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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZYHF

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 **02/23/2015** (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: * Code: **A*** (L12)

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

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, Supervisor 02/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
03/03/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-E166

Electronically Delivered: March 4, 2015

Mr. Randal Hagemeyer, Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, Minnesota 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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective February 16, 2015 the above facility is certified for:

60 - Nursing Facility II 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: February 23, 2015

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

RE: Project Number SE166024

Dear Mr. Hagemeyer:

On January 26, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 8, 2015. 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 February 23, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 16, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 8, 2015, effective February 16, 2015 and therefore remedies outlined in our letter to you dated January 26, 2015, 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.

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E166	A. Building B. Wing	2/23/2015

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **01/08/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **02/16/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **02/16/2015**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/16/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/16/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/16/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/02/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **02/16/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **02/04/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/06/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **02/16/2015**	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	Date:	Signature of Surveyor:	Date:
	GD/AK	02/23/2015	18623	02/23/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/8/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZYHF

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)

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 **01/08/2015** (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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	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 :
Mary Bruess, HFE NE II — 02/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Kleppe, Enforcement Specialist — 02/25/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
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28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
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30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL 3/4/15

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

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

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03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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* Code: B (L12)

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18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/25/2015 (L20)

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

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03/31/1974
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27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
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26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
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02-Dissatisfaction W/ Reimbursement
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04-Other Reason for Withdrawal
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05-Fail to Meet Health/Safety
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(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: January 26, 2015

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

RE: Project Number SE166024

Dear Mr. Hagemeyer:

On January 8, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 17, 2015, 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 February 17, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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 April 8, 2015 (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 July 8, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 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 _____	01/08/2015

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 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 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the results of the most recent State agency (SA) survey were available for residents, families and public visitors to review. This deficient practice had the potential to affect all 58 of 58 residents residing in the facility, families and public visitors.	F 167	F167: Posting of Nursing Home Survey Results Birchwood Care Home respectfully disagrees with this statement of deficiency. We do post these results. Upon inspection it was determined that	1/8/15

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

Electronically Signed | 02/05/2015

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 167	Continued From page 1 Findings include: On 1/5/15, at 11:07 a.m. a three-ring binder titled Birchwood Care Home Survey Results on the front of the binder, was observed to be stored across from the dining room to the right side of the employee lounge on a wooden shelf. Upon looking inside the binder, the dated survey results posted were from survey conducted on 7/18/13. At 1:42 p.m. the administrator stated he thought he told another staff member to update the survey book. The administrator then walked to the activity area towards the back of the facility. At 1:43 p.m. the director of nursing (DON) verified the survey results in the three-ring binder were from the 2013 SA survey and no other SA survey results were in the binder. The administrator returned, stated he did not locate the current survey. Although requested, no policy related to the posting of survey results was provided.	F 167	the most recent survey results had been removed from the book. On the same day that this was noted, the most current survey results were again put into the book and placed in front lobby. * Birchwood Care Home will post most recent survey results and will check for compliance on a quarterly basis. Policy/Procedure attached. The Director of Therapeutic Programs, Director of Nursing and Administrator will be responsible for compliance. Completion date: 1/16/15	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine whether the	F 176	F 176: SELF ADMINISTRATION OF MEDICATIONS (See also attachment	2/16/15

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F 176	Continued From page 2 practice of self-administration of medication (SAM) was safe for 1 of 1 resident (R33) observed to self-administer medications during a medication administration observation. Findings include: On 1/5/15, at 7:46 a.m. the trained medication aide (TMA)-A was observed to hand R33, who was standing outside on the other side of the glass window located in the nursing station, two bottles of Artificial tears and Deep Sea nasal spray after taking them out of clear plastic bags. R33 was observed taking off the cap of the eye drop and was observed attempting to squeeze a drop into the right eye three times before she indicated she was able to get a drop out. R33 then went over to the left eye and had to attempt to squeeze the drop out two times and then indicated to TMA-A she thought she was getting low and TMA-A stated she would put it on the side and order more. -At 7:49 a.m. R33 proceeded to take the cap off the Deep Sea nasal spray and squeezed the middle of the bottle into both nostrils as she sniffed the medication, then handed the nasal spray back to the TMA-A inside the nursing station. On 1/5/15, at 8:44 a.m. registered nurse (RN)-A verified after going through the physician orders dated 12/1/14, R33 did not have an order to self-administer either the eye drops or nasal spray and indicated R33 had only an order to self-administer the inhaler. On 1/6/14, at 3:43 p.m. when asked if she expected R33 to have had an order to self-administer the eye drops and Deep Sea	F 176	F176) An individual resident may self administer drugs if the interdisciplinary team, as defined by S483.20(d)(2)(ii), has determined that this practice is safe. Birchwood Care Home mission is to assure that all residents receive accurate Pharmaceutical services and procedures. The survey indicates that we failed to meet this requirement because 1 of 1 resident's in the sample whose medication administration was observed (R33), did not have an order for self administration of eye drops. It is the desire of Birchwood Care Home to provide the best practicable care to every resident and to reach the highest level of independence attainable. The following steps have been taken: How will we correct for this individual resident: The SAM assessment was reviewed, a new SAM assessment was completed including discussion and observation of resident self administering her eye drops and it did classify this resident as capable of self administration of eye drops and nasal inhaler. Physician order was obtained on same day this was identified that specifies "okay to self administer eye drops and nasal spray." How the facility will identify other residents having the potential to be affected: *All self administration of medication	

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F 176	Continued From page 3 nasal spray the director of nursing (DON) acknowledged R33 should have had orders to self-administer and should have been assessed. DON also stated the Minimum Data Set (MDS) nurse had missed the assessment as she ensured the assessments were done with MDS. R33's diagnoses included bipolar disorder and schizoaffective disorder obtained from the quarterly MDS dated 10/17/14. In addition, the MDS indicated R33 had intact cognition. R33's cognitive loss/dementia Care Area Assessment (CAA) dated 7/31/14, indicated R33 showed short term memory loss remembering ..." R33's Physician Orders dated 12/17/14, revealed R33 had the following orders: -Artificial Tears solution 1.4% 1 drop to both eyes four times daily for dry eyes as needed (PRN) -Deep Sea Nasal Spray (Saline) solution 0.65%to each nostril every 30 minutes PRN R33's self-administration of medications care plan dated 10/3/2007, indicated the interdisciplinary team (IDT) had determined R33 was unable to self-administer medications due to cognitive deficits and poor insight into her disease. The care plan directed staff to give all medications and supervises self-administration of inhalers. In addition, the care plan directed "Nursing will medicate and do treatments per M.D. [physician] order." Review of Self Administration of Medication Assessment dated 10/17/14, revealed the assessment indicated "Resident continues to be ineligible for SAM due to cognitive deficits and poor insight into her disease. Staff gives all medications..."	F 176	assessments will be audited to be sure the orders for "okay to self administer medications" is current, there is a current physician order and it is written on the MAR/TAR/IAR if the assessment indicated they have the ability to do so. *All Careplans will be reviewed to be sure any orders for self administration of medications are written on the careplan specific to the findings of the assessment and physician orders. How the facility will monitor performance: Resident Care Coordinator will thoroughly review Self Administration of medication assessment during each MDS/Care Conference review, including checking to be sure that current physician order is present, order is clearly written on the MAR/TAR/IAR and that it is included in the current careplan. Resident Care Coordinator/ Director of Nursing will be responsible for compliance.	

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F 176	Continued From page 4 Self-Administration Of Medication policy dated 5/2/07, directed "When the determination is made that a resident is qualified candidate for medication self-administration the interdisciplinary team [IDT] will acquire a physician's order for this purpose that is specific to the type such as oral, creams, drops, inhalers..."	F 176		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		2/16/15

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F 225	Continued From page 5 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their Abuse Prevention policy for promptly reporting to the State agency (SA) 5 of 6 incidents reviewed who involved residents (R15, R65, R66, R27, R59) that were identified for alleged sexual abuse, resident to resident altercation, and misappropriation of property. In addition, the facility's policy was unclear as to when the facility staff was to report the alleged incidents to the SA. This had the potential to affect 47 of 58 residents who resided in the facility. Findings include: Lack of reporting to the SA: R15 was interviewed on 1/5/15, at 10:25 a.m. an allegedly reported sexual abuse during the interview. R15 indicated four men came into her room, forced themselves on her and sexually abused her. The alleged abuse was immediately reported to the director of nursing (DON) after the interview. The facility did not immediately report the incident to the SA. R15's Minimum Data Set (MDS) dated 10/24/14, noted R15 had diagnoses of depression and	F 225	Birchwood Care Home respectfully disagrees with this statement of deficiency in the matter of not reporting allegations of abuse. Consistent with federal requirements, Birchwood Care Home is providing this plan of correction. This plan of correction is not a legal admission that a deficiency exists or that the statement of deficiency was correctly cited, and is not to be construed as an admission of fault by the facility or any facility employees. Birchwood Care Home prides itself on ensuring that all reportable instances of suspected abuse and neglect are reported, and investigated in a timely manner, as well as make sure that preventative measures are taken to ensure the safety of the resident. Staff would never willfully or purposely not report a suspected incident of abuse or neglect if we felt a resident had been harmed in any way. Resident R15 has a diagnosis of paranoid Schizophrenia with symptoms that manifest in the form of delusional	

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F 225	Continued From page 6 schizophrenia. R15 was identified by the facility to have intact cognition. R15's MDS also noted R15 had hallucinations and delusions. On 1/8/15, at 11:45 a.m. the licensed social worker (LSW) was interviewed and stated "Is aid we did not call in [R15's] incident to OHFC [Office of Health Facility Complaints or SA] because she is delusional and it happens all of the time." - at 12 noon the DON was interviewed and stated the incident was not reported as R15 had delusions and diagnosis of schizophrenia. R65 had many reports which included pregnancy and nurse sitting on her. R65's Vulnerable Adult Internal Investigation Reporting Form dated 3/2/14, noted R65 was hospitalized after a resident to resident altercation (R66 hit R65 on the head) on 3/1/14. The report noted R65 reported the incident to the charge nurse immediately. R66 then verbally threatened R65 by stating "Your [sic] done" and "Your [sic] dead" after R66 found out R65 was overheard by facility staff while on the phone talking about the incident. R27 reported to the facility staff that R66 hit R65 on the head. R66 came to the nurse's station and starting yelling at R27. The facility reported the incident to the SA on 3/2/14, (the next day). R65's Admission Record dated 3/4/14, indicated R65's diagnoses included paranoid schizophrenia and depression. R65's Birchwood Care Home Progress note dated 3/13/14, at 8:15 a.m. read R65 had a problem with anger as he kicked at a door. - at 10:05 a.m. the progress note depicted R65 to be cognitively intact, able to understand and	F 225	statements alleging various things happening that have never occurred; as stated in her care plan, she has made various delusional statements like, "the water here has gasoline in it" "people pushed me against the wall and pumped gasoline from my arm", and "three teammates from the Vikings raped her. This resident was interviewed immediately after she made the statement to surveyors about 4 men coming into her room. Resident R15 stated, Oh I think it was a flashback, I□m not sure where I thought it happened. R15 went continued to share other delusional ideations about the event happening at St. Mary□s hospital when she was having ECT. Resident R15 was able to identify that she hasn□t been to St. Mary□s hospital in 20 years and had never had an ECT. Resident R15 declined needing a PRN medication, stating that she felt safe at Birchwood Care Home. Resident R15 further stated that there has never been any inappropriate contact of any kind since she has been a resident at Birchwood Care Home. Staff responded to her comments by appropriately utilizing one of R15□s care plan interventions (Staff will offer reality based support and reassurance to resident when she is expressing delusional thoughts.) once a quick determination was made that her statement had been a delusion. According to a phone conversation with OHFC staff on 1/12/2015, nursing home staff have the right to determine whether an event is reportable under the Minnesota Vulnerable Adults Act and the	

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F 225	Continued From page 7 answer questions appropriately. R66's MDS dated 12/11/13, indicated R66 was moderately cognitively impaired, had trouble focusing, and was easily distracted. R27's MDS dated 4/25/14, noted R27 was cognitively intact, had a diagnosis of schizophrenia and had displayed behavioral symptoms of cursing, threatening and screaming at other one to three times a week. R59's Vulnerable Adult Internal Investigation Reporting Form dated 10/31/14, and time unknown that her "I-Phone" was missing on 10/30/14, at 9:30 a.m. The facility did not immediately report the incident to the SA until the next day, at 9:24 a.m. (24 hours later). R59's MDS dated 11/28/14, identified R59 as being cognitively intact and having behaviors such as inattention, disorganized thinking and altered level of consciousness. On 1/7/15, at 3:20 p.m. the licensed social worker (LSW) was interviewed and stated missing items and abuse were to be reported immediately. "Don't we have time to investigate first? We report within 24 hours after staff has time to investigate in IDT [interdisciplinary team] meetings each morning." On 1/8/15, at 11:05 a.m. registered nurse (RN)-A was interviewed and stated she would report any abuse or incidents right away and replied, "I would call CEP [common entry point] myself." - at 11:10 a.m. licensed practical nurse (LPN)-B was interviewed and stated she would report	F 225	Federal Nursing Facility regulatory requirements. In the example provided, facility interdisciplinary staff determined that the communicated event was not reportable due to it being determined a delusional statement. Consistent with R15□s diagnoses and historical actions. Plan of Correction: 1.R15 continues to be a resident at Birchwood Care Home. The care plan and approaches continue to be appropriate for R15□s diagnoses and care. R15 states she feels safe at the facility. Said incident was reported to OHFC and the CEP on 1/8/2015. Internal facility investigation was completed 1/12/15, within the required five-day time period. On 1/12/2015, three hours after submission of the internal facility investigation, OHFC returned a reply that no further investigation was necessary. 2. All residents currently residing at Birchwood Care Home who report similar statements and/or allegations will be reported to the State Agency immediately. 3. All front-line nursing staff have received re-education, based on direction given by MDH surveyors, to take all statements made by residents at face value and report any statements regarding sexual acts, abuse, or neglect immediately to the designated State Agency, even if staff have determined that the statements or allegations were delusional in nature. Full staff in-service on this approach will be	

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F 225	Continued From page 8 immediately to the administrator, DON and CEP. According to the facility policy titled Vulnerable Adult Policy undated, indicated all staff members at Birchwood Care Home were mandated reporters. Staff were to report assault, prostitution, criminal sexual conduct, mistreatment, of confined persons, mistreatments of resident and/or drugs use of drugs to injure or facilitate crime. In addition, the facility staff were to report financial exploitation which included misappropriation of funds. The policy also included two sections of how to report abuse to the SA. The first section read "immediately charge nurse or the director of resident services, director of nursing, or the administrator if they are in the building." That person would then make an initial report to the SA and the CEP. The second section read, "The charge nurse on duty at the time that staff become aware of a reportable incident, or the director of resident services, director of nursing or the administrator is responsible for submitting an incident report to the SA as soon as possible (within 24 hours from the time of initial knowledge that the incident occurred)." The facility did not repot timely to the SA and in addition it could not be determined at what point the facility staff should call the SA due to the inconsistent timeframes listed in the policy.	F 225	conducted February 16, 2015. 4. Policies and procedures have been updated to reflect immediate reporting of suspected abuse or neglect to the designated State Agency rather than the 24 hour time period that is reflected in the Federal Surveyor Guidance document. 5. The Director of Nursing and/or Director of Resident Services will be responsible to monitor that allegations of abuse and neglect are responded to with appropriate and timely reporting, investigations, and interventions. Correction action completed: February 16, 2015 As a matter of correction on the summary of deficiencies the licensed social worker is listed at a licensure level of LSW. Licensure level is LGSW as was indicated on name badge worn by the licensed social worker during entire survey.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		1/16/15

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F 226	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize the Abuse Prevention policy for promptly reporting to the State agency (SA) 5 of 6 incidents reviewed who involved residents (R15, R65, R66, R27, R59) that were identified for alleged sexual abuse, resident to resident altercation, and misappropriation of property. In addition, the facility's policy was unclear as to when the facility staff was to report the alleged incidents to the SA. This had the potential to affect 47 of 58 residents who resided in the facility. Findings include: According to the facility policy titled Vulnerable Adult Policy undated, indicated all staff members at Birchwood Care Home were mandated reporters. Staff were to report assault, prostitution, criminal sexual conduct, mistreatment, of confined persons, mistreatments of resident and/or drugs use of drugs to injure or facilitate crime. In addition, the facility staff were to report financial exploitation which included misappropriation of funds. Lack of reporting to the SA: R15 was interviewed on 1/5/15, at 10:25 a.m. an allegedly reported sexual abuse during the interview. The alleged abuse was immediately reported to the director of nursing (DON) after the interview. The facility did not immediately report the incident to the SA. R65's Vulnerable Adult Internal Investigation Reporting Form dated 3/2/14, noted R65 was	F 226	F226 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriateion of resident property. Incident involving Resident R15 was reported to the Common Entry Point on 1/8/2015, investigation was completed on 1/12/2015. On 1/12/2015 OHFC returned a reply that no further investigation was needed. Birchwood Care Home acknowledges that it did not follow federal guidelines regarding timely reporting of Vulnerable Adult incident on 5 of 6 incidents. Birchwood Care Home was following Minnesota Department of Health guidelines for timely reporting, which states within 24 hours. All 6 incidents that were reviewed by MDH surveyors were throughly investigated within 5 business days, and OHFC returned a reply on all that no further investigation was needed. DON and Licensed Social Worker (LGSW) reviewed Vulnerable Adult Policy that was updated last on May 23, 2012. Policy was updated to include Federal guidelines as follows: -Addition of mistreatment to all language where maltreatment was listed -Removing statement on page 6 that	

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	24E166	A. BUILDING _____ B. WING _____	01/08/2015

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F 226	Continued From page 10 hospitalized after a resident to resident altercation (R66 hit R65 on the head) on 3/1/14. The report noted R65 reported the incident to the charge nurse immediately. R66 then verbally threatened R65 by stating "Your [sic] done" and "Your [sic] dead" after R66 found out R65 was overheard by facility staff while on the phone talking about the incident. R27 reported to the facility staff that R66 hit R65 on the head. R66 came to the nurse's station and starting yelling at R27. The facility reported the incident to the SA on 3/2/14, (the next day). R59's Vulnerable Adult Internal Investigation Reporting Form dated 10/31/14, and time unknown that her "I-Phone" was missing on 10/30/14, at 9:30 a.m. The facility did not immediately report the incident to the SA until the next day, at 9:24 a.m. (24 hours later). Inaccurate policy: The facility's Vulnerable Adult Policy undated, included two sections of how to report abuse to the SA. The first section read "immediately charge nurse or the director of resident services, director of nursing, or the administrator if they are in the building." That person would then make an initial report to the SA and the common entry point (CEP). The second section read, "The charge nurse on duty at the time that staff become aware of a reportable incident, or the director of resident services, director of nursing or the administrator is responsible for submitting an incident report to the SA as soon as possible (within 24 hours from the time of initial knowledge that the incident occurred)." On 1/7/15, at 3:20 p.m. the licensed social worker	F 226	facility has up to 24 hours to report that an incident has occurred. In order to operationalize the policy these changes have been made so reporting and recordkeeping are more accurate and easier to follow and monitor. -A file cabinet was created in Resident Services Office with all completed reports being placed in alphabetical order. Policy and forms are also kept in same filing cabinet. - A new log form was created to reflect current record keeping practices -The website to report incidents was put on the desktop of the charge nurse computer. -Front line nursing staff were educated regarding the need to report all incidents immediately. -Instructions for timely completion of all Vulnerable Adult incidents is kept at the charge nurse desk, this has been updated with new policy. -Added to Vulneral Adult Policy direct phone number to Hennepin County CEP for staff to use when website and/or computer is not functioning properly. Education has already been provided to	

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F 226	Continued From page 11 (LSW) was interviewed and stated missing items and abuse were to be reported immediately. "Don't we have time to investigate first? We report within 24 hours after staff has time to investigate in IDT [interdisciplinary team] meetings each morning." On 1/8/15, at 11:05 a.m. registered nurse (RN)-A was interviewed and stated she would report any abuse or incidents right away and replied, "I would call CEP myself." - at 11:10 a.m. licensed practical nurse (LPN)-B was interviewed and stated she would report immediately to the administrator, DON and CEP. It could not be determined at what point the facility staff should call the SA due to the inconsistent timeframes listed in the policy.	F 226	front line nursing department staff outlining the need to immediately report any suspicions of mistreatment/ maltreatment. An inservice for all staff has been scheduled for February 19th, 2015 at which time all staff will be educated on revisions of the Vulnerable Adult policy and new recordkeeping practices. See updated Vulnerable Adult Policy attached See updated log form attached	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care in accordance to the care plan for 1 of 1 resident (R33) who self-administered medications during a medication administration observation. Findings include: R33 was observed on 1/5/15, at 7:46 a.m. to self-administer their medication at the nursing	F 282	F282 Services provided by the facility must be provided by qualified persons in accordance with each residents's written plan of care. Birchwood Care Home mission is to assure that all residents receive accurate Pharmaceutical services and procedures. The survey indicates that we failed to	2/16/15

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F 282	Continued From page 12 station. The trained medication aide (TMA)-A was observed handing R33 who was standing outside on the other side of the glass window located in the nursing station, two bottles of Artificial tears and Deep Sea nasal spray after taking them out of clear plastic bags. R33 was observed open the cap of the eye drop and was observed attempt to squeeze a drop into the right eye three times before she indicated she was able to get a drop out. R33 then went over to the left eye and had to attempt to squeeze the drop out two times and then indicated to TMA-A she thought she was getting low and TMA-A stated she would put it on the side and order more. -At 7:49 a.m. R33 proceeded to take the cap off the Deep Sea nasal spray and squeezed the middle of the bottle into both nostrils as she sniffed the medication then handed the nasal spray back to the TMA-A inside the nursing station. On 1/5/15, at 8:44 a.m. registered nurse (RN)-A verified after going through the physician orders dated 12/1/14, R33 did not have an order to self-administer either the eye drops or nasal spray and indicated R33 had only an order to self-administer the inhaler. On 1/6/14, at 3:43 p.m. when asked if she expected R33 to have had an order to self-administer the eye drops and Deep Sea nasal spray the director of nursing (DON) acknowledged R33 should have had orders to self-administer (SAM) and should have been assessed. DON also stated the MDS nurse had missed the assessment as she ensured the assessments were done with MDS. R33's diagnoses included bipolar disorder and	F 282	meet this requirement because 1 of 1 resident's (R33) who self-administered medications during a medication administration observation did not have a physician order to self administer eye drops or a nasal spray (although same resident did have okay to self administer inhalers). The survey also states that the resident should have been assessed however this is incorrect because the resident had been assessed during her last quarterly MDS as per facility policy. How the facility will correct for this individual resident: The SAM assessment was reviewed, a new SAM assessment was completed as resident is currently in her MDS window. Physician order was obtained on same day this issue was identified that states "okay to self administer eye drops and nasal spray." The careplan has been updated to specify that "resident does not SAM oral meds" and "Nursing supervises inhalers, nebs, eyedrops, and nasal spray." How facility will identify other residents having the potential to be affected: *All self administration of medication assessments will be audited to be sure the orders for "okay to self administer medications" matches what is written on careplan as well as MAR/TAR/IAR where appropriate (based on SAM assessment). *All careplans will be reviewed to be sure any orders for self administration of medications are present on the careplan and that they match the SAM assessments.	

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F 282	Continued From page 13 schizoaffective disorder obtained from the quarterly Minimum Data Set (MDS) dated 10/17/14. In addition the MDS indicated R33 had intact cognition. R33's cognitive loss/dementia Care Area Assessment (CAA) dated 7/31/14, indicated R33 showed short term memory loss remembering ..." R33's physician orders dated 12/17/14, revealed R33 had the following orders: -Artificial Tears solution 1.4% 1 drop to both eyes four times daily for dry eyes as needed (PRN) -Deep Sea Nasal Spray (Saline) solution 0.65%to each nostril every 30 minutes PRN R33's self-administration of medications care plan dated 10/3/07, indicated the interdisciplinary team (IDT) had determined R33 was unable to self-administer medications due to cognitive deficits and poor insight into her disease. The care plan directed staff to give all medications and supervises self-administration of inhalers. In addition the care plan directed "Nursing will medicate and do treatments per M.D. order." Review of Self Administration of Medication Assessment dated 10/17/14, revealed the assessment indicated " Resident continues to be ineligible for SAM due to cognitive deficits and poor insight into her disease. Staff gives all medications..." Self-Administration Of Medication policy dated 5/2/07, directed "When the determination is made that a resident is qualified candidate for medication self-administration the interdisciplinary team [IDT] will acquire a physician's order for this purpose that is specific to the type such as oral, creams, drops, inhalers ..."	F 282	*During periodic reviews based on the MDS and care conference schedules, the verbage that states "Resident does not SAM medications" which was defining oral medications will be changed to state "Resident does not SAM oral medications" and the ability to SAM other medications will be listed separately based on SAM assessment indicating ability to SAM ancillary meds. Resident Care Coordinator/ Director of Nursing will be responsible for compliance.	

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 5 residents (R59) had adequate indication for use of Seroquel (anti-psychotic). In addition the facility failed to ensure medications had appropriate parameters for use reviewed for unnecessary medications. Findings include:	F 329	F329 Drug regimen is free from unnecessary drugs. Birchwood Care Home mission is to assure that all residents receive accurate Pharmaceutical services and procedures. The survey indicates that we failed to meet this requirement because 1 of 1	2/16/15

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F 329	Continued From page 15 On 1/7/2015, at 7:36 a.m. R59 was observed walking through the hallway drinking pop and went to the breakfast line to get her meal. She was well-groomed and appeared to be in a happy mood. Surveyor approached R59 at this time and R59 indicated she would be in her room in twenty minutes to talk. -At 8:00 a.m. R59 was observed in her room lying in her bed. When approached R59 refused to talk stating she was tired and would get up later. R59's diagnoses included: generalized anxiety, major depression, narcolepsy, somatization and psychotic disorder with hallucinations obtained from minimum data set dated 11/28/14. In addition the MDS indicated R59 had behaviors not directed towards others, had little interest or pleasure, feeling down depressed and hopeless, trouble falling or staying asleep, had little energy and trouble concentrating. R59 's signed and dated by physician Medication Review Report revealed R59 had the following orders: -Effexor XR capsule extended Release 24 Hour 225 milligram (mg) oral (PO) everyday (qd) -Klonopin Tablet 1 mg PO twice a day (bid) for anxiety. - Seroquel Tablet 25 mg PO take 2-3 tabs as needed (prn) (50-75 mg) -Trazadone HCL Tablet 50 mg PO for lack of sleep 0.5-1 tablet PO nightly prn. Falls Care Area Assessment (CAA) dated 5/27/14 identified R59 had mental illness diagnosis and was being treated with antipsychotic medications which included Seroquel, Effexor and Wellbutrin. Psychotropic drug use CAA dated 5/27/14	F 329	resident's in the sample did not having adequate indication for use of Seroquel. This resident discharged from facility 1/12/2015. The survey also indicates that there was no tool used to monitor side effects, please see attachment labeled F329 which is our tool that we use to monitor side effects on a monthly basis and to document behavior monitoring, this was completed on 12/28/14 for R(59) according to our policy and had been completed on a monthly basis since her admission. It is the desire of Birchwood Care Home to provide the best practicable care to every resident and to reach the highest level of independence attainable. The following steps have been taken: How will we correct for this individual resident: R(59) discharged from facility on 1/12/2014. How the facility will identify other residnets having the potential to be affected: *All residents on psychotropic medications have their behaviors on their careplans and addressed in our monthly nursing summary. We have designated a specific careplan area which we are labeling "target behavior" and nursing staff have been educated to include these "target behaviors" in their monthly summary including a summary of the previous months behaviors as well as a summary	

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F 329	Continued From page 16 identified R59 had triggered due to diagnosis of generalized anxiety and depression disorder for which she tool Wellbutrin Effexor and Seroquel to control her symptoms. Although both CAAs identified R59 received antipsychotic and antidepressants, neither addressed what the clear indication was for use and lacked behavior monitoring. R59's behavior care plan dated 12/3/14, identified R59 had socially inappropriately behaviors, became sarcastic, made numerous accusations about staff, was verbally abusive, was medication seeking, and had medication hoarding issues. The care plan directed staff to administer medications as ordered, weekly psychologist visits and staff was to notify psychiatrist of increased verbal abusive behaviors. Review of Birchwood Care Home Referral forms dated 6/11/14 through 1/5/15, revealed R59 had been to several appointments with the psychiatrist and psychologist for services including psychotherapy and routine visits, had several medication changes but neither addressed medication parameters or a clear indication for use of Seroquel. During further document review, it was revealed in the Birchwood Care Home interdisciplinary progress notes from 12/7/14 to 1/8/15, R59 had received Seroquel thirteen times for anxiety and no non-pharmacological interventions were documented prior to administering the medications and in addition staff did not clarify the parameters Seroquel. In addition, R59 had also received Trazadone six times between 12/9/14 through 1/8/15, and no non-pharmacological interventions were initiated	F 329	of the previous months PRN usage (if PRN's are ordered). *All residents on PRN psychotropic medications will also have listed on the same careplan area labeled "target behavior" a list of non-pharmacological interventions to be used prior to giving a PRN. *We are currently working with Point Click Care to have a generic box included in with the PRN medications which will allow the nurse to have the non-pharmacological interventions listed to check off prior to being able to sign out a PRN medication. *A copy of Target Behavior Policy/Procedure attached. Resident Care Coodinator and Director of Nursing will be responsible for compliance.	

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F 329	Continued From page 17 and no clarifications regarding medication parameters were requested. On 1/7/15 at 10:37 a.m., the consultant pharmacist was interviewed and acknowledged R59's behaviors warranting seroquel use were not monitored on a reglar basis by the facility. The pharmacist agreed the behaviors should be monitored and assessed on a regular basis and that target behavior monitoring would be necessary. The pharmacist confirmed the facility currently had no behavior monitoring of R59's target behaviors. During an interview on 1/8/14 at 12:25 p.m., the director of nursing (DON) stated R59 is receiving Seroquel for dx of major depression disorder and receives it upon request from R59 for anxiety and intrusive thoughts. The DON further explained behaviors for R59 were not monitored, specific target behaviors have not been identified and no tools were used to monitor side effects, target behaviors or non-pharmacological interventions. The Birchwood Care Home Psychotropic Medication Side Effect Monitoring Policy dated and signed 5/2/07 directs staff to use a monitoring tool named Common Psychotropic medication Side effects and every resident on a psychotropic medication with be assessed on a monthly basis.	F 329		
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	F 371		2/2/15

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F 371	Continued From page 18 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure dining room microwave for resident use, baking sheets and the walkin freezer floor were maintained under sanitary conditions. These practices had the potential to affect 58 of 58 residents in the facility. Findings include: An initial tour of the kitchen was conducted on 1/5/15, at 7:15 a.m. with the director of nutritional services present throughout the tour. The following discrepancies were found: - The microwave located in the dining room had baked on debris on the inside of the microwave which could come in contact with food. - The floor in the walk in freezer had dried mud caked the floor of the freezer. - There were 10 of 10 large baking sheets had baked on dark brown greasy substance on all four corners of the baking pans which could come in contact with food. During the tour, the director of nutritional services verified the above findings and stated the microwave was "frequently" used by the facility residents. On 1/6/15, at 12:40 p.m. the microwave was observed to be used by residents.	F 371	F371: See attachment labeled F371: The microwave has been scheduled for cleaning after meals, see attached policy and schedule. The floor in the walk in freezer has been cleaned, see attached policy and schedule. The baking sheets were cleaned, see attached policy. Dietary manager will be responsible for supervision of cleaning schedules including checking to be sure the daily, weekly and monthly cleaning schedules are being followed. Consultant Dietician will monitor kitchen sanitation monthly for compliance.	

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F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to assure the consultant pharmacist identified and reported drug regimen irregularities for 1 of 5 residents in the sample (R59) reviewed for unnecessary medications. Findings include: On 1/7/15, at 7:36 a.m. R59 was observed walking through the hallway drinking pop and went to the breakfast line to get her meal. She was well-groomed and appeared to be in a happy mood. Surveyor approached R59 at that time and R59 indicated she would be in her room in twenty minutes to talk. -At 8:00 a.m. R59 was observed in her room lying in her bed. When approached R59 refused to talk stating she was tired and would get up later. Falls Care Area Assessment (CAA) dated 5/27/14, identified R59 had mental illness diagnosis and was being treated with antipsychotic medications which included	F 428	F428 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of Nursing, and these reports must be acted upon. The survey indicated that the consultant pharmacist failed to identify and report drug regimen irregularities for 1 of 5 residents in the sample (R59) reviewed for unnecessary medications. This resident discharged from facility on 1/12/15. The survey also indicated that the DON stated that the resident was using Seroquel for depression, the diagnosis I stated it was for was psychotic disorder with hallucinations. Re: parameters on the Seroquel, we had	2/16/15

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F 428	Continued From page 20 Seroquel, Effexor (antidepressant) and Wellbutrin (antidepressant). Psychotropic drug use CAA dated 5/27/14, identified R59 had triggered due to diagnosis of generalized anxiety and depression disorder for which she tool Wellbutrin, Effexor, and Seroquel to control her symptoms. Although both CAAs identified R59 received antipsychotic and antidepressants, neither addressed what the clear indication was for use and lacked behavior monitoring. R59's diagnosis included generalized anxiety, major depression, narcolepsy, somatization and psychotic disorder with hallucinations obtained from minimum data set dated 11/28/14. In addition, the MDS indicated R59 had behaviors not directed towards others, had little interest or pleasure, feeling down depressed and hopeless, trouble falling or staying asleep, had little energy and trouble concentrating. R59's signed and dated 12/1/14, by physician Medication Review Report revealed R59 had the following orders: -Effexor XR capsule extended Release 24 Hour 225 milligram (mg) oral (PO) everyday (qd) -Klonopin (anti-psychotic) tablet 1 mg PO twice a day (bid) for anxiety. - Seroquel tablet 25 mg PO take 2 to 3 tabs as needed (prn) (50-75 mg) -Trazodone HCL (anti-depressant) tablet 50 mg PO for lack of sleep 0.5 to 1 tablet PO nightly prn. R59's behavior care plan dated 12/3/14, identified R59 had socially inappropriately behaviors, became sarcastic, made numerous accusations about staff, was verbally abusive, was medication seeking, and had medication hoarding issues. The care plan directed staff to administer	F 428	contacted her psychiatrist and DON had consulted with our Medical Director, see attachment 428 for physician responses. How the facility will identify other residents having the potential to be affected: *Consulting pharmacist will review drug regimen at least once a month and point out any irregularities to physician and DON. *All residents on psychotropic medications have their behaviors on their careplans and addressed in our monthly nursing summary. We have designated a specific careplan area which we are labeling "target behavior" and nursing staff have been educated to include these "target behaviors" in their monthly summary including a summary of the previous months behaviors as well as a summary of the previous months PRN usage (if PRN's are ordered). *All residents on PRN psychotropic medications will also have listed on the same careplan area labeled "target behavior" a list of non-pharmacological interventions to be used prior to giving a PRN. *We are currently working with Point Click Care to have a generic box included in with the PRN medications which will allow the nurse to have the non-pharmacological interventions listed to check off prior to being able to sign out a PRN medication. Consulting Pharmacist, Resident Care Coordinator and Director of Nursing will be responsible for compliance.	

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medications as ordered, weekly psychologist visits and staff was to notify psychiatrist of increased verbal abusive behaviors.

Review of Birchwood Care Home Referral forms dated 6/11/14 through 1/5/15, revealed R59 had been to several appointments with the psychiatrist and psychologist for services including psychotherapy and routine visits, had several medication changes but neither addressed medication parameters or a clear indication for use of Seroquel.

During further document review, it was revealed in the Birchwood Care Home interdisciplinary progress notes from 12/7/14 to 1/8/15, R59 had received Seroquel thirteen times for anxiety and no non-pharmacological interventions were documented prior to administering the medications and in addition staff did not clarify the parameters Seroquel. In addition, R59 had also received Trazodone six times between 12/9/14 through 1/8/15, and no non-pharmacological interventions were initiated and no clarifications regarding medication parameters were requested.

On 1/7/15, at 10:37 a.m. the consultant pharmacist (CP) verified the facility had not been monitoring behaviors related to R59's Seroquel use on a reglar basis. The pharmacist confirmed there should be behavior monitoring assessed on a regular basis.

On 1/08/15, at 10:15 a.m. The CP stated the Seroquel had been ordered for major depression. He further stated anxiety was not an appropriate indication for use of the Seroquel for R59.

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F 428	Continued From page 22 During an interview on 1/8/14, at 12:25 p.m. the director of nursing (DON) stated R59 was receiving Seroquel for diagnosis of major depression disorder and receives it upon request from R59 for anxiety and intrusive thoughts. The DON further explained behaviors for R59 were not monitored, specific target behaviors have not been identified and no tools were used to monitor side effects, target behaviors or non-pharmacological interventions. The Birchwood Care Home Psychotropic Medication Side Effect Monitoring Policy dated and signed 5/2/07, directs staff to use a monitoring tool named Common Psychotropic medication side effects and every resident on a psychotropic medication with be assessed on a monthly basis.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		2/4/15

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F 431	Continued From page 23 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure expired medications were discarded; medication carts were kept clean. This had the potential to affect all 58 residents at the facility. Findings included: On 1/6/15, from 12:30 p.m. to 12:52 p.m. a tour of the facility's two medication carts (each for a separate floor) was completed with trained medication aide (TMA)-B present throughout the tour. - The drawers of both carts were observed to contain and store multiple cassettes of pills, bottles and other ready to use resident medications. The drawers in both carts were observed to have a fluffy white powdered substance built up and coating the surfaces at the back, on the bottom, and sides of the drawers; the drawers were observed to have multiple	F 431	F431 Drugs and biologicals in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Birchwood Care Home mission is to assure that all residents receive accurate Pharmaceutical services and procedures. The survey indicates that we failed to meet this requirement because the facility did not ensure expired medications were discarded; medication carts were kept clean. This had the potential to affect all 58 residents in the facility. Birchwood Care Home respectfully disagrees with the statement of deficiency	

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F 431	Continued From page 24 pieces of foil and approximately 15 bubble packages of loose pills. - In addition, the following expired resident medications were noted to be stored in the medication carts: R23 - seven tablets of Bisacodyl (Bisac-Evac) suppositories (a laxative) 10 milligrams (mg) stored in a light protective bottle with a filled date 8/13/12, and a discard after date 8/13/13; R45's bottle of Ibuprofen 100 quantity coated 200 mg filled 6/19/13, with expiration date 12/14; R61's EPIPEN 2-PAK (R) 0.3 mg auto-inject pen (used for emergency treatment of allergic reactions) filled 3/14/14, with expiration date December 14. On 1/6/14, at 12:33 p.m. when asked who was responsible for cleaning the carts, TMA-B stated all the TMA's were responsible for ensuring the carts were kept clean and stated, "It's a team effort." TMA-B acknowledged the expired medication should not have been stored in the carts. On 1/6/14, at 3:43 p.m. the director of nursing (DON) stated her expectation was expired medications should have not been stored in the cart and acknowledged the carts should have been kept clean. DON stated, "We just had an audit a few months ago and are not perfect I guess." On 1/7/15, at 10:50 a.m. the consultant pharmacist stated his expectation was that expired medications would not be stored in the medication cart, and should be removed and reordered if the resident still had an order for the medication.	F 431	in the matter of carts not being clean, these carts are fairly new and when staff checked them following the audit, we did not find their condition unclean. However, we did do a thorough cleaning of them immediately following the survey and have revised our med cart cleaning schedule to include all shifts. The new schedule started immediately and rotates each month to ensure that everyone cooperates in this duty. Copy of schedule available upon request. Medication Cart cleaning policy/ procedure attached. How we corrected for the expired medication: The medication was immediately removed from the cart and a replacement was obtained from pharmacy. We had a med room audit done by Omnicare Pharmacy on November 7, 2014 and we are scheduled for quarterly med room audits. Assigned staff will check for expired meds during routine med passes plus a more comprehensive and thorough check for expired meds will be done on a monthly basis when the med cart cleaning is performed, this task will be divided out to all shifts on a rotating basis. How we will identify other residents having the potential to be affected: *Each shift will check for expired meds during their routine med pass. *A more comprehensive and thorough check will be done with the med cart cleaning on a monthly basis. *Omnicare Pharmacy Nurse Consultant will do a quarterly med room audit, I have	

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F 431	Continued From page 25 An undated Medication Expiration Dating policy directed, "It is the policy of Birchwood Care Home for staff to date medications with limited expiration times when opening them ..." The policy also indicated medications were to be utilized according to manufacturer's guidelines and expected practice. The policy did not indicate who was responsible for overseeing to ensure medications carts were kept clean and free of expired medications. The facility lacked a policy and procedure for cleaning medication carts.	F 431	communicated with them that part of the audit will include feedback on cleanliness of carts. *Staff Development Coordinator will do random med pass audits and check for expired meds on a weekly basis for 4 weeks, then monthly for 3 months, then on random basis. Staff Development Coordinator/ Director of Nursing will be responsible for compliance.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		2/6/15

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F 441	Continued From page 26 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure 1 of 1 sharps container stored on top of the counter in the treatment room, was changed when full to prevent access to used syringe and potential spread of blood borne infections. This had the potential to affect all 58 of 58 residents; in addition, the facility did not ensure individually assigned glucometers were not shared and/or were cleaned between use to prevent the potential spread of blood borne infections. This had the potential to affect 20 of 58 residents who were identified as requiring blood glucose checks. Findings include: Glucometers and Sharps container On 1/5/15, at 10:54 a.m. R25 was observed to come into the nursing station. R25 walked into the treatment room as registered nurse (RN)-A cued him to wash his hands. R25 was observed to wash his hands in the sink (located to the right	F 441	F441 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The survey indicates that 1 of 1 sharps containers was not changed when full: *Sharps container was immediately replaced, we have developed a system whereby at the end of each shift the charge nurse will check the sharps container to be sure it is not nearing the full line and replace as indicated. See attachment F441-1 for nursing worksheet where the charge nurse will initial each shift when checked. Staff Development Coordinator will do weekly audits x 3 months, then monthly audits x 3 months. The survey also indicates that a used strip was found in 2 of the glucometer	

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F 441	Continued From page 27 corner when entering the treatment room) then after he dried his hands with paper towels, R25 sat on the black straight back chair located in front of the counter prior to the blood sugar. -At 10:57 a.m. R25 was observed to grab his own personal glucometer machine from the cubicles located right on top of the counter in front of him. R25 opened the pouch which had the glucometer and the glucometer was observed to have a used strip. The strip was observed to have dried blood on it and was stored with the glucometer machine. R25 immediately stated, "Someone again used my machine." R25 then proceeded to remove the used blood contaminated strip. Although the strip was contaminated with blood, R25 tossed it into the trash can located under the counter. R25 opened a container of new strips and placed a fresh strip into the glucometer. RN-A was then observed to come into the treatment room and apply a pair of gloves. RN-A cleaned R25's third left finger with an alcohol wipe, dried it with a piece of cotton, then punched the finger with a lancet. The lancet was then tossed into a filled sharps container located on top of the counter to R25's right hand. RN-A squeezed out a drop of blood and applied the drop to the strip and obtained a reading of 93 mg/dl. RN-A did not acknowledged the sharps container was filled past the line and both used syringes and lancets were easily accessible at the top of the container. In addition RN-A did not clean the glucometer machine prior to use. RN-A then indicated to R25 she would give him regular dose of insulin. -At 11:05 a.m. RN-A was observed to give R25 seven units of insulin. -At 11:07 a.m. when asked where and when the glucometers were cleaned, RN-A stated they were cleaned at night. When asked why she had	F 441	machines. * The Infection Control Policy for Infection Control and Blood Glucose Meter checks has been revised and reviewed with nursing staff, see attachment 441-1. We have developed a system whereby at the end of each shift the charge nurse/ designee will check each individual meter to assure there are no strips left in them, wipe them down if any visible blood is present and assure correct machine is in correct pouch. Charge nurse will initial on her daily worksheet when this is complete. Staff Development Coordinator will do weekly audits x 3 months, then monthly audits x 3 months. The survey also indicates that the specimen refrigerator needed cleaning. *Specimen refrigerator was immediately cleaned, Surveyors were given a checklist by Housekeeping/ Maintenance Department that has cleaning schedule for it. Cleaning schedule has been reviewed with Housekeeping. New ice packs have been obtained that can be disinfected between use. Staff Development Coordinator will audit refrigerator to assure cleanliness and that temperature log is current. Audits will be done weekly x 3 months, then monthly audits x 3 months by Staff Development Coordinator. Staff Development Coordinator and Director of Nursing will be responsible for compliance.	

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not cleaned the machine when R25 had stated someone had used his glucometer, she stated, "He always says that I think he is forgetful."
-At 11:08 a.m. surveyor asked RN-A what R25's blood sugar had been that morning, RN-A stated 113. Surveyor then asked RN-A to look in the Assure (R) Platinum (Arkray) glucometer to verify if R25's blood sugar level was last done in the glucometer, it was revealed another reading of 133 time stamped at 6:22 a.m. had been obtained using the machine (which was done after R25's blood sugar level of 113 obtained on 1/5/15, at 3:52 a.m.). Upon further review R25's glucometer, another reading of 133 was noted to have been obtained with R25's glucometer. RN-A indicated it was probably R37's according to the night work sheet but was not sure. RN-A verified R25's glucometer was used for another resident.
-At 11:09 a.m. when asked what the facility policy was for cleaning the glucometers, RN-A stated she would check with the director of nursing (DON). When asked regarding the facility's policy, RN-A directed the surveyor to DON.

On 1/5/15, at 11:27 a.m. DON checked R25's glucometer and verified another reading for another resident had been obtained with R25's glucometer. DON stated all residents had their own glucometers for the purpose of not needing to be cleaned each time and the night shift had two glucometers to use as spares. DON stated the nurses had time to clean the glucometers after each use. DON stated the personal glucometers were not supposed to be shared. DON appeared upset and stated, "I don't have an answer for you. I was not here during the night shift, but I will get the policy for you." DON walked out of the nursing station.

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On 1/5/15, at 1:11 p.m. two surveyors completed the review of all the glucometers stored in the cubicles located in the treatment room with TMA-A. R28's glucometer for was observed to be stored in a cubicle and was labeled with R28's name. Upon opening the pouch, the glucometer was observed to have a strip contaminated with dried blood attached to glucometer.
-At 1:14 p.m. R45's glucometer pouch was observed stored in the cubicle and labeled with R54's name. An unlabeled pouch with a glucometer inside it, was also observed to be stored in R45's cubicle. TMA-A opened the pouch went over to RN-A and showed her the contents. TMA-A stated R54 had taken his blood sugar using the glucometer stored in R45's cubicle. TMA-A verified the pouch was not labeled with a name, and verified the glucometer had a reading of 52 which was R54's last recorded blood sugar level prior to lunch.

On 1/5/15, at 1:20 p.m. DON verified R28's glucometer was stored in a pouch with an attached strip contaminated with dried blood. DON stated, "I don't know I have never seen this happen before." DON then proceeded to remove the strip and tossed the blood contaminated strip in the trash can underneath the counter. DON stated staff supervised the residents' check their own blood sugar levels and further stated, "this has not been a problem in the past, I have to look into it."
-At 1:22 p.m. when asked about the filled sharps container, DON stated, "I will fix it." DON then picked up the container, left the treatment room and went out of the nursing station.

On 1/5/15, at 2:45 p.m. DON approached the surveyors and stated the glucometer marked as

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R45's had not been used since November 2014. DON stated she did not know what had happened, but was going to "revamp surveillance" of glucometer use. DON further stated regarding the sharps container she had removed the full sharps container and was getting two new ones from pharmacy. DON stated because of so many diabetics residents in the facility, "we have doubled our need and budget."

On 1/7/15, at 7:06 a.m. licensed practical nurse (LPN)-A stated she had used the facility glucometers to check the blood sugars the morning of 1/5/15, and asked surveyor to go with her to verify it. Upon entering the Oxygen room LPN-A was observed take out the common use facility glucometers stored in the cart. LPN-A then went through the two glucometers, but was not able to find a reading from 1/5/15. LPN-A further stated she had verified the readings with the DON and was not sure if the glucometers had been switched after.
-At 7:10 a.m. when asked how often she cleaned the individual resident glucometers, LPN-A stated, "I normally did not clean them, unless I had used any of them." LPN-A stated, "I always use the facility ones [glucometers] which I clean with the pink-Wipes between residents."

The Assure ® Platinum Blood Glucose Monitoring System user manual dated as revised 10/11, directed user to remove the used test stripe after each use.
The undated Birchwood Care Home Infection Control And Blood Glucose Meter Checks policy directed, "Nursing will provide a Blood Glucose meter for each individual resident to use with the exception of some Blood Glucose monitoring done ..." In addition, the policy directed, "After

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each accu-check [blood glucose check], nursing staff will use a germicidal wipe to clean the outside of the individually designated blood glucose meter if there is visual soiling, per product company recommendation..."
Specimen refrigerator

On 1/5/15, at 9:03 a.m. during the medication room tour, a specimen refrigerator was observed stationed at the far end of the medication room behind the nurse's desk.
-When registered nurse (RN)-A was asked what it was used for, she indicated it was a specimen refrigerator. Upon opening the refrigerator, it was noted there were four compartments which all had ice packs stored in them.
-When asked what the ice packs were used for, RN-A stated, "Residents use them for ice packs."
-When asked if they were cleaned prior to being stacked together, RN-A stated, "Yes they are cleaned."
-When asked who cleaned the freeze/refrigerator, as three ice packs were observed to be embedded in a thick approximately two inch build-up of ice in the freezer, she stated, "The night nurse cleans it."

On 1/7/15, at 7:12 a.m. licensed practical nurse (LPN)-A verified the built-up ice and ice packs in the specimen refrigerator. When asked who was responsible for cleaning the refrigerator, LPN-A stated it was the night shift. LPN-A stated she had been off for "a little while," had returned to work and just did not have time to clean it up yet. LPN-A stated "any nurse" was also responsible to clean it.

A cleaning policy for the ice packs was requested, RN-A indicated the facility did not have a policy.

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 _____	01/08/2015

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 441	Continued From page 32 The Specimen Refrigerator policy, dated as signed off on 5/2/07, indicated specimens were kept refrigerated before being picked up by the lab. The policy directed specimens were not to be kept in the main refrigerator with food, insulin's etc. The procedure directed: 1. Collect specimen, 2. Place in specimen bag, 3. Place bag in white refrigerator on the back counter in nursing station. 4. The refrigerator was to remain plugged in at all times. The procedure directed the refrigerator should have been wiped out with disinfectant (Oasis 499) after each use. The specimen refrigerator in the nursing station was observed on 1/7/15, at 1:00 p.m. with registered nurse (RN)-A. The specimen refrigerator was observed to have 19 ice packs of which 2 ice packs were in a zip lock bag with a discharged resident's name. RN-A discarded the ice packs. After the two ice packs were removed from the refrigerator, three frozen gel like pyramid shaped substances were observed on the shelf. RN-A stated the frozen substance was leakage from the ice bags. Three ice packs were observed to be imbedded in the ice buildup in the small freezer portion of refrigerator. There was no thermometer in the refrigerator, there were no logs on when the refrigerator had last been cleaned. RN-A confirmed there was no documentation as to when the specimen refrigerator had last been cleaned or defrosted.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		2/16/15

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 _____	01/08/2015

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 465	Continued From page 33 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 shared bathroom reviewed for environmental concerns for 3 of 3 residents (R25, R30, R13) was kept clean and free of urine odors. The facility failed to ensure the closets for 3 of 3 residents (R21, R24, R7) had a closet door or had the closet door affixed properly; in addition, the facility failed to ensure the linoleum in R21, R24, and R7's room was kept clean. Findings include: On 1/5/15, at 1:52 p.m. the bathroom shared by R25, R30 and R13 was noted to have a strong malodorous musty (urine) smell. In addition, the base of the toilet was observed to have a dark brown substance built-up all around the base. The inside of the toilet bowl was observed to have a large brown stain. During the observation, housekeeping staff was noted to be cleaning several other rooms down the hallway. On 1/6/14, from 11:30 a.m. to 5:15 p.m. the bathroom was observed to have a strong urine smell, the grout on the base of the toilet also still had the brown build-up. On 1/7/14, at 8:30 a.m. during a random room tour, the bathroom was observed to have a strong musty urine smell, the bowl and grout continued to have the built-up brown stains. On 1/7/15, at 9:23 a.m. housekeeping aide	F 465	The bathroom shared by R25,R30 and R13 was thoroughly cleaned and sanitized on 1/8/15.Housekeeping/Laundry supervisor has done an audit of all bathrooms to be sure there is no odor or built up residue. The 2 closet doors have been fixed. The plan is to replace all 3 door closet doors due to the 3 door closets having chronic problems and no longer able to secure parts. Maintenance/ Housekeeping had a discussion with the State Fire Dept and have been given authorization to replace all 3 door closets with curtains. The black marks on the floor have been buffed out, this problem will be solved once the closet doors have been replaced. See attachment F465 for updated policy/procedure and housekeeping checklist. Director of Housekeeping and Maintenance Director will be responsible for compliance.	

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	24E166	A. BUILDING _____ B. WING _____	01/08/2015

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 34	F 465		

(HA)-A was observed down the hallway standing by the housekeeping cart. When approached and asked how often she cleaned both rooms and resident bathrooms, HA-A stated cleaning was completed daily, except for the shared shower room which she cleaned twice daily. HA-A explained the shower room was cleaned twice daily because residents "shared it and used it often." HA-A further stated she was only responsible for cleaning the 3rd Floor area and her supervisor cleaned the 2nd Floor.

On 1/7/14, at 2:30 p.m. R25, R30 and R13's shared bathroom was observed to continue to have a strong musty urine smell; the brown stained grout on the base and around the toilet remained.

On 1/8/15, at 8:25 a.m. the environmental service director verified the strong musty smell R25, R30 and R13's shared toilet was a "urine" smell. When asked how often the toilets/bathrooms were cleaned he stated daily Monday through Friday and on the weekend if there was a concern. When asked what the built-up brown matter was on the base of the toilet, he stated the building was "fifty years old" and he was not able to state what it was. The environmental service director stated, "A bleach mop would take care of it."

On 1/8/15, at 9:37 a.m. housekeeping/laundry supervisor stated she was not aware the bathroom had a strong urine odor. When asked who was responsible to make sure residents' toilets were kept clean, the supervisor stated she was responsible. The supervisor stated she had other rooms at the facility that had the same problem and was using a cleaning agent which

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	24E166	A. BUILDING _____ B. WING _____	01/08/2015

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 she was going to use for this toilet also. On 1/8/15, at approximately 9:00 a.m. the housekeeping policy was requested, but instead an undated daily Work Routine 1st Shift Housekeeping was provided. The routine directed staff to clean the bathroom and toilet with specific attention to the inside of the toilet, under the rims, on the bottom, top of toilet, toilet seat, sweep and mop the floors. The routine did not indicate who was responsible to ensure resident shared toilets were kept clean. Closet Doors and Linoleum The director of environmental services, confirmed on 1/8/15, at 8:30 a.m. room 307 had three residents (R21, R24, R7). In the room, there were three separate closets along the back of the room. There was one properly hung closet door on the first closet, on the second closet the door was off the hinge, and the third closet had no door. The maintenance director indicated the building was 50 years old and he was having a problem with closet doors. The floor directly in front of the closets, was a linoleum floor and had blacked area almost the full length of the three closets. The director of environmental services stated they could use Bravo (floor cleaner) to take care of the black marks on the floor.	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 _____	**01/09/2015**

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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Birchwood Care Home was found to be 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. 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 60 beds and had a census of 60 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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