and tub bath were not listed for staff to follow. The occupational therapy notes dated 7/30/12, 8/3/12, 8/10/12, 8/19/12, and 8/22/12, were reviewed along with the undated initial care plan, the comprehensive care plan dated 8/16/12, and	F 242		

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F 242	Continued From page 7 care conference notes from 8/15/12. There was no indication that R49's preferences were reviewed, care planed or discussed. The director of nursing (DON) was interviewed on 8/23/12, at 2.00 p.m. The DON explained it was the facilities policy to offer choices to residents, and staff were expected to offer choices, to ask residents when they would like to get up, when to go to bed, if they preferred shower or tub bath. The DON was not sure how the MDS data was processed and communicated to the staff. The DON confirmed the facility had tub rooms, and she did not "approve staff's approach", when staff did not offer choices to R49. The Routine Nursing Cares Policy and Procedure dated 3/08, indicated, "Birchwood Health Care Center staff will care for the residents in a manner that promotes maintenance or enhancement of each resident's quality of life. Reasonable accommodations or enhancement of individual needs and preferences will be made." The policy also directed staff to "remember to encourage them, thank them, allowing the resident to make choices and participate in their cares."	F 242		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280		

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F 280	Continued From page 8 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, document review, the facility failed to revise the care plan to provide services to promote healing and prevent further skin breakdown for 1 of 3 residents (R168) reviewed for pressure ulcers when he developed multiple open areas at the facility. Findings include: The care plan for R168 had not been revised to reflect new open areas which were first identified on 8/1/12. The care plan did not include any revision to the interventions to prevent further breakdown and to promote healing. R168's diagnoses included Parkinson's, dementia, edema and C-diff (bacteria that causes diarrhea) and was admitted to the facility from the hospital on 6/14/12. The admission Minimum Data Set (MDS) dated	F 280	F280 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to resident # 168; a Comprehensive Risk Assessment for Pressure Ulcers has been completed. Daily Wound Monitoring has been imitated and Weekly Wound Documentation done including measurements. The care plan has been updated to reflect risk factors and interventions identified in the assessment for Pressure Ulcers. The NAR Assignment Sheet reflects all interventions. Resident #168 was seen by the wound Nurse on August 28, 2012. 2. The Interdisciplinary Team (including nursing, MDS, social services, therapeutic recreation, and food service) will meet weekly to discuss any resident condition changes and implement new strategies. Nursing will be responsible for updating the plan of care as indicated. Therapy recommendations are to be documented on a Therapy Communication Form, and turned into nursing for updating the resident's plan of care and implementing recommendations. 3. The interdisciplinary team responsible for reviewing changes in condition will receive education regarding the procedure/agenda for the IDT Meeting each week.	

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F 280	Continued From page 9 6/22/12, indicated R168 had moderately intact cognition (brief interview of mental status (BIMS) score of 11). R168 required extensive assist of two for transfers, bed mobility and toileting, and was frequently incontinent of bowel and bladder. No alterations in skin integrity were noted on the assessment and identified R168 at being at risk for pressure ulcers. The Pressure Ulcer Care Area Assessment (CAA) dated 6/22/12, identified R168's risk factors as immobility, incontinence, altered mental status, delirium limits mobility, cognitive loss and poor nutrition. R168 needed a special mattress or seat cushion to reduce or relieve pressure per the CAA analysis. R168 returned to the facility from the hospital on 7/19/12. A body audit dated 7/19/12, indicated the skin was intact. The Pressure Ulcer Comprehensive Risk Assessment dated 7/19/12, indicated that R168 had high risk factors and high risk diagnosis or co-morbidities for pressure ulcer development. The care plan created on 7/24/12, indicated R168 had the potential for pressure ulcer development related to impaired mobility, bowel and bladder incontinence, need for assist with transfers and repositioning. The goals for R168 were to "have intact skin, free of redness, blisters or discoloration" and "will remain free from skin breakdown due to incontinence and brief use". Interventions directed staff to use a pressure reduction mattress on bed and pressure reduction cushion in wheelchair, assist to turn/reposition at least every two hours, more often as needed or requested, apply moisturizer	F 280	4. The Director of Nursing and/or designee will audit three resident records each week for one month and then two residents/week for two months for monitoring residents for changes in condition and assuring appropriate follow-up has been done. 5. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Council Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies. 10-1-12	

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F 280	Continued From page 10 to skin with cares, notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, and discoloration noted during bath or cares. However, the care plan did not identify the existing open areas and there was no evidence of new interventions related to new open areas identified on 8/1/12 and 8/3/12. A progress note dated 8/1/12, noted R168 had reddened buttocks and received order for Calmoseptine (a cream used to protect skin from moisture). A progress note dated 8/3/12, indicated pin point open area to coccyx and excoriation to right inner buttock measuring 1.8 centimeter (cm) x 0.7 cm. A progress note dated 8/5/12, indicated barrier cream applied to open area on coccyx and Calmoseptine applied to reddened buttocks. Progress notes dated 8/7/12 and 8/8/12, indicated skin intact. Progress note dated 8/10/12 noted, Allevyn (a wound dressing) to coccyx area and right buttocks. There was no evidence of additional measurements after 8/3/12 (for 18 days). Nurse manager (NM)-A was unable to provide any wound measurements or condition of wound documentation for R168. The NM-A measured the open areas on 8/21/12, and documented the findings in the progress notes. The progress note dated 8/21/12, revealed the following, "Resident has ongoing skin breakdown associated with moisture/incontinence maceration. Currently has 4 superficial open areas. Superficial open area to mid coccyx currently measures 2.0 cm x 0.6 cm surrounding skin pink and blanchable, 2 cm below is another superficial open area currently measuring 0.3 cm x 0.2 cm surrounding skin is intact, pink and blanchable. Superficial open area	F 280		

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F 280	Continued From page 11 1.5 cm above anus currently measures 0.1 cm x 0.1 cm surrounding skin intact, pink and blanchable. Superficial open area to right gluteal fold currently measures 1.8 cm x 0.7 cm surrounding skin intact, pink but blanchable. MD [physician] examined open areas yesterday upon rounds and changed treatment to Calmoseptine cream BID [twice a day] and diagnosed maceration secondary to moisture. No drainage from open areas. Denies pain or discomfort to the area except when stool comes in contact with the areas." However, the note lacked depth measurements or clear description of the wound beds and evidence of re-assessment (which included causative factors) were not present. In addition, there were no new interventions identified. Braden Scales (an assessment used to determine pressure ulcer risk) dated 7/19/12, 8/2/12, 8/10/12 and 8/13/12 indicated that R168's skin is rarely moist (skin is usually dry; linen only requires changing at routine intervals). The medical record lacked evidence of the ability of the skin and its supporting structures to endure the effects of pressure without adverse effects for R168. The Pressure Ulcer Comprehensive Risk Assessments dated 7/19/12 and 8/2/12, directed the staff to turn and reposition R168 every two hours while in bed and to reposition, off load (relieving pressure for one full minute) while in chair every one hour. The Nursing Assistant (NA) Assignment Sheet directed staff to off load every two hours and every two-three hours in bed. However, the care plan dated 7/24/12, directed the staff to turn and reposition at least every two	F 280		

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F 280	Continued From page 12 hours and more often as needed or requested. Both the care plan and the NA Assignment Sheet was inconsistent with the Pressure Ulcer Comprehensive Risk Assessments. The Pressure Ulcer Comprehensive Clinical Assessment dated 8/13/12, indicated R168 had pressure ulcers identified as open area (o/a) to right buttock and directed to locate all pressure ulcers on the body diagram and complete the Pressure Ulcer Record. However, the body diagram and Pressure Ulcer Record were not completed. During interview on 8/20/12, at 5:51 p.m. the NM-A stated R168 had moisture related skin breakdown; However, she was unable to describe the status of the open area. NM-A stated that the MD/nurse practitioner (NP) had done wound rounds on 8/20/12, and she was unsure of what they had documented. During interview with the director of nursing (DON) on 8/23/12, at 1:49 p.m. she stated that pressure would need to be ruled out for any open area on the coccyx or bottom. Any open area would need to be monitored daily on the daily wound monitoring sheet and if measurable should be measured weekly by the nurse manager during wound rounds. The nurse manager was responsible to monitor healing and evaluate effectiveness of the interventions. During interview on 8/23/12, at 3:28 p.m. the DON verified the facility did not complete an assessment of R168's ability of the skin and its supporting structures to endure the effects of pressure without adverse effects. Should have this been on the plan of care per the DON and	F 280		

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F 280	Continued From page 13 NM-A? Did the NM-A monitor and evaluate the effectiveness the skin and should have she? was she aware of what the stated she was responsible for? The undated Guidelines for Pressure Ulcer Prevention Guidelines directed that revisions in the prevention plan are made as the resident's condition changes or new risk factors are identified. In addition, the guidelines direct that revisions to the prevention plan should be made when an intervention is determined to be ineffective. Also, it indicated that "the individualized care plan addresses these prevention or treatment strategies and monitors the effectiveness of interventions and revisions/Modifications." Components of pressure ulcer prevention education include care plan development, review and revision. The standards of practice listed in the guideline direct that the plan of care reflects approaches to stabilize, reduce or remove risk factors for pressure ulcer development and/or to promote healing of existing pressure ulcers.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to follow the written care plan for 1 of 1 resident (R168) who had		F282 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to; 1. Resident #168; a 3 Day Bowel and Bladder Diary was completed, a comprehensive assessment was completed for bowel and bladder. The resident's plan of care was revised as indicated and the NAR Assignment Sheet updated to assure consistency between the assessment and plan of care.	

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F 282	Continued From page 14 bowel incontinence. Findings include: R168's diagnoses included Parkinson's, dementia, edema and C-diff (bacteria that causes diarrhea). R168 was not offered toileting after breakfast per the plan of care on 8/22/12. R168 was observed continuously from 7:47 a.m. until 10:00 a.m. on the morning of 8/22/12. R168 was seated in the wheelchair at 7:47 a.m. R168 finished eating at 8:26 a.m. and at 8:31 a.m. was taken from the dining room to the lobby. No repositioning, off loading or toileting were provided until the physical therapy staff approached R168 at 9:47 a.m. to start the therapy session. At 9:51 a.m. R168 stood up with the assist of two staff members and a walker. R168's skin was observed at that time. The buttocks, coccyx and skin folds appeared dark red in color. The nurse was unable to complete a skin assessment for tissue perfusion as the resident immediately began to have an episode of bowel incontinence. The brown colored feces was loose and dripped on the wheel chair cushion. R168 let go of the walker and attempted to pull his brief back up. The two staff members present assisted R168 to the commode in the room. The Care Area Assessment (CAA) dated 6/22/12, indicated that R168 was incontinent of bowel and bladder and required assist of two staff for toileting. The CAA also noted, "Staff to offer/assist with toileting every 2 hrs and prn (as needed)." The care plan initiated on 7/24/12, directed staff to assist R168 to the bathroom in the a.m., before and after meals, p.m. and PRN.	F 282	2. All residents with open areas and/or c-difficile infections have been reassessed to assure proper interventions, documentation and revisions to care plans has been completed. The NAR Assignment Sheet has been updated as indicated. The Interdisciplinary Team (including nursing, MDS, social services, therapeutic recreation, and food service) will meet weekly to discuss any resident condition changes and implement new strategies. All resident care plans will be reviewed quarterly, annually and when a significant change in status occurs by the MDS Coordinators to assure the resident care plan is current. The NAR Assignment Sheet will be revised as indicated. 3. The interdisciplinary team responsible for reviewing changes in condition will receive education regarding the procedure/agenda for the IDT Meeting each week. All licensed staff will receive education regarding the procedure for updating care plans and NAR Assignment Sheets to maintain consistency of care. 4. The Director of Nursing and/or designee will audit three residents each week for one month and then two residents per week for two months to assure the plan of care for the individual resident is being revised and followed. 5. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Council Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies. 10-1-12	

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F 282	Continued From page 15 The care plan contraindicated the CAA dated 6/22/12. R168's nursing assistant (NA)-C was interviewed on 8/22/12, at 11:30 a.m. NA-C stated R168 used the commode after 7:00 a.m. and she transferred R168 to the wheelchair around 7:30 a.m. NA-C verified she had not toileted or repositioned/off loaded R168 between 7:30 a.m. and 9:47 a.m. and stated R168 always wants to go to the bathroom after breakfast. NA-C explained she assisted R168 to the toilet when requested and verified the assignment assignment group sheet did not specify frequency. In addition, she stated she was aware that R168 had "three sores on his bottom" and she applied barrier cream after toileting. On 8/23/12, at 1:49 p.m. the director of nursing (DON) was interviewed and stated the nurse managers were responsible for updating the assignment group sheets. The DON verified the frequency of toileting was not included on the group sheet and should have been there to direct the NA's. The bowel and bladder evaluation policy dated November 2010, indicated, "Upon admission and as necessary each residents bowel and bladder function will be evaluated." The policy also indicated, "The individualized resident plan of care is made part of the Nursing Assistant Care Plan, and should be specific including any incontinence product used, preferred toileting schedule (including times/frequency), assistance needed and any other personal information to care appropriately for the individual."	F 282		
F 311	483.25(a)(2) TREATMENT/SERVICES TO	F 311		

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F 311 SS=D	Continued From page 16 IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide bowel elimination services for 1 of 1 resident (R168) in the sample who had been identified to require these services. Findings include: R168's diagnoses included Parkinson's, dementia, edema and C-diff (bacteria that causes diarrhea). R168 was not toileted per his plan of care and had an episode of bowel incontinence. In addition, R168 had four open areas on his coccyx/buttocks. R168 was observed continuously from 7:47 a.m. until 10:00 a.m. on the morning of 8/22/12. R168 was sitting in the wheelchair at 7:47 a.m. R168 finished eating at 8:26 a.m. and at 8:31 a.m. was taken from the dining room to the lobby. No repositioning, off loading or toileting were provided until the physical therapy staff approached R168 at 9:47 a.m. to start the therapy session. At 9:51 a.m. R168 stood up with the assist of two staff members and a walker. R168's skin was observed. The buttocks, coccyx and skin folds appeared dark red in color. The nurse was unable to complete a skin assessment for tissue perfusion as the resident immediately	F311	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect; 1. To Resident #168; a Comprehensive Assessment of bowel and bladder was completed including; the type of incontinence, medication status, visual assessment of the perineum, medical status and a summary of the data finding and the three day tool for determining voiding patterns. The resident's plan of care was revised to include any new information and interventions. 2. All residents will have a comprehensive assessment completed for urinary incontinence upon admission, quarterly, annually, with a significant change in status, new onset of incontinence and upon removal of a catheter to maintain or restore as much bladder function as possible. 3. All nursing staff will receive re-education on the comprehensive assessment for urinary incontinence by October 1, 2012. 4. The Director of Nursing and/or designee will audit three residents each week for one month and then two residents each week for two months for assuring the plan of care for maintaining or restoring bladder function is being followed. 5. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Council Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies.	10-1-12

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F 311	Continued From page 17 began to have an episode of bowel incontinence. The brown colored feces was loose and dripped on the wheel chair cushion. R168 let go of the walker and attempted to pull his brief back up. The two staff members present assisted R168 to the commode in the room. The admission Minimum Data Set (MDS) dated 6/22/12, indicated R168 had moderately intact cognition (brief interview of mental status (BIMS) score of 11). R168 required extensive assist of two for transfers, bed mobility and toileting and was frequently incontinent of bowel and bladder. The Care Area Assessment (CAA) dated 6/22/12, indicated R168 was incontinent of bowel and bladder and required assist of two staff for toileting. The CAA also noted that "staff to offer/assist with toileting every 2 hrs and prn [as needed]." The care plan initiated on 7/24/12, directed staff to assist R168 to the bathroom in the a.m., before and after meals, p.m. and PRN. The care plan contraindicated the CAA dated 6/22/12. The Nursing Assistant (NA) Assignment Sheet undated, directed staff to "assist of 2 to commode" but did not include frequency per the care plan. Upon return from the hospital on 7/19/12, Per physician's orders, R168 received Flagyl (a medication for C-Diff) until 8/2/12. The Flagyl was resumed on 8/6/12, again for the diagnosis of C-Diff. The bladder and bowel assessment dated 8/6/12, indicated R168 had functional incontinence (decreased mental awareness/decreased or loss	F 311		

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F 311	Continued From page 18 of mobility or personal unwillingness). The assessment further indicated R168 could sometimes use the call light and ask to use the toilet. Normal bowel pattern was listed as "varies-multiple times daily." The plan determined a schedule of, toilet upon rising before and after meals at HS (hour of sleep) and PRN to avoid incontinent episodes. R168's regular nursing assistant (NA)-C was interviewed on 8/22/12, at 11:30 a.m. NA-C stated R168 used the commode after 7:00 a.m. and she transferred R168 to the wheelchair around 7:30 a.m. NA-C verified she had not toileted or repositioned/off loaded R168 between 7:30 a.m. and 9:51 a.m. and stated R168 always wants to go to the bathroom after breakfast. NA-C explained she assisted R168 to the toilet when requested and verified the assignment assignment group sheet did not specify frequency. In addition, she stated she was aware that R168 had "three sores on his bottom" and she applied barrier cream after toileting. On 8/23/12, at 1:49 p.m. the director of nursing (DON) was interviewed and stated the nurse managers were responsible for updating the assignment group sheets. The DON verified the frequency of toileting was not included on the group sheet and should have been there to direct the NA's. The MDS Coordinator was interviewed on 8/23/12, at 3:50 p.m. she stated R168 should have been toileted right away after meals but within one hour would be acceptable when following a care plan directing to toilet after meals.	F 311		

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F 311	Continued From page 19 The bowel and bladder evaluation policy dated November 2010, indicated, "Upon admission and as necessary each residents' bowel and bladder function will be evaluated". The policy also indicated, "The individualized resident plan of care is made part of the Nursing Assistant Care Plan, and should be specific including any incontinence product used, preferred toileting schedule (including times/ frequency), assistance needed and any other personal information to care appropriately for the individual."	F 311		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: Nelson, Sandra Based on observation, interview, and document review, the facility failed to monitor, re-evaluate and revise interventions when R168 first developed pressure ulcers and failed to implement interventions on the plan of care to minize skin breakdown for 1 of 3 residents (R168) in the sample reviewed for pressure ulcers who was admitted with intact skin. This practice resulted in actual harm for R168 who acquired		F314 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect; 1. A Comprehensive Assessment for skin risk factors including the Braden and Turning and Repositioning Guidance was completed for resident #168. The information was documented on the resident's plan of care and the NAR Assignment Sheet. Resident #168 was seen by the Wound Nurse on August 28, 2012. All residents with open areas have been reassessed to assure proper interventions, documentation and revisions to care plans has been completed. The NAR Assignment Sheet has been updated as indicated. Daily Wound Monitoring was initiated and Weekly Documentation has been completed ongoing through resolution of open areas. 2. The Interdisciplinary Team (including nursing, MDS, social services, therapeutic recreation, and	

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F 314	Continued From page 20 four open areas in the facility after being admitted. Findings include: R168 was admitted on 6/14/12, and had diagnoses which included Parkinson's, dementia, edema and C-diff (bacteria that causes diarrhea). R168 did not receive the necessary care and services to prevent development of open areas. As a result, R168 developed four open areas since return from the hospital on 7/19/12. On 8/21/12, at 1:15 p.m. R168 stood up with the assist of two staff and a standing lift. The buttocks and coccyx were observed and four open areas were noted with clearly defined edges and visible depth. The bilateral buttocks had deep red skin covered with peeling, dry flakes and the skin was noted to be loose and sagging. The licensed practical nurse (LPN)-A stated the two larger open areas looked like they were caused by pressure. R168 was observed continuously from 7:47 a.m. until 10:00 a.m. on the morning of 8/22/12. R168 was sitting in the wheelchair at 7:47 a.m. No repositioning, off-loading or toileting were provided until the physical therapy staff approached R168 at 9:47 a.m. to start the therapy session. The surveyor intervened and requested to observe R168's skin. At 9:51 a.m. R168 stood up with the assist of two staff members and a walker. The buttocks, coccyx and skin folds appeared dark red in color. The nurse was unable to complete a skin assessment as the resident immediately began to have an episode of bowel incontinence.	F 314	food service) will meet weekly to discuss any resident condition changes and implement new strategies. All resident care plans will be reviewed quarterly, annually and when a significant change in status occurs by the MDS Coordinators to assure the resident care plan is current. The NAR Assignment Sheet will be revised as indicated. 3. The interdisciplinary team responsible for reviewing changes in condition will receive education regarding the procedure/agenda for the IDT Meeting each week. Comprehensive Risk Assessments, Braden, turning and repositioning guidance will be completed on all new open areas with the implementation of the Daily Wound Monitoring Record, and Weekly Wound Documentation. 4. The Director of Nursing and/or designee will audit two residents with skin alterations each week for one month and then one resident with skin alterations per week for two months to assure the plan of care for the individual resident is being revised and followed. 5. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Council Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies. 10-1-12	

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F 314	Continued From page 21 The admission Minimum Data Set (MDS) dated 6/22/12, indicated R168 had moderately intact cognition (brief interview of mental status (BIMS) score of 11). R168 required extensive assist of two for transfers, bed mobility and toileting and was frequently incontinent of bowel and bladder. No alterations in skin integrity were noted on the assessment. The Pressure Ulcer Care Area Assessment (CAA) dated 6/22/12, identified R168's risk factors as; immobility, incontinence, altered mental status, delirium limits mobility, cognitive loss and poor nutrition. R168 needed a special mattress or seat cushion to reduce or relieve pressure per the CAA analysis. R168 returned to the facility on 7/19/12 after a hospitalization. A body audit dated 7/19/12, indicated the skin was intact. The Pressure Ulcer Comprehensive Risk Assessment dated 7/19/12, indicated that R168 had high risk factors and high risk diagnosis or co-morbidities for pressure ulcer development. The care plan created on 7/24/12, indicated R168 had the potential for pressure ulcer development related to: impaired mobility, bowel and bladder incontinence, need for assist with transfers and repositioning. The goals for R168 were to "have intact skin, free of redness, blisters or discoloration" and "will remain free from skin breakdown due to incontinence and brief use". Interventions directed staff to use a pressure reduction mattress on bed and pressure reduction cushion in wheelchair, assist to turn/reposition at least every two hours, more	F 314		

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F 314	Continued From page 22 often as needed or requested, apply moisturizer to skin with cares, notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, and discoloration noted during bath or cares. However, the care plan did not identify the existing open areas and there was no evidence of new interventions related to new open areas identified on 8/1/12 and 8/3/12. A progress note dated 8/1/12, noted R168 had reddened buttocks and received an order for Calmoseptine (a cream used to protect skin from moisture). A progress note dated 8/3/12, indicated pin point open area to coccyx and excoriation to right inner buttock measuring 1.8 centimeter (cm) x 0.7 cm. A progress note dated 8/5/12, indicated barrier cream applied to open area on coccyx and Calmoseptine applied to reddened buttocks. Progress notes dated 8/7/12 and 8/8/12, indicated skin intact. Progress note dated 8/10/12, showed Allevyn (a wound dressing) to coccyx area and right buttocks. There was no evidence of additional measurements after 8/3/12. The nurse manager (NM)-A measured the open areas on 8/21/12, and documented her findings in the progress notes. The progress note dated 8/21/12, revealed the following, "resident has ongoing skin breakdown associated with moisture/incontinence maceration. Currently has 4 superficial open areas. Superficial open area to mid coccyx currently measures 2.0 cm x 0.6 cm surrounding skin pink and blanchable, 2 cm below is another superficial open area currently measuring 0.3 cm x 0.2 cm surrounding skin is intact, pink and blanchable. Superficial open area 1.5 cm above anus currently measures 0.1 cm x	F 314		

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	245200	A. BUILDING _____ B. WING _____	08/23/2012

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F 314	Continued From page 23 0.1 cm surrounding skin intact, pink and blanchable. Superficial open area to right gluteal fold currently measures 1.8 cm x 0.7 cm surrounding skin intact, pink but blanchable. MD [physician] examined open areas yesterday upon rounds and changed treatment to Calmoseptine cream BID [twice a day] and diagnosed maceration secondary to moisture. No drainage from open areas. Denies pain or discomfort to the area except when stool comes in contact with the areas." However, the note lacked depth measurements or clear description of the wound beds and evidence of re-assessment (including causative factors) were not present. In addition, there were no new interventions identified. Further record review revealed, the MD progress note dated 8/6/12, indicated, "Skin: inspection of skin and subcutaneous tissue baseline." The NP (nurse practitioner) progress note dated 8/10/12, did not address skin. The MD progress note dated 8/13/12, indicated, "Skin: inspection of skin and subcutaneous tissue baseline." Braden Scales (an assessment used to determine pressure ulcer risk) dated 7/19/12, 8/2/12, 8/10/12, and 8/13/12, indicated R168's skin was rarely moist (skin was usually dry; linen only requires changing at routine intervals). The Pressure Ulcer Comprehensive Risk Assessments dated 7/19/12 and 8/2/12, showed that the resident should be turned and repositioned every two hours while in bed and to reposition, off load (relieving pressure for one full minute) while in chair every one hour. There was no assessment of R168's ability of the skin and its supporting structures to endure the effects of	F 314		

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F 314	Continued From page 24 pressure without adverse effects completed for R168. The Pressure Ulcer Comprehensive Clinical Assessment dated 8/13/12, indicated R168 had pressure ulcers identified as open area (o/a) to right buttock and directed to locate all pressure ulcers on the body diagram and complete the Pressure Ulcer Record. However, the body diagram and Pressure Ulcer Record were not completed The NP assessed R168's skin. The NP progress note dated 8/22/12, indicated inspection of skin and subcutaneous tissue on coccyx and buttocks assessed. R168 "Has superficial stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough) open area on the mid coccyx line with creamy colored slough in the base. No granulation tissue noted. Also has 3 superficial open areas on left buttock. Surrounding skin is deep pink and blanchable. No drainage. Not consistent with shearing injury." R168's regular nursing assistant (NA)-C was interviewed on 8/22/12, at 11:30 a.m. she stated she got R168 up to the commode after 7:00 a.m. and she transferred R168 to the wheelchair around 7:30 a.m. NA-C verified she had not toileted or repositioned/off loaded R168 between 7:30 a.m. and 9:47 a.m. She stated R168 always wanted to go to the bathroom after breakfast. She further indicated R168 had been on a repositioning schedule since the last return from the hospital. She verified the only repositioning that occurred was with toileting and she was not sure what off-loading meant. In addition, she	F 314		

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F 314	Continued From page 25 stated she was aware R168 had "three sores on his bottom" and she thought they looked better now. During interview on 8/20/12, at 5:51 p.m. the NM-A stated R168 had moisture related skin breakdown; however, she was unable to describe the status of the open area. NM-A stated the MD/NP had done wound rounds on 8/20/12, and she was unsure of what they had documented. During interview with the NP on 8/22/12, at 2:00 p.m. she indicated she had last seen R168's skin one and a half weeks ago, it had just been reddened and not open at that time. The NP verified the MD progress note from 8/20/12, did not address R168's skin status. The NP stated she could not say what the wound status and had not received an update from the staff regarding the four open areas. In addition, the NP indicated she should receive updates from the staff after weekly wound rounds. During interview with the director of nursing (DON) on 8/23/12, at 1:49 p.m. she stated pressure would need to be ruled out for any open area on the coccyx or bottom. Any open area would need to be monitored daily on the daily wound monitoring sheet and if measurable should be measured weekly during wound rounds. During interview on 8/23/12, at 3:28 p.m. the DON verified the facility did not complete an assessment of R168's ability of the skin and its supporting structures to endure the effects of pressure without adverse effects. The Wound Assessment Record policy dated January 2011, directed staff to complete a weekly	F 314		

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F 314	Continued From page 26 report "on each resident with a wound or skin condition that has not resolved after the standing order protocol has been completed. The Nurses Weekly Wound assessment will be reviewed weekly at the IDT (interdisciplinary team) meetings for wound progress and treatment recommendations." The Daily Wound Monitoring Form Policy and Procedure dated January 2011, instructed the daily monitoring of pressure and non pressure wounds promoted early recognition of problems with wound healing, a dressing failure or unrelieved pain associated with the wound or dressing change. The undated Guidelines for Pressure Ulcer Prevention Guidelines indicated that skin subjected to excess friction, shear and weakened by moisture was at risk for pressure ulcers. R168 went from 8/3/12 until 8/21/12, without the staff documenting the progress of the four wounds, the facility staff did not update the NP on R168's wound, the facility did not operationalize the wound policy for monitoring and assessment, and the facility failed to follow the plan of care for the off-loading hourly while in the chair.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		

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F 329	Continued From page 27 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure that 1 of 3 residents (R178) reviewed for antidepressant use for weight loss was free of unnecessary medications. Findings include: R178 was admitted to the transitional care unit on 7/24/12, with diagnoses which included mild major depression, generalized weakness, dysphagia, and chronic obstructive pulmonary disease (COPD). The nurse practitioner (NP) progress note dated 7/25/12, indicated R178 was attempting to quit smoking by using a nicotine patch and R178 had no cravings. The discharging physician wrote orders on 7/25/12, for Wellbuterin, Nicotine tablets and gum.	F 329	F329 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect; 1. Resident #178 had a PHQ9 completed. A pharmacy review was done on Sept. 14, 2012 and the physician notified for the continued use of/indication for Remeron and Zoloft. The Remeron has been discontinued. Resident #178 has been discharged to his home with his wife. Spouse of resident #178 has received education regarding symptoms of depression and physician contact information should symptoms of depression worsen. 2. All resident's receiving psychoactive medications will be reviewed to assure there are appropriate indications for the medications, care plans will be updated and behavior or sleep monitoring initiated as indicated. Residents receiving duplicate therapies will be referred to the pharmacy consultant for review with physician notification as indicated 3. All staff will receive education regarding the requirements for monitoring for adequate	

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F 329	Continued From page 28 The admission Minimum Data Set (MDS) dated 7/30/12, indicated a PHQ9 (resident mood interview) score of 1 (minimal depression). The PHQ9 score on 8/3/12, was 0 (which indicated no indicators of depression). A mood Care Area Assessment (CAA) was not triggered for the admission MDS. The MDS also revealed R178 was not on a physician weight loss program. The Nutrition CAA dated 8/3/12, showed a weight of 209 pounds (#) and the weight was stabilized. The CAA's did not identify that R178 received antipsychotic medication. A referral was to be made to the dietician. The nutrition care plan initiated on 8/3/12, listed a goal of "weight to remain +/- 5# of 209" with an intervention to provide supplements. Weight loss was not identified on the care plan as a focus. Remeron was not included as an intervention for weight loss. Per the physician's order and progress note review, R178 received the following three antidepressants: -Wellbutrin 150 milligrams (mg) twice daily was started while R178 was in the hospital for smoking cessation 7/25/12. -Zoloft 50 mg daily prior to hospitalization which was increased to 75 mg daily on 8/6/12. -Remeron 15 mg daily was added on 8/6/12 (on the same day the Zoloft was increased). The medical doctor (MD) progress note dated 8/6/12, showed a weight of 209#. The note listed instructions that included, increase Zoloft-depression, labs-weight loss, Magic Cup (nutritional supplement) twice daily, discontinue house supplement, Remeron-weight	F 329	indications for use of psychoactive medications by October 1, 2012. 4. The Director of Nursing and/or designee will audit three resident medication regimens each week for one month and then two resident medication regimens each week for two months to assure there are appropriate indications for psychoactive medications. 5. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Council Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies. 10-1-12	

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F 329	Continued From page 29 loss/depression and a chest x-ray was ordered for weight loss. The care plan dated 8/10/12, for depression had a focus statement and a goal however, there were no interventions listed. The facility staff did not identify the duplicative therapy of the antidepressants. R178 had a hospital admission weight of 213# on 7/19/12. The first facility weight on 7/25/12, was documented as 222.9# but was later struck out as being "incorrect documentation." The following weights were also recorded on the Weights and Vitals Summary: 211.2 (7/29/12) 209.2 (8/1/12) 204.6 (8/6/12) 205.6 (8/12/12) 206.0 (8/20/12) 202.6 (8/26/12) On 8/22/12, at 1:13 p.m. the NP was interviewed. The NP stated that she was not aware R178 recived Wellbutrin. The NP also stated R178 should not be on both Wellbutrin and Nicotine patches at the same time. After the NP reviewed the physician progress notes, she stated R178's wife was concerned about weight loss, poor appetite and mood. The NP stated that a weight loss of 20 percent would trigger the use of Remeron and she reviewed weights at every visit. The facility did not monitor R178's efficacy to the antidepressants as R178 continued to lose weight.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 30 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation interview and policy review, the facility did not have a system in place to clean the refrigerators in 2 of 3 kitchenettes, and did not store resident food properly in the refrigerators. This had the potential to affect the 104 residents that resided at the facility. Findings include: The facility had re-usable ice bags, and ice bag holders stored with in the kitchenette refrigerator with food items. Resident left over food items were not properly stored in air tight containers and removed in a timely manner. The refrigerators were not kept clean of spills and debris. At 11:45 a.m. on 8/20/12, a tour of the main kitchen was conducted, followed by a tour of the kitchenettes. The kitchenette in the main dining room on first floor had stains at the bottom of the refrigerator, unidentifiable resident food was stored on a paper plate and covered with plastic wrap that was dated 8/16/12, a McDonalds box container was dated 8/17/12. Two glass bowls	F 371	F371 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. All identified refrigerators have been cleaned and checked for unlabeled and/or expired food or resident care items. The unlabeled and/or expired food items have been disposed and replaced as needed and the care items have been removed and stored in the appropriate area. 2. A system for cleaning and checking refrigerators on the units has been implemented to assure routine cleaning of equipment in the kitchens and kitchenettes. Food Service will check each kitchenette every day for expiration and unlabeled/undated open food items and date/dispose as indicated and wipe up spills when appropriate. 3. All food service and housekeeping staff will be re-educated regarding the procedure for cleaning refrigerators and dating open containers and checking for expiration, and regarding the cleaning schedule for all equipment. This education will be completed by October 1, 2012	

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F 371	Continued From page 31 with red covers were undated, one had food debris inside, the other was half full of a rice dish. A red "lunch box type" container was also undated. The findings were verified by the dietary director (DD) and removed from the refrigerator. The second floor, memory care kitchenette refrigerator had a foam plate of food, covered with a foam plate, labeled with a resident name and eggplant 8/19/12, and the crisper drawers at the bottom of the refrigerator contained debris. A bread bag was open on the counter and crumbs are in the toaster at 12:30 p.m. licensed practical nurse (LPN)-A verified that was not proper food storage and threw away the foam plate covered food. At 2:19 p.m. on 8/23/12, the director of environmental services (DEVS) stated that housekeeping was not responsible for cleaning the kitchenette refrigerators, dietary was responsible for checking food outdates and cleaning the refrigerator, but housekeeping would be glad to help clean up spills etc. At 2:30 p.m. the transitional care unit (TCU) dining room kitchenette refrigerator had nine reusable ice bags, one disposable and filled ice bag, and two fabric covered ice bags (one labeled with a patient name and in a plastic Ziploc bag) stored in the freezer along with a container of magic cup orange cream and a McDonalds frozen shake labeled with a resident name and undated. There was a large dried stain across the bottom of the refrigerator. At 2:35 p.m. on 8/23/12, nurse manager (NM)-A was shown the TCU refrigerator, and stated	F 371	4. The Director of Food Service and/or designee will audit three kitchenettes each week for one month and then two kitchenettes each week for two months to assure foods are labeled/dated, resident care items removed and expired food items have been disposed. 5. The data collected will be presented to the QA committee by the Director of Food Service. The data will be reviewed/discussed at the monthly Quality Council Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies. 10-1-12	

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F 371	Continued From page 32 housekeeping was responsible for the refrigerator cleaning. At 2:49 p.m. on 8/23/12, The DD and NM-A stated there were no refrigerator cleaning logs that they were aware of and the facility will probably need to develop a policy around kitchenette refrigerator cleaning and storage. The policies for Food Storage and Food Storage Guidelines were provided, but did not address resident leftover food in the dining room kitchenettes.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that; 1. With respect to resident #168, a clean, covered cushion was placed on the resident's chair while the original cover was laundered. The cold packs were removed, cleaned with PDI wipes and stored in a covered bin in the medication room refrigerators. 2. All resident cushions were checked to assure proper, washable covers were covering all cushions. All unit refrigerators were checked and plastic bins purchased for the storage of cold packs in the medication room refrigerators.	

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F 441	Continued From page 33 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review the facility did not have a system in place to clean the refrigerators in 2 of 3 kitchenettes and did not store resident food properly in food refrigerators and the facility had reusable medical equipment stored in the kitchenette refrigerators and medication refrigerators. This had the potential to affect the 104 residents that resided at the facility. The three facility medication rooms were checked at 1:00 p.m. on 8/23/12, with the acting director of nursing (DON). The freezer in the front station medication room was observed to store two re-usable cold packs, right next to a chocolate ice cream cup. The DON confirmed food should not be stored with the multi-use ice packs. At 2:30 p.m. the transitional care unit (TCU) dining room kitchenette refrigerator had nine reusable ice bags, one disposable and filled ice	F 441	3. All nursing staff will receive education regarding the policy and procedure for the storage, cleaning and application of cold packs as well as monitoring equipment for intact surfaces for cleaning and maintaining infection control by October 1, 2012. 4. The Director of Nursing and/or designee will audit three medication room refrigerators each week for one month and then two med room refrigerators each week for two months to assure proper storage of the cold packs. Three resident's equipment will be monitored each week for one month and then two resident's equipment per week for two months to assure proper coverage and washable surfaces are intact. 5. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Council Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies. 10-1-12	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34 bag, and two fabric covered ice bags (one labeled with a patient name and in a plastic Ziploc bag) stored in the freezer along with a container of magic cup orange cream and a McDonalds frozen shake labeled with a resident name and undated. At 2:35 p.m. on 8/23/12, nurse manager (NM)-A was shown the TCU refrigerator, and stated housekeeping was responsible for the refrigerator cleaning, and she was not aware that ice bags could not be stored with food. At 2:49 p.m. on 8/23/12, The dietary director and NM-A stated the physical therapy (PT) department stores overflow ice bags in the fireside freezer. The facility policy on storage and use of reusable ice packs was requested, however, no policy was provided.	F 441		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to stop billing as required for 1 of 1 resident in the sample (R145) who requested a demand bill be submitted.	F492	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to resident # 145, the resident was not billed for services until Medicare Coverage was determined upon receipt of the official payment decision from CMS, however the resident chose to make payment expressing concern about "getting behind" should the official determination to end coverage is made. 2. A system for monitoring Demand Bills pending official CMS decision has been implemented and will be communicated between the MDS Coordinator and the billing office with written notification of deferred payment pending that decision.	

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F 492	Continued From page 35 Findings include: R145's representative received a Medicare Denial Notice on 6/25/12, which indicated that Medicare services ended on 6/27/12. R145's representative requested a demand bill be submitted for a Medicare review decision. The facilities Denial/Demand Bill Log showed that a demand bill had been submitted by the facility on 8/1/12. Upon review of the Monthly Statement dated 9/1/12, and the Transaction History by Effective Date for R145, the resident had been charged for room and board services during the time of the Medicare review and the charges had been paid. During interview with the administrator at 2:30 p.m. on 8/23/12, she verified that the resident received a bill for services after a demand bill had been requested and during the review period. The administrator acknowledged R145 should not have received a bill for room and board.	F 492	3. All Financial Service, MDS , Social Services, Admissions and Nurse Management has received education regarding proper billing procedures through the use of CMS' Medicare Booklet. 4. The Executive Director and/or designee will audit Demand Bills each month for three months to ensure proper billing for services until official determinations have been received. 5. The data collected will be presented to the QA committee by the Executive Director The data will be reviewed/discussed at the monthly Quality Council Meeting. At this time the QA committee will make the decision/re-commendation regarding any necessary follow-up studies. 10-1-12	

Birchwood Health Care Center

605 NE First Street
Forest Lake, MN 55025
651-464-5600

September 20, 2012

Gloria Derfus
Minnesota Department of Health
PO BOX 64900
St Paul, MN 55164-0900

Dear Ms Derfus,

On August 23, 2012 a standard survey was conducted at Birchwood Health Care Center. Attached is the completed copy of the original plan of correction for your review. I have also attached a copy of the state fire marshal plan of correction and a copy was sent the their office.

Please feel free to contact me with any questions at my office number 651-466-1022 or by cell phone at 651-248-5615.

Sincerely,

Diane Willette

Diane Willette
Executive Director
Birchwood Senior Living

F 5200020

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

PRINTED: 09/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Birchwood Health Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145, or By email to: Barbara.Lundberg@state.mn.us and	K 000	RECEIVED SEP 21 2012 DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL POC ok FS 9-27-12	

DC: 10.02.2012
EXIT: 08.23.2012

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

Diane Willetta | Executive Director | 9-20-12

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Birchwood Health Care Center is a 2-story building with partial basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1971, an addition was constructed to the south side of the building that was determined to be of Type II(111)construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 132 beds and had a census of 106 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6. This deficient practice could affect all residents, staff and visitors. Findings include: On facility tour between 09:00 AM and 01:00 PM on 08/22/2012, it was observed that the walls above the smoke barrier doors had penetrations that had not been sealed in an approved manner in the following areas; 1) Penetrations around pipes and conduit above the suspended ceiling and above the smoke barrier door on the first floor by room 141. 2) Penetrations around pipes and conduit above the suspended ceiling and above the smoke	K 025	K 025 1. Re-sealing penetrations have been completed for the identified areas 141, 162, and Therapy completed by 10/1/2012. 2. Policy has been written to review smoke barriers during and after completion of construction or remodeling. 3. This correction will be monitored by Director of Environmental Services.	

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K 025	Continued From page 3 barrier door on the first floor by room 162. 3) Penetrations around pipes and conduit above the suspended ceiling and above the smoke barrier door on the first floor by Therapy. This deficiency was verified by facility Administrator (DW),	K 025		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of available reports and records, it was determined that the facility has failed to properly conduct fire drills in accordance with NFPA 101 (00), Chapter 19, Section 19.7.1.2.. This deficient practice could affect how staff react in a fire emergency. FINDINGS INCLUDE: On facility tour between 09:00 AM and 01:00 PM on 08/22/2012, during a review of fire drill reports provided by the facility. it was noted that the facility did have documentation that fire drills were conducted during all shifts for the last 12 months,	K 050	K 050 1. A new fire drill calendar has been implemented 9/21/12 to ensure fire drills will be varied during the evening shift. 2. Completed 9/21/12. 3. This correction will be monitored by Director of Environmental Services.	

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K 050	Continued From page 4 however the fire drills were not varied throughout the shift during the evening shift. All drills were conducted between 3:00 PM and 4:05 PM. This deficiency was verified by facility Administrator (DW),	K 050		