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

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **24E166**

2. STATE VENDOR OR MEDICAID NO. (L2) **458995500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BIRCHWOOD CARE HOME**
(L4) **715 WEST 31ST STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **01/01/2004**

6. DATE OF SURVEY **3/22/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		60		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 04/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/04/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/31/1974** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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

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

MDH
Minnesota
Department
of Health

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

Kamala Fiske-Downing, Program Specialist
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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
24E166 Y1	A. Building 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	Correction	ID Prefix F0279	Correction	ID Prefix F0309	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.25	Completed
LSC	03/14/2016	LSC	03/14/2016	LSC	03/14/2016
ID Prefix F0371	Correction	ID Prefix F0425	Correction	ID Prefix F0465	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.60(a),(b)	Completed	Reg. # 483.70(h)	Completed
LSC	03/14/2016	LSC	03/14/2016	LSC	03/14/2016
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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	04/05/2016	18623	03/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/24/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
24E166	A. Building 01 - MAIN BUILDING 01 B. Wing	4/4/2016

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 Reg. # NFPA 101 LSC K0050	Correction Completed 03/09/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 4/5/2016	SIGNATURE OF SURVEYOR 37009	DATE 4/4/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
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

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **24E166**
2. STATE VENDOR OR MEDICAID NO. (L2) **458995500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BIRCHWOOD CARE HOME**
(L4) **715 WEST 31ST STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **01/01/2004**

6. DATE OF SURVEY **02/24/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **60** (L18)
13. Total Certified Beds **60** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___2. Technical Personnel
___3. 24 Hour RN
___4. 7-Day RN (Rural SNF)
___5. Life Safety Code
___6. Scope of Services Limit
___7. Medical Director
___8. Patient Room Size
___9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		60		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date : 03/23/2016 (L19)
Amy Charais, HFE NE II

18. STATE SURVEY AGENCY APPROVAL — Date: 04/14/2016 (L20)
Kamala Fiske-Downing, Enforcement Specialist

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/31/1974** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30) **00**

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE 4-14-2016 (L33)

DETERMINATION APPROVAL

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

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(L4) **715 WEST 31ST STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **01/01/2004**

6. DATE OF SURVEY **02/24/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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FISCAL YEAR ENDING DATE: (L35) **09/30**

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

And/Or Approved Waivers Of The Following Requirements:
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* Code: **B*** (L12)

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(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : Amy Charais, HFE NE II 03/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Enforcement Specialist 04/14/2016 (L20)

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

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

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23. LTC AGREEMENT BEGINNING DATE (L41)

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

26. TERMINATION ACTION: (L30) **00**
VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the

attached deficiencies.

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

DEPARTMENT CONTACT

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

Gloria Derfus, 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

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

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

Kamala Fiske-Downing, Program Specialist
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING _____ B. WING _____	02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	715 WEST 31ST STREET MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS EPOC: federal: The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157		3/14/16

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.

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F 157	Continued From page 1 or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the medical doctor (M.D.) of medications being unavailable for 5 of 59 residents (R8, R55, R14, R22, R38) whose medication administration records were reviewed for missed medication doses. Findings include: R8's Face Sheet printed on 2/24/16, indicated R8 had diagnoses of paranoid schizophrenia, delusional disorder, history of a suicide attempt and squamous cell carcinoma (cancer). During medication administration observation on 2/23/16, at 7:38 a.m. R8's Abilify (a medication for the treatment schizophrenia) was unavailable. A review of electronic Medication Administration Record (MAR) on 2/24/16, did not indicate the resident had received medication when it arrived from the pharmacy. Licensed practical nurse (LPN)-A verified medication had not been ordered and was observed to order medication. R8's annual Minimum Data Set (MDS) dated	F 157	A new policy and procedure regarding missing medications has been developed, copy attached. Education has been initiated for all nursing staff. Remainder of Nursing staff will be trained on new Policy and Procedures for missing medications by their direct charge nurses and at a mandatory Nursing Meeting on March 17, 2016. A new "Missing medication tracking form" has been implemented to be completed for any missing medications, this form will be completed by the TMA and Charge nurse and will be monitored by the Director of Nursing and Resident Care 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	

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F 157	Continued From page 2 11/27/15, was cognitively intact with minimal symptoms of depression, and experienced hallucinations and delusions during the observation period and had daily behaviors that did not affect others. The Medication Review Report printed 2/24/16, indicated R8 was to receive Abilify 20 milligram (mg) every day for 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." On 2/23/16, at 1:47 p.m. trained medication aide (TMA)-A verified she had charted "9" on the MAR to indicate that a Progress Note (PN) was written and the PN dated 2/23/16, at 7:41 a.m. "medication is n.a. [non-available]" meant the medication was not available. A "9" instructed staff or others to see the PN. During interview on 2/24/16, at 1:44 p.m. LPN-A reviewed the MAR and verified the Abilify arrived on 2/23/16, but was not given when it arrived. LPN-A stated unsure why it was not given	F 157	during her weekly audit of the EMAR to ensure all medications have been appropriately signed out. She will also be watching for patterns or trends. The next 3 monthly Nursing meetings which are held every third Thursday of each month will be dedicated to discussing missing medications. These discussions will include root cause analysis of reasons for missing medications. Interventions and outcomes will be discussed in order to identify patterns and to assist in developing best practices for quickly resolving issues. Director of Nursing, Resident Care Coordinator and Staff Development Coordinator will be responsible for ensuring compliance.	

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F 157	Continued From page 3 because she was not here. R55 was observed on 2/24/16, at 1:12 p.m. R55 was observed lying on bed with covers over the head. When R55 sat 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. Review of current electronic MAR indicated, staff signed "9" for Celexa (a medication for the treatment of depression) 10 mg instead of a check mark on 2/10/16, 2/16/16, 2/19/16, 2/21/16, and 2/23/16. Review of PN indicated: 2/10/16, no PN regarding oral medications, 2/16/16, "medication is n.a." 2/19/16, "medication is n.a." 2/21/16, "medication is n.a." 2/23/16, "medication is n.a." R55's admission MDS dated 1/27/16, was moderately cognitively impaired with symptoms of mild depression, and experienced delusions during the observation period. Mood State CAA dated 2/3/16, indicated, "...Resident reported having little interest in things, feeling tired and sluggish, and trouble concentrating 7 to 11 days. Stated feeling better off dead 2 to 6 days. Completed suicide risk assessment with client: resident that he has no intention or plan to hurt himself. He stated that he feels like this when everything start to get bad. Resident stated that he will reach out to staff if he ever feels this way." Psychotropic Drug Use CAA dated 2/3/16,	F 157		

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F 157	Continued From page 4	F 157		

indicated, "staff will continue to follow current plan of care to maintain current level of functioning for improvement as indicated and to minimize risks when necessary with re-direction and cueing from staff, and case manager with assistance as needed with use of M.D. ordered Psychotropics, as directed with goals and interventions as stated in his current plan of care."

The mood care plan dated 2/15/16, indicated during assessment on 1/27/16, R55 voiced symptoms of mild depression and mentioned feeling like he would be better off dead. Suicide risk assessment was done and resident did not have a plan or desire to hurt himself. Interventions included, "Staff would follow interventions to decrease symptoms under individualized care plan areas as needed." In addition, the Self Administration of Medication (SAM) care plan initiated on 2/14/16, indicated resident unable to SAM due to decreased cognition and instructed staff, "Nursing will dispense all medications when resident is in facility." "Nursing will medicate and do treatments per M.D. order."

The hospital Discharge Summary dated 1/21/16, indicated R55's suicide risk level impression was "Heightened-has identified many risk factors but protective factors have influence to keep from imminent risk." No suicide attempts although R55 had thoughts about suicide. R55 had four psychiatric hospitalizations since 2013.

The Medication Review Report printed 2/24/16, indicated R55 was to receive Celexa 10 mg every day for depression.

The PN dated 2/19/16, indicated, "Resident

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F 157	Continued From page 5 voiced being upset to MR [medical records] in the morning, talking about leaving and not coming back and being treated poorly. Talked to resident in office. He stated being upset that no one knows when his appointments are, stated he has not gotten any mail and thinks that his address has not been changed at the VA [Veterans Administration hospital]. Stated if this was not addressed he was going to leave and kill himself. Allowed him to vent feelings. Offered to call the VA and see if we could get a list of his appointments and ask them about his address change. He stated this lifted so much off and he feels much better, stated he would not leave and/or hurt himself. Talked to CM [case manager] Supervisor, she stated his address at the VA has been changed to facility address, she also faxed a copy of all the appointments that he currently has scheduled. Showed resident, he was very happy, stating he was so stressed about this and now he is not." The PN dated 2/23/16, indicated "Resident came to office upset about his medications not being delivered. Stated two of us had called his CM to see if she can bring them. He stated over and over again that she cannot bring the medications. I really need that pill that helps me calm down otherwise I don't know what I am going to do. Assured him that if she couldn't bring them, staff would go to the VA to pick them up. The CM called back and they are now instructed not to transport medications unless there is an emergency, she was able to get an emergency exception and will bring his medications when he comes to visit resident at facility this afternoon. Notified resident, she [sic] thanked writer for the help."	F 157		

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F 157	Continued From page 6 During interview on 2/24/16, at 1:12 p.m. R55 said, "My mood gets bad when I do not have my medications. I get very anxious. Yesterday was bad." During interview on 2/24/16, at 1:44 p.m. LPN-A verified the Celexa was not available from at least 2/16/16. LPN-A stated, "The medications were delivered yesterday at about 10:00 a.m. or 11:00 a.m. by his VA case manager." LPN-A verified the MAR was not accurate. LPN-A stated "If I knew I (the medications were not available) I would call the M.D. on day two of not getting the medications. I am responsible for the TMA, but if they do not tell me that they are out, how would I know." During interview on 2/24/16, at 2:28 p.m. the social worker said R55 was irritable yesterday. If he had a complaint, R55 could become aggressive. R55 had a history of making statement of killing himself but if you take care of the complaint it immediately clears. There was the potential that depression would worsen without the Celexa and R55 would act on his statements. R14 was observed on 2/24/16, at 1:15 p.m. sitting on edge of bed. A fine tremor was observed in hands but R14 was able to hold water cup without spilling. R14's Face Sheet printed on 2/24/16, indicated R14 had diagnoses of major depressive disorder, and neuroleptic induced Parkinsonism, abnormalities of gait and mobility and history of falling.	F 157		

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F 157	Continued From page 7 Review of electronic MAR indicated, staff signed "9" instead of a check mark for Sinemet (used to manage the symptoms of Parkinson's disease) 10/100 mg. - At 8:00 a.m. 1/15/16 and 1/16/16 (2 of 54 doses), - At 2:00 p.m. 1/12 1/15 through 1/19, 1/21, 1/23, 1/25, 1/28 through 1/30, 2/1, 2/2, 2/5, 2/6, 2/8, 2/10 through 2/17, and 2/20 through 23 (29 of 54 doses) - At 8:00 p.m. 1/25, 1/27, 2/1, and 2/10 (4 of 54 doses) The totaled missed medications was 35 of 162 possible doses. Review of PN from 11/24/15 through 2/24/15, indicated 20 progress notes that medication was unavailable. PN dated 1/26/16, at 2:37 p.m. indicated, "Call placed to pharmacy re: Sinemet order and requiring a new script. Updated by VA pharmacy that resident needs to be seen by prescribing M.D. to get this med reordered. Updated medical records and resident has an appointment with [name of M.D.], per medical records." Birchwood Care Home Referral dated 1/27/16, indicated R14 had an appointment with primary care physician for a physical. No information was provided to primary care physician about the need for a new prescription for Sinemet or that R14 had missed at least 15 doses of Sinemet since the first of January. R14's quarterly MDS dated 11/20/15, indicated was cognitively intact with symptoms of mild depression, and experienced hallucinations and delusions during the observation period. R14 required supervision with dressing, toileting and hygiene and used a walker for ambulation. No falls recorded.	F 157		

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F 157	Continued From page 8 The Falls CAA dated 2/23/15, indicated R14 received antidepressant and antipsychotic daily increasing fall risk and had a history of falls. R14 was seen at the VA hospital after a fall on 11/2/14, at which time the VA stated R14 had Parkinson gait likely related to medications and added Sinemet and a course of physical therapy to reduce fall risks. Care plan considerations instructed staff to "...follow current plan of care to maintain current level of functioning with re-direction and cueing, staff assistance as needed with fall safety, with goals and interventions as stated in current plan of care." The psychotropic drug use care plan revised 2/28/08, instructed staff that goal was for "Resident will have no increase in TD [tardive dyskinesia is a neurological disorder resulting in involuntary repetitive body movements] symptoms or EPSE [extrapyramidal side effects are movement disorders caused by medications]." Interventions included nursing to administer medications per doctor ' s orders, monitor for signs of TD or EPSE, and notify doctor of changes in behavior. The PN dated 1/26/16, indicated, "Call placed to pharmacy re: Sinemet order and requiring a new script. Updated by VA pharmacy that resident needs to be seen by prescribing M.D. to get this med reordered. Updated medical records and resident has an appointment with [name of M.D.] per medical records." The Medication Review Report printed 2/24/16, indicated R14 was to receive Sinemet 10/100 mg. three times a day for neuroleptic induced Parkinsonism.	F 157		

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During interview on 2/24/16, at 1:15 p.m. R14 said, "I am not sure what my Sinemet is for. The nurses give me my meds. Please do not ask me more questions."

During interview on 2/24/16, at 1:44 p.m. LPN-A reviewed the MAR and verified R14 was out of Sinemet from at least February 10th until now. "We are waiting on the doctor to decide if he is going to reorder. R14 is completely out of Sinemet and we do not borrow medications. R14's Parkinson's is not really bad. He gets his medications from the VA hospital. (registered nurse (RN)-A) orders all medications from the VA." LPN-A verified there was no documentation that the doctor was notified R14 had missed at least 40 doses of Sinemet in progress notes. LPN-A verified that the MAR was not accurate. LPN-A stated (R14) saw primary MD at the VA on 1/27/16, and the referral said, "continue current regimen." LPN-A verified there was no information regarding Sinemet written on the referral form.

During interview on 2/24/16, at 2:28 p.m. RN-A said, "On 1/26/16 I made a call to the VA. We are trying to get [medical doctor] to write a script but he will not write it. We are working on neurology but they are unable to get a hold of the doctor." RN-A said the risks of missing Sinemet was the Parkinson's symptoms could increase.

R22's face sheet printed on 2/24/16, indicated R22 had diagnoses of major depressive disorder, acute pain and convulsions.

Review of electronic MAR indicated, staff signed

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F 157	Continued From page 10 "9" instead of a check mark on 2/15/16, for gabapentin. R22's quarterly MDS dated 1/15/16, was cognitively intact with symptoms of mild depression. R22 required supervision with dressing and hygiene and used a walker for ambulation. No pain or falls recorded. Seizure disorder noted on the quarterly MDS. Falls CAA dated 7/31/15, indicated resident had diagnosis of seizure disorder. Medication Review Report printed 2/24/16, indicated R22 was to receive gabapentin 600 mg at bedtime for convulsions. Review of PNs from 12/24/15, to 2/23/16, do not indicate any seizure activity or falls. During in interview on 2/24/16, at 1:10 p.m. R22 said, "I do not always get all of my medications but I am ok. The nurses give me my meds." During interview on 2/24/16, at 1:44 p.m. LPN-A reviewed the MAR and verified R22 did not receive gabapentin on 2/15/16 because it was not available. LPN-A said "9" means other and a progress note should have been written each time a "9" was listed by the TMA who put the code in. LPN-A said gabapentin was for neuropathy not seizures as listed. "We have not had any episodes of a seizure since (R22) has been here." LPN-A said if the gabapentin was for neuropathy then (R22) would be at risk for increased pain. If it was for seizures there would be a low risk for (R22) having a seizure.	F 157		

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BIRCHWOOD CARE HOME	715 WEST 31ST STREET MINNEAPOLIS, MN 55408

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F 157	Continued From page 11	F 157		

R38 was observed sitting on couch in day room on 2/24/16, at 1:20 p.m. R38 did not display any respiratory issues at that time.

R38's face sheet printed on 2/24/16, indicated R38 had diagnoses of dysphagia (swallowing problems), diabetes, major depressive disorder, and schizophrenia.

Review of electronic MAR indicated, staff signed "9" instead of a check mark for Levofloxacin (an antibiotic) 750 mg for pneumonia on 2/6/16, and Budesonide (a steroid medication used for the treatment of respiratory problems) inhaler on 2/6, 2/7, 2/8, 2/10, 2/11, and 2/12/16.

R38's quarterly MDS dated 1/22/16, indicated R38 was cognitively intact and experienced delusions during the observation period. R38 required supervision with dressing, eating and hygiene. No shortness of breath noted.

Dietary CAA dated 10/28/15, indicated R38 was at increased risk for choking related to pocketing food and diagnosis of dysphasia.

PN dated 2/6/16, "Med (medication) not in."
PN 2/8/16, Not available.
2/12/16, "not avsil [sic - available]"

Discharge Summary dated 2/5/16, indicated that R38 had been admitted for community acquired pneumonia with increased risk for aspiration pneumonia related to medications. Discharge orders included finish levofloxacin 750 mg every days for two days and use Budersonide inhaler three puffs twice daily for seven days.

During interview on 2/24/16, at 1:20 p.m. R38

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F 157	Continued From page 12 said, "I had pneumonia. I guess I got my meds. I don't know if I got all my meds, that the nurse's job." During interview on 2/24/16, at 1:44 p.m. LPN-A reviewed the MAR and verified the levofloxacin was not available on 2/6/16, and Budersonide was charted as not available for eight of 14 doses. LPN-A said "9" means other and a progress note should have been written each time a "9" was listed by the TMA who put the code in. LPN-A stated the procedure for a readmission was to get the orders early and let the pharmacy know what new medications were required. If the pharmacy was unable to deliver a medication LPN-A stated they would call the doctor and obtain orders to complete dose when medication was available or to make the changes the doctor wanted. LPN-A said the risk of not completing a course of antibiotics and inhaler was that the resident might relapse. During interview on 2/24/16, at 2:28 p.m. the assistant director of nurses (ADON) verified there was no evidence that the doctor was notified for any of the residents that they missed their medications. ADON said, "I expect the nurses would let the doctor know about a resident missing medications and obtain new orders. The TMA is expected to tell the nurse if a medication is unavailable. The nurse is to check with the pharmacy and if necessary order the medication. The nurse is also to update the doctor if the medication is not available." Notification of physician of missed medication doses was requested but not provided.	F 157		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		3/14/16

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F 279 SS=D	Continued From page 13 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive care plan was developed for 1 of 1 resident (R64) who was newly admitted to the facility. Findings include: R64's admission Minimum Data Set (MDS) dated 2/8/16, indicated she was cognitively intact, moderately depressed, and displayed behaviors that interfered with her social interactions and put others at risk for injury. A Care Area Assessment	F 279	A comprehensive care plan was immediately completed for this resident. A new auditing/ tracking system has been implemented to be sure the Temporary care plan is always completed upon admission. All charge nurses have been re educated on importance of always completing the Temporary care plan upon admission. Director of Nursing, Resident Care	

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F 279	Continued From page 14 (CAA) dated 2/12/16, indicated R64 reported pain rated ten of ten but did not receive scheduled or as needed pain medication during the assessment period. The CAA directed staff to follow the care plan to maximize comfort. The CAA further identified R64 had potential for a decline in functional status, psychosocial wellbeing and behavioral status. In each identified area, the CAA directed staff to develop a plan of care to improve functioning and minimize risks. A review of Birchwood Care Home Progress Notes dated 2/1/16 to 2/24/16, indicated R64 admitted to the facility with diagnoses that included leukemia and lung cancer. The Progress Notes indicated R64 had a poor appetite, complaints of pain rated 10/10, was resistive to taking narcotic pain medication and displayed behaviors exhibited by " loud and angry yelling." R64's medical record lacked evidence of a care plan to direct staff regarding non pharmacological interventions for pain, behavioral management interventions or safety interventions even though the CAA identified risk in these areas. During an observation on 2/22/16, at 1:30 p.m., R64 was lying in bed, alert and able to respond to questions by surveyor. During an observation on 2/23/16 at 1:18 p.m., R64 was observed lying in bed with her eyes closed. A few minutes later, R64 was sitting up on the edge of her bed digging through a bag. During an interview on 2/24/16, at 8:22 a.m., R64 was again observed lying in her bed. R64 was not observed out of her room during the course of the survey from 2/22/16 to 2/24/16.	F 279	Coordinator and Staff Development Coordinator will be responsible to ensure compliance.	

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F 279	Continued From page 15 During an interview on 2/22/16, at 1:30 p.m., R64 stated she had been in the facility since the beginning of the month. She stated she had been living independently for the last five years and was admitted to the facility due to her Leukemia. During an interview on 2/23/16, at 2:25 p.m., the assistant director of nursing (ADON) stated she was responsible for the development of R64's care plan. She stated a temporary care plan should be started immediately upon admission, and a comprehensive care plan should be completed within 7 days of the assessment date. The ADON stated the temporary care plan was a paper form found in the resident ' s paper record. During an interview on 2/23/16, at 2:31 p.m., licensed practical nurse (LPN)-A reviewed R64's chart and stated, the care plan in R64's paper chart was "left blank." She stated, "This one did not get started yet." A facility policy titled Bircwood [sic] Care Home, Care Planning, dated 5/2/07, indicated "A comprehensive care plan will be developed for each resident within 7 days after completion of the comprehensive resident assessment."	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		3/14/16

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F 309	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure coordination of care with the hospice company 1 of 1 residents (R64) who was receiving hospice services. Findings include: R64's admission Minimum Data Set (MDS) dated 2/8/16, indicated she was cognitively intact, required assistance for bathing, and displayed behaviors. A Hospice IDG Comprehensive Assessment and Plan of Care Update report dated 2/17/16, indicated R64 would receive visits with a skilled nurse, home health aide (HHA), and medical social worker. The assessment indicated the roles of the hospice team, but did not identify problems, goals or interventions. The assessment further indicated the number of visits each week for each discipline, but did not identify which day ' s visits would take place. During an observation on 2/22/16, at 1:30 p.m., R64 was lying in bed, alert and able to respond to questions by surveyor. During an observation on 2/23/16 at 1:18 p.m., R64 was observed lying in bed with her eyes closed. Hospice registered nurse (HRN)-H was visiting with R64. During an interview on 2/24/16, at 8:22 a.m., R64 was again observed lying in her bed.	F 309	A detailed Plan of Care report from Hospice is present in residents chart with Skilled nursing services, goals and interventions, copy of this report attached. A calendar outlining each Hospice staff schedule of visits was immediately obtained and placed in resident chart. All nursing staff have been educated to where this calendar is located. Hospice staff wears name badges during each visit and always checks in with staff prior to visiting resident. Director of Nursing and Social Services Director are responsible to ensure compliance.	

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F 309	Continued From page 17	F 309		

During an interview on 2/22/16, at 1:30 p.m., R64 stated she had been in the facility since the beginning of the month. She stated she had been living independently for the last five years and was admitted to the facility for hospice care due to her Leukemia.

During an interview on 2/23/16, at 1:30 p.m., HRN-H stated R64 admitted to hospice shortly after admission to the facility. She stated the hospice team has a set schedule for visits with R64. She stated the schedule was supposed to be faxed to the facility. HRN-H stated the hospice HHA assisted R64 with showers, shampoo, skin care and lotion. She stated R64's "biggest concern" at this time was her mental health history and stated she displays "paranoia." HRN-H indicated R64 was currently having a problem with nausea as well. HRN-H stated she was unsure if R64's care plan was in the chart or not or if it was completed.

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.

During an interview on 2/24/16, at 11:59 a.m., licensed practical nurse (LPN)-A stated she did not know ahead of time when the hospice nurse was coming. LPN-A further stated a hospice aide comes in once a week to assist R64 with showers, but she did not know when she comes. She stated there was no calendar that she was aware of.

During an interview on 2/24/16, at 1:41 p.m., the assistant director of nursing (ADON) stated the

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F 309	Continued From page 18 hospice nurse would tell staff when she was coming and when the aide was coming, but was not sure if there was a schedule. She stated the hospice care team documented in the medical record following visits. The ADON stated nursing was responsible for coordinating care with the hospice team.	F 309		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure clean and sanitary conditions for kitchen equipment that had direct contact with food preparation surfaces and clean dishes. This had the potential to affect all 59 residents in the facility and visitors who ate out of the kitchen. Findings include: During the initial kitchen tour on 2/22/16, at 11:44 a.m. with the facility's director of nutrition services (DNS) the following sanitation concerns were observed - A wall mounted fan directly above the clean dish	F 371	Air conditioning unit was cleaned immediately. A new policy and procedure was developed along with a checklist for Dish room Air conditioning unit to be cleaned on a bi-weekly basis, see attached copy of Policy/Procedure and checklist for cleaning.	3/14/16

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F 371	Continued From page 19	F 371		

area was turned on and blowing directly towards three racks containing clean dishes which were drying. The fan was dirty with heavy dust/dirt buildup. The DNS verified that the fan was dirty and needed to be cleaned.

During follow-up kitchen tour on 2/24/16, at 9:23 a.m. with DNS and the registered dietitian (RD) the following was observed:
- Six burner stove had a heavy buildup of a brown/black substance on the backsplash to the back of the stove. The two oven doors below the six burner stove had a buildup of a black/brown greasy substance on and around the handle, on the knobs and sides of the door. DNS verified it needed to be cleaned and stated major oven cleaning is completed monthly.
- The air conditioning unit located above the clean area where knifes and clean towels are kept, to the left of the six burner stove and across from the food preparation area was noted to be dirty with dust/dirt build up. The air conditioning unit was turned on and blowing directly towards the food preparation area. DNS verified that the air conditioning unit needed to be cleaned and stated that maintenance is responsible for cleaning it.

During an interview on 2/24/16, at 9:23 a.m. DNS stated staff are expected to clean daily, weekly and monthly, and sign the cleaning log that the task was completed. At 11:23 a.m. DNS was able to provide daily cleaning logs. DNS stated weekly and monthly cleaning was not done.

During interview on 2/24/16, at 11:30 a.m. the facility's maintenance director (MD) verified the air conditioning unit and wall mounted fan in the dishwashing area of the kitchen was dirty with dust/dirt build up. MD further stated all areas of

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F 371	Continued From page 20 the kitchen were cleaned the week of 2/15/16 to 2/21/16, but forgot to clean the wall mounted fan. Review of undated Birchwood Care Home policies: - "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 Ovens", the policy indicated ovens will be cleaned according to the schedule at least once every 2 weeks and as needed. - "Clean Stove Top", the policy indicated that the range will be kept clean during meal preparation, range will be cleaned after each use and spills will be cleaned up as they occur. Cleaning policy for wall mounted fan and air conditioning unit was requested but none provided.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425		3/14/16

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F 425	Continued From page 21 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that they had sufficient medications for 5 of 5 (R8, R55, R14, R22, R38) residents who were reviewed for medications. Findings include: R8's Face Sheet printed on 2/24/16, indicated R8 had diagnoses of paranoid schizophrenia, delusional disorder, history of a suicide attempt and squamous cell carcinoma (cancer). During medication administration observation on 2/23/16, at 7:38 a.m. R8's Abilify (a medication for the treatment schizophrenia) was unavailable. A review of electronic Medication Administration Record (MAR) on 2/24/16, did not indicate the resident had received medication when it arrived from the pharmacy. Licensed practical nurse (LPN)-A verified medication had not been ordered and was observed to order medication. R8's annual Minimum Data Set (MDS) dated 11/27/15, was cognitively intact with minimal symptoms of depression, and experienced	F 425	A new policy and procedure regarding missing medications has been developed, copy attached. Education has been initiated for all nursing staff. Remainder of Nursing staff will be trained on new Policy and Procedures for missing medications by their direct charge nurses and at a mandatory Nursing Meeting on March 17, 2016. A new "Missing medication tracking form" has been implemented to be completed for any missing medications, this form will be completed by the TMA and Charge nurse and will be monitored by the Director of Nursing and Resident Care 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 during her weekly audit of the EMAR to	

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F 425	Continued From page 22 hallucinations and delusions during the observation period and had daily behaviors that did not affect others. The Medication Review Report printed 2/24/16, indicated R8 was to receive Abilify 20 milligram (mg) every day for 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." On 2/23/16, at 1:47 p.m. trained medication aide (TMA)-A verified she had charted "9" on the MAR to indicate that a Progress Note (PN) was written and the PN dated 2/23/16, at 7:41 a.m. "medication is n.a. [non-available]" meant the medication was not available. A "9" instructed staff or others to see the PN. During interview on 2/24/16, at 1:44 p.m. LPN-A reviewed the MAR and verified the Abilify arrived on 2/23/16, but was not given when it arrived. LPN-A stated unsure why it was not given because she was not here.	F 425	ensure all medications have been appropriately signed out. The next 3 monthly Nursing meetings which are held every third Thursday of each month will be dedicated to discussing missing medications. These discussions will include root cause analysis of reasons for missing medications. Interventions and outcomes will be discussed in order to identify patterns and to assist in developing best practices for quickly resolving issues. Director of Nursing, Resident Care Coordinator and Staff Development Coordinator will be responsible for ensuring compliance.	

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F 425	Continued From page 23 R55 was observed on 2/24/16, at 1:12 p.m. R55 was observed lying on bed with covers over the head. When R55 sat 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. Review of current electronic MAR indicated, staff signed "9" for Celexa (a medication for the treatment of depression) 10 mg instead of a check mark on 2/10/16, 2/16/16, 2/19/16, 2/21/16, and 2/23/16. Review of PN indicated: 2/10/16, no PN regarding oral medications, 2/16/16, "medication is n.a." 2/19/16, "medication is n.a." 2/21/16, "medication is n.a." 2/23/16, "medication is n.a." R55's admission MDS dated 1/27/16, was moderately cognitively impaired with symptoms of mild depression, and experienced delusions during the observation period. Mood State CAA dated 2/3/16, indicated, "...Resident reported having little interest in things, feeling tired and sluggish, and trouble concentrating 7-11 days. Stated feeling better off dead 2-6 days. Completed suicide risk assessment with client: resident that he has no intention or plan to hurt himself. He stated that he feels like this when everything start to get bad. Resident stated that he will reach out to staff if he ever feels this way." Psychotropic Drug Use CAA dated 2/3/16, indicated, "staff will continue to follow current plan of care to maintain current level of functioning for	F 425		

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improvement as indicated and to minimize risks when necessary with re-direction and cueing from staff, and case manager with assistance as needed with use of M.D. [medical doctor] ordered Psychotropics, as directed with goals and interventions as stated in his current plan of care."

Mood Care Plan dated 2/15/16, indicated during assessment on 1/27/16, R55 voiced symptoms of mild depression and mentioned feeling like he would be better off dead. Suicide risk assessment was done and resident did not have a plan or desire to hurt himself. Interventions included, "Staff would follow interventions to decrease symptoms under individualized care plan areas as needed." In addition Self Administration of Medication (SAM) care plan initiated on 2/14/16, indicated resident unable to SAM due to decreased cognition and instructed staff, "Nursing will dispense all medications when resident is in facility." "Nursing will medicate and do treatments per M.D. order."

The hospital Discharge Summary dated 1/21/16, indicated R55 ' s suicide risk level impression was "Heightened-has identified many risk factors but protective factors have influence to keep from imminent risk." No suicide attempts although R55 had thoughts about suicide. R55 had four psychiatric hospitalizations since 2013.

The Medication Review Report printed 2/24/16, indicated R55 was to receive Celexa 10 mg. every day for depression.

The PN dated 2/19/16, indicated, "Resident voiced being upset to MR [medical records] in the morning, talking about leaving and not coming

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back and being treated poorly. Talked to resident in office. He stated being upset that no one knows when his appointments are, stated he has not gotten any mail and thinks that his address has not been changed at the VA [Veterans Administration hospital]. Stated if this was not addressed he was going to leave and kill himself. Allowed him to vent feelings. Offered to call the VA and see if we could get a list of his appointments and ask them about his address change. He stated this lifted so much off and he feels much better, stated he would not leave and/or hurt himself. Talked to CM [case manager] Supervisor, she stated his address at the VA has been changed to facility address, she also faxed a copy of all the appointments that he currently has scheduled. Showed resident, he was very happy, stating he was so stressed about this and now he is not."

The PN dated 2/23/16, indicated "Resident came to office upset about his medications not being delivered. Stated two of us had called his CM to see if she can bring them. He stated over and over again that she cannot bring the medications. I really need that pill that helps me calm down otherwise I don't know what I am going to do. Assured him that if she couldn't bring them, staff would go to the VA to pick them up. The CM called back and they are now instructed not to transport medications unless there is an emergency, she was able to get an emergency exception and will bring his medications when he comes to visit resident at facility this afternoon. Notified resident, she [sic] thanked writer for the help."

During interview on 2/24/16, at 1:12 p.m. R55 said, "My mood gets bad when I do not have my

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medications. I get very anxious. Yesterday was bad."

During interview on 2/24/16, at 1:44 p.m. LPN-A verified the Celexa was not available from at least 2/16/16. LPN-A stated, "The medications were delivered yesterday at about 10:00 a.m. or 11:00 a.m. by his VA case manager." LPN-A verified the MAR was not accurate. LPN-A stated "If I knew I (the medications were not available) I would call the MD on day two of not getting the medications. I am responsible for the TMA, but if they do not tell me that they are out, how would I know."

During interview on 2/24/16, at 2:28 p.m. the social worker said R55 was irritable yesterday. If he had a complaint, R55 could become aggressive. R55 had a history of making statement of killing himself but if you take care of the complaint it immediately clears. There was the potential that depression would worsen without the Celexa and R55 would act on his statements.

R14 was sitting on edge of bed on 2/24/16, at 1:15 p.m. A fine tremor observed in hands but R14 was able to hold water cup without spilling.

R14's face sheet printed on 2/24/16, indicated R14 had diagnoses of major depressive disorder, and neuroleptic induced Parkinsonism, abnormalities of gait and mobility and history of falling.

Review of electronic MAR indicated, staff signed "9" instead of a check mark for
Sinemet (a medication used to control tremors) 10-100 mg. 8:00 a.m. 1/15/16, 1/16/16 (2 of 54

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doses); Sinemet 10-100 mg. 2:00 p.m. 1/12, 1/15 through 1/19, 1/21, 1/23, 1/25, 1/28 through 1/30, 2/1, 2/2, 2/5, 2/6, 2/8, 2/10 through 2/17, 2/20 through 23 (29 of 54 doses); Sinemet 10-100 mg. 8:00 p.m. 1/25, 1/27, 2/1, 2/10 (4 of 54 doses) for a total (35 of 162 possible doses).

Review of PN from 11/24/15 until 2/24/15, indicated 20 progress notes that medication was unavailable. PN dated 1/26/16 at 2:37 p.m. indicated, "Call placed to pharmacy re: Sinemet order and requiring a new script. Updated by VA pharmacy that resident needs to be seen by prescribing MD to get this med reordered. Updated medical records and resident has an appointment with [name of M.D.], per medical records." The Birchwood Care Home Referral dated 1/27/16, indicated R14 had an appointment with primary care physician for a physical. No information was provided to primary care physician about the need for a new prescription for Sinemet or that R14 had missed at least 15 doses of Sinemet since the first of January.

R14's quarterly MDS dated 11/20/15, indicated was cognitively intact with symptoms of mild depression, and experienced hallucinations and delusions during the observation period. R14 required supervision with dressing, toileting and hygiene and used a walker for ambulation. No falls recorded.

Falls CAA dated 2/23/15, indicated R14 receives antidepressant and antipsychotic daily increasing fall risk and had a history of falls. R14 was seen at the VA hospital after a fall on 11/2/14 at which time the VA stated R14 had Parkinson gait likely related to medications and added Sinemet and a course of physical therapy to reduce fall risks.

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Care plan considerations instructed staff to "...follow current plan of care to maintain current level of functioning with re-direction and cueing, staff assistance as needed with fall safety, with goals and interventions as stated in current plan of care."

Psychotropic drug use care plan revised 2/28/08, instructed staff that goal was for "Resident will have no increase in TD [Tardive dyskinesia is a neurological disorder resulting in involuntary repetitive body movements.] Symptoms or EPSE [extrapyramidal side effects are movement disorders caused by medications]." Interventions included, nursing to administer medications per doctors' orders, monitor for signs of TD or EPSE, and notify doctor of changes in behavior.

Progress Note dated 1/26/16, indicated, "Call placed to pharmacy re: Sinemet order and requiring a new script. Updated by VA pharmacy that resident needs to be seen by prescribing M.D. to get this med reordered. Updated medical records and resident has an appointment with [name of M.D.], per medical records."

Medication Review Report printed 2/24/16, indicated R14 was to receive Sinemet 10-100 mg. three times a day for neuroleptic induced Parkinsonism.

During interview on 2/24/16 at 1:15 p.m. R14 said, "I am not sure what my Sinemet is for. The nurses give me my meds. Please do not ask me more questions."

During interview on 2/24/16, at 1:44 p.m. LPN-A reviewed the MAR and verified R14 was out of Sinemet from at least February 10th until now.

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"We are waiting on the doctor to decide if he is going to reorder. R14 is completely out of Sinemet and we do not borrow medications. R14's Parkinson ' s is not really bad. He gets his medications from the VA hospital. (Registered nurse (RN)-A) orders all medications from the VA." LPN-A verified there was no documentation that the doctor was notified R14 had missed at least 40 doses of Sinemet in progress notes. LPN-A verified that the MAR was not accurate. LPN-A stated (R14) saw primary MD at the VA on 1/27/16, and the referral said, "Continue current regimen". LPN-A verified there was no information regarding Sinemet written on the referral form

During interview on 2/24/16 at 2:28 p.m. RN-A said, "On 1/26/16 I made a call to the VA. We are trying to get (medical doctor) to write a script but he will not write it. We are working on neurology but they are unable to get a hold of the doctor." RN-A said the risks of missing Sinemet was the Parkinson's symptoms could increase.

R22's face sheet printed on 2/24/16, indicated R22 had diagnoses of major depressive disorder, acute pain and convulsions.

Review of electronic MAR indicated, staff signed "9" instead of a check mark on 2/15/16, for gabapentin.

R22's quarterly MDS dated 1/15/16, was cognitively intact with symptoms of mild depression. R22 required supervision with dressing, and hygiene and used a walker for ambulation. No pain or falls recorded. Seizure disorder noted on the quarterly MDS.

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F 425	Continued From page 30 Falls CAA dated 7/31/15, indicated resident had diagnosis of seizure disorder. Medication Review Report printed 2/24/16, indicated R22 was to receive Gabapentin 600 mg at bedtime for convulsions. Review of PNs from 12/24/15 to 2/23/16, do not indicate any seizure activity or falls. During an interview on 2/24/16, at 1:10 p.m. R22 said, "I do not always get all of my medications but I am ok. The nurses give me my meds." During interview on 2/24/16, at 1:44 p.m. LPN-A reviewed the MAR and verified R22 did not receive gabapentin on 2/15/16 because it was not available. LPN-A said "9" means other and a progress note should have been written each time a "9" was listed by the TMA who put the code in. LPN-A said gabapentin was for neuropathy not seizures as listed. "We have not had any episodes of a seizure since (R22) has been here." LPN-A said if the gabapentin was for neuropathy then (R22) would be at risk for increased pain. If it was for seizures there would be a low risk for (R22) having a seizure. R38 was observed sitting on couch in day room on 2/24/16, at 1:20 p.m. R38 did not display any respiratory issues at that time. R38's face sheet printed on 2/24/16, indicated R38 had diagnoses of dysphagia (swallowing problems) diabetes, major depressive disorder, and schizophrenia.	F 425		

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Review of electronic MAR indicated, staff signed "9" instead of a check mark for Levofloxacin (an antibiotic) 750 mg for pneumonia on 2/6/16, and Budesonide (a steroid medication used for the treatment of respiratory problems) inhaler 2/6, 2/7, 2/8, 2/10, 2/11, and 2/12.

R38's quarterly MDS dated 1/22/16, indicated R38 was cognitively intact and experienced delusions during the observation period. R38 required supervision with dressing, eating and hygiene. No shortness of breath noted.

Dietary CAA dated 10/28/15, indicated R38 was at increased risk for chocking related to pocketing food and diagnosis of dysphasia.

PN dated 2/6/16 "Med (medication) not in."
PN 2/8/16 Not available.
2/12/16 "not avsil [sic] [available]"

Discharge Summary dated 2/5/16, instructed staff that resident had been admitted for community acquired pneumonia with increased risk for aspiration pneumonia related to medications. Discharge orders included finish levofloxin 750 mg every days for two days and use Budersonide inhaler three puffs twice daily for seven days.

During interview on 2/24/16, at 1:20 p.m. R38 said, "I had pneumonia. I guess I got my meds. I don't know if I got all my meds, that the nurse's job."

During interview on 2/24/16, at 1:44 p.m. LPN-A reviewed the MAR and verified the levofloxin was not available on 2/6/16 and Budersonide was charted as not available for eight of 14 doses. LPN-A said "9" means other and a progress note

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should have been written each time a "9" was listed by the TMA who put the code in. LPN-A verified LPN-A stated the procedure for a readmission was to get the orders early and let the pharmacy know what new medications were required. If the pharmacy was unable to deliver a medication LPN-A stated they would call the doctor and obtain orders to complete dose when medication was available or to make the changes the doctor wanted. LPN-A said the risk of not completing a course of antibiotics and inhaler was that the resident might relapse.

During interview on 2/24/16 at 2:28 p.m. RN-A said, "Based on all of this I need to question staff who are charting '9' on the MAR what is happening and ensure we have medications for the residents. I was just auditing the MARs for holes not missed medications."

During interview on 2/24/16, at 2:28 p.m. the assistant director of nurses (ADON) verified R55's Celexa arrived yesterday because the pharmacy sent the medications to the pharmacy window instead of mailing them out. ADON said R55 was irritable yesterday. ADON verified the correct diagnosis for R22's gabapentin is seizure disorder and missing it would increase risk of seizures. ADON verified R38 did not receive the first dose of antibiotics. ADON said, "I am not sure why not. We have it in our emergency kit, so they could take it from there." ADON verified there was no evidence that the doctor was notified for any of the residents that they missed their medications. ADON said I expect the nurses would let the doctor know about a resident missing medications and obtain new orders. The TMA is expected to tell the nurse if a medication is unavailable. The nurse is to check with the

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F 425	Continued From page 33 pharmacy and if necessary order the medication. The nurse is also to update the doctor if the medication is not available. I expect the medication sheets to be accurate." Facility policy Medication Ordering from the Veteran's Administration dated 5/2/07, instructed staff: "It is the policy of Birchwood Care Home to order all physician ordered medications for residents associated with the Minnesota Veterans Administration in a timely manner to ensure that they are available for them as ordered." Facility policy Ordering Medications From Pharmacy dated 5/2/07, instructed staff: "1. Each Nurse/TMA med pass person will be responsible for pulling the label of and over the counter medication, cream or lotion, or injectable medication that is not on automatic renewal that has less than a five day supply of the medication left." "3. If a medication is needed for the same day or the next morning, the Nurse/TMA should write beside the label "NEED TODAY PLEASE."	F 425		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a sanitary and	F 465	The cracked tile by the entrance to the dishwashing area has been replaced.	3/14/16

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F 465	Continued From page 34 clean environment in the kitchen. This had the potential to affect all 59 residents in the facility and visitors who ate out of the facility kitchen. Findings include: During kitchen tour on 2/24/16, at 9:23 a.m. with the facility's director of nutritional services (DNS) and registered dietitian (RD) the following environmental concerns were identified and verified by both the DNS and RD. - A cracked tile, missing half tile to the left of the door frame on the entrance to the dishwashing area. DNS stated that noticed it today after surveyor pointed it out to him. - The entire kitchen wall, the kitchen door and the dining room wall by the serving counter noted with heavy spillage and splatter of food. - The kitchen wall across from the three compartment sink was heavily splattered with food and dust build up. - Around the entire perimeter of the kitchen refrigerator along the walls there was pieces of broken plate, heavy buildup of dust, black/brown grime and food debris. - The metal food preparation surface in the middle of the kitchen that contained storage cabinets for pots and pan, all around the sides, and around all legs of equipment there was buildup of black/brown grime and food splatter. Underneath the metal food preparation surface was buildup of black/brown grime and food debris. - The storage cabinet by the milk and coffee dispenser, the cabinet doors, on the sides and on top underneath the milk and coffee dispenser was heavily splatted with food and coffee stains. - The knife storage rack located underneath the air conditioning unit had dust and dirt buildup.	F 465	The kitchen door, the wall behind the door, and the wall across from the 3 compartment sink has been cleaned. The floor and wall by the kitchen refrigerator and the knife rack have been cleaned. The metal storage area under the milk and coffee dispensers, the cabinet doors and counter top and the wall under the serving counter in the dining room have been cleaned. The metal serving counter, drawers and shelves have been cleaned. The Dietary Manager will be responsible for monitoring the kitchen and dining room cleaning schedules to ensure daily, weekly and monthly cleaning is completed. The Consultant Dietician will be responsible for monitoring kitchen and dining room sanitation monthly. Audits will be done weekly to monitor compliance. Audits will be reviewed at the quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING _____ B. WING _____	02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	715 WEST 31ST STREET MINNEAPOLIS, MN 55408

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F 465	Continued From page 35 - The storage cabinets in the metal food preparation area had two pots that had black/brown grime buildup on the inside of the pots. The DNS verified the buildup and stated the inside of the two pots was not cleanable and needed to be thrown away. - Inside the cabinets of a metal cabinet used for storage of pans and serving utensils by the serving counter was noted with heavy splatter of food, food debris and dust buildup. During an interview on 2/24/16, at 9:23 a.m. DNS stated staff are expected to clean daily, weekly and monthly, and sign the cleaning log that the task was completed. At 11:23 a.m. DNS was able to provide daily cleaning logs. DNS stated weekly and monthly cleaning was not done. Review of undated Birchwood Care Home policies: - "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.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	**715 WEST 31ST STREET** **MINNEAPOLIS, MN 55408**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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:	K 000	EPOC	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2016**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Birchwood Care Home is a 3-story building with a partial basement. The building was constructed at 2 different times. The original 3 story building was constructed in 1966 and was determined to be of Type II(222) construction. In 2000, a 1 story addition was constructed to the East that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 59 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 050		3/10/16

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	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2016**

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K 050	Continued From page 2 conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 59 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on February 25, 2016, review of the fire drill documentation revealed that the first shift conducted their fire drills at 1138, 1229, 0948, and 1040; the third shift conducted their drills at 0200, 0137, 0225, and 0130. These times are not varied in accordance with the 2000 edition of the Life Safety Code (NFPA 101). This deficient practice was confirmed by the Director of Environmental Services at the time of inspection.	K 050	All future fire drills will be at least two hours difference per shift per fire drill. To ensure this does not happen again we will look @ the fire drill log and attempt to conduct fire drills three hours different if possible. Pete Stinar, Director of Maintenance will be responsible to assure compliance effective 3/9/16.	

MDH
Minnesota
Department
of Health

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.

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
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	02/24/2016

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3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: Citation Text for Tag 0000, Regulation D0OQ Charais, Amy You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	3 000		

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3 000	Continued From page 1 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 02/24/2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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	3 000		

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3 000	Continued From page 2 PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3 000		
3 601	MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control (a) A boarding care home must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of The guidelines. (b) Written compliance with this subdivision must be maintained by the boarding care home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Mantoux testing was completed for 3 of 5 residents (R6, R38, R64)	3 601	Corrected.	3/14/16

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3 601	Continued From page 3 and 1 of 5 staff members. Findings include: A review of R6's medical record indicated she admitted to the facility on 5/14/08. The Medical record lacked evidence of a symptom screen, as well as documentation of a 2 step TB (tuberculin) skin test. A review of R38's medical record indicated he admitted to the facility on 9/16/15. The medical record lacked evidence of a symptom screen and a 2 step TB skin test. A review of R64's medical record indicated he admitted to the facility on 2/1/16. The medical record lacked evidence of a symptom screen and a 2 step TB skin test. A review of E1's employee file indicated a hire date of 2/16/16. There was no indication of a symptom screen or a TB skin test. During an interview on 2/24/16, at 1:22 p.m. the assistant director of nursing stated resident's should have a two-step TB skin test upon admission. A facility policy titled Birchwood Care Home Mantoux Test Policy dated 5/2/07, indicated all new residents and staff receive an intradermal Mantoux test to screen for infection. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 601		
31105	MN Rule 4655.7810 Distribution of Medications	31105		3/14/16

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31105	Continued From page 4 A system shall be developed in each boarding care home to assure that all medications are distributed safely and properly. All medications shall be distributed and taken exactly as ordered by the physician. Any medication errors or resident reactions shall be reported to the physician at once and an explanation made in the resident's personal care record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that they had sufficient medications for 5 of 5 (R8, R55, R14, R22, R38) residents who were reviewed for medications. Findings include: R8's Face Sheet printed on 2/24/16, indicated R8 had diagnoses of paranoid schizophrenia, delusional disorder, history of a suicide attempt and squamous cell carcinoma (cancer). During medication administration observation on 2/23/16, at 7:38 a.m. R8's Abilify (a medication for the treatment schizophrenia) was unavailable. A review of electronic Medication Administration Record (MAR) on 2/24/16, did not indicate the resident had received medication when it arrived from the pharmacy. Licensed practical nurse (LPN)-A verified medication had not been ordered and was observed to order medication. R8's annual Minimum Data Set (MDS) dated 11/27/15, was cognitively intact with minimal symptoms of depression, and experienced hallucinations and delusions during the observation period and had daily behaviors that	31105	Corrected	

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31105	Continued From page 5 did not affect others. The Medication Review Report printed 2/24/16, indicated R8 was to receive Abilify 20 milligram (mg) every day for 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." On 2/23/16, at 1:47 p.m. trained medication aide (TMA)-A verified she had charted "9" on the MAR to indicate that a Progress Note (PN) was written and the PN dated 2/23/16, at 7:41 a.m. "medication is n.a. [non-available]" meant the medication was not available. A "9" instructed staff or others to see the PN. During interview on 2/24/16, at 1:44 p.m. LPN-A reviewed the MAR and verified the Abilify arrived on 2/23/16, but was not given when it arrived. LPN-A stated unsure why it was not given because she was not here. R55 was observed on 2/24/16, at 1:12 p.m. R55 was observed lying on bed with covers over the	31105		

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31105	Continued From page 6 head. When R55 sat 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. Review of current electronic MAR indicated, staff signed "9" for Celexa (a medication for the treatment of depression) 10 mg instead of a check mark on 2/10/16, 2/16/16, 2/19/16, 2/21/16, and 2/23/16. Review of PN indicated: 2/10/16, no PN regarding oral medications, 2/16/16, "medication is n.a." 2/19/16, "medication is n.a." 2/21/16, "medication is n.a." 2/23/16, "medication is n.a." R55's admission MDS dated 1/27/16, was moderately cognitively impaired with symptoms of mild depression, and experienced delusions during the observation period. Mood State CAA dated 2/3/16, indicated, "...Resident reported having little interest in things, feeling tired and sluggish, and trouble concentrating 7-11 days. Stated feeling better off dead 2-6 days. Completed suicide risk assessment with client: resident that he has no intention or plan to hurt himself. He stated that he feels like this when everything start to get bad. Resident stated that he will reach out to staff if he ever feels this way." Psychotropic Drug Use CAA dated 2/3/16, indicated, "staff will continue to follow current plan of care to maintain current level of functioning for improvement as indicated and to minimize risks when necessary with re-direction and cueing from staff, and case manager with assistance as needed with use of M.D. [medical doctor] ordered	31105		

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31105	Continued From page 7 Psychotropics, as directed with goals and interventions as stated in his current plan of care." Mood Care Plan dated 2/15/16, indicated during assessment on 1/27/16, R55 voiced symptoms of mild depression and mentioned feeling like he would be better off dead. Suicide risk assessment was done and resident did not have a plan or desire to hurt himself. Interventions included, "Staff would follow interventions to decrease symptoms under individualized care plan areas as needed." In addition Self Administration of Medication (SAM) care plan initiated on 2/14/16, indicated resident unable to SAM due to decreased cognition and instructed staff, "Nursing will dispense all medications when resident is in facility." "Nursing will medicate and do treatments per M.D. order. " The hospital Discharge Summary dated 1/21/16, indicated R55 ' s suicide risk level impression was "Heightened-has identified many risk factors but protective factors have influence to keep from imminent risk." No suicide attempts although R55 had thoughts about suicide. R55 had four psychiatric hospitalizations since 2013. The Medication Review Report printed 2/24/16, indicated R55 was to receive Celexa 10 mg. every day for depression. The PN dated 2/19/16, indicated, "Resident voiced being upset to MR [medical records] in the morning, talking about leaving and not coming back and being treated poorly. Talked to resident in office. He stated being upset that no one knows when his appointments are, stated he has not gotten any mail and thinks that his address has not been changed at the VA [Veterans	31105		

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Administration hospital]. Stated if this was not addressed he was going to leave and kill himself. Allowed him to vent feelings. Offered to call the VA and see if we could get a list of his appointments and ask them about his address change. He stated this lifted so much off and he feels much better, stated he would not leave and/or hurt himself. Talked to CM [case manager] Supervisor, she stated his address at the VA has been changed to facility address, she also faxed a copy of all the appointments that he currently has scheduled. Showed resident, he was very happy, stating he was so stressed about this and now he is not."

The PN dated 2/23/16, indicated "Resident came to office upset about his medications not being delivered. Stated two of us had called his CM to see if she can bring them. He stated over and over again that she cannot bring the medications. I really need that pill that helps me calm down otherwise I don't know what I am going to do. Assured him that if she couldn't bring them, staff would go to the VA to pick them up. The CM called back and they are now instructed not to transport medications unless there is an emergency, she was able to get an emergency exception and will bring his medications when he comes to visit resident at facility this afternoon. Notified resident, she [sic] thanked writer for the help."

During interview on 2/24/16, at 1:12 p.m. R55 said, "My mood gets bad when I do not have my medications. I get very anxious. Yesterday was bad."

During interview on 2/24/16, at 1:44 p.m. LPN-A verified the Celexa was not available from at least 2/16/16. LPN-A stated, "The medications were

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delivered yesterday at about 10:00 a.m. or 11:00 a.m. by his VA case manager." LPN-A verified the MAR was not accurate. LPN-A stated "If I knew I (the medications were not available) I would call the MD on day two of not getting the medications. I am responsible for the TMA, but if they do not tell me that they are out, how would I know."

During interview on 2/24/16, at 2:28 p.m. the social worker said R55 was irritable yesterday. If he had a complaint, R55 could become aggressive. R55 had a history of making statement of killing himself but if you take care of the complaint it immediately clears. There was the potential that depression would worsen without the Celexa and R55 would act on his statements.

R14 was sitting on edge of bed on 2/24/16, at 1:15 p.m. A fine tremor observed in hands but R14 was able to hold water cup without spilling.

R14's face sheet printed on 2/24/16, indicated R14 had diagnoses of major depressive disorder, and neuroleptic induced Parkinsonism, abnormalities of gait and mobility and history of falling.

Review of electronic MAR indicated, staff signed "9" instead of a check mark for
Sinemet (a medication used to control tremors) 10-100 mg. 8 a.m. 1/15/16, 1/16/16 (2 of 54 doses)
Sinemet 10-100 mg. 2:00 p.m. 1/12, 1/15 through 1/19, 1/21, 1/23, 1/25, 1/28 through 1/30, 2/1, 2/2, 2/5, 2/6, 2/8, 2/10 through 2/17, 2/20 through 23 (29 of 54 doses); Sinemet 10-100 mg. 8:00 p.m. 1/25, 1/27, 2/1, 2/10 (4 of 54 doses) for a total (35 of 162 possible doses).

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31105	Continued From page 10 Review of PN from 11/24/15 until 2/24/15, indicated 20 progress notes that medication was unavailable. PN dated 1/26/16 at 2:37 p.m. indicated, " call placed to pharmacy re: Sinemet order and requiring a new script. Updated by VA pharmacy that resident needs to be seen by prescribing MD to get this med reordered. Updated medical records and resident has an appointment with Dr. Erickson, per medical records." The Birchwood Care Home Referral dated 1/27/16, indicated R14 had an appointment with primary care physician for a physical. No information was provided to primary care physician about the need for a new prescription for Sinemet or that R14 had missed at least 15 doses of Sinemet since the first of January. R14's quarterly MDS dated 11/20/15, indicated was cognitively intact with symptoms of mild depression, and experienced hallucinations and delusions during the observation period. R14 required supervision with dressing, toileting and hygiene and used a walker for ambulation. No falls recorded. Falls CAA dated 2/23/15, indicated R14 receives antidepressant and antipsychotic daily increasing fall risk and had a history of falls. R14 was seen at the VA hospital after a fall on 11/2/14 at which time the VA stated R14 had Parkinson gait likely related to medications and added Sinemet and a course of physical therapy to reduce fall risks. Care plan considerations instructed staff to "...follow current plan of care to maintain current level of functioning with re-direction and cueing, staff assistance as needed with fall safety, with goals and interventions as stated in current plan of care."	31105		

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Psychotropic drug use care plan revised 2/28/08, instructed staff that goal was for "Resident will have no increase in TD [Tardive dyskinesia is a neurological disorder resulting in involuntary repetitive body movements.] Symptoms or EPSE [extrapyramidal side effects are movement disorders caused by medications]." interventions included Nursing to administer medications per doctors ' orders, monitor for signs of TD or EPSE and notify doctor of changes in behavior.

Progress Note dated 1/26/16, indicated, "Call placed to pharmacy re: Sinemet order and requiring a new script. Updated by VA pharmacy that resident needs to be seen by prescribing MD to get this med reordered. Updated medical records and resident has an appointment with [medical doctor], per medical records."

Medication Review Report printed 2/24/16, indicated R14 was to receive Sinemet 10-100 mg. three times a day for neuroleptic induced Parkinsonism.

During interview on 2/24/16 at 1:15 p.m. R14 said, "I am not sure what my Sinemet is for. The nurses give me my meds. Please do not ask me more questions."

During interview on 2/24/16, at 1:44 p.m. LPN-A reviewed the MAR and verified R14 was out of Sinemet from at least February 10th until now. " We are waiting on the doctor to decide if he is going to reorder. R14 is completely out of Sinemet and we do not borrow medications. R14's Parkinson ' s is not really bad. He gets his medications from the VA hospital. (Registered nurse (RN)-A) orders all medications from the VA. " LPN-A verified there was no documentation that the doctor was notified R14 had missed at least

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40 doses of Sinemet in progress notes. LPN-A verified that the MAR was not accurate. LPN-A stated (R14) saw primary MD at the VA on 1/27/16, and the referral said, "Continue current regimen". LPN-A verified there was no information regarding Sinemet written on the referral form

During interview on 2/24/16 at 2:28 p.m. RN-A said, "On 1/26/16 I made a call to the VA. We are trying to get (medical doctor) to write a script but he will not write it. We are working on neurology but they are unable to get a hold of the doctor." RN-A said the risks of missing Sinemet was the Parkinson ' s symptoms could increase.

R22's face sheet printed on 2/24/16, indicated R22 had diagnoses of major depressive disorder, acute pain and convulsions.

Review of electronic MAR indicated, staff signed "9" instead of a check mark on 2/15/16, for gabapentin.

R22's quarterly MDS dated 1/15/16, was cognitively intact with symptoms of mild depression. R22 required supervision with dressing, and hygiene and used a walker for ambulation. No pain or falls recorded. Seizure disorder noted on the quarterly MDS.

Falls CAA dated 7/31/15, indicated resident had diagnosis of seizure disorder.

Medication Review Report printed 2/24/16, indicated R22 was to receive Gabapentin 600 mg at bedtime for convulsions.

Review of PNs from 12/24/15 to 2/23/16, do not

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31105	Continued From page 13 indicate any seizure activity or falls. During an interview on 2/24/16, at 1:10 p.m. R22 said, "I do not always get all of my medications but I am ok. The nurses give me my meds." During interview on 2/24/16, at 1:44 p.m. LPN-A reviewed the MAR and verified R22 did not receive gabapentin on 2/15/16 because it was not available. LPN-A said "9" means other and a progress note should have been written each time a " 9 " was listed by the TMA who put the code in. LPN-A said gabapentin was for neuropathy not seizures as listed. " We have not had any episodes of a seizure since (R22) has been here. " LPN-A said if the gabapentin was for neuropathy then (R22) would be at risk for increased pain. If it was for seizures there would be a low risk for (R22) having a seizure. R38 was observed sitting on couch in day room on 2/24/16, at 1:20 p.m. R38 did not display any respiratory issues at that time. R38's face sheet printed on 2/24/16, indicated R38 had diagnoses of dysphagia (swallowing problems) diabetes, major depressive disorder, and schizophrenia. Review of electronic MAR indicated, staff signed "9" instead of a check mark for Levofloxacin (an antibiotic) 750 mg for pneumonia on 2/6/16, and Budesonide (a steroid medication used for the treatment of respiratory problems) inhaler 2/6 2/7 2/8 2/10 2/11 2/12. R38's quarterly MDS dated 1/22/16, indicated R38 was cognitively intact and experienced delusions during the observation period. R38	31105		

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31105	Continued From page 14 required supervision with dressing, eating and hygiene. No shortness of breath noted. Dietary CAA dated 10/28/15, indicated R38 was at increased risk for chocking related to pocketing food and diagnosis of dysphasia. PN dated 2/6/16 "Med (medication) not in." PN 2/8/16 Not available. 2/12/16 "not avsil [sic] [available]" Discharge Summary dated 2/5/16, instructed staff that resident had been admitted for community acquired pneumonia with increased risk for aspiration pneumonia related to medications. Discharge orders included finish levofloxin 750 mg every days for two days and use Budersonide inhaler three puffs twice daily for seven days. During interview on 2/24/16, at 1:20 p.m. R38 said, "I had pneumonia. I guess I got my meds. I don't know if I got all my meds, that the nurse's job." During interview on 2/24/16, at 1:44 p.m. LPN-A reviewed the MAR and verified the levofloxin was not available on 2/6/16 and Budersonide was charted as not available for eight of 14 doses. LPN-A said "9" means other and a progress note should have been written each time a " 9 " was listed by the TMA who put the code in. LPN-A verified LPN-A stated the procedure for a readmission was to get the orders early and let the pharmacy know what new medications were required. If the pharmacy was unable to deliver a medication LPN-A stated they would call the doctor and obtain orders to complete dose when medication was available or to make the changes the doctor wanted. LPN-A said the risk of not completing a course of antibiotics and inhaler was	31105		

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31105	Continued From page 15 that the resident might relapse. During interview on 2/24/16 at 2:28 p.m. RN-A said, " Based on all of this I need to question staff who are charting ' 9 ' on the MAR what is happening and ensure we have medications for the residents. I was just auditing the MARs for holes not missed medications. " During interview on 2/24/16, at 2:28 p.m. the assistant director of nurses (ADON) verified R55's Celexa arrived yesterday because the pharmacy sent the medications to the pharmacy window instead of mailing them out. ADON said R55 was irritable yesterday. ADON verified the correct diagnosis for R22's gabapentin is seizure disorder and missing it would increase risk of seizures. ADON verified R38 did not receive the first dose of antibiotics. ADON said, "I am not sure why not. We have it in our emergency kit, so they could take it from there." ADON verified there was no evidence that the doctor was notified for any of the residents that they missed their medications. ADON said I expect the nurses would let the doctor know about a resident missing medications and obtain new orders. The TMA is expected to tell the nurse if a medication is unavailable. The nurse is to check with the pharmacy and if necessary order the medication. The nurse is also to update the doctor if the medication is not available. I expect the medication sheets to be accurate. Facility policy Medication Ordering from the Veteran's Administration dated 5/2/07, instructed staff: " It is the policy of Birchwood Care Home to order all physician ordered medications for residents associated with the Minnesota Veterans Administration in a timely manner to ensure that they are available for them as ordered."	31105		

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31105	Continued From page 16 Facility policy Ordering Medications From Pharmacy dated 5/2/07, instructed staff: "1. Each Nurse/TMA med pass person will be responsible for pulling the label of and over the counter medication, cream or lotion, or injectable medication that is not on automatic renewal that has less than a five day supply of the medication left." "3. If a medication is needed for the same day or the next morning, the Nurse/TMA should write beside the label "NEED TODAY PLEASE." TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	31105		
31240	MN Rule 4655.8520 E Dietary Staff Requirements;Sanitary condition Dietary staff: E. Sanitary procedures and conditions shall be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a sanitary and clean environment in the kitchen. This had the potential to affect all 59 residents in the facility and visitors who ate out of the facility kitchen. Findings Include: During the initial kitchen tour on 2/22/16, at 11:44 a.m. with the facility's director of nutrition services	31240	Corrected.	3/14/16

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31240	Continued From page 17 (DNS) the following sanitation concerns were observed - A wall mounted fan directly above the clean dish area was turned on and blowing directly towards three racks containing clean dishes which were drying. The fan was dirty with heavy dust/dirt buildup. The DNS verified that the fan was dirty and needed to be cleaned. During follow-up kitchen tour on 2/24/16, at 9:23 a.m. with DNS and the registered dietitian (RD) the following was observed - Six burner stove had a heavy buildup of a brown/black substance on the backsplash to the back of the stove. The two oven doors below the six burner stove had a buildup of a black/brown greasy substance on and around the handle, on the knobs and sides of the door. DNS verified it needed to be cleaned and stated major oven cleaning is completed monthly. - The air conditioning unit located above the clean area where knifes and clean towels are kept, to the left of the six burner stove and across from the food preparation area was noted to be dirty with dust/dirt build up. The air conditioning unit was turned on and blowing directly towards the food preparation area. DNS verified that the air conditioning unit needed to be cleaned and stated that maintenance is responsible for cleaning it. During an interview on 2/24/16, at 9:23 a.m. DNS stated staff are expected to clean daily, weekly and monthly, and sign the cleaning log that the task was completed. At 11:23 a.m. DNS was able to provide daily cleaning logs. DNS stated weekly and monthly cleaning was not done. During interview on 2/24/16, at 11:30 a.m. the facility's maintenance director (MD) verified the air conditioning unit and wall mounted fan in the	31240		

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31240	Continued From page 18 dishwashing area of the kitchen was dirty with dust/dirt build up. MD further stated all areas of the kitchen were cleaned the week of 2/15/16 to 2/21/16, but forgot to clean the wall mounted fan. Review of undated Birchwood Care Home policies: - "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 Ovens", the policy indicated ovens will be cleaned according to the schedule at least once every 2 weeks and as needed. - "Clean Stove Top", the policy indicated that the range will be kept clean during meal preparation, range will be cleaned after each use and spills will be cleaned up as they occur. Cleaning policy for wall mounted fan and air conditioning unit was requested but none provided. During kitchen tour on 2/24/16, at 9:23 a.m. with the facility's director of nutritional services (DNS) and registered dietitian (RD) the following environmental concerns were identified and verified by both the DNS and RD. - A cracked tile, missing half tile to the left of the door frame on the entrance to the dishwashing area. DNS stated that noticed it today after surveyor pointed it out to him. - The entire kitchen wall, the kitchen door and the dining room wall by the serving counter noted with heavy spillage and splatter of food. - The kitchen wall across from the three	31240		

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31240	Continued From page 19 compartment sink was heavily splattered with food and dust build up. - Around the entire perimeter of the kitchen refrigerator along the walls there was pieces of broken plate, heavy buildup of dust, black/brown grime and food debris. - The metal food preparation surface in the middle of the kitchen that contained storage cabinets for pots and pan, all around the sides, and around all legs of equipment there was buildup of black/brown grime and food splatter. Underneath the metal food preparation surface was buildup of black/brown grime and food debris. - The storage cabinet by the milk and coffee dispenser, the cabinet doors, on the sides and on top underneath the milk and coffee dispenser was heavily splatted with food and coffee stains. - The knife storage rack located underneath the air conditioning unit had dust and dirt buildup. - The storage cabinets in the metal food preparation area had two pots that had black/brown grime buildup on the inside of the pots. The DNS verified the buildup and stated the inside of the two pots was not cleanable and needed to be thrown away. - Inside the cabinets of a metal cabinet used for storage of pans and serving utensils by the serving counter was noted with heavy splatter of food, food debris and dust buildup. During an interview on 2/24/16, at 9:23 a.m. DNS stated staff are expected to clean daily, weekly and monthly, and sign the cleaning log that the task was completed. At 11:23 a.m. DNS was able to provide daily cleaning logs. DNS stated weekly and monthly cleaning was not done. Review of undated Birchwood Care Home policies:	31240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00168	A. BUILDING: _____ B. WING _____	02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	715 WEST 31ST STREET MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 (21) days.	31240		