Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 13, 2026

Administrator
BIRCHWOOD HEALTH CARE CENTER
604 1ST STREET NE
FOREST LAKE, MN 55025

RE: CCN: 245200

Cycle Start Date: November 13, 2025

Dear Administrator:

On December 19, 2025, we notified you a remedy was imposed. On February 5, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 23, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 13, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 19, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 13, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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February 13, 2026

Administrator
BIRCHWOOD HEALTH CARE CENTER
604 1ST STREET NE
FOREST LAKE, MN 55025

Re: Reinspection Results
Event ID: 1DECC8-H2

Dear Administrator:

On February 5, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 19, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 7, 2026

Administrator
BIRCHWOOD HEALTH CARE CENTER
604 1ST STREET NE
FOREST LAKE, MN 55025

RE: CCN: 245200
Cycle Start Date: November 13, 2025

Dear Administrator:

On December 19, 2025, we informed you that we may impose enforcement remedies.

On December 19, 2025, the Minnesota Department of Health and completed a survey and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 13, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 13, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 13, 2026.

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 13, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, BIRCHWOOD HEALTH CARE CENTER will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 13, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal.   Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 13, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)
In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

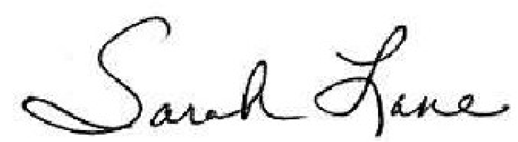
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 7, 2026

Administrator
BIRCHWOOD HEALTH CARE CENTER
604 1ST STREET NE
FOREST LAKE, MN 55025

Re: State Nursing Home Licensing Orders
Event ID: 1DECC8-H1

Dear Administrator:

The above facility survey was completed on December 19, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308   Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245200**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/19/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 12/18/25 through 12/19/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52001482C (2694206) H52001482C (2694621) An unrelated deficiency was issued at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.	F0000		01/09/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F0880	F0880 – Infection Prevention & Control: Personal Protective Equipment (PPE) and Enhanced Barrier Precautions • R1 and R2 currently reside in center with no adverse reactions from deficient practice. R3 no longer resides in center. • All Residents have the potential to be affected. • The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: All nursing and direct care staff received mandatory in-service training on PPE usage and hand hygiene.	01/23/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245200**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/19/2025**
NAME OF PROVIDER OR SUPPLIER **BIRCHWOOD HEALTH CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **604 1ST STREET NE , FOREST LAKE, Minnesota, 55025**	

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F0880 SS = D	Continued from page 1 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	Continued from page 1 Proper donning and doffing of PPE, including gowns and gloves Hand hygiene protocols before and after resident contact and treatments Facility policy for Enhanced Barrier Precautions (EBP) Education will be provided for all nursing staff, certified nursing assistants (CNAs), and therapy staff regarding the updated policies and processes Supervisory staff will conduct random spot checks to reinforce compliance and provide immediate feedback. • Birchwood health Care Center will monitor performance to ensure sustained compliance. The Infection Preventionist or designee will audit PPE use and hand hygiene practices for all residents on EBP three (3) times weekly for 2 weeks, and then two (2) times a week for two weeks. Audit results will be presented to the QAPI committee monthly, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. • Birchwood Health Care Center will be in substantial compliance by 01/23/2026. Responsible Party: Director of Nursing (DON)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245200**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/19/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 2 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper use of personal protective equipment (PPE) for 2 of 3 (R2, R3) residents who were on enhanced barrier precautions (EBP), required personal cares and ordered treatments and staff did not maintain proper hand hygiene practices or use of gowns while performing cares and treatments. Findings include: R2's Face Sheet dated 2/16/25, indicated R2 had neuromuscular dysfunction of bladder and was a carrier or suspected carrier of methicillin resistant staphylococcus aureus (MRSA). R1's quarterly Minimum Data Set (MDS) dated 11/24/25, indicated R2 was cognitively intact, had a suprapubic catheter in place, and was on EBPs. R3's Face Sheet dated 10/18/25, indicated R1 had retention of urine and was a carrier or suspected carrier of MRSA. R3's admission Minimum Data Set (MDS) dated 10/24/25, indicated R3 had memory problems, had an indwelling catheter, had a feeding tube was dependent on staff for hygiene, and was on EBPs. Enhanced Barrier Precautions signage on R2 and R3's door undated, indicated providers and staff would wear gloves and gown for the following High-Contact Resident Care Activities: dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toilet use, and when caring for wounds or device cares. During an observation on 12/18/25 at 9:54 a.m., registered nurse (RN)-A sanitized her hands, applied gloves, and entered R2's room. RN-A told R2 she was going to change her suprapubic catheter dressing. RN-A	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245200	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025

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

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F0880 SS = D	Continued from page 3 did not have a gown on, she removed the drainage sponge from R2’s abdomen and indicated “purulent tan medium amount of drainage”, and discarded the soiled dressing in the garbage. RN-A removed her gloves, applied new gloves without preforming hand hygiene, and cleansed the catheter site. RN-A applied a clean dressing to catheter site with same gloves she cleansed site with. RN-A removed her gloves and sanitized her hands. During an interview on 12/18/25 at 10:13 a.m., RN-A stated it was expected that staff wear personal protective equipment for residents on EBPs when they come into contact with the resident. RN-A stated she forgot to wear a gown when completing R2’s treatment. RN-A stated staff were expected to wash or sanitize hands after removing soiled gloves and when going from dirty to clean areas. RN-A stated she should have sanitized her hands after removed her gloves and after cleansing R2’s suprapubic site but the sanitizer and gloves were on the other side of the room so she did not do either step. During an observation on 12/18/25 at 11:18 a.m., nursing assistant (NA)-A and NA-B sanitized hands applied gown and gloves and entered R3’s room. NA-A and NA-B assisted R3 to bed and lowered his pants. NA-B held R3 on his right side and NA-A cleansed bowel from R3’s buttocks with wipes. NA-A removed the bowel soiled brief and placed it in the garbage and removed her gloves. NA-A applied clean gloves without sanitizing hands, applied barrier cream to R3’s buttocks, applied a clean brief on R3, and placed clothes back on. NA-A emptied urine out of R3’s catheter bag, removed her gloves, and applied clean gloves without sanitizing hands. NA-A and NA-B assisted R3 back to his wheelchair, took off gown and gloves, and sanitized hands. During an interview on 12/18/25 at 1:14 p.m., NA-A stated staff were expected to sanitize hands when taking gloves off. NA-A stated she did not sanitize her hands because she got nervous. During an observation on 12/18/25 at 3:48 p.m., licensed practical nurse (LPN)-A and NA-A sanitized hands, applied gown and gloves, and entered R3’s room. LPN-A gathered supplies and explained to R3 that she was going to change his feeding tube dressing. LPN-A removed her gloves, washed her hands, and applied clean gloves. LPN-A removed R3’s dressing with no drainage on	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245200	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 4 it and placed it in the garbage, removed her gloves, sanitized her hands, and applied clean gloves. LPN-A cleansed the insertion site and applied a clean dressing without changing her gloves or sanitizing her hands. LPN-A removed her gloves, dated a piece of tape, sanitized her hands, applied a clean pair of gloves, and put the tape on the clean dressing. During an interview on 12/18/25 at 4:01 p.m., LPN-A stated she should have changed her gloves and sanitized her hands after cleansing R3's feeding tube insertion site but she did not because she was nervous. On 12/19/25 at 11:55 a.m., the director of nursing (DON) stated staff were expected to perform hand hygiene per policy. When residents are on EBPs staff were expected to wear a gown and gloves with cares and when completing dressing changes. On 12/19/25 at 11:57 a.m., the administrator stated staff were expected to follow the hand hygiene policy. Staff were expected to follow EBP guidelines when preforming dressing changes on a resident on EBPs. The facility Hand Hygiene policy revised 8/2025, indicated staff would cleanse hands before putting on gloves, after removal of gloves, and before moving from a soiled body site to a clean body site. The facility Personal Protective Equipment Selection and Use policy reviews 9/2023, indicated staff would apply a gown and gloves prior to high contact care, which may apply to indwelling medical devices regardless of MDRO colonization. EBPs would be used during high contact resident activities such as hygiene, incontinence cares, and devices or wound care.	F0880		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/19/2025**

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

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/18/25 through 12/19/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		01/09/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/19/2025**
NAME OF PROVIDER OR SUPPLIER **BIRCHWOOD HEALTH CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **604 1ST STREET NE , FOREST LAKE, Minnesota, 55025**	

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20000	Continued from page 1 The following complaints were reviewed: H52001482C (2694206) H52001482C (2694621) As a result of the investigation a licensing order was issued at 4658.0800 Subp 1. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper use of personal protective equipment (PPE) for 2 of 3 (R2, R3) residents who were on enhanced barrier precautions (EBP), required personal cares and ordered treatments and staff did not maintain proper hand hygiene practices or use of gowns while performing cares and treatments. Findings include: R2's Face Sheet dated 2/16/25, indicated R2 had neuromuscular dysfunction of bladder and was a carrier or suspected carrier of methicillin resistant staphylococcus aureus (MRSA). R1's quarterly Minimum Data Set (MDS) dated 11/24/25, indicated R2 was cognitively intact, had a suprapubic catheter in place, and was on EBPs. R3's Face Sheet dated 10/18/25, indicated R1 had retention of urine and was a carrier or suspected carrier of MRSA. R3's admission Minimum Data Set (MDS) dated 10/24/25, indicated R3 had memory problems, had an indwelling	21375	F0880 – Infection Prevention & Control: Personal Protective Equipment (PPE) and Enhanced Barrier Precautions • R1 and R2 currently reside in center with no adverse reactions from deficient practice. R3 no longer resides in center. • All Residents have the potential to be affected. • The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: All nursing and direct care staff received mandatory in-service training on PPE usage and hand hygiene. Proper donning and doffing of PPE, including gowns and gloves Hand hygiene protocols before and after resident contact and treatments Facility policy for Enhanced Barrier Precautions (EBP) Education will be provided for all nursing staff, certified nursing assistants (CNAs), and therapy staff regarding the updated policies and processes Supervisory staff will conduct random spot checks to reinforce compliance and provide immediate feedback. • Birchwood health Care Center will monitor performance to ensure sustained compliance.	01/23/2026

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21375	Continued from page 2 catheter, had a feeding tube was dependent on staff for hygiene, and was on EBPs. Enhanced Barrier Precautions signage on R2 and R3's door undated, indicated providers and staff would wear gloves and gown for the following High-Contact Resident Care Activities: dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toilet use, and when caring for wounds or device cares. During an observation on 12/18/25 at 9:54 a.m., registered nurse (RN)-A sanitized her hands, applied gloves, and entered R2's room. RN-A told R2 she was going to change her suprapubic catheter dressing. RN-A did not have a gown on, she removed the drainage sponge from R2's abdomen and indicated "purulent tan medium amount of drainage", and discarded the soiled dressing in the garbage. RN-A removed her gloves, applied new gloves without preforming hand hygiene, and cleansed the catheter site. RN-A applied a clean dressing to catheter site with same gloves she cleansed site with. RN-A removed her gloves and sanitized her hands. During an interview on 12/18/25 at 10:13 a.m., RN-A stated it was expected that staff wear personal protective equipment for residents on EBPs when they come into contact with the resident. RN-A stated she forgot to wear a gown when completing R2's treatment. RN-A stated staff were expected to wash or sanitize hands after removing soiled gloves and when going from dirty to clean areas. RN-A stated she should have sanitized her hands after removed her gloves and after cleansing R2's suprapubic site but the sanitizer and gloves were on the other side of the room so she did not do either step. During an observation on 12/18/25 at 11:18 a.m., nursing assistant (NA)-A and NA-B sanitized hands applied gown and gloves and entered R3's room. NA-A and NA-B assisted R3 to bed and lowered his pants. NA-B held R3 on his right side and NA-A cleansed bowel from R3's buttocks with wipes. NA-A removed the bowel soiled brief and placed it in the garbage and removed her gloves. NA-A applied clean gloves without sanitizing hands, applied barrier cream to R3's buttocks, applied a clean brief on R3, and placed clothes back on. NA-A emptied urine out of R3's catheter bag, removed her gloves, and applied clean gloves without sanitizing hands. NA-A and NA-B assisted R3 back to his	21375	Continued from page 2 The Infection Preventionist or designee will audit PPE use and hand hygiene practices for all residents on EBP three (3) times weekly for 2 weeks, and then two (2) times a week for two weeks. Audit results will be presented to the QAPI committee monthly, which will review and provide feedback on audit frequency, content, and additional interventions if indicated. • Birchwood Health Care Center will be in substantial compliance by 01/23/2026. Responsible Party: Director of Nursing (DON)	

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21375	Continued from page 3	21375		

wheelchair, took off gown and gloves, and sanitized hands.

During an interview on 12/18/25 at 1:14 p.m., NA-A stated staff were expected to sanitize hands when taking gloves off. NA-A stated she did not sanitize her hands because she got nervous.

During an observation on 12/18/25 at 3:48 p.m., licensed practical nurse (LPN)-A and NA-A sanitized hands, applied gown and gloves, and entered R3's room. LPN-A gathered supplies and explained to R3 that she was going to change his feeding tube dressing. LPN-A removed her gloves, washed her hands, and applied clean gloves. LPN-A removed R3's dressing with no drainage on it and placed it in the garbage, removed her gloves, sanitized her hands, and applied clean gloves. LPN-A cleansed the insertion site and applied a clean dressing without changing her gloves or sanitizing her hands. LPN-A removed her gloves, dated a piece of tape, sanitized her hands, applied a clean pair of gloves, and put the tape on the clean dressing.

During an interview on 12/18/25 at 4:01 p.m., LPN-A stated she should have changed her gloves and sanitized her hands after cleansing R3's feeding tube insertion site but she did not because she was nervous.

On 12/19/25 at 11:55 a.m., the director of nursing (DON) stated staff were expected to perform hand hygiene per policy. When residents are on EBPs staff were expected to wear a gown and gloves with cares and when completing dressing changes.

On 12/19/25 at 11:57 a.m., the administrator stated staff were expected to follow the hand hygiene policy. Staff were expected to follow EBP guidelines when preforming dressing changes on a resident on EBPs.

The facility Hand Hygiene policy revised 8/2025, indicated staff would cleanse hands before putting on gloves, after removal of gloves, and before moving from a soiled body site to a clean body site.

The facility Personal Protective Equipment Selection and Use policy reviews 9/2023, indicated staff would apply a gown and gloves prior to high contact care,

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21375	Continued from page 4 which may apply to indwelling medical devices regardless of MDRO colonization. EBPs would be used during high contact resident activities such as hygiene, incontinence cares, and devices or wound care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures regarding hand hygiene and enhanced barrier precautions (EBPs). The DON or designee could provide education on these policies and procedures to all staff who provide direct care. The DON or designee could and establish a system to monitor staff for infection control practices including hand hygiene and EBPs then report the results of these audits to the Quality Assessment Performance Improvement (QAPI) committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		