DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	ZS/O
Fac	ility ID: 00168

							•
MEDICARE/MEDICAID PROVID	DER	3. NAME AND AD	DDRESS OF FAC	CILITY		4. TYPE OF ACT	ION: 7 (L8)
NO.(L1) 24E166		(L3) BIRCHWOO				1. Initial	2. Recertification
2. STATE VENDOR OR MEDICAID	NO.	(L4) 715 WEST 3		1	G 0 FF400	3. Termination	4. CHOW
(L2) 458995500		(L5) MINNEAPO	DLIS, MN		(L6) 55408	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEG	GORY	<u>10</u> (L7)	8. Full Survey Af	ter Complaint
(L9) 01/01/2004		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	o. Puli bul vey Al	ter Complaint
	2/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENI	DING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		09/30	(12)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	' IS CERTIFIED	AS:			
From (a):		x A. In Complia	nce With		And/Or Approved Waivers Of	The Following Require	ments:
To (b):		Program Re	•		2. Technical Personne	6. Scope of	Services Limit
		_	e Based On:		3. 24 Hour RN	7. Medical I	
12.Total Facility Beds	60 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SI	<u> </u>	
13.Total Certified Beds	60 (L17)	B. Not in Compl	liance with Progr	am	5. Life Safety Code	9. Beds/Roo	m
		Requirements	and/or Applied V	Waivers:	* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
	60						
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION 1	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
		0	4/05/2016				
Gloria Derfus, Unit Sup	ervisor		4/05/2016	(L19)	Kamala Fiske-Downing	g, Enforcement Sp	ecialist 05/04/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBII	LITY	20. COM	IPLIANCE WITH	H CIVIL	21. 1. Statement of Fina		
1. Facility is Eligible to I	Participate	RIGH	HTS ACT:		 Ownership/Contr Both of the Abov 	rol Interest Disclosure Stra	nt (HCFA-1513)
2. Facility is not Eligible	_				J. Bour of the rice.		
	(L21)						
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	[:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 0	<u>0</u> <u>INVOLU</u>	UNTARY
03/31/1974					01-Merger, Closure	05-Fail t	o Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail t	o Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminati	on <u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Prov	ider Status Change
(L27)			(L44)			00-Activ	ve
(L21)	B. Rescind Su	ispension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 24E166

April 12, 2016

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

Dear Mr. Hagemeyer:

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

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

Effective March 14, 2016 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Kumala Fiske Downing

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 5, 2016

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

RE: Project Number SE166025

Dear Mr. Hagemeyer:

On March 4, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 24, 2016 This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 4, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 24, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 14, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 24, 2016, effective March 14, 2016 and therefore remedies outlined in our letter to you dated March 4, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REV	/ISIT
	B. Wing		Y2	3/22/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
BIRCHWOOD CARE HOME		715 WEST 31ST STREET			
		MINNEAPOLIS, MN 55408			

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix F0157 Reg. # 483.10(b)(1)	Correction	ID Prefix Reg. #	F0279 483.20(d), 483.20(k)(1)	Correction Completed	ID Prefix Reg. #	F0309 483.25		Correction Completed
LSC	0	3/14/2016	LSC		03/14/2016	LSC			03/14/2016
ID Prefix F0371 483.35(i)		Correction	ID Prefix	F0425 483.60(a),(b)	Correction	ID Prefix	F0465 483.70(h)		Correction
Reg. #		3/14/2016	Reg. # LSC		O3/14/2016	Reg. # LSC			Ompleted 03/14/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	C	Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix	(Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	C	Completed	Reg. # LSC		Completed	Reg. # LSC			Completed
REVIEWED BY STATE AGENCY	REVIEWEI (INITIALS) GD/kfd		DATE 04/05/201	SIGNATURE OF	SURVEYOR 18623		I	DATE 03/22/	2016
REVIEWED BY CMS RO	REVIEWEI (INITIALS)		DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 2/24/2016		ED ON		CK FOR ANY UNCORREC				YES	S 🗆 NO

	POST-C	CERTIFIC	CATION I	REVISIT F	REPORT		
PROVIDER / SUPPLIER IDENTIFICATION NUMB 24E166	BER A. Building 01	ISTRUCTION - MAIN BUILDIN	NG 01				DATE OF REVISIT
NAME OF FACILITY BIRCHWOOD CARE			71	REET ADDRESS, C 5 WEST 31ST STRE NNEAPOLIS, MN 55	EET	12	74/2010 Y3
program, to show those corrected and the date	ed by a qualified State some deficiencies previously a such corrective action with the identification prefix on the identification prefix of the identification p	reported on the was accomplish	e CMS-2567, S ned. Each defic	statement of Defici iency should be fu	encies and Plar Illy identified usi	n of Correction of City of the	n, that have been regulation or LSC
ITEM	DATE	ITEM		DATE	ITEM		DATE
Y4	Y5	Y4		Y5	Y4		Y5
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC K0050	03/09/2016	LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC		<u> </u>	LSC		·
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE	OF SURVEYOR			ATE
DEVIEWED BY	TL/kfd	4/5/2016	TITI E	37009			4/4/2016

FOLLOWUP TO SURVEY COMPLETED ON

(INITIALS)

CMS RO

2/25/2016

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZS7O PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00168 3. NAME AND ADDRESS OF FACILITY 1. MEDICARE/MEDICAID PROVIDER 4. TYPE OF ACTION: 2(L8) (L3) BIRCHWOOD CARE HOME 24E166 NO.(L1) 2. Recertification 1. Initial (L4) 715 WEST 31ST STREET 4. CHOW 3. Termination 2. STATE VENDOR OR MEDICAID NO. (L5) MINNEAPOLIS, MN (L6) 55408 5. Validation 6. Complaint 458995500 (L2) 9. Other 7. On-Site Visit 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 10 (L7) 8. Full Survey After Complaint 13 PTIP 01 Hospital 05 HHA 09 ESRD 22 CLIA (L9) 01/01/2004 02 SNF/NF/Dual 06 PRTE 10 NE 6. DATE OF SURVEY 02/24/2016 (L34) 14 CORF (1.35)FISCAL YEAR ENDING DATE: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 8. ACCREDITATION STATUS: __ (L10) 09/30 12 RHC 16 HOSPICE 0 Unaccredited 1 TIC 04 SNR 08 OPT/SP 2 AOA 3 Other 10.THE FACILITY IS CERTIFIED AS: 11. LTC PERIOD OF CERTIFICATION From A. In Compliance With And/Or Approved Waivers Of The Following Requirements: (a): ____ 2. Technical Personnel __ 6. Scope of Services Limit (b): Program Requirements Compliance Based On: ___ 3. 24 Hour RN ___ 7. Medical Director ___1. Acceptable POC 4. 7-Day RN (Rural SNF) 8. Patient Room Size 12. Total Facility Beds 60 (L18) ___ 5. Life Safety Code __ 9. Beds/Room 60 (L17) 13. Total Certified Beds X B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)* Code: B* 15. FACILITY MEETS 14. LTC CERTIFIED BED BREAKDOWN IID (L15)ICE 1861 (e) (1) or 1861 (j) (1): 18 SNF 18/19 SNF 19 SNF 60 (L42)(L43)(L37)(L38)(L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date: 03/23/2016 Kamala Fiske-Downing, Enforcement Specialist 04/14/2016 Amy Charais, HFE NE II (L19) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: 1. Facility is Eligible to Participate 3. Both of the Above : 2. Facility is not Eligible (L21) 22, ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30)00 ENDING DATE **VOLUNTARY** INVOLUNTARY OF PARTICIPATION BEGINNING DATE 03/31/1974 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (L41)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS **OTHER** 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (LA4) (L27)B. Rescind Suspension Date: (L45)30. REMARKS

(L31)

(L33)

DETERMINATION APPROVAL

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

4-14-2016

(L28)

(L32)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	25/0
Faci	ility ID: 00168

		10 22 00::11	3515557		ESCHVETHOLICE		Tueling IB. 00100
MEDICARE/MEDICAID PROVID	ER	3. NAME AND AL				4. TYPE OF ACTION	ON: <u>2</u> (L8)
NO.(L1) 24E166		(L4) 715 WEST 3				1. Initial	2. Recertification
2. STATE VENDOR OR MEDICAID (L2) 458995500	NO.	(L5) MINNEAPO		L	(L6) 55408	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEO	GORY	<u>10</u> (L7)	7. On-Site Visit	9. Other
(L9) 01/01/2004		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey Afte	er Complaint
6. DATE OF SURVEY 02/2	24/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR END	ING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	' IS CERTIFIED	AS:			
From (a):		A. In Complia	ince With		And/Or Approved Waivers Of	The Following Requiren	nents:
To (b):		Program Re	equirements		2. Technical Personnel	6. Scope of S	ervices Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical D	irector
12 Tetal Feellite Dede	(0 (119)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Roo	om Size
12.Total Facility Beds	60 (L18)	V D V C	# 14 B		5. Life Safety Code	9. Beds/Roon	n
13.Total Certified Beds	60 (L17)	X B. Not in Con Requirements	and/or Applied of	~	* Code: B*	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN	•			15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
	60				•		
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Amy Charais, HFE NE	II		3/23/2016	(L19)	Kamala Fiske-Downing	, Enforcement Spe	ecialist 04/14/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBII	JITY		IPLIANCE WIT	H CIVIL	21. 1. Statement of Fina		
1. Facility is Eligible to l	Participate	RIGI	HTS ACT:		Ownership/Control Both of the Above	ol Interest Disclosure Stm	t (HCFA-1513)
2. Facility is not Eligible	_				5. Bom of me ricon		
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOLU</u>	NTARY
03/31/1974					01-Merger, Closure	05-Fail to	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provid	ler Status Change
(1.25)			(L44)			00-Active	2
(L27)	B. Rescind St	spension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	
-							



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered March 4, 2016

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

RE: Project Number SE166025

Dear Mr. Hagemeyer:

On February 24, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

Birchwood Care Home March 4, 2016 Page 2

attached deficiencies.

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us

Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 4, 2016, the Department of Health will impose the following remedy:

State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 4, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its

effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the

Birchwood Care Home March 4, 2016 Page 4

level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 24, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 24, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

Birchwood Care Home March 4, 2016 Page 5

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

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

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

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

> Tom Linhoff, Fire Safety Supervisor **Health Care Fire Inspections** State Fire Marshal Division

Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		LE CONSTRUCTION		E SURVEY IPLETED
		24E166	B. WING			02/	24/2016
	PROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408	•	
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	INITIAL COMMENT EPOC: federal: The facility's plan or as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electron be used as verificated Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. 483.10(b)(11) NOT (INJURY/DECLINE) A facility must immed consult with the resist known, notify the resonant transfer or an interested fan accident involving the injury and has the printervention; a significant physical, mental, or deterioration in head status in either life to clinical complication significantly (i.e., a existing form of treat consequences, or to treatment); or a decrease in the significant of the consequences, or to treatment); or a decrease in the significant of the consequences, or to the significant of the significant	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an our facility may be conducted to antial compliance with the en attained in accordance with		000	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
L ABOBATOR'	The facility must als and, if known, the re	so promptly notify the resident esident's legal representative	NATURE		TITLE		(X6) DATE

Electronically Signed 03/14/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE COMF	TE SURVEY MPLETED	
		24E166	B. WING		02/2	24/2016	
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F 157	change in room or specified in §483.1 resident rights underegulations as specithis section. The facility must rethe address and phegal representative. This REQUIREMED by: Based on observative review, the facility foctor (M.D.) of mestides of 59 residents (Fwhose medication reviewed for missed f	member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or sified in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member. NT is not met as evidenced tion, interview, and document ailed to notify the medical edications being unavailable for 88, R55, R14, R22, R38) administration records were dimedication doses. Inted on 2/24/16, indicated R8 aranoid schizophrenia, history of a suicide attempt carcinoma (cancer). administration observation on n. R8's Abilify (a medication for ophrenia) was unavailable. A medication Administration 2/24/16, did not indicate the ed medication when it arrived a Licensed practical nurse edication had not been ordered to order medication.	F 157	A new policy and procedure regard missing medications has been dev copy attached. Education has been initiated for all nursing staff. Remainder of Nursing will be trained on new Policy and Procedures for missing medication their direct charge nurses and at a mandatory Nursing Meeting on Ma 2016. A new "Missing medication tracking has been implemented to be compfor any missing medications, this for be completed by the TMA and Chanurse and will be monitored by the Director of Nursing and Resident Coordinator. Results of missing medications and outcomes will be discussed at the quarterly QAPI committee meeting for their input. Staff Development Coordinator will include auditing for missing medications medications medications medications and outcomes will be discussed at the quarterly QAPI committee meeting for their input.	g staff s by rch 17, g form" leted orm will rge		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 157	symptoms of depre hallucinations and cobservation period did not affect others. The Medication Regindicated R8 was to (mg) every day for processed of the second composition of the Medication Regindicated R8 was to (mg) every day for processed of the second composition of the Medication Regindicated R8 was to (mg) every day for processed of the second composition of the Medication in the symptoms and seeing the Interventions instruction of the symptoms of the Medication of the Medication in the PN dated 2 medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others to second composition of the Medication was not staff or others.	itively intact with minimal ssion, and experienced delusions during the and had daily behaviors that is. view Report printed 2/24/16, or receive Abilify 20 milligram paranoid schizophrenia. on 3/11/15, indicated, 1.) Delusions [persistent false the medical conditions (cancer) more that they removed was a and Hallucinations regarding pugs in the sheets." of care Area Assessment 15, indicated, "Resident has a losis of Schizophrenia and has a losis of Schizo	F 15	during her weekly audit of the ensure all medications have appropriately signed out. She watching for patterns or trend. The next 3 monthly Nursing which are held every third The each month will be dedicated discussing missing medication discussions will include root analysis of reasons for missi medications. Interventions at will be discussed in order to patterns and to assist in developractices for quickly resolving. Director of Nursing, Residem Coordinator and Staff Development Coordinator will be responsible ensuring compliance.	been e will also be ds. meetings aursday of d to ons. These cause ng nd outcomes identify eloping best g issues. t Care opment	

-	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ,	MPLETED	
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F 157	because she was n	ot here.	F 1	57			
	was observed lying	on 2/24/16, at 1:12 p.m. R55 on bed with covers over the at up was wearing sunglasses.					
	R55 had diagnoses	orinted on 2/24/16, indicated of major depressive disorder, dementia and glaucoma.					
	signed "9" for Celex treatment of depres check mark on 2/10 2/21/16, and 2/23/1	n is n.a." n is n.a."					
	moderately cognitiv	DS dated 1/27/16, was rely impaired with symptoms of a experienced delusions ion period.					
	"Resident reporte things, feeling tired concentrating 7 to 1 off dead 2 to 6 days assessment with cl intention or plan to feels like this when Resident stated that ever feels this way.						
	Psychotropic Drug	Use CAA dated 2/3/16,					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER OOD CARE HOME			STREET ADDRESS, CITY, STATE, ZIP COE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408			
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F 157	of care to maintain improvement as ind when necessary wistaff, and case marneeded with use of as directed with goain his current plan of the mood care plan during assessment symptoms of mild of feeling like he would risk assessment was have a plan or designative andividualized care addition, the Self Act (SAM) care plan initial resident unable to scognition and instructional medicated accility." "Nursing we per M.D. order." The hospital Dischalindicated R55's suid "Heightened-has id protective factors himminent risk." No had thoughts about psychiatric hospital. The Medication Resindicated R55 was day for depression.	continue to follow current plan current level of functioning for dicated and to minimize risks the re-direction and cueing from mager with assistance as M.D. ordered Psychotropics, als and interventions as stated of care." In dated 2/15/16, indicated on 1/27/16, R55 voiced depression and mentioned depression and mentioned depression and resident did not as done and resident did not re to hurt himself. Ided, "Staff would follow brease symptoms under plan areas as needed." In diministration of Medication tiated on 2/14/16, indicated SAM due to decreased acted staff, "Nursing will ations when resident is in ill medicate and do treatments arge Summary dated 1/21/16, cide risk level impression was entified many risk factors but ave influence to keep from suicide attempts although R55 is suicide. R55 had four izations since 2013. View Report printed 2/24/16, to receive Celexa 10 mg every	F 15	57			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E166	B. WING			02/2	24/2016
	PROVIDER OR SUPPLIER OOD CARE HOME			STREET ADDRESS, CITY, STATE, ZIF 715 WEST 31ST STREET MINNEAPOLIS, MN 55408	, CODE		
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F 157	morning, talking abback and being treatin office. He stated knows when his apnot gotten any mail has not been change. Administration hospaddressed he was a Allowed him to vent VA and see if we coappointments and a change. He stated the feels much better, sand/or hurt himself. Supervisor, she stated to the seen changed to fate a copy of all the apphas scheduled. She happy, stating he whow he is not." The PN dated 2/23/to office upset about delivered. Stated two see if she can bring over again that she I really need that pill otherwise I don't know Assured him that if would go to the VA called back and the transport medicatio emergency, she was exception and will be comes to visit reside.	to MR [medical records] in the out leaving and not coming ated poorly. Talked to resident being upset that no one pointments are, stated he has and thinks that his address ged at the VA [Veterans pital]. Stated if this was not going to leave and kill himself. It feelings. Offered to call the	F 1	57			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 157	said, "My mood get medications. I get v bad." During interview on verified the Celexa 2/16/16. LPN-A stated elivered yesterday a.m. by his VA case MAR was not accur (the medications with the M.D. on day two medications. I am rethey do not tell mesknow." During interview on social worker said I he had a complaint aggressive. R55 has statement of killing the complaint it immediates the complaint it immediates the complaint it immediates as the potential that do without the Celexa statements. R14 was observed on edge of bed. A few hands but R14 was spilling. R14's Face Sheet processing the completic independent of the potential that describes and neuroleptic independent.	2/24/16, at 1:12 p.m. R55 s bad when I do not have my very anxious. Yesterday was 2/24/16, at 1:44 p.m. LPN-A was not available from at least ted, "The medications were vat about 10:00 a.m. or 11:00 e manager." LPN-A verified the rate. LPN-A stated "If I knew I ere not available) I would call	F 15	7		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E166	B. WING			02/:	24/2016
	PROVIDER OR SUPPLIER OOD CARE HOME			7	TREET ADDRESS, CITY, STATE, ZIP CODE 15 WEST 31ST STREET MINNEAPOLIS, MN 55408		
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F 157	"9" instead of a chemanage the sympto 10/100 mg At 8:00 a.m. 1/15/doses), - At 2:00 p.m. 1/12 1/25, 1/28 through 2/10 through 2/17, doses) - At 8:00 p.m. 1/25, doses) - At 8:00 p.m. 1/25, doses) The totaled missed possible doses. Review of PN from indicated 20 progreunavailable. PN daindicated, "Call placorder and requiring pharmacy that resic prescribing M.D. to Updated medical reappointment with [rrecords." Birchwood 1/27/16, indicated Fprimary care physician about the for Sinemet or that doses of Sinemet services and exceptions during the required supervisions during the required supervisions.	ge 7 c MAR indicated, staff signed ock mark for Sinemet (used to oms of Parkinson's disease) 16 and 1/16/16 (2 of 54 1/15 through 1/19, 1/21, 1/23, 1/30, 2/1, 2/2, 2/5, 2/6, 2/8, and 2/20 through 23 (29 of 54 1/27, 2/1, and 2/10 (4 of 54 medications was 35 of 162 11/24/15 through 2/24/15, as notes that medication was ted 1/26/16, at 2:37 p.m. bed to pharmacy re: Sinemet a new script. Updated by VA dent needs to be seen by get this med reordered. Becords and resident has an ame of M.D.], per medical decay and cay and appointment with stan for a physical. No ovided to primary care a need for a new prescription R14 had missed at least 15 ince the first of January. S dated 11/20/15, indicated ct with symptoms of mild perienced hallucinations and a observation period. R14 n with dressing, toileting and a walker for ambulation. No	F 1	57			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
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F 157	received antidepresincreasing fall risk awas seen at the VA at which time the VA gait likely related to Sinemet and a coureduce fall risks. Cainstructed staff to "maintain current levere-direction and cueneeded with fall satinterventions as stated "Resident will have dyskinesia is a neuinvoluntary repetitive symptoms or EPSE are movement disomedications]." Internadminister medicatemonitor for signs of doctor of changes in The PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in The PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in The PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in The PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in The PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in The PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in The PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in The PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in The PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in The PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in The PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in The PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in the PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in the PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in the PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in the PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in the PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in the PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in the PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in the PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in the PN dated 1/26 pharmacy re: Sinemonitor for signs of doctor of changes in the	and 2/23/15, indicated R14 assant and antipsychotic daily and had a history of falls. R14 and hospital after a fall on 11/2/14, A stated R14 had Parkinson and added are of physical therapy to are plan considerations and of care to are plan of care to are plan of care to are plan revised astaff assistance as atted in current plan of care." arug use care plan revised astaff that goal was for ano increase in TD [tardive arological disorder resulting in are body movements] and [extrapyramidal side effects arders caused by aventions included nursing to a ions per doctor 's orders, a TD or EPSE, and notify an behavior. A16, indicated, "Call placed to anet order and requiring a new aventions included records and another with [name of M.D.]	F 15	7		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 157	said, "I am not sure nurses give me my more questions." During interview or reviewed the MAR Sinemet from at least We are waiting on going to reorder. R Sinemet and we do R14's Parkinson's medications from to nurse (RN)-A) order VA." LPN-A verified that the doctor was least 40 doses of SLPN-A verified that LPN-A stated (R14 1/27/16, and the regimen." LPN-A vinformation regarding interview or said, "On 1/26/16 I trying to get [medicate he will not write it." but they are unable RN-A said the risks Parkinson's symptoms."	a 2/24/16, at 1:15 p.m. R14 e what my Sinemet is for. The meds. Please do not ask me a 2/24/16, at 1:44 p.m. LPN-A and verified R14 was out of ast February 10th until now. The doctor to decide if he is 14 is completely out of an onot borrow medications. It is not really bad. He gets his he VA hospital. (registered ers all medications from the dithere was no documentation in notified R14 had missed at sinemet in progress notes. The MAR was not accurate. It is said, "continue current erified there was no ing Sinemet written on the said doctor] to write a script but we are working on neurology at o get a hold of the doctor." Sof missing Sinemet was the oms could increase.	F1	,		
	R22 had diagnoses acute pain and cor					
	Review of electron	ic MAR indicated, staff signed				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
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F 157	"9" instead of a che gabapentin. R22's quarterly MD cognitively intact wi depression. R22 redressing and hygier ambulation. No pair disorder noted on the Falls CAA dated 7/3 diagnosis of seizure Medication Review indicated R22 was at bedtime for convenional to the form of the Falls CAA dated 7/3 diagnosis of seizure Medication Review indicated R22 was at bedtime for convenional to the form of the f	S dated 1/15/16, was th symptoms of mild quired supervision with ne and used a walker for nor falls recorded. Seizure ne quarterly MDS. 81/15, indicated resident had e disorder. Report printed 2/24/16, to receive gabapentin 600 mg ulsions.	F1	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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-	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 715 WEST 31ST STREET MINNEAPOLIS, MN 55408		/21/2010
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F 157	on 2/24/16, at 1:20 respiratory issues at R38's face sheet properties and schizophrenia. Review of electroni "9" instead of a cheantibiotic) 750 mg f Budesonide (a stertreatment of respira 2/7, 2/8, 2/10, 2/11, R38's quarterly MD R38 was cognitively delusions during the required supervision hygiene. No shortout Dietary CAA dated at increased risk for food and diagnosis PN dated 2/6/16, "New 2/8/16, Not ava 2/12/16, "not avail [Discharge Summan R38 had been admission pneumonia with incompression properties of two days at three puffs twice data."	sitting on couch in day room p.m. R38 did not display any at that time. rinted on 2/24/16, indicated of dysphagia (swallowing s, major depressive disorder, c MAR indicated, staff signed eck mark for Levofloxacin (and for pneumonia on 2/6/16, and oid medication used for the atory problems) inhaler on 2/6, and 2/12/16. S dated 1/22/16, indicated y intact and experienced e observation period. R38 in with dressing, eating and ess of breath noted. 10/28/15, indicated R38 was r choking related to pocketing of dysphasia. Med (medication) not in." ilable. sic - available]" ry dated 2/5/16, indicated that itted for community acquired creased risk for aspiration to medications. Discharge sh levofloxacin 750 mg every and use Budersonide inhaler	F 19	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		24E166	B. WING _		02/	24/2016
	PROVIDER OR SUPPLIER OOD CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	don't know if I got a job." During interview on reviewed the MAR a was not available of was charted as not doses. LPN-A said progress note shou time a "9" was listed code in. LPN-A stat readmission was to the pharmacy know required. If the pharmedication LPN-A succept doctor and obtain of medication was available as a completing a course that the resident minum During interview on assistant director of was no evidence the any of the residents medications. ADON would let the doctor missing medication TMA is expected to is unavailable. The pharmacy and if ne The nurse is also to medication is not available in the pharmacy and if ne The nurse is also to medication is not available.	onia. I guess I got my meds. I II my meds, that the nurse's 2/24/16, at 1:44 p.m. LPN-A and verified the levofloxacin of 2/6/16, and Budersonide available for eight of 14 "9" means other and a lid have been written each did by the TMA who put the edithe procedure for a get the orders early and let of what new medications were macy was unable to deliver a stated they would call the riders to complete dose when allable or to make the changes LPN-A said the risk of not e of antibiotics and inhaler was ght relapse. 2/24/16, at 2:28 p.m. the finurses (ADON) verified there at the doctor was notified for a that they missed their I said, "I expect the nurses throw about a resident and obtain new orders. The tell the nurse if a medication nurse is to check with the cessary order the medication. In update the doctor if the vailable."	F 1!	57		
F 279	483.20(d), 483.20(k	•	F 2	79		3/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		24E166	B. WING _		02/	24/2016	
	PROVIDER OR SUPPLIER OOD CARE HOME	,		STREET ADDRESS, CITY, STATE, ZIP COI 715 WEST 31ST STREET MINNEAPOLIS, MN 55408			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AR DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 279 SS=D	to develop, review comprehensive plate The facility must deplan for each reside objectives and time medical, nursing, an eeds that are identification assessment. The care plan must to be furnished to a highest practicable psychosocial well-by §483.25; and any side to the resident	the results of the assessment and revise the resident's n of care. Evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial attified in the comprehensive It describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided is exercise of rights under the right to refuse treatment	F 2'	79			
	by: Based on observa review, the facility f comprehensive can 1 resident (R64) wh facility. Findings include: R64's admission M 2/8/16, indicated sh moderately depres that interfered with	NT is not met as evidenced tion, interview and document railed to ensure a re plan was developed for 1 of no was newly admitted to the linimum Data Set (MDS) dated ne was cognitively intact, sed, and displayed behaviors her social interactions and put jury. A Care Area Assessment		A comprehensive care plan wimmediately completed for this A new auditing/ tracking system implemented to be sure the Tocare plan is always completed admission. All charge nurses have been on importance of always com Temporary care plan upon addirector of Nursing, Resident	s resident. em has been emporary d upon re educated pleting the mission.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		24E166	B. WING			02/	24/2016	
	PROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE 15 WEST 31ST STREET INNEAPOLIS, MN 55408	, , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 279	(CAA) dated 2/12/1 rated ten of ten but as needed pain me assessment period follow the care plan CAA further identified decline in functional wellbeing and behaviors are to improve fund A review of Birchword Notes dated 2/1/16 admitted to the faci included leukemia and Notes indicated R6 complaints of pain taking narcotic pain taking narcotic pain taking narcotic pain taking narcotic pain to direct staff in interventions for pain the CAA identified in During an observat R64 was lying in being an observed closed. A few minutions decided in the edge of her bedomining an interview was again observed R64 was not ob	6, indicated R64 reported pain did not receive scheduled or dication during the . The CAA directed staff to a to maximize comfort. The ed R64 had potential for a all status, psychosocial evioral status. In each identified sted staff to develop a plan of actioning and minimize risks. Food Care Home Progress to 2/24/16, indicated R64 lity with diagnoses that and lung cancer. The Progress 4 had a poor appetite, rated 10/10, was resistive to a medication and displayed by "loud and angry yelling." rd lacked evidence of a care regarding non pharmacological in, behavioral management ety interventions even though risk in these areas. Sion on 2/22/16, at 1:30 p.m., ad, alert and able to respond to yor. Jon on 2/23/16 at 1:18 p.m., lying in bed with her eyes tes later, R64 was sitting up on a digging through a bag.	F 2	279	Coordinator and Staff Development Coordinator will be responsible to ecompliance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E166	B. WING _		02/	24/2016
	PROVIDER OR SUPPLIER OOD CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	stated she had bee beginning of the moliving independently was admitted to the During an interview assistant director of was responsible for care plan. She state should be started in and a comprehensi completed within 7 The ADON stated the paper form found in the state of the s	on 2/22/16, at 1:30 p.m., R64 in in the facility since the onth. She stated she had been of for the last five years and a facility due to her Leukemia. on 2/23/16, at 2:25 p.m., the finursing (ADON) stated she the development of R64's and a temporary care plan inmediately upon admission, we care plan should be days of the assessment date. The temporary care plan was a the resident's paper record.	F 27	9		
F 309 SS=D	licensed practical n chart and stated, th chart was "left bland not get started yet." A facility policy titled Care Planning, date comprehensive car each resident within the comprehensive 483.25 PROVIDE CHIGHEST WELL B	d Bircwood [sic] Care Home, ed 5/2/07, indicated "A e plan will be developed for n 7 days after completion of resident assessment."	F 30	9		3/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24E166	B. WING		02/2	4/2016
	PROVIDER OR SUPPLIER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 15 WEST 31ST STREET IINNEAPOLIS, MN 55408	1 02/2	14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 16	F 309			
	by: Based on observat review, the facility for care with the hospic (R64) who was reconstruction Findings include: R64's admission M 2/8/16, indicated sh required assistance behaviors. A Hospice IDG Conform Plan of Care Updat indicated R64 would nurse, home health social worker. The roles of the hospice problems, goals or assessment further each week for each which day's visits During an observat R64 was lying in be questions by survey During an observed closed. Hospice reconstruction visiting with R64.	indicated the number of visits discipline, but did not identify would take place. ion on 2/22/16, at 1:30 p.m., ed, alert and able to respond to yor. ion on 2/23/16 at 1:18 p.m., lying in bed with her eyes gistered nurse (HRN)-H was		A detailed Plan of Care report from Hospice is present in residents cha Skilled nursing services, goals and interventions, copy of this report at A calendar outlining each Hospice schedule of visits was immediately obtained and placed in resident characteristic control of the calendar is located. All nursing staff have been educated where this calendar is located. Hospice staff wears name badges each visit and always checks in with prior to visiting resident. Director of Nursing and Social Service Director are responsible to ensure compliance.	art with tached. staff art. ed to during h staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SUF COMPLET		
		24E166	B. WING _			02/24/201	6
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD CARE HOME				STREET ADDRESS, CITY, STATE, ZIP C 715 WEST 31ST STREET MINNEAPOLIS, MN 55408	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BI		ETION
F 309	Continued From pa	_	F 30	09			
	stated she had bee beginning of the mo living independently	on 2/22/16, at 1:30 p.m., R64 in the facility since the both. She stated she had been of for the last five years and a facility for hospice care due					
	HRN-H stated R64 after admission to thospice team has a R64. She stated the befaxed to the facing HHA assisted R64 care and lotion. She concern at this time history and stated she indicated R64 was with nausea as well	o on 2/23/16, at 1:30 p.m., admitted to hospice shortly he facility. She stated the a set schedule for visits with e schedule was supposed to lity. HRN-H stated the hospice with showers, shampoo, skin e stated R64's "biggest e was her mental health the displays "paranoia." HRN-as currently having a problem I. HRN-H stated she was e plan was in the chart or not ed.					
	During an interview on 2/24/16, at 11:57 a.m., trained medication aide (TMA)-C stated he did not know when hospice staff was coming to the facility. He further stated he did not know where to find the information.						
	licensed practical n not know ahead of was coming. LPN-A comes in once a we showers, but she di	on 2/24/16, at 11:59 a.m., urse (LPN)-A stated she did time when the hospice nurse A further stated a hospice aide eek to assist R64 with id not know when she comes. as no calendar that she was					
		on 2/24/16, at 1:41 p.m., the f nursing (ADON) stated the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED		
		24E166	B. WING		02/24/2016		
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD CARE HOME			7	TREET ADDRESS, CITY, STATE, ZIP CODE 15 WEST 31ST STREET IINNEAPOLIS, MN 55408			
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F 309	coming and when the not sure if there was hospice care team record following viswas responsible for hospice team.	d tell staff when she was ne aide was coming, but was is a schedule. She stated the documented in the medical its. The ADON stated nursing coordinating care with the	F 309		0/44/40		
F 3/1 SS=F	The facility must - (1) Procure food fro considered satisfac authorities; and	m sources approved or tory by Federal, State or local distribute and serve food	F 371		3/14/16		
	by: Based on observat review, the facility fa sanitary conditions direct contact with f clean dishes. This h 59 residents in the of the kitchen. Findings include:	ion, interview, and document ailed to ensure clean and for kitchen equipment that had ood preparation surfaces and had the potential to affect all facility and visitors who ate out other tour on 2/22/16, at 11:44		Air conditioning unit was cleaned immediately. A new policy and proced was developed along with a checklist Dish room Air conditioning unit to be cleaned on a bi-weekly basis, see attached copy of Policy/Procedure ar checklist for cleaning.	for		
	a.m. with the facility (DNS) the following observed	's director of nutrition services sanitation concerns were					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		24E166	B. WING _		02	/24/2016		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 715 WEST 31ST STREET MINNEAPOLIS, MN 55408	-			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 371	((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 37					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	E SURVEY MPLETED
		24E166	B. WING		02/	/24/2016
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD CARE HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408	·	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 425 SS=E	2/21/16, but forgot in Review of undated policies: - "Sanitation of dieta directed staff to ma condition. Indicated be posted for all cleafter completion of cleaning checklists and the RD will more monthly "Cleaning Ovens" be cleaned according once every 2 weeks - "Clean Stove Top' range will be kept or range will be cleaned up as the Cleaning policy for conditioning unit was provided. 483.60(a),(b) PHAFACCURATE PROCURATE PROCUR	eaned the week of 2/15/16 to to clean the wall mounted fan. Birchwood Care Home ary department", the policy intain the kitchen in a sanitary that a cleaning schedule will eaning tasks and staff will initial tasks, the DNS will monitor weekly to ensure completion nitor kitchen sanitation the policy indicated ovens willing to the schedule at least and as needed. the policy indicated that the lean during meal preparation, ed after each use and spills will ney occur. Wall mounted fan and air as requested but none RMACEUTICAL SVC - EDURES, RPH Ovide routine and emergency als to its residents, or obtain element described in eart. The facility may permit need to administer drugs if State by under the general	F 3			3/14/16
		de pharmaceutical services es that assure the accurate , dispensing, and				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
		24E166	B. WING _		02/	24/2016
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD CARE HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408	, ,	
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F 425	The facility must en a licensed pharmac on all aspects of the services in the facil	drugs and biologicals) to meet resident. Inploy or obtain the services of cist who provides consultation e provision of pharmacy ity.	F 42	25		
	by: Based on observareview the facility fasufficient medication R22, R38) resident medications. Findings include: R8's Face Sheet prhad diagnoses of pedelusional disorder and squamous cell During medication 2/23/16, at 7:38 a.m. the treatment schiz review of electronic Record (MAR) on 2 resident had receive from the pharmacy (LPN)-A verified meand was observed R8's annual Minimu 11/27/15, was cognitive to the facility of the pharmacy (LPN) was cognitive to the facility of the pharmacy (LPN)-A verified meand was observed R8's annual Minimum 11/27/15, was cognitive to the facility of t	tion, interview and document ailed to ensure that they had ans for 5 of 5 (R8, R55, R14, s who were reviewed for the strain of t		A new policy and procedure regmissing medications has been of copy attached. Education has been initiated for nursing staff. Remainder of Nurwill be trained on new Policy and Procedures for missing medicat their direct charge nurses and a mandatory Nursing Meeting on 2016. A new "Missing medication track has been implemented to be cofor any missing medications, this be completed by the TMA and Conurse and will be monitored by the Director of Nursing and Resider Coordinator. Results of missing medications and outcomes will discussed at the quarterly QAPI committee meeting for their input Staff Development Coordinator include auditing for missing medication her weekly audit of the E	all sing staff d ions by t a March 17, sing form" mpleted s form will charge he at Care be ut.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		24E166	B. WING		02/2	4/2016
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD CARE HOME			7	STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 425	observation period did not affect others. The Medication Reindicated R8 was to (mg) every day for Care plan revised of "Resident displays: belief] about curren believes that the turplastic. 2.) Paranois germs and seeing la Interventions instruanti-psychotic medication Symptom (CAA) dated 12/10/long standing diagreceived treatments symptoms. With the interventions that a places no risk to other conditions of the PN dated 2 "medication is n.a. medication was not staff or others to see During interview on reviewed the MAR on 2/23/16, but was	delusions during the and had daily behaviors that so. view Report printed 2/24/16, or receive Abilify 20 milligram paranoid schizophrenia. on 3/11/15, indicated, 1.) Delusions [persistent false to medical conditions (cancer) mor that they removed was a and Hallucinations regarding bugs in the sheets." of cted staff, "Nursing will give cation as ordered by Doctor." so Care Area Assessment (15, indicated, "Resident has a posis of Schizophrenia and has so over the years to treat his emedications, treatments and the recurrently in place resident thers." ip.m. trained medication aide to had charted "9" on the MAR progress Note (PN) was written to be had charted "9" on the MAR progress Note (PN) was written to be available. A "9" instructed the PN. 2/24/16, at 1:44 p.m. LPN-A and verified the Abilify arrived to not given when it arrived. The why it was not given	F 425	ensure all medications have been appropriately signed out. The next 3 monthly Nursing meeting which are held every third Thursday each month will be dedicated to discussing missing medications. It discussions will include root cause analysis of reasons for missing medications. Interventions and out will be discussed in order to identify patterns and to assist in developing practices for quickly resolving issue. Director of Nursing, Resident Care Coordinator and Staff Development Coordinator will be responsible for ensuring compliance.	tcomes fy g best es.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E166	B. WING			02/2	24/2016	
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD CARE HOME				STREET ADDRESS, CITY, STATE, ZIP CO 715 WEST 31ST STREET MINNEAPOLIS, MN 55408	DE.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE	
F 425	was observed lying head. When R55 starts Face Sheet properties and diagnoses delusional disorder. Review of current esigned "9" for Celeptreatment of deprescheck mark on 2/10/2/21/16, and 2/23/12/10/16, no PN regize 2/16/16, "medication 2/21/16, "medication 2/23/16, "medication 2/2	on 2/24/16, at 1:12 p.m. R55 on bed with covers over the at up was wearing sunglasses. Orinted on 2/24/16, indicated of major depressive disorder, dementia and glaucoma. Alectronic MAR indicated, staff (a (a medication for the sision) 10 mg instead of a 0/16, 2/16/16, 2/19/16, 6. Review of PN indicated: arding oral medications, is n.a." In is n.a. and trouble days. Stated feeling better off inpleted suicide risk ient: resident that he has no hurt himself. He stated that he everything start to get bad. It he will reach out to staff if he in the stated of the control of the	F 4	.25				
	indicated, "staff will	Use CAA dated 2/3/16, continue to follow current plan current level of functioning for						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED			
		24E166	B. WING _		02	/24/2016
	PROVIDER OR SUPPLIER OOD CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CC 715 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 425	when necessary wi staff, and case man needed with use of Psychotropics, as of interventions as statement."	ge 24 dicated and to minimize risks th re-direction and cueing from nager with assistance as M.D. [medical doctor] ordered directed with goals and tted in his current plan of	F 42	5		
	assessment on 1/2 mild depression an would be better off was done and resid desire to hurt himse "Staff would follow symptoms under in as needed." In addit Medication (SAM) of indicated resident a decreased cognition will dispense all medication as medicated resident and the state of the st	area 2/15/16, Indicated during 7/16, R55 voiced symptoms of dimentioned feeling like he dead. Suicide risk assessment lent did not have a plan or elf. Interventions included, interventions to decrease dividualized care plan areas tion Self Administration of care plan initiated on 2/14/16, inable to SAM due to an and instructed staff, "Nursing edications when resident is in ill medicate and do treatments				
	indicated R55 's su was "Heightened-h but protective facto imminent risk." No had thoughts about	arge Summary dated 1/21/16, vicide risk level impression as identified many risk factors rs have influence to keep from suicide attempts although R55 suicide. R55 had four izations since 2013.				
	indicated R55 was every day for depre The PN dated 2/19 voiced being upset	view Report printed 2/24/16, to receive Celexa 10 mg. ssion. /16, indicated, "Resident to MR [medical records] in the out leaving and not coming				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		24E166	B. WING			02/24/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 715 WEST 31ST STREET MINNEAPOLIS, MN 55408)E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		
F 425	in office. He stated knows when his ap not gotten any mail has not been change. Administration host addressed he was allowed him to vent VA and see if we compointments and a change. He stated feels much better, sand/or hurt himself. Supervisor, she stated to the seen changed to far a copy of all the apply has scheduled. She happy, stating he won whe is not." The PN dated 2/23 to office upset about delivered. Stated the see if she can bring over again that she I really need that pill otherwise I don't known assured him that if would go to the VA called back and the transport medication emergency, she was exception and will be comes to visit resid Notified resident, shelp." During interview on	ated poorly. Talked to resident being upset that no one pointments are, stated he has and thinks that his address ged at the VA [Veterans bital]. Stated if this was not going to leave and kill himself.	F4	25			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			TE SURVEY MPLETED			
		24E166	B. WING _		02	/24/2016
	PROVIDER OR SUPPLIER OOD CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CO 715 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 425	bad." During interview on verified the Celexa 2/16/16. LPN-A stardelivered yesterday a.m. by his VA case MAR was not accur (the medications with e MD on day two I am responsible fo tell me that they are During interview on social worker said I he had a complaint aggressive. R55 has tatement of killing the complaint it immithe potential that definition of the complaint it immithe potential that definition in the potential that definition of the complaint it immithe potential that definition in the potential that definition of the complaint it immithe potential that definition in the complaint it immitted the complaint it immitted the complaint it immitted the complaint it immitted the complaint in the	ery anxious. Yesterday was 2/24/16, at 1:44 p.m. LPN-A was not available from at least ted, "The medications were at about 10:00 a.m. or 11:00 manager." LPN-A verified the rate. LPN-A stated "If I knew I ere not available) I would call of not getting the medications. The TMA, but if they do not e out, how would I know." 2/24/16, at 2:28 p.m. the R55 was irritable yesterday. If R55 could become ad a history of making himself but if you take care of mediately clears. There was epression would worsen and R55 would act on his	F 42	25		
	1:15 p.m. A fine tre R14 was able to ho R14's face sheet pi	edge of bed on 2/24/16, at mor observed in hands but ld water cup without spilling.				
	and neuroleptic ind abnormalities of ga falling.	s of major depressive disorder, uced Parkinsonism, it and mobility and history of				
	"9" instead of a che Sinemet (a medica	c MAR indicated, staff signed eck mark for tion used to control tremors) m. 1/15/16, 1/16/16 (2 of 54				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E166	B. WING _		02	/24/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408	, 0=	21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 425	through 1/19, 1/21, 2/1, 2/2, 2/5, 2/6, 2 through 23 (29 of 5 8:00 p.m. 1/25, 1/2 a total (35 of 162 p) Review of PN from indicated 20 progreunavailable. PN daindicated, "Call placorder and requiring pharmacy that resipprescribing MD to gupdated medical reappointment with [irrecords." The Birch dated 1/27/16, indiwith primary care pinformation was prophysician about the for Sinemet or that doses of Sinemet states and example of the sinemet of the sine	D-100 mg. 2:00 p.m. 1/12, 1/15 1/23, 1/25, 1/28 through 1/30, /8, 2/10 through 2/17, 2/20 64 doses); Sinemet 10-100 mg. 7, 2/1, 2/10 (4 of 54 doses) for	F 42	5		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E166	B. WING		02	/24/2016
_	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 715 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 425	Care plan consider "follow current pla level of functioning staff assistance as goals and intervent of care." Psychotropic drug unistructed staff that have no increase in neurological disorder repetitive body move [extrapyramidal side disorders caused boundled, nursing to doctors' orders, mound notify doctor of the placed to pharmacy requiring a new scruthat resident needs M.D. to get this me records and resider [name of M.D.], per Medication Review indicated R14 was three times a day for Parkinsonism. During interview on said, "I am not sure nurses give me my more questions."	ations instructed staff to an of care to maintain current with re-direction and cueing, needed with fall safety, with ions as stated in current plan use care plan revised 2/28/08, goal was for "Resident will a TD [Tardive dyskinesia is a er resulting in involuntary rements.] Symptoms or EPSE e effects are movement y medications]." Interventions administer medications per onitor for signs of TD or EPSE, changes in behavior. 2d 1/26/16, indicated, "Call or re: Sinemet order and ipt. Updated by VA pharmacy to be seen by prescribing d reordered. Updated medical int has an appointment with	F4	25		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E166	B. WING _		02	/24/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 715 WEST 31ST STREET MINNEAPOLIS, MN 55408	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 425	going to reorder. R Sinemet and we do R14's Parkinson's medications from t nurse (RN)-A) orde VA." LPN-A verified that the doctor was least 40 doses of S LPN-A verified that LPN-A stated (R14 1/27/16, and the re regimen". LPN-A v information regardi referral form During interview or said, "On 1/26/16 I trying to get (medic he will not write it. V but they are unable RN-A said the risks Parkinson's sympte R22's face sheet p R22 had diagnoses acute pain and cor Review of electron "9" instead of a che gabapentin.	a the doctor to decide if he is 14 is completely out of o not borrow medications. It is not really bad. He gets his he VA hospital. (Registered ers all medications from the dithere was no documentation is notified R14 had missed at Sinemet in progress notes. It the MAR was not accurate. It is many MD at the VA on it is said, "Continue current erified there was no ing Sinemet written on the control of the VA. We are said doctor) to write a script but we are working on neurology et to get a hold of the doctor." It is of missing Sinemet was the orms could increase. Trinted on 2/24/16, indicated is of major depressive disorder, invulsions. The MAR indicated, staff signed eck mark on 2/15/16, for	F 42	25		
	cognitively intact w depression. R22 re dressing, and hygic	OS dated 1/15/16, was ith symptoms of mild equired supervision with ene and used a walker for in or falls recorded. Seizure the quarterly MDS.				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED				
		24E166	B. WING			02/2	24/2016
	PROVIDER OR SUPPLIER OOD CARE HOME			71	TREET ADDRESS, CITY, STATE, ZIP CODE IS WEST 31ST STREET IINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	Medication Review indicated R22 was that bedtime for conviction Review of PNs from indicate any seizure. During an interview said, "I do not alway but I am ok. The number of the progress of	Report printed 2/24/16, to receive Gabapentin 600 mg ulsions.	F 4	425	DEFICIENCY)		
	respiratory issues a R38's face sheet pr R38 had diagnoses						

AND BLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		24E166	B. WING _		02	/24/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 715 WEST 31ST STREET MINNEAPOLIS, MN 55408		,_ ,,_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 425	Review of electroni "9" instead of a che antibiotic) 750 mg f Budesonide (a stei treatment of respira 2/7, 2/8, 2/10, 2/11, R38's quarterly MD R38 was cognitively delusions during the required supervision hygiene. No shorton Dietary CAA dated at increased risk for food and diagnosis PN dated 2/6/16 "N PN 2/8/16 Not avail 2/12/16 "not avail [s Discharge Summan that resident had be acquired pneumoni aspiration pneumon Discharge orders in mg every days for the inhaler three puffs to During interview on said, "I had pneumod don't know if I got a job." During interview on reviewed the MAR not available on 2/6 charted as not avail	c MAR indicated, staff signed eck mark for Levofloxacin (an or pneumonia on 2/6/16, and roid medication used for the atory problems) inhaler 2/6, and 2/12. S dated 1/22/16, indicated y intact and experienced e observation period. R38 in with dressing, eating and ess of breath noted. 10/28/15, indicated R38 was r chocking related to pocketing of dysphasia. Ited (medication) not in."		5			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E166	B. WING			02/:	24/2016
_	PROVIDER OR SUPPLIER OOD CARE HOME			7	STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			BE	(X5) COMPLETION DATE
F 425	listed by the TMA wereified LPN-A state readmission was to the pharmacy know required. If the pharmedication LPN-A state doctor and obtain of medication was avaithe doctor wanted. Completing a course that the resident mind During interview on said, "Based on all who are charting '9' happening and ensithe residents. I was holes not missed mind During interview on assistant director of R55's Celexa arriver pharmacy sent the window instead of r R55 was irritable year correct diagnosis for disorder and missing seizures. ADON verified for any of the their medications. A would let the doctor missing medication TMA is expected to	written each time a "9" was the put the code in. LPN-A ed the procedure for a get the orders early and let what new medications were macy was unable to deliver a stated they would call the rders to complete dose when allable or to make the changes LPN-A said the risk of not e of antibiotics and inhaler was ght relapse. 2/24/16 at 2:28 p.m. RN-A of this I need to question staff on the MAR what is ure we have medications for just auditing the MARs for	F 4	125			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E166	B. WING		02/	24/2016
	PROVIDER OR SUPPLIER OOD CARE HOME		7	STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	pharmacy and if ne The nurse is also to medication is not av medication sheets to Facility policy Medic Veteran's Administr staff: "It is the policy order all physician of residents associate Administration in a they are available for	cessary order the medication. o update the doctor if the vailable. I expect the to be accurate." cation Ordering from the ation dated 5/2/07, instructed y of Birchwood Care Home to ordered medications for d with the Minnesota Veterans timely manner to ensure that or them as ordered."	F 425			
F 465 SS=F	Pharmacy dated 5/2 "1. Each Nurse/TM. responsible for pulli counter medication medication that is n has less than a five left." "3. If a medication i the next morning, th beside the label "NI 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro	ring Medications From 2/07, instructed staff: A med pass person will be ing the label of and over the cream or lotion, or injectable of on automatic renewal that day supply of the medication is needed for the same day or ne Nurse/TMA should write EED TODAY PLEASE." AL/SANITARY/COMFORTABL	F 465			3/14/16
	residents, staff and This REQUIREMEN by: Based on observat	ortable environment for the public. NT is not met as evidenced ion, interview, and document ailed to ensure a sanitary and		The cracked tile by the entrance to dishwashing area has been replace		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24E166	B. WING		02/2	24/2016
	PROVIDER OR SUPPLIER OOD CARE HOME		7	STREET ADDRESS, CITY, STATE, ZIP CODE 115 WEST 31ST STREET MINNEAPOLIS, MN 55408	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	clean environment potential to affect a and visitors who at Findings include: During kitchen tour the facility's directo and registered diet environmental converified by both the - A cracked tile, mis door frame on the area. DNS stated the surveyor pointed it - The entire kitcher dining room wall by with heavy spillage - The kitchen wall a compartment sink of food and dust build - Around the entire refrigerator along the broken plate, heavy grime and food deby and around all legs buildup of black/brounderneath the me was buildup of black/brounderneath the was heavily splatte - The knife storage	in the kitchen. This had the II 59 residents in the facility e out of the facility kitchen. on 2/24/16, at 9:23 a.m. with r of nutritional services (DNS) itian (RD) the following cerns were identified and DNS and RD. ssing half tile to the left of the entrance to the dishwashing nat noticed it today after out to him. In wall, the kitchen door and the rether the serving counter noted and splatter of food. Secross from the three was heavily splattered with lup. In perimeter of the kitchen ne walls there was pieces of y buildup of dust, black/brown	F 465	The kitchen door, the wall behind to door, and the wall across from the compartment sink has been clean. The floor and wall by the kitchen refrigerator and the knife rack have cleaned. The metal storage area under the and coffee dispensers, the cabinet and counter top and the wall unde serving counter in the dining room been cleaned. The metal serving counter, drawer shelves have been cleaned. The Dietary Manager will be respot for monitoring the kitchen and dinic cleaning schedules to ensure daily weekly and monthly cleaning is completed. The Consultant Dieticibe responsible for monitoring kitch dining room sanitation monthly. Aube done weekly to monitor complia Audits will be reviewed at the quar QAPI meeting.	an will len and idits will ance.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E166	B. WING		02	/24/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 715 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 465	preparation area hablack/brown grime pots. The DNS veri inside of the two poneeded to be throw - Inside the cabinet storage of pans and serving counter was food, food debris as During an interview stated staff are expand monthly, and stask was completed to provide daily clean and monthly cleanis. Review of undated policies: - "Sanitation of diet directed staff to macondition. Indicated be posted for all cleafter completion of cleaning checklists and the RD will momonthly "Cleaning Cabinet indicated cabinets a food particles and twice a month "Cleaning Walls", walls will be free of should be cleaned of the standard transport of the should be cleaned of the standard transport of the should be cleaned of the standard transport of th	tets in the metal food and two pots that had buildup on the inside of the fied the buildup and stated the sits was not cleanable and in away. It is of a metal cabinet used for discring utensils by the sign noted with heavy splatter of and dust buildup. Ton 2/24/16, at 9:23 a.m. DNS ected to clean daily, weekly ign the cleaning log that the discrete that a sign of the same possible aning logs. DNS stated weekly	F 4	65		

FE166025

PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 24E166 B. WING 02/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET **BIRCHWOOD CARE HOME** MINNEAPOLIS, MN 55408 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 25, 2016. At the time of this survey, Birchwood Care Home was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR. Subpart 483.70(a). Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES TO:** Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/14/2016

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.

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	IPLE CONSTRUCTION IG 01 - Main Building 01	6 01 (X3) DA		
		24E166	B. WING		02	/25/2016
	PROVIDER OR SUPPLIER	3.	STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	DEFICIENCY MUSE FOLLOWING INF 1. A description of to correct the defice 2. The actual, or push and a responsible for corprevent a reoccurrent and a requirement and a requir	state.mn.us an@state.mn.us DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. proposed, completion date. prection and monitoring to rence of the deficiency. Iome is a 3-story building with a The building was constructed at The original 3 story building was 66 and was determined to be of ruction. In 2000, a 1 story tructed to the East that was por Type II(222) construction. In all building and the 1 addition the perior of construction, the facility one building. Ily fire sprinklered. The facility one building. Ily fire sprinklered. The facility one building. Ily fire sprinklered. The facility one building. Ily fire sprinklered detection in spaces open to the corridors or automatic fire department acility has a capacity of 65 beds of 59 at the time of the survey. Int 42 CFR, Subpart 483.70(a) is enced by:				
K 050 SS=D	NFPA 101 LIFE SA	AFETY CODE STANDARD the transmission of a fire alarm ion of emergency fire	K 05	50		3/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		24E166	B. WING		02/	25/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
K 050	times under varying on each shift. The sand is aware that droutine. Responsible conducting drills is persons who are quality where drills are consisted of audible at 18.7.1.2, 19.7.1.2. This STANDARD is Based on docume interview, the facility documentation that all staff under varying required by 2000 N. This deficient practice and 1040; the third 0200, 0137, 0225, varied in accordance in accordance of the safety Code (N. This deficient practice.)	Is are held at unexpected g conditions, at least quarterly staff is familiar with procedures rills are part of established lility for planning and assigned only to competent ualified to exercise leadership. Inducted between 9:00 PM and Innouncement may be used alarms. Is not met as evidenced by: Intation review and staff y could not provide if fire drills were conducted for ing times and conditions as FPA 101, Section 19.7.1.2. ice could affect all 59 Interview of the fire drill ealed that the first shift e drills at 1138, 1229, 0948, shift conducted their drills at and 0130. These times are not be with the 2000 edition of the	KO	All future fire drills will be at lea hours difference per shift per fire ensure this does not happen a look @ the fire drill log and atte conduct fire drills three hours of possible. Pete Stinar, Director of Mainte be responsible to assure compeffective 3/9/16.	re drill. To gain we will empt to ifferent if nance will		



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered March 4, 2016

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

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SE166025

Dear Mr. Hagemeyer:

The above facility survey was completed on February 24, 2016 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.

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

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

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

When all orders are corrected, the order form should be acknowledged electronically and submitted to this office at Minnesota Department of Health.

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

Birchwood Care Home March 4, 2016 Page 2

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

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

Feel free to contact me with any questions related to this letter.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Kumalu Fiske Downing

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 04/14/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00168	B. WING		02/2	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BIRCHW	OOD CARE HOME		T 31ST STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
3 000 INITIAL COMMENTS		3 000				
	****ATTENTIC)N*****				
	BOARDING CAF LICENSING CORR					
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	INITIAL COMMENT Citation Text for Tag	S: g 0000, Regulation D0OQ				
		participate in the electronic nsure orders consistent with artment of Health				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/14/16 **Electronically Signed**

STATE FORM 6899 ZS7011 If continuation sheet 1 of 21

TITLE

(X6) DATE

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Minnesota Department of Health

winnesc	ita Department of He	aim	1			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00168	B. WING		02/24/2016	
NAME OF I		OTDEET AD		OTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BIRCHW	BIRCHWOOD CARE HOME 715 WES					
			OLIS, MN 5	5408		
(X4) ID		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
3 000	Continued From pa	ge 1	3 000			
0 000	•					
		in 14-01, available at				
		tate.mn.us/divs/fpc/profinfo/inf				
		e licensing orders are				
	delineated on the a					
		Ith orders being submitted to Although no plan of correction				
		ate Statutes/Rules, please				
		rected" in the box available for				
		indicate in the electronic				
		cess, under the heading				
		e date your orders will be				
	corrected prior to e	lectronically submitting to the				
	Minnesota Departm					
		rveyors of this Department's				
		ove provider and the following				
		re issued. Please indicate in				
		of correction that you have				
	they will be comple	ers, and identify the date when				
		nent of Health is documenting				
		Correction Orders using				
		ag numbers have been				
		ota state statutes/rules for				
		e assigned tag number				
	appears in the far le	eft column entitled "ID Prefix				
		tute/rule out of compliance is				
		ary Statement of Deficiencies"				
		es the "To Comply" portion of				
		This column also includes				
		are in violation of the state				
		tement, "This Rule is not met ollowing the surveyors findings				
		Method of Correction and				
	Time period for Cor					
		RD THE HEADING OF THE				
	FOURTH COLUMN					
		N OF CORRECTION." THIS				
		RAL DEFICIENCIES ONLY.				
	THIS WILL APPEA	R ON EACH PAGE.				

Minnesota Department of Health STATE FORM

THERE IS NO REQUIREMENT TO SUBMIT A

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU AND PLAN OF CORRECTION IDENTIFICATION			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00168	B. WING		02/2	24/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
BIRCHW	OOD CARE HOME		731ST STRE OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
3 000	Continued From page 2		3 000				
	PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.						
3 601	MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control		3 601			3/14/16	
	maintain a compreh control program acc tuberculosis infection issued by the United Control and Preven Division of Tuberculosis Elin CDC's Morbidity and Report (MMWR). The United Covers all paid and contractors, student volunteers. The Department of assistance regarding of The guidelines.	nination, as published in d Mortality Weekly his program must include a on control plan unpaid employees, ts, residents, and Health shall provide technical ag implementation					
	(b) Written compliant be maintained by the care home.	nce with this subdivision must ne boarding					
	by: Based on interview facility failed to ensu	and document review, the ure Mantoux testing was 5 residents (R6, R38, R64)		Corrected.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00168		B. WING		02/2	4/2016
	PROVIDER OR SUPPLIER	715 WEST	ORESS, CITY, S 31ST STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
3 601	admitted to the facility record lacked evide well as documentation skin test. A review of R38's madmitted to the facility record lacked evide a 2 step TB skin test. A review of R64's madmitted to the facility record lacked evide a 2 step TB skin test. A review of R64's madmitted to the facility record lacked evide a 2 step TB skin test. A review of E1's emdate of 2/16/16. The symptom screen or During an interview assistant director of should have a two-sadmission. A facility policy titled Mantoux Test Policy new residents and signature of the properties of th	edical record indicated she lity on 5/14/08. The Medical ence of a symptom screen, as ion of a 2 step TB (tuberculin) nedical record indicated he lity on 9/16/15. The medical ence of a symptom screen and st. nedical record indicated he lity on 2/1/16. The medical ence of a symptom screen and st. nedical record indicated he lity on 2/1/16. The medical ence of a symptom screen and st. neployee file indicated a hire ere was no indication of a a TB skin test. on 2/24/16, at 1:22 p.m. the finursing stated resident's step TB skin test upon d Birchwood Care Home of dated 5/2/07, indicated all staff receive an intradermal	3 601			
31105	(21) days. MN Rule 4655.7810	Distribution of Medications	31105			3/14/16

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00168	B. WING	·····	02/2	4/2016
NAME OF PROVI	DER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BIRCHWOOD	CARE HOME		31ST STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
A care districts shall by the residual shall sha	e home to assur- ributed safely ar ill be distributed a he physician. A dent reactions s sician at once a dent's personal MN Requirement ed on observative ew the facility fa icient medication c, R38) residents dications. dings include: s Face Sheet pri diagnoses of pa usional disorder, squamous cell ing medication a 3/16, at 7:38 a.m treatment schize ew of electronic cord (MAR) on 2 dent had receive n the pharmacy. N)-A verified me was observed t s annual Minimus 27/15, was cogni ptoms of depres ucinations and of	e developed in each boarding e that all medications are nd properly. All medications and taken exactly as ordered ny medication errors or hall be reported to the nd an explanation made in the	31105	Corrected		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00168	B. WING		02/24/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 02/2	4/2010
	OOD CARE HOME	715 WES	T 31ST STRE	ET		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
31105	Continued From pa	age 5	31105			
	did not affect others	S.				
	indicated R8 was to	view Report printed 2/24/16, o receive Abilify 20 milligram paranoid schizophrenia.				
	Care plan revised on 3/11/15, indicated, "Resident displays: 1.) Delusions [persistent false belief] about current medical conditions (cancer) believes that the tumor that they removed was plastic. 2.) Paranoia and Hallucinations regarding germs and seeing bugs in the sheets." Interventions instructed staff, "Nursing will give anti-psychotic medication as ordered by Doctor."					
	Behavior Symptoms Care Area Assessment (CAA) dated 12/10/15, indicated, "Resident has a long standing diagnosis of Schizophrenia and has received treatments over the years to treat his symptoms. With the medications, treatments and interventions that are currently in place resident places no risk to others."					
	(TMA)-A verified sh to indicate that a Pr and the PN dated 2 "medication is n.a.	'p.m. trained medication aide ne had charted "9" on the MAR rogress Note (PN) was written 2/23/16, at 7:41 a.m. [non-available]" meant the t available. A "9" instructed see the PN.				
	reviewed the MAR on 2/23/16, but was	a 2/24/16, at 1:44 p.m. LPN-A and verified the Abilify arrived so not given when it arrived. The why it was not given not here.				
		on 2/24/16, at 1:12 p.m. R55 on bed with covers over the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00168	B. WING		02/2	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 02/2	1/2010
BIRCHW	OOD CARE HOME		31ST STRE			
(VA) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES	OLIS, MN 5		ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
31105	Continued From page 6		31105			
	head. When R55 sa	at up was wearing sunglasses.				
	R55's Face Sheet printed on 2/24/16, indicated R55 had diagnoses of major depressive disorder, delusional disorder, dementia and glaucoma.					
	signed "9" for Celex treatment of depres check mark on 2/10 2/21/16, and 2/23/1	n is n.a." n is n.a."				
	moderately cognitiv	DS dated 1/27/16, was rely impaired with symptoms of a experienced delusions ion period.				
	"Resident reporte things, feeling tired concentrating 7-11 dead 2-6 days. Con assessment with cli intention or plan to feels like this when	ient: resident that he has no hurt himself. He stated that he everything start to get bad. It he will reach out to staff if he				
	indicated, "staff will of care to maintain improvement as inc when necessary wit staff, and case mar	Use CAA dated 2/3/16, continue to follow current plan current level of functioning for dicated and to minimize risks th re-direction and cueing from nager with assistance as M.D. [medical doctor] ordered				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00168	B. WING		02/2	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
BIRCHW	OOD CARE HOME		T 31ST STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31105	Continued From pa	ge 7	31105			
	Psychotropics, as directed with goals and interventions as stated in his current plan of care."					
	assessment on 1/2 mild depression and would be better off was done and resid desire to hurt himse "Staff would follow i symptoms under indicated." In addi Medication (SAM) of indicated resident undecreased cognition will dispense all me	ted 2/15/16, indicated during 7/16, R55 voiced symptoms of d mentioned feeling like he dead. Suicide risk assessment lent did not have a plan or elf. Interventions included, interventions to decrease dividualized care plan areas tion Self Administration of care plan initiated on 2/14/16, inable to SAM due to an and instructed staff, "Nursing dications when resident is in ill medicate and do treatments				
	indicated R55's su was "Heightened-ha but protective factor imminent risk." No s had thoughts about psychiatric hospitali The Medication Rev	arge Summary dated 1/21/16, nicide risk level impression as identified many risk factors are have influence to keep from suicide attempts although R55 suicide. R55 had four sizations since 2013.				
		to receive Celexa 10 mg.				
	voiced being upset morning, talking ab- back and being trea in office. He stated knows when his ap- not gotten any mail	116, indicated, "Resident to MR [medical records] in the out leaving and not coming ated poorly. Talked to resident being upset that no one pointments are, stated he has and thinks that his address ged at the VA [Veterans				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00168	B. WING		02/2	4/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
BIRCHW	BIRCHWOOD CARE HOME 715 WES						
			OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE	
31105	Continued From pa	ge 8	31105				
	Administration hospaddressed he was a Allowed him to vent VA and see if we coappointments and a change. He stated the feels much better, sand/or hurt himself. Supervisor, she stated to feels much better, sand/or hurt himself. Supervisor, she stated to feel a copy of all the apphas scheduled. She happy, stating he won whe is not." The PN dated 2/23/to office upset about delivered. Stated two see if she can bring over again that she I really need that pill otherwise I don't knowled and the transport medication emergency, she was exception and will be comes to visit resid Notified resident, shelp." During interview on said, "My mood get	oital]. Stated if this was not going to leave and kill himself.					
		2/24/16, at 1:44 p.m. LPN-A					

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2/16/16. LPN-A stated, "The medications were

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00168	B. WING		02/2	24/2016
	PROVIDER OR SUPPLIER	715 WEST	DRESS, CITY, S T 31ST STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
31105	delivered yesterday a.m. by his VA case MAR was not accur (the medications we the MD on day two I am responsible fo tell me that they are During interview on social worker said Fhe had a complaint aggressive. R55 ha statement of killing the complaint it imm the potential that dewithout the Celexa statements. R14 was sitting on 1:15 p.m. A fine tree	ge 9 That about 10:00 a.m. or 11:00 a manager." LPN-A verified the rate. LPN-A stated "If I knew I are not available) I would call of not getting the medications. The TMA, but if they do not a out, how would I know." 2/24/16, at 2:28 p.m. the R55 was irritable yesterday. If R55 could become a history of making himself but if you take care of nediately clears. There was a pression would worsen and R55 would act on his edge of bed on 2/24/16, at mor observed in hands but Id water cup without spilling.	31105			
	R14 had diagnoses and neuroleptic indiabnormalities of ga falling. Review of electronia "9" instead of a che Sinemet (a medicat 10-100 mg. 8 a.m. doses) Sinemet 10-100 mg. 1/19, 1/21, 1/23, 1/2 2/5, 2/6, 2/8, 2/10 th	it and mobility and history of c MAR indicated, staff signed ck mark for tion used to control tremors) 1/15/16, 1/16/16 (2 of 54 g. 2:00 p.m. 1/12, 1/15 through 25, 1/28 through 1/30, 2/1, 2/2, prough 2/17, 2/20 through 23				
	(29 of 54 doses); S	inemet 10-100 mg. 8:00 p.m. 0 (4 of 54 doses) for a total (35				

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			7t. Boilebiiva.			
		00168	B. WING		02/2	4/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BIRCHW	OOD CARE HOME		「31ST STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
31105	Continued From pa	ge 10	31105			
	Review of PN from indicated 20 progre unavailable. PN dat indicated, " call plac order and requiring pharmacy that resic prescribing MD to gupdated medical reappointment with D records." The Birch dated 1/27/16, indic with primary care plinformation was prophysician about the for Sinemet or that doses of Sinemet s. R14's quarterly MD was cognitively intained supervision, and exide depression, and exidelusions during the required supervision hygiene and used a falls recorded. Falls CAA dated 2/2 antidepressant and fall risk and had a hat the VA hospital a time the VA stated I related to medication course of physical to Care plan considers."follow current platevel of functioning staff assistance as	11/24/15 until 2/24/15, ss notes that medication was ted 1/26/16 at 2:37 p.m. Deed to pharmacy re: Sinemet a new script. Updated by VA dent needs to be seen by get this med reordered. Decords and resident has an and the script of the script				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00168	B. WING		02/2	4/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BIRCHW	OOD CARE HOME		T 31ST STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
31105	Continued From pa		31105			
	instructed staff that have no increase in neurological disorder repetitive body move [extrapyramidal side disorders caused be included Nursing to doctors orders, mand notify doctor of the placed to pharmacy requiring a new scretiat resident needs to get this med reor records and resider [medical doctor], per Medication Review indicated R14 was a side of the placed to pharmacy requiring a new scretiat resident needs to get this med reor records and resider [medical doctor], per Medication Review indicated R14 was a side of the placed to pharmacy requiring a new scretiation of the placed to pharmacy requiring a new scretiation of the placed to pharmacy requiring a new scretiation of the placed to pharmacy requirements of the pharmacy requirements of t	use care plan revised 2/28/08, goal was for "Resident will in TD [Tardive dyskinesia is a er resulting in involuntary vements.] Symptoms or EPSE e effects are movement by medications]." interventions administer medications per nonitor for signs of TD or EPSE changes in behavior. ed 1/26/16, indicated, "Call by re: Sinemet order and lipt. Updated by VA pharmacy is to be seen by prescribing MD redered. Updated medical in thas an appointment with the medical records." Report printed 2/24/16, to receive Sinemet 10-100 mg. or neuroleptic induced				
	said, "I am not sure	a 2/24/16 at 1:15 p.m. R14 what my Sinemet is for. The meds. Please do not ask me				
	reviewed the MAR Sinemet from at lease We are waiting on to going to reorder. Rosinemet and we do R14's Parkinson's medications from the nurse (RN)-A) orde	a 2/24/16, at 1:44 p.m. LPN-A and verified R14 was out of ast February 10th until now. " the doctor to decide if he is 14 is completely out of a not borrow medications. It is not really bad. He gets his ne VA hospital. (Registered ers all medications from the VA. ere was no documentation that				

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the doctor was notified R14 had missed at least

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	715 WES	DRESS, CITY, S T 31ST STRE OLIS, MN 5			
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31105	40 doses of Sinema verified that the MA stated (R14) saw point 1/27/16, and the reforegimen". LPN-A verified information regarding referral form During interview on said, "On 1/26/16 Itrying to get (mediche will not write it. Vout they are unable RN-A said the risks Parkinson's sympton R22's face sheet point R22 had diagnoses acute pain and continuing instead of a chegabapentin. R22's quarterly MD cognitively intact with depression. R22 redressing, and hygicambulation. No pair disorder noted on the Falls CAA dated 7/3 diagnosis of seizure Medication Review indicated R22 was at bedtime for convenience.	et in progress notes. LPN-A R was not accurate. LPN-A rimary MD at the VA on ferral said, "Continue current erified there was no ng Sinemet written on the 2/24/16 at 2:28 p.m. RN-A made a call to the VA. We are al doctor) to write a script but Ve are working on neurology to get a hold of the doctor." of missing Sinemet was the toms could increase. Finted on 2/24/16, indicated of major depressive disorder, vulsions. C MAR indicated, staff signed ock mark on 2/15/16, for S dated 1/15/16, was th symptoms of mild quired supervision with ene and used a walker for n or falls recorded. Seizure ne quarterly MDS. B1/15, indicated resident had a disorder. Report printed 2/24/16, to receive Gabapentin 600 mg	31105			

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			7.1. 20.22.1.0.1			
		00168	B. WING		02/2	4/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BIRCHW	OOD CARE HOME		T 31ST STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
31105	Continued From pa	ige 13	31105			
	indicate any seizure	e activity or falls.				
	said, "I do not alwa	y on 2/24/16, at 1:10 p.m. R22 ys get all of my medications urses give me my meds."				
	reviewed the MAR receive gabapentin available. LPN-A sa progress note shoutime a "9" was list code in. LPN-A said neuropathy not seizhad any episodes obeen here. "LPN-A for neuropathy ther increased pain. If it	and verified R22 did not on 2/15/16 because it was not aid "9" means other and a alld have been written each sted by the TMA who put the d gabapentin was for zures as listed. "We have not of a seizure since (R22) has A said if the gabapentin was in (R22) would be at risk for was for seizures there would 22) having a seizure.				
		sitting on couch in day room p.m. R38 did not display any at that time.				
	R38 had diagnoses	rinted on 2/24/16, indicated s of dysphagia (swallowing s, major depressive disorder,				
	"9" instead of a che antibiotic) 750 mg f Budesonide (a ste	c MAR indicated, staff signed eck mark for Levofloxacin (an for pneumonia on 2/6/16, and roid medication used for the atory problems) inhaler 2/6 2/7				
	R38 was cognitively	S dated 1/22/16, indicated y intact and experienced e observation period. R38				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION		E SURVEY PLETED
İ		00168	B. WING		02/	24/2016
	PROVIDER OR SUPPLIER	715 WES1	DRESS, CITY, S T 31ST STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
31105	required supervision hygiene. No shortner Dietary CAA dated at increased risk for food and diagnosis PN dated 2/6/16 "M PN 2/8/16 Not avail 2/12/16 "not avail [standard present that resident had be acquired pneumoniaspiration pneumor Discharge orders in mg every days for training interview on said, "I had pneumor don't know if I got a job." During interview on reviewed the MAR anot available on 2/6 charted as not avail LPN-A said "9" meas should have been where the pharmacy know required. If the pharmacy know required. If the pharmacy know required. If the pharmacy know required as available on 2/6 charted as not avail LPN-A state readmission was to the pharmacy know required. If the pharmacy know required as available on 2/6 charted as not avail LPN-A state readmission was to the pharmacy know required. If the pharmacy know required are doctor and obtain of medication was available of the pharmacy know required are doctor wanted.	n with dressing, eating and ess of breath noted. 10/28/15, indicated R38 was r chocking related to pocketing of dysphasia. led (medication) not in."	31105			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00168	B. WING		02/2	4/2016	
NAME OF PR	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BIRCHWO	OD CARE HOME		T 31ST STRE OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
31105 (Continued From pa	ge 15	31105				
t	hat the resident mi	ght relapse.					
Essister the second sec	During interview on said, "Based on all staff who are chartin appening and ensithe residents. I was noles not missed muring interview on assistant director of R55's Celexa arrive charmacy sent the elementary of the correct diagnosis for disorder and missing seizures. ADON verified for any of the heir medications. A would let the doctor missing medications are unavailable. The charmacy and if neon the nurse is also to medication is not as medication sheets the collection of the collection of the nurse is also to medication is not as medication sheets the collection of the nurse is also to medication is not as medication sheets the collection of the nurse is also to medication is not as medication sheets the collection of the physician of the nurse is also to medication is not as medication sheets the collection of the physician	2/24/16 at 2:28 p.m. RN-A I of this I need to question ng '9' on the MAR what is ure we have medications for just auditing the MARs for edications. " 2/24/16, at 2:28 p.m. the inurses (ADON) verified ded yesterday because the medications to the pharmacy nailing them out. ADON said esterday. ADON verified the or R22's gabapentin is seizure ng it would increase risk of rified R38 did not receive the cics. ADON said, "I am not ave it in our emergency kit, so om there." ADON verified have it he doctor was he residents that they missed had DON said I expect the nurses have how about a resident s and obtain new orders. The tell the nurse if a medication nurse is to check with the cessary order the medication. o update the doctor if the vailable. I expect the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
			A. BOILDING.	7. BOLLDING.			
		00168	B. WING		02/2	24/2016	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BIRCHW	OOD CARE HOME		T31ST STRE OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
31105	Continued From pa	ge 16	31105				
	Pharmacy dated 5/2 "1. Each Nurse/TM. responsible for pulli counter medication medication that is n has less than a five left." "3. If a medication i the next morning, th beside the label "NI	ring Medications From 2/07, instructed staff: A med pass person will be ing the label of and over the , cream or lotion, or injectable into a day supply of the medication as needed for the same day or ne Nurse/TMA should write EED TODAY PLEASE." R CORRECTION: Twenty-one					
31240	be maintained in the department at all tire	tary condition cedures and conditions shall e operation of the dietary	31240			3/14/16	
	by: Based on observati review, the facility facility facility facility facility for the facility facil	on, interview, and document ailed to ensure a sanitary and in the kitchen. This had the II 59 residents in the facility e out of the facility kitchen.		Corrected.			
	Findings Include:						
		chen tour on 2/22/16, at 11:44 y's director of nutrition services					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00168	B. WING		02/2	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BIRCHW	OOD CARE HOME		31ST STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
31240	(DNS) the following observed - A wall mounted fa area was turned on three racks contain drying. The fan was buildup. The DNS wand needed to be contained the following was of the following was of the stove. The six burner stove has back of the stove. The six burner stove has greasy substance of the knobs and side needed to be clean cleaning is completed to the food preparation with dust/dirt build the food preparation with dust/dirt build the was turned on and food preparation are conditioning unit needed staff are expand monthly, and situated staff are expand monthly, and situated staff are expand monthly cleaning the puring interview on the provide daily clean and monthly cleaning the puring interview on the provide daily clean and monthly cleaning the puring interview on the provide daily clean and monthly cleaning the provide on the provide daily clean and monthly cleaning the provide daily clean and monthly clean and mont	sanitation concerns were n directly above the clean dish and blowing directly towards ing clean dishes which were didity with heavy dust/dirt verified that the fan was dirty leaned. chen tour on 2/24/16, at 9:23 the registered dietitian (RD) beserved and a heavy buildup of a nace on the backsplash to the heavy oven doors below the did a buildup of a black/brown on and around the handle, on sof the door. DNS verified it ed and stated major oven ed monthly. In unit located above the clean and clean towels are kept, to urner stove and across from a rea was noted to be dirty up. The air conditioning unit blowing directly towards the ea. DNS verified that the air eded to be cleaned and stated a responsible for cleaning it. On 2/24/16, at 9:23 a.m. DNS ected to clean daily, weekly ign the cleaning log that the daining logs. DNS stated weekly	31240			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00168	B. WING		02/2	24/2016
	PROVIDER OR SUPPLIER	715 WES1	DRESS, CITY, S T 31ST STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
31240	dishwashing area of dust/dirt build up. Method the kitchen were cleed 2/21/16, but forgot to directed staff to may condition. Indicated the posted for all cleed after completion of cleaning checklists and the RD will more monthly. - "Cleaning Ovens" be cleaned according once every 2 weeks. - "Clean Stove Top" range will be kept or cange will be cleaned to be cleaned up as the clean	If the kitchen was dirty with ID further stated all areas of eaned the week of 2/15/16 to to clean the wall mounted fan. Birchwood Care Home ary department", the policy intain the kitchen in a sanitary that a cleaning schedule will eaning tasks and staff will initial tasks, the DNS will monitor weekly to ensure completion nitor kitchen sanitation In the policy indicated ovens willing to the schedule at least is and as needed. If the policy indicated that the lean during meal preparation, ed after each use and spills will ney occur. Wall mounted fan and air as requested but none on 2/24/16, at 9:23 a.m. with of nutritional services (DNS) tian (RD) the following terms were identified and DNS and RD. Is sing half tile to the left of the entrance to the dishwashing nat noticed it today after				

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE : COMPI		
		00168	B. WING		02/2	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BIRCHW	OOD CARE HOME		31ST STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
31240	compartment sink of food and dust build - Around the entire refrigerator along the broken plate, heavy grime and food debender of the kitcher cabinets for pots are and around all legs buildup of black/brounderneath the mewas buildup of black debris. The storage cabing dispenser, the cabing underneath the was heavily splatted. The knife storage air conditioning unit. The storage cabing preparation area has black/brown grime pots. The DNS veri inside of the two poneeded to be throw. Inside the cabinet storage of pans and serving counter was food, food debris as During an interview stated staff are expand monthly, and stask was completed to provide daily clean and monthly cleaning and monthly cl	was heavily splattered with up. perimeter of the kitchen he walls there was pieces of a buildup of dust, black/brown wris. Peparation surface in the en that contained storage had pan, all around the sides, of equipment there was own grime and food splatter. It allow the milk and coffee het doors, on the sides and on milk and coffee dispenser did with food and coffee stains. Tack located underneath the shad dust and dirt buildup. The sine the metal food and two pots that had buildup on the inside of the fied the buildup and stated the ts was not cleanable and naway. It is noted with heavy splatter of the solution of the serving utensils by the solution of the solution. On 2/24/16, at 9:23 a.m. DNS ected to clean daily, weekly ign the cleaning log that the daily of the solution of the serving utensils of the solution. DNS was able aning logs. DNS stated weekly stated weekly	31240			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE T15 WEST 31ST STREET MINNEAPOLIS, MN 55408 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 31240 Continued From page 20 - "Sanitation of dietary department", the policy directed staff to maintain the kitchen in a sanitary condition. Indicated that a cleaning schedule will be posted for all cleaning tasks and staff will initial	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 WEST 31ST STREET MINNEAPOLIS, MN 55408 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 31240 Continued From page 20 - "Sanitation of dietary department", the policy directed staff to maintain the kitchen in a sanitary - "Sanitation of maintain the kitchen in a sanitary"		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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BIRCHWOOD CARE HOME 715 WEST 31ST STREET MINNEAPOLIS, MN 55408 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 31240 Continued From page 20 - "Sanitation of dietary department", the policy directed staff to maintain the kitchen in a sanitary condition. Indicated that a cleaning schedule will TAG PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) 31240 - "Sanitation of dietary department", the policy directed staff to maintain the kitchen in a sanitary condition. Indicated that a cleaning schedule will	SUMMARY STATEMENT OF DEFICIENCIES MINNEAPOLIS, MN 55408			00168	B. WING		02/2	4/2016
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) STATE TAG SUMMARY STATEMENT OF DEFICIENCY ID PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE 31240 Continued From page 20 31240 - "Sanitation of dietary department", the policy directed staff to maintain the kitchen in a sanitary condition. Indicated that a cleaning schedule will STATE CROSS-REFERENCED TO THE APPROPRIATE DATE COMPLETE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE COMPLETE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE COMPLETE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE COMPLETE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CR	X2 ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE 31240 Continued From page 20 "Sanitation of dietary department", the policy directed staff to maintain the kitchen in a sanitary condition. Indicated that a cleaning schedule will be posted for all cleaning tasks and staff will initial after completion of tasks, the DNS will monitor cleaning checklists weekly to ensure completion and the RD will monitor kitchen sanitation monthly. - "Cleaning Cabinets and Drawers", the policy indicated cabinets and drawers will be free of food particles and dirt, and to be cleaned at least twice a month. - "Cleaning Walls", the policy indicated that the walls will be free of food particles and dirt and should be cleaned once a month and as needed. Maintenance policy was requested but none provided. TIME PERIOD FOR CORRECTION: Twenty-one	NAME OF I	PROVIDER OR SUPPLIER					
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