



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,

A handwritten signature in cursive script that reads '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: 1DB1FE-H2

Dear Administrator:

On January 12, 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 November 13, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads '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

An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 19, 2025

Administrator
BIRCHWOOD HEALTH CARE CENTER
604 NE 1ST STREET
Forest Lake, MN, 55025

RE: CCN: 245200

Cycle Start Date: November 13, 2025

Dear Administrator:

On November 13, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On November 9, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 - Free of Accident Hazards/Supervision/Devices was removed.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

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.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 \$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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 13, 2026. 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.

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

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

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.

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** (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

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 Tamika Brown at (312) 353-1502. 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)

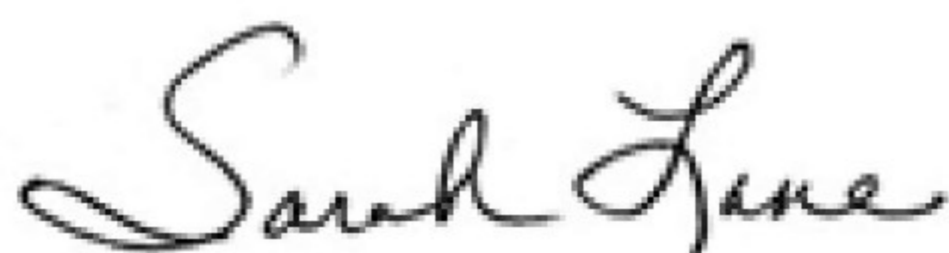
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments 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.

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,



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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December 19, 2025

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

Re: State Nursing Home Licensing Orders

Event ID: 1DB1FE-H1

Dear Administrator:

The above facility survey was completed on November 13, 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/infbulletins/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

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 11/13/2025
NAME OF PROVIDER OR SUPPLIER BIRCHWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On 11/12/25 and 11/13/25, 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.</p> <p>The following complaint was reviewed: H52007424C (2665322 and 2665258) with no licensing order issued.</p>	20000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 11/13/2025
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20000	Continued from page 1 However, as a result of the investigation a licensing order was issued at 0625.	20000		
20625	<p>Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p> <p>Clinical Record Contents; In General</p> <p>CFR(s): MN Rule 4658.0450 Subp. 1 A-P</p> <p>Subpart 1. In general. Each resident's clinical record, including nursing notes, must include:</p> <p>A. the condition of the resident at the time of admission;</p> <p>B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I;</p> <p>C. the resident's height and weight, according to part 4658.0520, subpart 2, item J;</p> <p>D. the resident's general condition, actions, and attitudes;</p> <p>E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;</p> <p>F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods;</p> <p>G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication;</p> <p>H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810;</p> <p>I. reports of laboratory examinations;</p>	20625		

Minnesota State Department of Health

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20625	<p>Continued from page 2</p> <p>J. dates and times of all treatments and dressings;</p> <p>K. dates and times of visits by all licensed health care practitioners;</p> <p>L. visits to clinics or hospitals;</p> <p>M. any orders or instructions relative to the comprehensive plan of care;</p> <p>N. any change in the resident's sleeping habits or appetite;</p> <p>O. pertinent factors regarding changes in the resident's general conditions; and</p> <p>P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to accurately assess elopement risk for 1 of 3 residents (R1) reviewed for elopement.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated 11/3/25, indicated R1 had severe cognitive impairment, diagnoses that included dementia, and had wandering behavior 1-3 days in the 7-day look back period.</p> <p>R1's orders dated 10/29/25, indicated check Wander Guard on right wrist every night.</p> <p>R1's progress notes dated 11/9/25 at 9:11 p.m., indicated R1 eloped out of the chapel doors and neighbors brought R1 back.</p> <p>R1's Elopement Risk Assessment dated 10/29/25, indicated R1 was at risk for elopement with a score of 6 because R1 was able to self-propel her wheelchair, had a history of wandering, exhibited pacing or agitated behavior, was asking to go home, had a diagnosis of dementia, and was currently taking medications which may cause confusion.</p>	20625		

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 11/13/2025
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20625	<p>Continued from page 3</p> <p>R1's Elopement Risk Assessment dated 11/9/25, indicated R1 was at risk for elopement with a score of 5 because R1 was able to self-propel her wheelchair, had a history of wandering, exhibited pacing or agitated behavior, was asking to go home, and had a diagnosis of dementia. The assessment lacked indication R1 had just eloped from the facility, family had just voiced concern about R1's elopement, and R1 was taking a medication that may cause confusion.</p> <p>R1's care plan dated 10/29/25, indicated R1 was an elopement risk and used a Wander Guard (security device that prevents residents at risk of wandering from leaving a designated area). The care plan further indicated R1 had impaired physical mobility and required a wheelchair for locomotion and had cognitive loss/dementia with deficits in memory/recall ability, judgement, decision-making and thought process related to anoxic brain damage with an intervention to supervise and assist with all decision-making.</p> <p>During an interview on 11/12/25 at 3:35 p.m., registered nurse (RN)-A stated after R1 eloped on 11/9/25, she performed an updated Elopement Risk assessment with R1, per policy after an elopement. RN-A stated R1 scored a 5, indicating elopement risk. RN-A acknowledged she had not reviewed the previous assessment, in which R1 scored a 6. Upon review of the assessment, RN-A stated she should have indicated R1 was taking a medication that was sedating because R1 was taking Seroquel which could contribute to an altered mental state. RN-A further acknowledged she should have scored a point for the elopement that just occurred, and should have scored a point for family who voiced concerned as R1's husband voiced concerns when RN-A notified him of R1's elopement. RN-A acknowledged it was not an accurate assessment, and stated she would update it.</p> <p>During an interview on 11/13/25 at 11:38 a.m., the director of nursing (DON) stated R1's elopement triggered RN-A to perform a new Elopement Risk Assessment, so RN-A should have known to assign a point for the elopement. The DON stated RN-A should have reviewed R1's medication list when it was completed to ensure accuracy of the assessment. The DON acknowledged the assessment was not accurate and had not been updated yet.</p>	20625		

Minnesota State Department of Health

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20625	<p>Continued from page 4 The Elopement Risk policy dated 5/24, indicated residents who scored 4 or more on the Elopement Risk Assessment required interventions that may include using a Wander Guard, and further stipulated a new assessment would be completed every 90 days and with attempted elopement.</p> <p>SUGGESTED METHOD OF CORRECTION:</p> <p>The Director of Nursing or designee person could review policies and procedures and provide education for accurate elopement risk assessments, and about accuracy of documentation requirements. The DON or designee could revise as necessary, educate staff on revisions, and monitor to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: twenty-one (21) days.</p>	20625		

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 11/13/2025
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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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(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
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F0000	<p>INITIAL COMMENTS</p> <p>On 11/12/25 and 11/13/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed: H52007424C (2665322 and 2665258) and a deficiency was issued at F689 at PAST NON-COMPLIANCE.</p> <p>However, as a result of the investigation, a deficiency was cited at F842.</p> <p>The immediate jeopardy began on 11/9/25 when R1 exited the facility chapel door at 6:25 p.m. The facility was made aware of R1 missing after CM-A arrived at the facility at 6:44 p.m., with R1 who was found two blocks away. The facility director of nursing (DON), administrator, regional nurse consultant (RNC), and regional director of operations (RDO) were notified of the immediate jeopardy on 11/13/25 at 5:02 p.m. The facility had implemented corrective action and therefore being cited as past non-compliance.</p> <p>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.</p> <p>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.</p>	F0000		
F0689 SS = SQC-J	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free</p>	F0689	"Past Noncompliance - no plan of correction required"	

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
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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 11/13/2025
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F0689 SS = SQC-J	<p>Continued from page 1 of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, observation, and document review the facility failed to provide adequate supervision resulting in the likelihood of serious harm, injury, impairment, or death for 1 of 3 residents (R1) who was assessed to be at risk for elopement, had exit seeking behavior, and wore a WanderGuard (security device that prevents residents at risk of wandering from a designated area). The facility's failure resulted in an immediate jeopardy when R1 exited the building without staff knowledge and was returned to the facility by a community member (CM)-A.</p> <p>The immediate jeopardy began on 11/9/25 when R1 exited the facility chapel door at 6:25 p.m. The facility was made aware of R1 missing after CM-A arrived at the facility at 6:44 p.m., with R1 who was found two blocks away. The facility director of nursing (DON), administrator, regional nurse consultant (RNC), and regional director of operations (RDO) were notified of the immediate jeopardy on 11/13/25 at 5:02 p.m. The facility had implemented corrective action and therefore being cited as past non-compliance.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) assessment, dated 11/3/25, indicated R1 had severe cognitive impairment, diagnoses of dementia, muscle weakness, required a wheelchair for locomotion, and had wandering behavior 1-3 days in the 7-day look back period.</p> <p>The facility Office of Health Facility Complaint (OHFC) report dated 11/9/25 at 9:00 p.m., indicated CM-A was driving and saw R1 on 11/9/25 at approximately 5:45 p.m., sitting in a wheelchair on the side of the road two blocks from the facility, in the dark, waving her hands frantically. CM-A indicated in the report R1 stated she was from another town, and didn't know how she got to her current location. CM-A noticed a sticker on R1's wheelchair identified the facility name, CM-A walked R1 back to the facility. A staff came to the door to let R1 in and stated they had no idea R1 was out of the facility.</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 2</p> <p>R1's care plan dated 10/29/25, indicated R1 was an elopement risk and used a WanderGuard. The care plan further indicated R1 had impaired physical mobility and required a wheelchair for locomotion and had cognitive loss/dementia with deficits in memory/recall ability, judgement, decision-making and thought process related to anoxic brain damage (brain loses oxygen supply) with an intervention to supervise and assist with all decision-making.</p> <p>R1's orders dated 10/29/25, indicated check WanderGuard on right wrist every night.</p> <p>R1's progress notes dated 11/9/25 at 9:11 p.m., indicated R1 eloped out of the chapel doors and neighbors brought R1 back. 1:1 supervision was implemented when resident was out of bed, and 15-minute checks when in bed.</p> <p>R1's Elopement Risk Assessment dated 10/29/25 indicated a score of 6. A score of 4 or greater indicates the potential for elopement.</p> <p>On 11/13/25 at 11:35 a.m., review of facility surveillance revealed on 11/9/25 the following occurred:</p> <p>-6:26:40 p.m. R1 was observed exiting the chapel door, activating WanderGuard alarm</p> <p>-6:27:03 p.m. R1 was observed to push on keypad button and then pushed on secured exit door handle</p> <p>-6:29:38p.m. R1 was observed to push secured exit door greater than 30 seconds, engaging fire safety feature and exited the building.</p> <p>-6:29:58 p.m. (3 minutes, 18 seconds from first alarm activating) NA-A appeared, silenced alarm, briefly looked through the door outside (did not step outside).</p> <p>-6:30:35 p.m. NA-A proceeds back to work.</p> <p>-6:40:10 p.m. (11 minutes 12 seconds) R1 returned to the facility by CM-A to front entry way.</p> <p>- In the video footage, R1 was noted in the video to be wearing a flannel shirt with gray undershirt, black sweatpants, slippers and socks. Additionally, R1 had</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 3 what appeared to resemble a throw or light blanket covering her thighs to just below her knees.</p> <p>Review of the weather on 11/9/25 from the Weather Channel revealed the daily temperature in Forest Lake was 29 degrees Fahrenheit with possibility of some snow flurries.</p> <p>During an observation on 11/12/25 at 1:12 p.m., R1 was observed in a wheelchair, wearing a WanderGuard on her right wrist, and used her arms to propel the wheelchair to move around the facility hallways and moved very quickly. R1 attempted to wander into the kitchen, but staff intervened before R1 could enter.</p> <p>During an interview on 11/12/25 at 1:45 p.m., registered nurse (RN)-B stated she was notified on 11/9/25 at 6:56 p.m., of R1's elopement after R1 returned, and RN-A informed her a neighbor brought R1 back to the facility. RN-B notified the director of nursing (DON) at 7:01 p.m., and the administrator at 7:39 p.m. The DON called RN-B at 9:14 p.m., and instructed RN-B to educate staff to not turn off the alarms until all risks (residents who wore WanderGuard bracelets) were accounted for. RN-B started the education on 11/9/25, as instructed. RN-B stated most of the time when the alarm was activated, the resident was nearby. RN-B was not sure why a Code Green was not initiated. Further, RN-B stated R1 was very quick, and very impulsive.</p> <p>During an interview on 11/12/25 at 3:22 p.m., R1's family member (FM)-A stated he was notified of R1's elopement on 11/9/25 at 7:15 p.m., and staff had notified him four days ago, on 11/8/25, the facility needed to move R1 to another facility because R1 kept trying to get out of the facility. R1 was not injured, but if she had kept going straight she would have gotten behind the church and they wouldn't have found her. FM-A said that Sunday night (11/9/25) it was very windy and cold.</p> <p>During an interview on 11/12/25 at 3:35 p.m., RN-A stated she was working on 11/9/25 when R1 eloped. RN-A stated she was on break and received a call from staff when R1 was brought back to the facility by a neighbor. RN-A checked her phone and saw R1's Wander Guard alarm activated at 6:29 p.m. and R1 exited through the chapel doors. RN-A interviewed staff and found nursing assistant (NA)-A disabled the alarms, and did not go</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 4 outside to look for a missing resident. RN-A stated NA-A acknowledged he turned off the outside door alarm but not the chapel door alarm, but both would have required a code to deactivate. RN-A further acknowledged a Code Green (missing resident) was not initiated because staff was not aware R1 was missing. RN-A stated she met with all five NAs working, explained elopement was serious and if it had been colder and she had not been found, R1 would have died. RN-A instructed the NAs to check for missing residents with each activated alarm.</p> <p>During an interview on 11/13/25 at 10:01 a.m., NA-A acknowledged he was working when R1 eloped. NA-A was coming out of a room when he heard the alarm, deactivated the alarm, looked around, and looked out the door to the parking lot but didn't see anyone. NA-A stated he deactivated the alarm to the door that led to the parking lot, but not the chapel door alarm, as it had not activated. NA-A stated he did not call a Code Green because he didn't know anyone was gone.</p> <p>During an interview on 11/13/25 at 11:29 a.m., the administrator stated video footage indicated NA-A deactivated the WanderGuard alarm for R1 on 11/9/25.</p> <p>During an interview on 11/13/25 at 11:38 a.m., the DON stated NA-A turned off both alarms, looked for a resident without going outside, did not alert any other staff, and NA-A failed to call a Code Green (missing resident) per the facility policy, and should have. The facility staff learned R1 was missing after a community member brought R1 back. The DON stated R1 was not safe to be outside alone, which was why she wore a WanderGuard. The DON stated staff education started on 11/9/25, after the elopement, to ensure staff would account for each resident who wore a WanderGuard prior to deactivating a WanderGuard alarm.</p> <p>During an interview on 11/13/25 at 1:37 p.m., NA-B stated staff education started on 11/9/25, to leave the alarm on until all the residents who wore Wander Guards were accounted for, and that had always been the policy. We are supposed to call a code green when the alarm goes off and a resident is not accounted for near the alarm.</p> <p>The Elopement Risk policy dated 5/24, indicated residents who scored 4 or more on the Elopement Risk</p>	F0689		

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F0689 SS = SQC-J	Continued from page 5 Assessment required interventions that may include using a Wander Guard. Residents who had an attempted elopement required a new review, and all residents who wore the WanderGuard were not to be outside the building without staff or family members. The past non-compliance immediate jeopardy began on 11/9/25. The immediate jeopardy was removed and the deficient practice corrected by 11/9/25, after the facility implemented a systemic plan that included the following actions: Upon R1 returning to the facility, R1 was assessed for injuries. R1 was placed on 1:1 staffing upon return. 15-minute observations following. Nursing assistant (NA)-A was suspended, was verbally retrained but remains on suspension until he gets a full retraining. All Wander Guard systems (exits and bracelets) were tested and found to be in working condition. (Testing continues to meet Manufacturer's recommendations). Training started 11/9/25, to ensure alarms are not shut off before residents at risk for elopement and wearing a Wander Guard are accounted for. R1's care plan was updated to include 1:1 initially, then 15 min checks when R1 went to bed. Activity staff increased activity options for R1 to assist with distraction. Doors to R1's unit to be shut at night to limit R1's movement to her own unit for increased supervision. Staff was educated on the care plan revisions.	F0689		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F0842		

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F0842 SS = D	<p>Continued from page 6</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p>	F0842		

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F0842 SS = D	<p>Continued from page 7</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to accurately assess elopement risk for 1 of 3 residents (R1) reviewed for elopement.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated 11/3/25, indicated R1 had severe cognitive impairment, diagnoses that included dementia, and had wandering behavior 1-3 days in the 7-day look back period.</p> <p>R1's orders dated 10/29/25, indicated check Wander Guard on right wrist every night.</p> <p>R1's progress notes dated 11/9/25 at 9:11 p.m., indicated R1 eloped out of the chapel doors and neighbors brought R1 back.</p> <p>R1's Elopement Risk Assessment dated 10/29/25, indicated R1 was at risk for elopement with a score of 6 because R1 was able to self-propel her wheelchair, had a history of wandering, exhibited pacing or agitated behavior, was asking to go home, had a diagnosis of dementia, and was currently taking medications which may cause confusion.</p> <p>R1's Elopement Risk Assessment dated 11/9/25, indicated R1 was at risk for elopement with a score of 5 because R1 was able to self-propel her wheelchair, had a history of wandering, exhibited pacing or agitated behavior, was asking to go home, and had a diagnosis of dementia. The assessment lacked indication R1 had just eloped from the facility, family had just voiced concern about R1's elopement, and R1 was taking a</p>	F0842		

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F0842 SS = D	<p>Continued from page 8 medication that may cause confusion.</p> <p>R1's care plan dated 10/29/25, indicated R1 was an elopement risk and used a Wander Guard (security device that prevents residents at risk of wandering from leaving a designated area). The care plan further indicated R1 had impaired physical mobility and required a wheelchair for locomotion and had cognitive loss/dementia with deficits in memory/recall ability, judgement, decision-making and thought process related to anoxic brain damage with an intervention to supervise and assist with all decision-making.</p> <p>During an interview on 11/12/25 at 3:35 p.m., registered nurse (RN)-A stated after R1 eloped on 11/9/25, she performed an updated Elopement Risk assessment with R1, per policy after an elopement. RN-A stated R1 scored a 5, indicating elopement risk. RN-A acknowledged she had not reviewed the previous assessment, in which R1 scored a 6. Upon review of the assessment, RN-A stated she should have indicated R1 was taking a medication that was sedating because R1 was taking Seroquel which could contribute to an altered mental state. RN-A further acknowledged she should have scored a point for the elopement that just occurred, and should have scored a point for family who voiced concerned as R1's husband voiced concerns when RN-A notified him of R1's elopement. RN-A acknowledged it was not an accurate assessment, and stated she would update it.</p> <p>During an interview on 11/13/25 at 11:38 a.m., the director of nursing (DON) stated R1's elopement triggered RN-A to perform a new Elopement Risk Assessment, so RN-A should have known to assign a point for the elopement. The DON stated RN-A should have reviewed R1's medication list when it was completed to ensure accuracy of the assessment. The DON acknowledged the assessment was not accurate and had not been updated yet.</p> <p>The Elopement Risk policy dated 5/24, indicated residents who scored 4 or more on the Elopement Risk Assessment required interventions that may include using a Wander Guard, and further stipulated a new assessment would be completed every 90 days and with attempted elopement.</p>	F0842		