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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XRLF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00853

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

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

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

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

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

6. DATE OF SURVEY 08/09/2021 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **100** (L18)

13.Total Certified Beds **100** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jamie Perell, Unit Supervisor 08/11/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 08/11/2021 (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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 11, 2021

CMS Certification Number (CCN): 245200

Administrator
Birchwood Health Care Center
604 - 1st Street Ne
Forest Lake, MN 55025

Dear Administrator:

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

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

Effective July 23, 2021 the above facility is certified for:

100 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 100 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 11, 2021

Administrator
Birchwood Health Care Center
604 - 1st Street Ne
Forest Lake, MN 55025

RE: CCN: 245200
Cycle Start Date: June 17, 2021

Dear Administrator:

On July 8, 2021, we notified you a remedy was imposed. On August 9, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 23, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 7, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 8, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 7, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 23, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XRLF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00853

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

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

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

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

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

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

6. DATE OF SURVEY **06/17/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **100** (L18)

13.Total Certified Beds **100** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Maudelin Saint Jean, HFE NE II 07/26/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/13/2021 (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

Electronically delivered
July 8, 2021

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

RE: CCN: 245200
Cycle Start Date: June 17, 2021

Dear Administrator:

On June 17, 2021, a survey was completed at your facility by the Minnesota Department(s) 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 7, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 7, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 7, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 7, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Birchwood Health Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 7, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Jamie Perell, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 December 17, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals

Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments From 6/14 through 6/17/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	E 000		
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following:	E 032		7/23/21

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

Electronically Signed | 07/14/2021

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 032	Continued From page 1 (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policies and procedures which addressed alternative means of communication with staff and outside agencies in the event of an emergency. This had the potential to affect all 73 residents who resided at the facility. Findings include: The facility Emergency Preparedness Operations Plan dated 3/29/21, lacked indication of a communication plan which included alternative means of communication with Federal, State, tribal, regional and local emergency management agencies. When interviewed on 6/16/21, at 12:00 p.m. the administrator stated the facility Emergency Preparedness Operations Plan had an alternate means of communication with local police; however, was unable to provide alternate communication methods to state and federal emergency management agencies.	E 032	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 all facility residents, alternative methods of communication including email addresses of local, state and federal emergency agencies were added to Emergency Preparedness Operations Plan on all nursing stations. 2.All staff will receive education on primary and alternate ways to communicate with federal, state, regional and local emergency management agencies by July 23, 2021. 3.Revision of the emergency plan and all staff training will be conducted annually. 4.The Executive Director and/or designee will audit contact information annually as part of the annual emergency	

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 032	Continued From page 2	E 032	preparedness plan review. The data collected will be presented to and discussed with the QA committee monthly. At that time the committee will make the decision/recommendation regarding any necessary follow-up studies.	
F 000	INITIAL COMMENTS On 6/14/21, through 6/17/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED however, no deficiencies were cited due to actions implemented by the facility prior to the survey: H5200050C (MN72893) H5200051C (MN71727) H5200052C (MN66666) H5200057C (MN57618) H5200058C (MN52956) The following complaints were found to be UNSUBSTANTIATED: H5200053C (MN64526) H5200054C (MN62977) H5200055C (MN58620) H5200056C (MN57748) H5200059C (MN68223) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 3 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		7/23/21

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 4 be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance	F 623		

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 5 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a written notice for transfer/discharge for 3 of 3 residents (R55, R66, R67) reviewed for facility initiated transfer or discharge. This had the potential to affect all 73 residents who resided at the facility. Findings include: R55's Face Sheet dated 6/17/21, indicated R55's	F 623	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	

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 6 diagnosis included heart failure, dementia, and chronic kidney disease stage 3. R55's quarterly Minimum Data Set (MDS) assessment dated 5/20/21, indicated R55 had moderate cognitive impairment. R55's progress note dated 6/15/21, at 1:07 p.m. indicated R55 was transferred to the hospital due to pneumonia and declining condition. R55's progress note dated 6/16/21, at 10:23 a.m. indicated the facility received a call from the hospital and was notified R55 was admitted to the intensive care unit. R55's medical record lacked indication a written notice of transfer was provided to R55 or their representative. When interviewed on 6/17/21, at 12:56 p.m. registered nurse (RN)-A stated she was not familiar with a transfer or discharge form. When interviewed on 6/17/21, at 1:21 p.m. the director of social services (DSS) verified the facility did not utilize a written transfer and discharge form which indicated why a resident was being transferred. The DSS stated when a resident was transferred to the hospital verbal communication occurred with the resident or their representative. On 6/17/21, at 1:37 p.m. DSS provided a document titled Notice of Transfer or Discharge. The Notice of Transfer or Discharge form indicated R55 was transferred to the hospital on 6/15/21. The DSS stated the facility had just created the form and would send it to R55's	F 623	the foregoing statement, the facility states that: 1.With respect to R55, R66 and R67 a transfer form has been sent to their representatives. 2.All resident transfers have been reviewed for appropriate transfer notifications. The IDT reviews all transfers and discharges regularly and Social Services staff will ensure notification form is sent to resident representatives timely. The facility transfer guideline has been updated to include transfer notifications. 3.All staff will receive education on transfer/discharge notifications by July 23, 2021. 4.The Director of Nursing and/or designee will complete audits on all transfers and discharges for three months to ensure proper notification is completed. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 7	F 623		

family.
R66's Face Sheet dated 6/17/21, indicated R66 had diagnoses which included dementia without behavioral disturbances and major depressive disorder.

R66's quarterly MDS dated 3/18/21, indicated R66 had severe cognitive impairment and had physical/verbal behavioral symptoms directed towards others one to three days during the assessment period.

R66's care plan dated 5/19/21, indicated R66 was aggressive towards other residents.

R66's progress note dated 5/18/21, indicated R66's representative was notified of a bed opening at a long-term care facility with a memory care unit.

R66's progress note dated 5/18/21, indicated R66 was discharged to a long-term care facility with a memory care unit for appropriate placement due to R66's behaviors at the facility.

Review of R66's medical record lacked indication a written notice of discharge was provided to R66 or their representative.

During an interview with social worker (SW)-A on 6/17/21, at 2:07 p.m. SW-A verified R66's discharge was initiated by the facility and stated R66's family was in agreement with the transfer. SW-A confirmed a written notice of discharge/transfer was not provided to R66 or the resident's representative, and stated the facility had not provided the notices in writing until today.
R67's quarterly MDS dated 4/6/21, identified R67's diagnoses included traumatic subdural

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 8 hemorrhage. R67 was cognitively intact. R67's progress note 4/27/21, at 1:32 p.m identified R67 was hospitalized on 4/27/21, for evaluation of increased edema (swelling), weakness, and kidney injury. Review of R67's medical record lacked indication either R67 or the representative, were provided a written notice of transfer/discharge for the hospitalization on 4/27/21. During an interview on 6/17/21, at 11:21 a.m. social worker (SW)-A stated a written notice was not provided to R67 because her daughter was at the facility. SW-A stated R67 was emergently transferred and the resident and their daughter consented to the transfer. During an interview on 6/17/21, at 12:56 p.m. the assistant director of nursing (ADON) confirmed a written notice of transfer was not provided. A facility policy regarding transfer and discharge was requested, but not provided	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		7/23/21

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 9 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement a comprehensive person-centered care plan to monitor weights for 1 of 1 resident (R4) reviewed for weight loss. Findings include:	F 656	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction	

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 10 R4's Face Sheet dated 6/17/21, indicated R4 had diagnoses which included dysphagia following a cerebral infarction (stroke) and altered mental status. R4's admission Minimum Data Set (MDS) assessment dated 3/16/21, indicated R4 had a severe cognitive impairment, needed two staff members for transfers and mobility, and required limited assistance in eating. R4's nutrition Care Area Assessment (CAA) dated 3/21/21, indicated R4 had a potential for nutritional problems related to diagnoses of cerebral infarction, aphasia (difficulty speaking), and cognitive impairment. Furthermore, the assessment indicated R4 had no chewing or swallowing problems and R4's weights would be monitored by the dietitian. R4's care plan dated 4/9/21, indicated R4 would be evaluated for weight loss. If significant weight loss were noted facility protocol would be followed. Furthermore, R4's care plan indicated a significant weight loss would include a loss of three pounds in one week, and greater than five percent loss in one month. R4's weights and vital summary indicated the following: On 3/15/21, R4's weight was 217.3 pounds (lbs.) On 3/22/21, R4's weight was 218.7 lbs. On 3/29/21, R4's weight was 219.1 lbs. On 4/5/21, R4's weight was 222.3 lbs. On 4/12/21, R4's weight was 221.9 lbs. On 4/26/21, R4's weight was 208.9 lbs. R4 had a 4.6% weight loss from 3/29/21 to 4/26/21.	F 656	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 R4, an updated weight was obtained. Upon review with hospice, weight frequency has been changed to monthly to reflect resident's personal preferences and goals of care. R4's care plan has been reviewed and updated to reflect reapproach interventions. 2.All resident's weights were reviewed to ensure physician orders were followed and interventions put in place as indicated. 3.All nursing staff will receive education on obtaining weights per orders and reproaching when a resident refuses by July 23, 2021. 4.The Director of Nursing and/or designee will complete weight audits to ensure appropriate documentation of weights twice weekly for one month, then once weekly for two months. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 11	F 656		

R4's nutrition assessment dated 6/9/21, indicated R4 had a weight change of 4.8% and required monitoring of weights by the dietitian. The progress note further indicated a request for an updated weight for R4 was requested.

R4's provider order summary dated 6/17/21, indicated weekly weights had been ordered starting 3/15/21.

During an observation on 6/16/21, at 10:24 a.m. the assistant director of nursing (ADON) and registered nurse (RN)-A assisted R4 to get out of bed. After cares were completed, R4 was assisted into a wheelchair with the use of a Hoyer lift which had the capability to record a weight. No attempt to record R4's weight was attempted.

When interviewed on 6/17/21, at 8:10 a.m. nursing assistant (NA)-B stated staff tried to get R4 out of bed during the morning, but R4 would push the Hoyer lift away or yelled out at times. NA-B stated R4's weights would be documented in the medical record by either a nurse or NA. NA-B stated weights were completed on Mondays and if R4 refused it would be documented in the medical recorded. NA-B stated they would let the nurse know if a resident refused to have their weight taken.

When interviewed on 6/17/21, at 8:14 a.m. licensed practical nurse (LPN)-A stated there was a list of residents at the nurses' station which was used to help record weights. LPN-A stated weights were done on Mondays. LPN-A stated when a weight was taken, the NA or nurse had to document it in the medical record and on the list at the nurses' station. LPN-A stated the list at the

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 12	F 656		

nurses' station was used by the nurse manager to monitor weights. LPN-A stated R4 refused cares at times, and if R4 refused to have her weight taken, it was important to try again at a different time.

When interviewed on 6/17/21, at 8:50 a.m. registered dietitian (RD)-A stated weekly weight reports were sent out to the nurse managers. RD-A stated weight reports were sent by Wednesdays and listed residents who refused a weight or had not had a weight obtained on Mondays. RD-A stated R4 was frequently on the report showing a weight had not been obtained. RD-A stated R4 refused weights often and verified R4 had not been weighed since April. RD-A had recommended to obtain a current weight for R4 and noted this in R4's progress notes. RD-A stated R4's nutritional status was high risk and not having an updated weight had impacted R4's nutritional assessment.

When interviewed on 6/17/21, at 9:14 a.m. NA-C stated weights were completed on Mondays. NA-C stated on Tuesdays, the nurse manager or nurse would notify NAs which residents still need weights to be obtained. NA-C verified R4 needed the Hoyer lift to get out of bed and was weighed on the wheelchair scale. NA-C stated the Hoyer scale was used only on days R4 had refused to get up.

When interviewed on 6/17/21, at 10:45 a.m. the director of nursing (DON) stated weights were written on the NA task sheet and on a list at the nurses' station. The DON stated weights were documented in the medical record and the managers reviewed the list located at the nurses' station to support staff in completing weights. The

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 13 DON further stated if residents refused weights, staff needed to try again at an opportune time for the resident at any point during the week. The DON verified all weights and refusals would be documented in the medical record. When interviewed on 6/17/21, at 3:45 p.m. the DON stated there were no policies on documentation of weights or following physician orders, but it was a nursing standard of practice. A policy on weights was requested but not provided. A policy on physician orders was requested but not provided. Documentation of R4's refusal of weights was requested but not provided.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was offered and/or provided for 1 of 5 residents (R34) who was dependent upon staff assistance for activities of daily living (ADLs). Findings include: R34's annual Minimum Data Set (MDS) assessment dated 4/29/21 included diagnoses of: dementia without behavioral disturbance, hemiplegia (paralysis of one side of the body),	F 677	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:	7/23/21

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 14 arthritis, cerebrovascular accident (stroke) and hemiparesis (weakness or loss of strength). In addition, the MDS indicated R34 did not reject cares and required extensive assistance of one staff with personal hygiene. R34's care plan dated 5/5/21, identified R34 had an ADL self-care deficit related to a stroke with left sided hemiplegia. The care plan directed staff to, "check nail length and trim and clean on bath day and as necessary." R34's communication Care Area Assessment dated 5/12/21, indicated R34 was dependent upon staff for ADL's and had little verbal expression. R34's nursing assignment team sheet dated 6/11/21, indicated R34 required assistance of one staff with grooming. R34's scheduled bath/shower days were identified as Sunday and Wednesday evenings. During interview on 6/14/21, at 2:37 p.m. family member (FM)-A stated, "Since we have been able to see her again the only thing we have noticed is her fingernails are long and have dirt underneath them. This was a problem even before COVID." FM-A stated the family had brought these concern to staffs' attention several times but it had not been addressed. On 6/14/21, at 3:03 p.m. R34 was observed lying in bed asleep. R34's hands were uncovered and R34's fingernails were observed to be approximately a quarter (1/4) inch long with brown matter under them, and the fingernails were also observed to have jagged edges.	F 677	1.With respect to R34, a feedback form was initiated on June 17, 2021. Facility addressed concerns with the family member and the resident received fingernail care. Staff will continue to provide assistance with nail care per resident's plan of care. 2.All residents' fingernails were checked for appropriate length and cleanliness and cares provided as indicated. 3.All staff will receive education regarding facility's standard care routines regarding fingernail care by July 23, 2021. 4.The Director of Nursing and/or designee will complete dignity audits on 4 residents weekly for three months to ensure proper nail care is completed for all residents. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 15 On 6/16/21, at 7:10 a.m. R34 was observed lying in bed and appeared dressed for the day. R34's nails remained long with jagged edges and had brown matter underneath them. On 6/16/21, from 7:38 a.m. to 8:02 a.m. nursing assistant (NA)-C was observed providing personal cares for R34. NA-C applied arm sleeves to R34's arms and a hand splint to R34's left hand. NA-C never offered or provided assistance with nail care. During a follow-up interview on 6/17/21, at 11:51 a.m. FM-A stated she had noticed during visits R34's fingernails on both hands were long with jagged edges, and were soiled with brown matter under the nails. FM-A stated R34 was unable to make her needs known or care for herself. FM-A stated R34 always liked to be kept clean, and maintained her nails. FM-A stated she had brought this concern to the attention the social worker. Further, FM-A stated she was concerned R34 would scratch herself with the jagged edge nails which could cause R34's skin to break and potentially cause an infection. During interview on 6/17/21, at 11:43 a.m. registered nurse (RN)-B confirmed R34's nails were approximately a quarter inch long. RN-B stated the activities director cleaned underneath R34's nails. RN-B stated nail care was supposed to be completed during scheduled weekly bath/shower days. RN-B reviewed R34's medical record and verified resident had received a bath/showers on 6/13/21 (Sunday) and 6/16/21 (Wednesday) however, R34's nails had not been trimmed at those times and continued to be long with jagged edges.	F 677		

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 16 During interview on 6/17/21, at 12:23 p.m. the DON stated she expected staff to provide ADL assistance per the care plan which included nail care. The DON stated she was going to complete a feedback form for the nail care concern of R34's family. On 6/17/21, at 3:00 p.m. the policy for ADL's was requested but was not provided.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer compression therapy as ordered, for 1 of 1 resident (R244) reviewed for lower extremity edema. Findings include: R244's Face Sheet dated 6/17/21, indicated the resident had diagnoses which included: acute kidney failure (when the kidneys suddenly become unable to filter waste products from the blood), anemia (low red blood cells), and hypokalemia (low potassium).	F 684	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.With respect to R244, compression garments were placed on June 16, 2021	7/23/21

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17 R244's admission Minimum Data Set (MDS) assessment dated 6/8/21, indicated R244 was cognitively intact. R244 did not have any ulcers, wounds, or other skin problems identified. R244's care plan dated 6/2/21, indicated R244 was a vulnerable adult related to impaired right humeral neck fracture (bone break that often extends to the shoulder), chronic kidney disease stage 3 (kidney failure), anemia, and lower extremity swelling. The care plan lacked interventions for monitoring and treatment of R244's bilateral lower extremity edema. R244's Physician Orders Report dated 6/1/21, indicated: wear ace wraps, knee high ted hose, or Tubigrip to lower legs. Wear during the day, remove and wash at night. R244's nurse practitioner (NP) progress notes dated 6/14/21, indicated the NP coordinated care with nursing who also reported concerns with increasing lower extremity edema. The NP notes included, "Provider coordinated care with rehabilitation services, who will start compression therapy and edema management moving forward." R244's Physician Orders Report dated 6/16/21, indicated R244 was to wear tensoshape (elastic bandage) to bilateral lower extremity daily for edema reduction. On in the morning and off at hour of sleep. During observation on 6/14/21, at 8:29 a.m. R244 was observed in bed. Several nursing staff assisted R244 to sit upright. R244's feet were dangling on the floor and bilateral lower extremity edema was noted. R244 was not wearing ace	F 684	and has since discharged from the facility. 2.All residents were observed for lower extremity edema and presence of compression garments if indicated. Residents receiving compression garment therapy received care plan reviews to ensure appropriate interventions and treatments were documented appropriately. 3.All nursing and therapy staff will receive education on observation for edema, following physician orders, and associated care plan interventions by July 23, 2021. 4.The Director of Nursing and/or designee will complete audits to ensure appropriate documentation of compression garments twice weekly for one month, then once weekly for two months. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18	F 684		

wraps, Tubigrips or knee-high ted stockings.

During observation on 6/15/21, at 8:19 a.m. R244 was noted sitting up in her wheelchair with a tray table in front of her. R244 was dressed and had noted bilateral lower extremity edema. R244 was not wearing ace wraps, Tubigrips, or knee-high ted stockings.

During observation on 6/16/21, at 8:29 a.m. R244 was noted sitting up in a wheelchair in her room. R244 was reading a book and her feet were noted resting partially on the floor. R244 was not wearing ace wraps, Tubigrips, or knee-high ted stockings.

During interview on 6/16/21, at 11:15 a.m., nursing assistant (NA)-G stated she had worked with R244 previously and was unsure if R244 had edema or whether she was to wear ace wraps to her bilateral lower extremities.

During interview on 6/16/21, at 11:27 a.m. NA-H stated nursing assistants were not responsible to do anything in particular for R244's bilateral feet. NA-H was unaware R244 had bilateral lower extremity edema and stated the nursing assistant care sheets lacked direction to apply ace wraps, teds or Tubigrips for R244.

During interview on 6/16/21, at 12:49 p.m. licensed practical nurse (LPN)-C stated she did not recall seeing orders for ace wraps, knee high ted hose or Tubigrip for R244. LPN-C stated R244 was getting massage treatments by therapy to her legs however, was unaware of edema concerns for R244. LPN-C stated she was unaware R244 had to wear ace wraps, knee high ted hose, or Tubigrip.

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19 During interview on 6/16/21, at 1:12 p.m. registered nurse (RN)-C stated occupational therapy was responsible to fit residents for appropriate sizing of ted hose, or Tubigrips. RN-C was unsure if R244 had edema or required ace wraps, ted hose, or Tubigrips. During a follow up interview on 6/17/21, at 9:53 a.m. RN-C stated R244 first was admitted with mild edema. RN-C stated she thought R244's edema had gotten worse as R244 sat up and her legs dangled downwards. RN-C stated R244 had non-pitting edema identified after an assessment on 6/17/21. During interview on 6/17/21, at 10:07 a.m. certified occupational therapist assistant (COTA)-H confirmed R244 was admitted with orders for ace wraps, but stated therapy had not been made aware of the order. COTA-H stated therapy completed an evaluation on 6/3/21, and noted a mild/near normal edema and had recommended to keep an eye on it. COTA-H stated the facility learned R244 was to wear ace wraps on 6/16/21. COTA-H stated therapy noticed R244's edema had increased and mentioned it to a nurse practitioner and an order was received on 6/15/21, for therapy to evaluate and treat edema. COTA-H stated R244 was measured for compression stockings on 6/16/21. During interview on 6/17/21, at 2:46 p.m. the director of nursing (DON) stated it was the expectation that nursing staff follow provider orders. The DON stated the nurses had access to ace wraps from facility supplies and they were expected to have placed R244's ace wraps on per the provider's orders and would not have had	F 684		

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20 to wait for therapy to measure for ted hose. Skin assessments and nursing progress notes from 6/2 to 6/14/21, were reviewed. Further, documentation of nursing assessments and monitoring of R244's bilateral lower extremity edema were requested, but were not provided. Policies regarding nursing care, skin assessment, edema monitoring and treatment, were requested but were not provided by the facility.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop smoking interventions to ensure safety for 1 of 1 resident (R5) who was observed to smoke at the facility. Findings include: R5's Admission Record dated 2/27/21, indicated diagnosis which included nicotine dependence. R5's quarterly Minimum Data Set (MDS) assessment dated 6/3/21, indicated R5 had a Brief Interview for Mental Status (BIMS) score of	F 689	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 R5, resident discharged	7/23/21

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21 13 which indicated intact cognition. The MDS also indicated R5 was independent with locomotion. A psychology note dated 5/4/21, indicated a clinician was made aware R5 had been caught smoking over the prior weekend. The psychology note further indicated R5 was "not willing" to give up smoking at this time. A progress note dated 5/4/21, at 8:30 a.m. indicated the writer was informed R5 went to the facility garden area to smoke over the weekend. The writer approached R5 and asked if he smoked; R5 replied "yes I was." R5 was reminded the facility was smoke free. R5 expressed other residents smoked and it was explained one other resident was "grandfathered in." R5 responded, "I don't think that's right that you let one person smoke but then nobody else can. I guess I will just have to leave the premises to smoke then." R5 was again remained the facility was smoke free to which R5 responded, "I don't care, I am going to smoke." The nurse manager and leadership team were updated. A progress note dated 5/10/21, at 11:22 p.m. indicated a nursing assistant caught R5 outside smoking. R5 was reminded he was unable to smoke at the facility. A warning letter dated 5/14/21, indicated R5 was reminded the facility was smoke free. Review of R5's medical record lacked indication a safety assessment was completed related to R5 smoking. During an interview on 6/14/21, at 3:06 p.m. R5 stated he was made aware the facility was a	F 689	to the community on June 19, 2021. 2.All new admissions will be notified of the facility's no smoking policy that has been updated to include interventions to promote safety for other residents. Interventions include offering smoking cessation products in coordination with providers, assisting with relocation to an appropriate setting for those who choose to continue to smoke, and/or a smoking assessment to ensure safety in the interim. 3.All staff will receive education on interventions to address a resident who chooses to smoke on facility premises by July 23, 2021. 4.The Executive Director and/or designee will audit facility staff for knowledge of interventions to put in place if a resident smokes twice weekly for one month, then once weekly for two months. The data collected will be presented to and discussed with the QA committee monthly. At that time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

non-smoking campus after he signed admission documents. R5 stated he would sneak out to the facility backyard twice weekly to smoke.

During observation on 6/16/21, from 8:29 a.m. to 8:54 a.m. R5 went out an exit door to the facility backyard and smoked. R5 disposed of his cigarette in a receptacle outside.

During interview on 6/16/21, at 8:40 a.m. registered nurse (RN)-A stated she had not seen R5 smoking, but was previously aware R5 had smoked at the facility.

During interview 6/16/21, at 8:48 a.m. trained medication assistant (TMA)- A stated she had not seen R5 smoke, but was aware that he had previously been caught smoking at the facility.

During interview on 6/16/21, at 8:52 a.m. nursing assistant (NA)-A stated he had not seen R5 smoking, but had seen R5 with a cigarette lighter once. NA-A stated he'd reported that incident to the nurse. NA-A said he had also heard staff had previously caught R5 smoking at the facility.

During observation on 6/16/21, 9:02 a.m. R5 went outside and removed a cigarette and lighter from a his pants pocket. R5 was observed to begin smoking. At 9:06 a.m., NA-A confirmed R5 was smoking and stated she would report the incident to the nurse.

During observation on 6/16/21, at 9:10 a.m. social worker (SW)-A and SW-B went outside where R5 was smoking and asked how he had obtained the cigarettes. R5 did not disclose about how he had obtained the cigarettes and lighter.

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23	F 689		

During interview on 6/16/21, at 9:39 a.m. the assistant director of nursing (ADON) stated management was aware R5 would sneak outside to smoke at the facility. The ADON stated R5 was reported to the interdisciplinary team (IDT) for smoking at the facility and R5 was reminded of the facility smoking policy and the consequences. The ADON confirmed a smoking assessment was not completed for R5 and stated, "We don't do smoking assessments because we are smoke free facility."

During interview on 6/16/21, at 2:08 p.m. SW-A stated the facility did not conduct a smoking assessment for R5 as the campus was smoke free. SW-A stated R5 was given a warning letter regarding smoking, and he had promised not to smoke again.

A progress note dated 6/16/21, at 4:44 p.m. indicated a safety evaluation was completed by the physical therapist (PT)-A to determine if R5 was safe to leave property independently. It was determined R5 had poor safety skills and was at high risk for injury. R5 was encouraged to wait until he was able to go home to smoke.

During interview on 6/17/21, at 10:33 a.m. the administrator stated management had reminded R5 a couple of times the facility was non-smoking. The administrator confirmed R5 was served a warning letter when he was caught smoking. The administrator stated the warning letter served as a risk assessment for R5, and if R5 chose to smoke he had the option to smoke off the facility's property. The administrator confirmed R5 did not have a smoking assessment completed as the facility was a non-smoking campus. The administrator stated

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 24 R5 had a planned discharge from the facility on 6/19/21, and R5's physician was updated. The facility's Resident Smoking Agreement undated, indicated the community was a smoke-free facility, and smoking was not allowed anywhere inside/outside the community (facility).	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		7/23/21

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 25 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain and administer medications as prescribed, for 1 of 1 resident (R415) who was reviewed for admission. Findings include: R415's diagnoses included hypertension (high blood pressure), fracture of right femoral neck, and hyperlipidemia (high level of fats or lipids in the blood) obtained from the Hospital Discharge Summary dated 6/13/21. During interview on 6/14/21, at 1:07 p.m. R415 stated she was admitted to the facility from the hospital around 3:00 p.m. on 6/13/21, for a fracture. R415 further stated there was concerns related to prescription medications being available which included pain medications and other prescriptions. Review of R415's Hospital Discharge Summary dated 6/13/21, indicated R415 had orders for Clonidine Hydrochloride (used to treat high blood pressure) 0.3 milligrams (mg) by mouth at bedtime and Clonidine Hydrochloride 0.15 mg by mouth daily. Review of R415's progress notes dated 6/13/21, through 6/17/21, revealed the following: - 6/13/21, at 10:24 p.m.: Clonidine HCl Tablet 0.3 mg give 1 tablet by mouth at bedtime for hypertension (HTN) not here from pharmacy. - 6/14/21, at 1:19 p.m.: Clonidine HCl Tablet give	F 755	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 R415, the orders were clarified and processed and medications were administered per orders. R415 had no adverse effects of the error and has since discharged from the facility. 2.All new admissions or hospital returns will receive a timely chart review to ensure medications are ordered and administered. The physician will be notified if unable to administer medications. 3.All licensed staff will receive education on following physician's orders for medication administration and addressing clarifications with providers promptly by July 23, 2021. 4.The Director of Nursing and/or designee will complete new medication administration audits on 4 residents weekly for three months to ensure all residents receive their medications as	

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 26 0.15 mg by mouth one time a day for HTN unavailable. - 6/15/21, at 8:03 a.m.: Clonidine HCl Tablet give 0.15 mg by mouth one time a day related to hypertension not available. R415's June 2021 medication administration record (MAR) revealed R415 was not administered Clonidine Hydrochloride 0.3 mg at 8:00 p.m. on 6/13/21, and 6/14/21. Further, R415 was not administered Clonidine Hydrochloride 0.15 mg on 6/14/21, and 6/15/21. During an interview on 6/16/21, at 11:45 a.m. registered nurse (RN)-C stated, "When a new patient comes the pharmacy has four to six hours to deliver the medications and they are also supposed to let us know via fax when not able to fill the medication." RN-C reviewed R415's medical record and verified there was no documentation a physician was notified Clonidine Hydrochloride was not available for R415. RN-C stated nurses were supposed to let the physician know. During an interview on 6/16/21, at 2:21 p.m. licensed practical nurse (LPN)-B stated R415's medications arrived at the facility late on 6/13/21 however, Clonidine Hydrochloride was not delivered. LPN-B stated the pharmacy had not dispensed the Clonidine Hydrochloride because they were waiting for clarification due to two different doses. LPN-B stated she did not administer the 8:00 p.m. dose on 6/13/21, and confirmed she did not call the physician to inform of the missing medication. During an interview on 6/17/21, at 12:21 p.m. the director of nursing (DON) stated she was just	F 755	ordered. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/recommendation regarding any necessary follow-up studies.	

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 27 made aware Clonidine was not available for R415 and nurses were not giving the medication. The DON stated that her expectation was if nurses were unable to administer medications as ordered, due to being unavailable from the pharmacy, staff were supposed to contact the provider. The DON further stated, "We would have this addressed timely." During interview on 6/17/21, at 1:06 p.m. the primary nurse practitioner (NP)-A stated she was at the facility on 6/14/21, and clarified the Clonidine Hydrochloride order because R415 had two orders. She stated the doses remained the same, but one was in the morning and the other at bedtime. NP-A stated she would have expected the nurses to call the on-call provider and let them know they were not able to give the medication as ordered. NP-A reviewed the on-call log and stated she did not see any calls made by the facility nurses for the resident. NP-A further stated she would have expected the medication to be available from the pharmacy on 6/14/21, after she had clarified the orders that morning. On 6/17/21, at 3:30 p.m. the policy for pharmacy and medication availability was requested but was not provided.	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		7/23/21

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 28 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 29 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure eye protection was worn during care for 1 of 1 residents (R45) reviewed for transfers to prevent and/or minimize the transmission of COVID-19. Findings include: R45's annual Minimum Data Set (MDS) dated 5/20/21, indicated R45 had diagnoses which included Alzheimer's disease with unspecified behavioral disturbance. R45 required two persons physical assistance with transfers. During observation on 6/17/21, at 8:49 a.m. nursing assistant (NA)-A transferred R45 to bed with an assistance of (NA)-B using mechanical transfer lift. NA-A's face shield was raised over his forehead and was not covering his eyes.	F 880	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.R45 has since discharged from the facility. The employee has received reeducation. 2.QAPI committee completed a root cause analysis on July 13, 2020 regarding area of concern. Committee also reviewed	

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 _____	C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 30 NA-A was within six feet for R45 for approximately six minutes during the transfer. During observation on 6/16/21, at 9:26 a.m. NA-A was observed wearing his face shield over his forehead while in the first floor hallway. Multiple unidentified residents were noted walking through the hallway at this time. During interview on 6/17/21, at 9:07 a.m. NA-A confirmed his face shield was not covering his eyes during care of R45. NA-A stated due to the high temperature, he placed the face shield on the top of his head so he could catch his breath. NA-A stated he forgot to place the face shield back on to cover his eyes. During interview on 6/17/21, at 9:53 a.m. the director of nursing (DON) stated staff had education on how to properly wear eye protection during the care the residents. The DON stated this was important to maintain infection control. A Practice Guideline and Procedure: PPE Selection and Use policy revised 6/14/21, directed position face shield over face and secure on brow with headband and a face shield provides splatter protection to skin, eyes, nose, and mouth.	F 880	the facility□s infection control program including standard and transmission based precautions, source control eye protection and masks, and donning and doffing of PPE. 3.All staff will receive education on the facility□s infection control program including standard and transmission based precautions, source control masks and eye protection and donning and doffing of PPE. Competencies with return demonstration of PPE donning and doffing will be completed by all staff. All education and competencies will be completed by July 23, 2021. 4.Director of Nursing and/or designee will complete four times weekly donning/doffing PPE including the use of gowns and eye protection with transmission-based precautions audits for one week, then twice weekly times one week or once 100% compliance is reached. The Director of Nursing and/or designee will complete real time audits on all aerosolized generating procedures to ensure appropriate PPE is in use. 5.The Director of Nursing and Infection Preventionist will review the results of the audits and monitoring with the facility□s QAPI program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/15/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/15/2021. At the time of this survey, Birchwood Health Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Birchwood Health Care Center is a 2-story building with a 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 facility has a capacity of 100 beds and had a census of 72 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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