Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 13, 2023

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

RE: CCN: 245200
Cycle Start Date: June 7, 2023

Dear Administrator:

On June 16, 2023, we notified you a remedy was imposed. On July 5, 2023 the Minnesota Department of Health 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 June 28, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 1, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 16, 2023, 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 June 7, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
June 16, 2023

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

RE: CCN: 245200
Cycle Start Date: June 7, 2023

Dear Administrator:

On June 7, 2023, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 7, 2023, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 1, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 1, 2023 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 1, 2023 (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 7, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Birchwood Health Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 7, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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 "E" tag), i.e., the plan of correction should be directed to:
Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village

11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 7, 2023 (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.

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 DENIAL OF PAYMENT

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:

Steven.Delich@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 Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 16, 2023

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

Re: Event ID: 14XP11

Dear Administrator:

The above facility survey was completed on June 7, 2023 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245200	A. BUILDING _____ B. WING _____	C 06/07/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 6/5/23, through 6/7/23, 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 survey resulted in an Immediate Jeopardy (IJ) to resident safety at F600. The IJ began on 5/20/23 at 2:16 p.m., when R3 was observed kissing R1's hand and touching R1's chest (breasts) and neck. The administrator and director of nursing (DON) were notified of the IJ on 6/6/23 at 12:33 p.m. The IJ was removed on 6/7/23 at 11:58 a.m. The above findings constituted substandard quality of care, and an extended survey was conducted on 6/7/23. The following complaints were reviewed: H52002552C (MN94047) with deficiencies issued at F600, F609, and F610. H52002549C (MN94048) with deficiencies issued at F600, F609, and F610. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		

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

Electronically Signed | 06/21/2023

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

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F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide adequate supervision and interventions to prevent ongoing sexual abuse of 1 of 3 residents (R1) reviewed for abuse. This resulted in an immediate jeopardy (IJ) for R1 who received unwanted sexual touching by R3 without facility intervention. The IJ began on 5/20/23 at 2:16 p.m., when R3 was observed kissing R1's hand and touching R1's chest (breasts) and neck. The administrator and director of nursing (DON) were notified of the IJ on 6/6/23 at 12:33 p.m. The IJ was removed on 6/7/23 at 11:58 a.m. but noncompliance remained at the lower scope and severity level of a D which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:	F 600	F600 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. R1 had their vulnerable adult status reassessed and care plan and NAR care sheets updated as indicated. The event on April 19, 2023 was reported to OHFC per facility policy. The event on May 20,	6/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 2 R1's Diagnosis List indicated R1 had a diagnosis of hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following cerebral infarction (stroke) on the non-dominant side. R1's quarterly Minimum Data Set (MDS) dated 5/12/23, indicated R1 had severe cognitive impairment with the ability to rarely or never make decisions, and had speech that was unclear and rarely understood. The MDS further indicated R1 required extensive assistance of one or two staff for activities of daily living (ADLs), and had impairment bilaterally in both her upper and lower extremities. R1's s care plan dated 5/23/22, indicated R1 preferred to not be alone with male peers. R1's electronic medical record lacked documentation of the allegations of sexual abuse by R3. R3's Diagnosis List indicated R3 had diagnoses which included spondylosis (degeneration of the spinal column) and spinal stenosis (abnormal narrowing of the spinal canal). R3's quarterly MDS dated 4/18/23, indicated R3 had intact cognition and was independent in moving around the facility in a wheelchair. R3's care plan dated 3/22/23, indicated R3 had behaviors of holding hands and touching faces of peers "as a sign of comfort," but lacked mention of interventions to prevent touching other peers. R3's progress notes indicated the following:	F 600	2023 was reported to OHFC per facility policy. The Washington County Long Term Care Ombudsman is scheduled to see R1 and their responsible party the week of June 26, 2023. R3 agreed to move to a room on another unit in the building, creating a greater distance from R1. R3 had continued counseling and education on not having any contact of with R1, go into her room or ask to speak with her and has been educated on the definition of abuse, the acceptable boundaries between peers and staff with regards to friendships, physical contact, and appropriate behavioral instances. The care plan has been updated to include redirection and documentation every day of every shift by licensed staff who will indicate in the EMR any concerns or interactions that are inappropriate, behavioral concerns or communication. Resident has not had any further contact with R1 nor any inappropriate contact or communication with any other resident in the facility. R3 had their vulnerable adult status reassessed and care plan and NAR care sheets updated as indicated. R3 continues to be seen by Associated Clinic of Psychology, who is onsite weekly to speak with R3 and counsel to ensure understanding and compliance with provisions set forward. The Washington County Long Term Care Ombudsman is scheduled to see R3 the week of June 26, 2023. 2. All residents in the facility have been interviewed regarding inappropriate sexual contact or any other form of abuse with appropriate follow up and reporting to	

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F 600	Continued From page 3 *On 4/19/23 at 4:30 p.m., R3 was watching TV near the office. Staff noticed R3 hold R1's hand, and touching R1's face in the mouth area. The progress note indicated R3 put his finger in R1's mouth, and stopped after he noticed staff observing him. The nurse manager (NM, registered nurse [RN]-D) and the DON were notified. *On 4/22/23 at 1:43 p.m., R3 was in the dining room holding hands with a female resident (unidentified) who kissed R3. Staff informed R3 he could not touch female residents or kiss them. LPN-A notified the supervisor (RN-D) of the interaction. *On 5/20/23 at 2:16 p.m., R3 was observed kissing R1's hand and touching R1's chest (breasts) and neck. RN-A reported the behavior to RN-D. *On 5/22/23 at 9:00 a.m., R3 was observed in R1's resident's room while R1 was in bed. Staff asked R3 to leave the room. RN-A reminded R3 he had been spoken to about this before. RN-A informed the assistant director of nursing (ADON) and social worker (SW)-A of the incident. *On 5/22/23 at 2:34 p.m., SW-A met with R3 to review how to have proper boundaries with peers. R3 acknowledged understanding. *On 5/25/23 at 11:21 a.m., SW-A observed R3 with a female resident in the hallway. The female resident leaned towards R3 and they kissed. The SW separated the residents. R3 stated, "It is okay, and I am not going to stop."	F 600	OHFC as indicated. All current residents have had their vulnerable adult assessments reviewed to ensure they are current and care plans are accurate. Reviews to be completed by June 28, 2023. 3. All staff will receive education on the definition and types of abuse, reporting (including channels of reporting, where to report, emphasis on the timeliness and resources of reporting), communication and notification of concerns, resident relationships with one another, and ageism. All education will be completed by June 28, 2023. 4. The Director of Nursing and/or designee will conduct five audits weekly for one month focusing on interviewing residents for any concerns or allegations of abuse, then two weekly audits for one month. Five random facility staff will be interviewed on care concerns and reporting expectations interviews weekly for one month, then two interviews weekly for one month. Audit results and the data collected will be presented to the QAPI Committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations.	

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F 600	Continued From page 4 *On 6/6/23 at 7:30 p.m., SW-A met with R3 to review behaviors of touching other residents. R3 denied the behavior. R3 was re-educated to not touch other residents, and acknowledged understanding. On 6/5/23 at 12:35 p.m., trained medication aide (TMA)-A was interviewed. TMA-A stated RN-A instructed her to keep R3 out of R1's room. TMA-A further stated she highly doubted R1 wanted R3 to touch her, as R1 was married and R1's husband visited almost daily. TMA-stated if she had witnessed the abuse, she would have reported it to administration. On 6/5/23 at 12:52 p.m., TMA-B stated R3 "targets" R1. TMA-B stated she has witnessed R3 caress R1's face, run his fingers across R1's lips, and kiss R1's hands three times. TMA-B stated she has reported the abuse to RN-A. TMA-B stated on another weekend a nurse called her from the front of the building to ask her to remove R1 from the area as R3 was touching R1 inappropriately. TMA-B stated, "She [R1] gets the furrowed brows when [R3] is touching her." TMA-B further stated, "We all watch [R1]. When we move her where we think she is in a visible place, [R3] still does it. I believe it is sexual abuse or assault. She is not capable of being a consenting partner. I reported it to [RN-A]. " On 6/5/23 at 1:10 p.m., R1 was interviewed. R1 was not able to answer questions verbally, but could nod her head. When asked if she wanted R3 to stop touching her, R1 nodded yes. R1 slowly lifted her right arm/hand a few inches off the bed to shake hands, but could not lift her left arm.	F 600		

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F 600	Continued From page 5 On 6/5/23 at 1:43 p.m., SW-A stated she knew R3 kissed and held hands with a couple of female residents. SW-A stated she reviewed the incident with R1's family member (FM)-A who stated he did not want R1 near R3, and this was updated on R1's care plan. On 6/5/23 at 2:06 p.m., NA-B stated she saw R1 with R3 by the television by the dining room. R3 was touching R1's face. NA-B stated she could not recall what day that was. NA-B stated she thought the behavior was weird because R3's fingers were so close to R1's mouth. NA-B could not recall which nurse she told. On 6/5/23 at 2:14 p.m., nursing assistant (NA)-A stated she found R3 in R1's room once and asked R3 to leave the room. NA-A stated, "Nothing has been done to prevent it. [R1] cannot do anything to prevent [R3] from touching her." NA-A further stated, "He [R3] took his fingers and rubbed them on her [R1] lips and shoved them in and out of her mouth, and grabbed her breasts." NA-A further stated R1 was visibly upset when R1 was left alone with R3 in a room, and NA-A had to reassure R1 she was not going to be left alone with R3. NA-A further stated she saw R3's hand next to R1's breast when R1 was lying in bed. On 6/5/23 at 2:36 p.m., FM-A was interviewed. FM-A stated a nurse had called him to notify him about R3 touching R1 inappropriately on the breasts, and kissing and caressing R1 on the hands. FM-A stated one day, prior to the conversation with the nurse, FM-A visited R1. FM-A stated when he held R1's hand, she pulled away and gave FM-A, "a dirty look." FM-A asked R1 for a kiss when he was leaving for the day as per normal routine, and R1 would not allow FM-A	F 600		

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F 600	Continued From page 6 to kiss her. FM-A stated when he heard about the incident the next day from the nurse he understood why R1 was upset, and stated, "She would not like that kind of attention from him. She would not like it. Absolutely not. I commented to her that she had a boyfriend and she said no." FM-A further stated he was not informed about action taken to prevent further occurrences, and he expected an action plan, but did not get one. FM-A added, "They said they had a meeting and talked about it. She has no ability to fight back. I totally disagree [R1] could fight back or help herself. The bottom line is [R1] couldn't do that." On 6/5/23 at 3:42 p.m., the DON stated she was not aware of R3 touching R1's breasts, but knew there were other behaviors and did not know if the incidents were reported to the state agency. On 6/5/23 at 3:48 p.m., RN-B stated, "I saw him [R3] putting his finger into her [R1] mouth." RN-B stated she informed RN-D and SW-A, and felt the facility did not respond to the abuse allegations. On 6/5/23 at 3:49 p.m., the administrator stated he was not aware of the allegations of abuse, but stated the facility adjusted the care plans to ensure R3 was kept from R1, and advised staff to keep them apart. On 6/5/23 at 5:33 p.m., RN-B stated R1 used to sit in the entrance area and look out the windows, but now she stayed mostly in her room. On 6/6/23 at 8:48 a.m. SW-A stated she implemented a notice to staff on 5/23/23 to observe for resident behaviors of kissing, holding hands, and entering other resident rooms. The notice indicated to redirect the resident (R3) when	F 600		

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F 600	Continued From page 7 it occurs, record a progress note, and update the nurse manager or social services via phone or in person. On 6/6/23 at 9:18 a.m., RN-C stated she was aware of R3 touching R1 by rubbing her arm in the TV area and stated, "It creeped me out and I put her back in her room. She has been staying in her room and he can go anywhere. I was pretty upset about it and said something had to be done; nothing has been done. I said it should have been reported to the State." RN-C stated she reported the incident to RN-D. On 6/6/23 at 9:31 a.m., NA-A stated she observed R3 in R1's room. R3's hand was next to R1's breast, and when NA-A addressed R3, "He got all scared and backed up. He knew he shouldn't be in there. [R1] looked very scared, very, very uncomfortable. I tried to ask if something happened and she would look at me and look away." NA-A further stated, "There was a sign in the front office to make us aware of it, but we all knew. The DON knew. [RN-D] knew and came into the nursing station and talked to us about it." On 6/6/23 at 9:55 a.m., RN-D stated she was aware of the abuse incidents staff reported to her, she did not keep notes about the reports, and conferred with the director of nursing and administrator. RN-D stated it was decided to monitor R3's behavior and keep R3 away from R1. RN-D further stated she would not find the kind of touching R3 was doing with R1 a "comfort" and stated the incidents should have been reported and investigated. RN-D acknowledged R3's care plan lacked interventions to prevent the abuse.	F 600		

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F 600	Continued From page 8 On 6/6/23 at 11:15 a.m., licensed practical nurse (LPN)-A stated she was aware of an incident where R3 touched R1 in the TV area about two months ago, and reported it to RN-D. LPN-A stated nothing had been done to change R3's behavior, and would expect to see behavioral interventions in R3's care plan. LPN-A acknowledged interventions had not been implemented. The Vulnerable Adult/ Maltreatment policy dated 10/22, indicated "Zero Tolerance" for resident abuse. The policy defined mandated reporter as each employee, and defined sexual abuse as non-consensual sexual contact of any type with a resident. The policy further indicated the supervisor, DON, or administrator would determine if the incident was reportable, and immediately institute an internal investigation of reported allegations. The facility implemented the following corrective action to prevent reoccurrence on 6/7/23: - Initiated 1:1 supervision of R3 until R3 was moved to a room away from R1. - Moved R3 to a room on different hallway. - Updated R3's care plan to monitor behaviors of touching other residents. - Updated R1's care plan to allow only female staff to provide care. - Performed a Vulnerable Adult Assessment for both R1 and R3. - Implemented orders to monitor for behaviors each shift. - Implemented retraining with a post-test for all staff about R3's behavior monitoring and the VA reporting policy. This was verified through staff interviews,	F 600		

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F 600	Continued From page 9 observations and document review on 6//7/23.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 immediately report (within two hours) allegations of sexual abuse to the State Agency (SA) for 1 of 3 residents (R1) reviewed	F 609	F609 The preparation of the following plan of correction for this deficiency does not	6/28/23

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F 609	Continued From page 10 for abuse. Findings include: Based on interview, and document review, the facility failed to provide adequate supervision and interventions to prevent sexual abuse of 1 of 3 residents (R1) reviewed for abuse. This resulted in an immediate jeopardy (IJ) for R1 who received unwanted sexual touching by R3 without facility intervention. The IJ began on 4/19/23 at 4:30 p.m., when staff observed R3 hold R1's hand, touch R1's face and mouth, and put his fingers in R1's mouth. The administrator and director of nursing (DON) were notified of the IJ on 6/6/23 at 12:33 p.m. The IJ was removed on 6/7/23 at 11:58 a.m. Findings include: R1's Diagnosis List indicated R1 had a diagnosis of hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following cerebral infarction (stroke) on the non-dominant side. R1's quarterly Minimum Data Set (MDS) dated 5/12/23, indicated R1 had severe cognitive impairment with the ability to rarely or never make decisions, and had speech that was unclear and rarely understood. The MDS further indicated R1 required extensive assistance of one or two staff for activities of daily living (ADLs), and had impairment bilaterally in both her upper and lower extremities. R1's s care plan dated 5/23/22, indicated R1 preferred to not be alone with male peers.	F 609	constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. R1 had their vulnerable adult status reassessed and care plan and NAR care sheets updated as indicated. The event on April 19, 2023, although untimely, was reported to OHFC per facility policy. The event on May 20, 2023, although untimely was reported to OHFC per facility policy. The Washington County Long Term Care Ombudsman is scheduled to see R1 and their responsible party the week of June 26, 2023. R3 agreed to move to a room on another unit in the building, creating a greater distance from R1. R3 had continued counseling and education on not having any contact of with R1, go into her room or ask to speak with her and has been educated on the definition of abuse, the acceptable boundaries between peers and staff with regards to friendships, physical contact and appropriate behavioral instances. The care plan has been updated to include redirection and documentation every day of every shift by licensed staff who will indicate in the EMR any concerns or interactions that are inappropriate, behavioral concerns or communication. Resident has not had	

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F 609	Continued From page 11 R1's electronic medical record lacked documentation of the allegations of sexual abuse by R3. R3's Diagnosis List indicated R3 had diagnoses which included spondylosis (degeneration of the spinal column) and spinal stenosis (abnormal narrowing of the spinal canal). R3's quarterly MDS dated 4/18/23, indicated R3 had intact cognition and was independent in moving around the facility in a wheelchair. R3's care plan dated 3/22/23, indicated R3 had behaviors of holding hands and touching faces of peers "as a sign of comfort," but lacked mention of interventions to prevent touching other peers. R3's progress notes indicated the following: *On 4/19/23 at 4:30 p.m., R3 was watching TV near the office. Staff noticed R3 hold R1's hand, and touching R1's face in the mouth area. The progress note indicated R3 put his finger in R1's mouth, and stopped after he noticed staff observing him. The nurse manager (NM, registered nurse [RN]-D) and the DON were notified. *On 4/22/23 at 1:43 p.m., R3 was in the dining room holding hands with a female resident (unidentified) who kissed R3. Staff informed R3 he could not touch female residents or kiss them. LPN-A notified the supervisor (RN-D) of the interaction. *On 5/20/23 at 2:16 p.m., R3 was observed kissing the hand and touching the chest and neck	F 609	any further contact with R1 nor any inappropriate contact or communication with any other resident in the facility. R3 had their vulnerable adult status reassessed and care plan and NAR care sheets updated as indicated. R3 continues to be seen by Associated Clinic of Psychology, who is onsite weekly to speak with R3 and counsel to ensure understanding and compliance with provisions set forward. The Washington County Long Term Care Ombudsman is scheduled to see R3 the week of June 26, 2023. 2. All residents in the facility have been interviewed regarding inappropriate sexual contact or any other form of abuse with appropriate follow up and reporting to OHFC as indicated. All current residents have had their vulnerable adult assessments reviewed to ensure they are current and care plans are accurate. All facility incidents and feedback forms over the past thirty days have been reviewed to ensure facility is in compliance with state and federal reporting regulations. Reviews to be completed by June 28, 2023. 3. All staff of Birchwood Health Care Center will receive education on the reporting of all alleged violations of abuse and or neglect within 2 hours of the report of alleged abuse. ED or DON will report the allegations through the OHFC portal promptly and immediately conduct an investigation. Birchwood Health Care Center will include as part of the plan of correction the education of policy and procedures that align with CMS guideline of reporting, with emphasis on timeliness	

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F 609	Continued From page 12 of R1. RN-A reported the behavior to RN-D. *On 5/22/23 at 9:00 a.m., R3 was observed in R1's resident's room while R1 was in bed. Staff asked R3 to leave the room. RN-A reminded R3 he had been spoken to about this before. RN-A informed the assistant director of nursing (ADON) and social worker (SW)-A of the incident. *On 5/22/23 at 2:34 p.m., SW-A met with R3 to review how to have proper boundaries with peers. R3 acknowledged understanding. *On 5/25/23 at 11:21 a.m., SW-A observed R3 with a female resident in the hallway. The female resident leaned towards R3 and they kissed. The SW separated the residents. R3 stated, "It is okay, and I am not going to stop." *On 6/6/23 at 7:30 p.m., SW-A met with R3 to review behaviors of touching other residents. R3 denied the behavior. R3 was re-educated to not touch other residents, and acknowledged understanding. On 6/5/23 at 12:52 p.m., TMA-B stated R3 "targets" R1. TMA-B stated she has witnessed R3 caress R1's face, run his fingers across R1's lips, and kiss R1's hands three times. TMA-B stated she has reported the abuse to RN-A. On 6/5/23 at 1:43 p.m., SW-A stated she knew R3 kissed and held hands with a couple of female residents. SW-A stated she reviewed the incident with R1's family member (FM)-A who stated he did not want R1 near R3, and this was updated on R1's care plan. On 6/5/23 at 2:06 p.m., NA-B stated she saw R1	F 609	and importance of ensuring all alleged violations are reported. Education to all staff at Birchwood Care Center about being mandated reporters by ensuring understanding of conduct of Mandated Reporters duty to report any suspicion of abuse or neglect to State or local authorities as well as follow Birchwood Health Care Centers Abuse Prevention Policy. Staff will be educated on the importance of timely reporting as well as the freedom from retaliation or punishment as a result of reporting. All education will be completed by June 28, 2023. 4. The Director of Nursing and/or designee will conduct five audits weekly for one month focusing on interviewing residents for any concerns or allegations of abuse, then two audits weekly for one month. Five random facility staff will be interviewed on care concerns and reporting expectations and timeliness interviews weekly for one month, then two interviews weekly for one month. DON or ED will perform weekly audits on with the focus on reporting and timeliness through interview and review of facility adverse events and feedback forms weekly to ensure facility is in compliance with state and federal reporting regulations for two months. Audit results and the data collected will be presented to the QAPI Committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations.	

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F 609	Continued From page 13 with R3 by the television by the dining room. R3 was touching R1's face. NA-B stated she could not recall what day that was. NA-B stated she thought the behavior was weird because R3's fingers were so close to R1's mouth. NA-B could not recall which nurse she told. On 6/5/23 at 2:14 p.m., nursing assistant (NA)-A stated she found R3 in R1's room once and asked R3 to leave the room. NA-A stated, "Nothing has been done to prevent it. [R1] cannot do anything to prevent [R3] from touching her." On 6/5/23 at 3:42 p.m., the DON stated she was not aware of R3 touching R1's breasts, but knew there were other behaviors and did not know if the incidents were reported. On 6/5/23 at 3:48 p.m., RN-B stated, "I saw him [R3] putting his finger into her [R1] mouth." RN-B stated she informed RN-D and SW-A, and felt the facility did not respond to the abuse allegations. On 6/5/23 at 3:49 p.m., the administrator stated he was not aware of the allegations of abuse, but stated the facility adjusted the care plans to ensure R3 was kept from R1, and advised staff to keep them apart. On 6/6/23 at 9:18 a.m., RN-C stated she was aware of R3 touching R1 by rubbing her arm in the TV area and stated, "It creeped me out and I put her back in her room. She has been staying in her room and he can go anywhere. I was pretty upset about it and said something had to be done; nothing has been done. I said it should have been reported to the State." RN-C stated she reported the incident to RN-D.	F 609		

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F 609	Continued From page 14 On 6/6/23 at 9:31 a.m., NA-A stated she observed R3 in R1's room. R3's hand was next to R1's breast, and when NA-A addressed R3, "He got all scared and backed up. He knew he shouldn't be in there. [R1] looked very scared, very, very uncomfortable. I tried to ask if something happened and she would look at me and look away." NA-A further stated, "There was a sign in the front office to make us aware of it, but we all knew. The DON knew. [RN-D] knew and came into the nursing station and talked to us about it." On 6/6/23 at 9:55 a.m., RN-D stated she was aware of the abuse incidents staff reported to her, she did not keep notes about the reports, and conferred with the director of nursing and administrator. RN-D stated it was decided to monitor R3's behavior and keep R3 away from R1. RN-D further stated she would not find the kind of touching R3 was doing with R1 a "comfort" and stated the incidents should have been reported and investigated. On 6/6/23 at 11:15 a.m., licensed practical nurse (LPN)-A stated she was aware of an incident where R3 touched R1 in the TV area about two months ago, and reported it to RN-D. LPN-A stated nothing had been done to change R3's behavior, and would expect to see behavioral interventions in R3's care plan. LPN-A acknowledged interventions had not been implemented. On 6/6/23 at 2:16 p.m., the DON stated the incident noted in the progress note on 4/19/23, was reported to the SA, (48 days after the incident).	F 609		

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F 609	Continued From page 15 The Vulnerable Adult/Maltreatment policy dated 10/22, indicated "Zero Tolerance" for resident abuse, defined mandated reporter as each employee, and defined sexual abuse as non-consensual sexual contact of any type with a resident. The policy further indicated the supervisor, DON, or administrator would determine if the incident was reportable, and all incidents deemed reportable under Minnesota statute were submitted to the SA immediately but no later than two hours after forming the suspicion.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 investigate allegations of sexual abuse for 1 of 3 residents (R1) reviewed for	F 610	F610 The preparation of the following plan of	6/28/23

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	245200	A. BUILDING _____ B. WING _____	C 06/07/2023

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F 610	Continued From page 16 abuse. Findings include: 1's Diagnosis List indicated R1 had a diagnosis of hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following cerebral infarction (stroke) on the non-dominant side. R1's quarterly Minimum Data Set (MDS) dated 5/12/23, indicated R1 had severe cognitive impairment with the ability to rarely or never make decisions, and had speech that was unclear and rarely understood. The MDS further indicated R1 required extensive assistance of one or two staff for activities of daily living (ADLs), and had impairment bilaterally in both her upper and lower extremities. R1's s care plan dated 5/23/22, indicated R1 preferred to not be alone with male peers. R1's electronic medical record lacked documentation of the allegations of sexual abuse by R3. R3's Diagnosis List indicated R3 had diagnoses which included spondylosis (degeneration of the spinal column) and spinal stenosis (abnormal narrowing of the spinal canal). R3's quarterly MDS dated 4/18/23, indicated R3 had intact cognition and was independent in moving around the facility in a wheelchair. R3's care plan dated 3/22/23, indicated R3 had behaviors of holding hands and touching faces of peers "as a sign of comfort," but lacked mention	F 610	correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. R1 had their vulnerable adult status reassessed and care plan and NAR care sheets updated as indicated. The event on April 19, 2023, was reported to OHFC per facility policy. The event on May 20, 2023, was reported to OHFC per facility policy. The Washington County Long Term Care Ombudsman is scheduled to see R1 and their responsible party the week of June 26, 2023. R3 agreed to move to a room on another unit in the building, creating a greater distance from R1. R3 had continued counseling and education on not having any contact of with R1, go into her room or ask to speak with her and has been educated on the definition of abuse, the acceptable boundaries between peers and staff with regards to friendships, physical contact and appropriate behavioral instances. The care plan has been updated to include redirection and documentation every day of every shift by licensed staff who will indicate in the EMR any concerns or interactions that are inappropriate, behavioral concerns or communication. Resident has not had	

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F 610	Continued From page 17 of interventions to prevent touching other peers. R3's progress notes indicated the following: *On 4/19/23 at 4:30 p.m., R3 was watching TV near the office. Staff noticed R3 hold R1's hand, and touching R1's face in the mouth area. The progress note indicated R3 put his finger in R1's mouth, and stopped after he noticed staff observing him. The nurse manager (NM, registered nurse [RN]-D) and the DON were notified. *On 4/22/23 at 1:43 p.m., R3 was in the dining room holding hands with a female resident (unidentified) who kissed R3. Staff informed R3 he could not touch female residents or kiss them. LPN-A notified the supervisor (RN-D) of the interaction. *On 5/20/23 at 2:16 p.m., R3 was observed kissing the hand and touching the chest and neck of R1. RN-A reported the behavior to RN-D. *On 5/22/23 at 9:00 a.m., R3 was observed in R1's resident's room while R1 was in bed. Staff asked R3 to leave the room. RN-A reminded R3 he had been spoken to about this before. RN-A informed the assistant director of nursing (ADON) and social worker (SW)-A of the incident. *On 5/22/23 at 2:34 p.m., SW-A met with R3 to review how to have proper boundaries with peers. R3 acknowledged understanding. *On 5/25/23 at 11:21 a.m., SW-A observed R3 with a female resident in the hallway. The female resident leaned towards R3 and they kissed. The SW separated the residents. R3 stated, "It is	F 610	any further contact with R1 nor any inappropriate contact or communication with any other resident in the facility. R3 had their vulnerable adult status reassessed and care plan and NAR care sheets updated as indicated. R3 continues to be seen by Associated Clinic of Psychology, who is onsite weekly to speak with R3 and counsel to ensure understanding and compliance with provisions set forward. The Washington County Long Term Care Ombudsman is scheduled to see R3 the week of June 26, 2023. 2. All residents in the facility have been interviewed regarding inappropriate sexual contact or any other form of abuse with appropriate follow up and reporting to OHFC as indicated. All current residents have had their vulnerable adult assessments reviewed to ensure they are current and care plans are accurate. All facility incidents and feedback forms over the past thirty days have been reviewed to ensure facility is in compliance with state and federal reporting regulations with focus on thorough investigation and indicated interventions. All Reviews to be completed by June 28, 2023. 3. All staff will receive education on the process of a formal investigation of alleged and reported abuse. Management and Leadership will be educated on the formal process of investigation of any allegations through education. Birchwood Healthcare Centers ED, DON and Leadership staff will promptly investigate all allegations of abuse upon notification and reporting to	

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F 610	Continued From page 18 okay, and I am not going to stop." *On 6/6/23 at 7:30 p.m., SW-A met with R3 to review behaviors of touching other residents. R3 denied the behavior. R3 was re-educated to not touch other residents, and acknowledged understanding. On 6/5/23 at 1:43 p.m., SW-A stated she was aware of the allegations of sexual abuse by R3. SW-A stated the facility process was to review with the supervisor (RN-D) and the DON to develop a care plan, or to determine if the facility would investigate or report suspected abuse to the State Agency (SA). On 6/5/23 at 3:42 p.m., the DON stated she had been away on leave, but acknowledged she knew R3 had been instructed to stay out of R1's room, and if R3 was near R1 he should be moved away, but was not aware of specific incidents. On 6/5/23 at 3:49 p.m., the administrator stated he knew of care plan interventions to keep R3 and R1 separate, acknowledged he heard about a kiss, but had not heard R1 did not consent to R3 touching her. The administrator further acknowledged SW-A advised staff to keep R3 and R1 apart, informed R1's family of R3's behavior, and further acknowledged knowing R1's family wanted R3 and R1 kept apart. The administrator stated he did not investigate because he inquired to SW-A if there was any behavior of concern, and SW-A said there was not. On 6/6/23 at 8:48 a.m., SW-A stated the incident on 5/20/23, was not investigated.	F 610	OHFC within 2 hours. Investigations will consist of interviews of staff and residents. Immediate review of all interviews will be conducted by the ED and DON to ensure any potential new findings are reported and interventions are implemented. The facility will ensure resident involved in alleged abuse is removed from harm and protected in a safe environment. The residents or any parties involved will be assessed, care plans updated with corrective and preventative interventions. Which may include report to local authority for additional support, contact of State Ombudsman for support, offer of counseling to resident alleged to have received the abuse. Education to resident and staff will be conducted to ensure the safety of all residents so any current or future distress will be handled in support of the resident□s needs. The Education will be completed by 6/28/23. 4. The Director of Nursing and/or designee will conduct five audits weekly for one month focusing on interviewing residents for any concerns or allegations of abuse, then two audits weekly for one month. Five random facility staff will be interviewed on care concerns and investigation process interviews weekly for one month, then two interviews weekly for one month. Executive Director and/or designee will audit facility adverse events and feedback forms weekly to ensure facility is in compliance with state and federal reporting regulations with focus on thorough investigation and indicated interventions for two months, this to	

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F 610	Continued From page 19 On 6/6/23 at 9:55 a.m., RN-D stated she was aware of four incidents in which R3 and R1 were sitting together, including once when R3 touched R1's face, neck, and chest, and of another incident when R3 was found in R1's room. RN-D acknowledged RN-A and RN-C reported the touching incidents to her. RN-D acknowledged LPN-A informed her of the incident in which R3 put his fingers in R1's mouth. RN-D stated she talked to the DON and SW and the facility plan was to keep the residents apart, "To make sure it doesn't get to a point where it crosses a line. She has a right to say no. We have to protect her." RN-D stated she informed the DON about the incident that occurred on 4/19/23 and texted the DON about the incident on 5/20/23. RN-D stated she interviewed R1 about the incidents and stated "She [R1] didn't complain about it." RN-D stated her interviews with R1 were not documented and acknowledged R1, "Would not like him stroking her chest in that area, not on the neck, and not on her face. It would not be a comfort to her." RN-D stated she did not have a good answer about why the incidents were not reported or investigated, and she had not interviewed staff about the incidents. The Vulnerable Adult/ Maltreatment policy dated 10/22, indicated "Zero Tolerance" for resident abuse, defined mandated reporter as each employee, and defined sexual abuse as non-consensual sexual contact of any type with a resident. The policy further indicated the supervisor, DON, or administrator would determine if the incident was reportable, and immediately institute an internal investigation of reported allegations.	F 610	ensure guidelines are followed in the formal investigation of all allegations. Audit results and the data collected will be presented to the QAPI Committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations.	

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2 000	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 6/5/23, through 6/7/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey: H52002549C (MN94048) H52002552C (MN94047) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		